



Commonwealth of Kentucky

MASTER AGREEMENT

CONTRACT INFORMATION

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Document Description: Medicaid Managed Care Organization (MCO) - All Regions

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COMMODITY / SERVICE INFORMATION

| Line | Quantity | UOM | Unit Price | Service Amount | Service From | Service To | Line Total |
|------|----------|-----|------------|----------------|--------------|------------|------------|
| 1 | 0.00000 | EA | \$0.000000 | \$0.00 | | | \$0.00 |

Medicaid Managed Care Organization (MCO) - All Regions

Extended Description:

Provided managed care services for Kentucky Medicaid recipients.

Estimated Rates contained in the contract are set by the Department within the actuarially sound range developed by the Department's Actuarial Contractor. These rates are subject to final approval by CMS.

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MASTER AGREEMENT
FOR
MEDICAID MANAGED CARE ORGANIZATION (MCO) - ALL REGIONS
BETWEEN
THE COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES (CHFS)
AND
AETNA BETTER HEALTH OF KENTUCKY INSURANCE COMPANY
(D/B/A AETNA BETTER HEALTH OF KENTUCKY, INC.)
9900 CORPORATE CAMPUS DRIVE, SUITE 1000
LOUISVILLE, KENTUCKY 40223

This Master Agreement ("Contract", "Award", or "Agreement") is entered into, by and between the Commonwealth of Kentucky ("Commonwealth") and Aetna Better Health of Kentucky Insurance Company, d/b/a Aetna Better Health of Kentucky, Inc. ("Contractor", "Vendor", or "Aetna"), to provided managed care services for Kentucky Medicaid recipients.

The Commonwealth and the Contractor agree to the following:

I. SCOPE OF CONTRACT

Aetna Better Health of Kentucky Insurance Company, d/b/a Aetna Better Health of Kentucky, Inc. shall provide a Medicaid Managed Care Organization (MCO) for all regions of the Commonwealth to deliver the highest quality health care services to Kentucky Medicaid Members at the most favorable, competitive prices.

Services shall be delivered in accordance with the Medicaid Managed Care Contract and Appendices found herein.

The initial term of the contract shall be effective July 01, 2020 through December 31, 2025 as in accordance with Section IV (50.2) of this agreement.

II. NEGOTIATED TERMS

The Commonwealth is not willing to entertain negotiations; this Agreement excludes any exceptions and deviations to RFP 758 1900000093.

III. SUMMARY OF FINANCIALS

Capitated Rates contained in the contract are set by the Department within the actuarially sound range developed by the Department's Actuarial Contractor. These rates are subject to final approval by CMS.

IV. TERMS AND CONDITIONS

To the extent unmodified by the above Sections I - III of this Contract, the following sections are incorporated pursuant to RFP 758 1900000093. In the event of any conflict between the following Sections 40 and 50 and the previous Sections I - III, the terms in Sections I - III shall prevail.

SECTION 40 – PROCUREMENT REQUIREMENTS

40.1 Procurement Requirements

Procurement requirements are listed under “Procurement Laws, Preference, Regulations and Policies” and “Response to Solicitation” located on the eProcurement Web page at <http://eprocurement.ky.gov> and <http://finance.ky.gov/services/eprocurement/Pages/VendorServices.aspx> respectively. The vendor must comply with all applicable statutes, regulations and policies related to this procurement.

40.2 Contract Components and Order of Precedence

The Commonwealth's acceptance of the contractor's offer in response to the solicitation, indicated by the issuance of a contract award by the Office of Procurement Services, shall create a valid contract between the Parties consisting of the following:

1. Procurement Statutes, Regulations, and Policies;
2. This written Agreement (Contract) between the Parties and any written amendments thereto;
3. Any Addenda to the Solicitation;
4. The Solicitation and all attachments;
5. Any Best and Final Offer;
6. Any clarifications concerning the Contractor's proposal in response to the Solicitation;
7. The Contractor's proposal in response to the Solicitation.

In the event of any conflict between or among the provisions contained in the contract, the order of precedence shall be as enumerated above.

40.3 Final Agreement

The contract represents the entire agreement between the parties with respect to the subject matter hereof. Prior negotiations, representations, or agreements, either written or oral, between the parties hereto relating to the subject matter hereof shall be of no effect upon this contract.

40.4 Contract Provisions

If any provision of this contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the Commonwealth and the contractor shall be relieved of all obligations arising under such provision. If the remainder of this contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed.

40.5 Type of Contract

The contract proposed in response to this solicitation shall be on the basis of a **firm fixed unit price** for the elements listed in this solicitation. This solicitation is specifically not intended to solicit proposals for contracts on the basis of cost-plus, open-ended rate schedule, nor any non-fixed price arrangement.

40.6 Contract Usage

As a result of this RFP, the contractual agreement with the selected vendor will in no way obligate the Commonwealth of Kentucky to purchase any services or equipment under this contract. The Commonwealth agrees, in entering into any contract, to purchase only such services in such quantities as necessary to meet the actual requirements as determined by the Commonwealth.

40.7 Addition or Deletion of Items or Services

The Office of Procurement Services reserves the right to add new and similar items, by issuing a contract modification, to this contract with the consent of the vendor. Until such time as the vendor receives a modification, the vendor shall not accept delivery orders from any agency referencing such items or services.

40.8 Changes and Modifications to the Contract

Pursuant to KRS 45A.210 (1) and 200 KAR 5:311, no modification or change of any provision in the contract shall be made, or construed to have been made, unless such modification is mutually agreed to in writing by the contractor and the Commonwealth, and incorporated as a written amendment to the contract and processed through the Office of Procurement Services and approved by the Finance and Administration Cabinet prior to the effective date of such modification or change pursuant to KRS 45A.210(1) and 200 KAR 5:311. Memorandum of understanding, written clarification, and/or correspondence shall not be construed as amendments to the contract.

If the contractor finds at any time that existing conditions made modification of the contract necessary, it shall promptly report such matters to the Commonwealth Buyer for consideration and decision.

40.9 Changes in Scope

The Commonwealth may, at any time by written order, make changes within the general scope of the contract. No changes in scope are to be conducted except at the approval of the Commonwealth.

40.10 Contract Conformance

If the Commonwealth Buyer determines that deliverables due under the contract are not in conformance with the terms and conditions of the contract and the mutually agreed-upon project plan, the Buyer may request the contractor to deliver assurances in the form of additional contractor resources and to demonstrate that other major schedules will not be affected. The Commonwealth shall determine the quantity and quality of such additional resources and failure to comply may constitute default by the contractor.

40.11 Assignment

The contract shall not be assigned in whole or in part without the prior written consent of the Commonwealth Buyer.

40.12 Payment

The Commonwealth will make payment within thirty (30) working days of receipt of contractor's invoice or of acceptance of goods and/or services in accordance with KRS 45.453 and KRS 45.454.

Payments are predicated upon successful completion and acceptance of the described work, services, supplies, or commodities, and delivery of the required documentation. Invoices for payment shall be submitted to the agency contact person or his representative.

40.13 Contractor Cooperation in Related Efforts

The Commonwealth of Kentucky may undertake or award other contracts for additional or related work, services, supplies, or commodities, and the contractor shall fully cooperate with such other contractors and Commonwealth employees. The contractor shall not commit or permit any act that will interfere with the performance of work by any other contractor or by Commonwealth employees.

40.14 Contractor Affiliation

"Affiliate" shall mean a branch, division or subsidiary that is effectively controlled by another party. If any affiliate of the contractor shall take any action that, if done by the contractor, would constitute a breach of this agreement, the same shall be deemed a breach by such party with like legal effect.

40.15 Commonwealth Property

The contractor shall be responsible for the proper custody and care of any Commonwealth-owned property furnished for contractor's use in connections with the performance of this contract. The contractor shall reimburse the Commonwealth for its loss or damage, normal wear and tear excepted.

40.16 Confidentiality of Contract Terms

The contractor and the Commonwealth agree that all information communicated between them before the effective date of the contract shall be received in strict confidence and shall not be necessarily disclosed by the receiving party, its agents, or employees without prior written consent of the

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other party. Such material will be kept confidential subject to Commonwealth and Federal public information disclosure laws.

Upon signing of the contract by all parties, terms of the contract become available to the public, pursuant to the provisions of the Kentucky Revised Statutes.

The contractor shall have an appropriate agreement with its subcontractors extending these confidentiality requirements to all subcontractors' employees.

40.17 Confidential Information

The contractor shall comply with the provisions of the Privacy Act of 1974 and instruct its employees to use the same degree of care as it uses with its own data to keep confidential information concerning client data, the business of the Commonwealth, its financial affairs, its relations with its citizens and its employees, as well as any other information which may be specifically classified as confidential by the Commonwealth in writing to the contractor. All Federal and State Regulations and Statutes related to confidentiality shall be applicable to the contractor. The contractor shall have an appropriate agreement with its employees, and any subcontractor employees, to that effect, provided however, that the foregoing will not apply to:

- A. Information which the Commonwealth has released in writing from being maintained in confidence;
- B. Information which at the time of disclosure is in the public domain by having been printed or published and available to the public in libraries or other public places where such data is usually collected; or
- C. Information, which, after disclosure, becomes part of the public domain as defined above, through no act of the contractor.

40.18 Advertising Award

The contractor shall not refer to the award of contract in commercial advertising in such a manner as to state or imply that the firm or its services are endorsed or preferred by the Commonwealth of Kentucky without the expressed written consent of the agency technical contact person. (see Section 50.4)

40.19 Patent or Copyright Infringement

The contractor shall report to the Commonwealth promptly and in reasonable written detail, each notice of claim of patent or copyright infringement based on the performance of this contract of which the contractor has knowledge.

The Commonwealth agrees to notify the contractor promptly, in writing, of any such claim, suit or proceeding, and at the contractor's expense give the contractor proper and full information needed to settle and/or defend any such claim, suit or proceeding.

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If, in the contractor's opinion, the equipment, materials, or information mentioned in the paragraphs above is likely to or does become the subject of a claim or infringement of a United States patent or copyright, then without diminishing the contractor's obligation to satisfy any final award, the contractor may, with the Commonwealth's written consent, substitute other equally suitable equipment, materials, and information, or at the contractor's options and expense, obtain the right for the Commonwealth to continue the use of such equipment, materials, and information.

The Commonwealth agrees that the contractor has the right to defend, or at its option, to settle and the contractor agrees to defend at its own expense, or at its option to settle, any claim, suit or proceeding brought against the Commonwealth on the issue of infringement of any United States patent or copyright or any product, or any part thereof, supplied by the contractor to the Commonwealth under this agreement. The contractor agrees to pay any final judgment entered against the Commonwealth on such issue in any suit or proceeding defended by the contractor.

If principles of governmental or public law are involved, the Commonwealth may participate in the defense of any such action, but no costs or expenses shall be incurred for the account of the contractor without the contractor's written consent.

The contractor shall have no liability for any infringement based upon:

- A. the combination of such product or part with any other product or part not furnished to the Commonwealth by the contractor
- B. the modification of such product or part unless such modification was made by the contractor
- C. the use of such product or part in a manner for which it was not designed

40.20 Permits, Licenses, Taxes and Commonwealth Registration

The contractor shall procure all necessary permits and licenses and abide by all applicable laws, regulations, and ordinances of all Federal, State, and local governments in which work under this contract is performed.

The contractor shall maintain certification of authority to conduct business in the Commonwealth of Kentucky during the term of this contract. Such registration is obtained from the Secretary of State, who will also provide the certification thereof. However, the contractor need not be registered as a prerequisite for responding to the RFP. Additional local registration or license may be required.

The contractor shall pay any sales, use, and personal property taxes arising out of this contract and the transaction contemplated hereby. Any other taxes levied upon this contract, the transaction, or the equipment or services delivered pursuant hereto shall be borne by the contractor.

40.21 EEO Requirements

The Equal Employment Opportunity Act of 1978 applies to All State government projects with an estimated value exceeding \$500,000. The contractor shall comply with all terms and conditions of the Act.

<http://finance.ky.gov/services/eprocurement/Pages/VendorServices.aspx>.

40.22 Provisions for Termination of the Contract

Any contract resulting from this solicitation shall be subject to the termination provisions set forth in 200 KAR 5:312.

40.23 Bankruptcy

In the event the contractor becomes the subject debtor in a case pending under the Federal Bankruptcy Code, the Commonwealth's right to terminate this contract may be subject to the rights of a trustee in bankruptcy to assume or assign this contract. The trustee shall not have the right to assume or assign this contract unless the trustee (a) promptly cures all defaults under this contract; (b) promptly compensates the Commonwealth for the monetary damages incurred as a result of such default, and (c) provides adequate assurance of future performance, as determined by the Commonwealth.

40.24 Conformance with Commonwealth & Federal Laws/Regulations

This contract shall be governed by and construed in accordance with the laws of the Commonwealth of Kentucky. Any action brought against the Commonwealth on the contract, including but not limited to actions either for breach of contract or for enforcement of the contract, shall be brought in Franklin Circuit Court, Franklin County, Kentucky in accordance with KRS 45A.245.

40.25 Accessibility

Vendor hereby warrants that the products or services to be provided under this contract comply with the accessibility requirements of Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794d), and its implementing regulations set forth at Title 36, Code of Federal Regulations, part 1194. Vendor further warrants that the products or services to be provided under this contract comply with existing federal standards established under Section 255 of the Federal Telecommunications Act of 1996 (47 U.S.C. § 255), and its implementing regulations set forth at Title 36, Code of Federal Regulations, part 1193, to the extent the vendor's products or services may be covered by that act. Vendor agrees to promptly respond to and resolve any complaint regarding accessibility of its products or services which is brought to its attention.

40.26 Access to Records

The state agency certifies that it is in compliance with the provisions of KRS 45A.695, "Access to contractor's books, documents, papers, records, or other evidence directly pertinent to the contract." The Contractor, as defined in KRS 45A.030, agrees that the contracting agency, the Finance and Administration Cabinet, the Auditor of Public Accounts, and the Legislative Research Commission, or their duly authorized representatives, shall have access to any books, documents, papers, records, or other evidence, which are directly pertinent to this agreement for the purpose of financial audit or program review. The Contractor also recognizes that any books, documents, papers, records, or other evidence, received during a financial audit or program review shall be subject to the Kentucky Open Records Act, KRS 61.870 to 61.884. Records and other prequalification information confidentially disclosed as part of the bid process shall not be deemed as directly pertinent to the agreement and shall be exempt from disclosure as provided in KRS 61.878(1)(c).

40.27 Prohibitions of Certain Conflicts of Interest

In accordance with KRS 45A.340, the contractor represents and warrants, and the Commonwealth relies upon such representation and warranty, that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services. The contractor further represents and warrants that in the performance of the contract, no person, including any subcontractor, having any such interest shall be employed.

In accordance with KRS 45A.340 and KRS 11A.040 (4), the contractor agrees that it shall not knowingly allow any official or employee of the Commonwealth who exercises any function or responsibility in the review or approval of the undertaking or carrying out of this contract to voluntarily acquire any ownership interest, direct or indirect, in the contract prior to the completion of the contract.

40.28 No Contingent Fees

No person or selling agency shall be employed or retained or given anything of monetary value to solicit or secure this contract, excepting bona fide employees of the offeror or bona fide established commercial or selling agencies maintained by the offeror for the purpose of securing business. For breach or violation of this provision, the Commonwealth shall have the right to reject the proposal or cancel the contract without liability.

40.29 Vendor Response and Proprietary Information

The RFP specifies the format, required information, and general content of proposals submitted in response to the RFP. ***The Finance and Administration Cabinet will not disclose any portions of the proposals prior to Contract Award to anyone outside the Finance and Administration Cabinet, representatives of the agency for whose benefit the contract is proposed, representatives of the Federal Government, if required, and the members of the evaluation committees.*** After a contract is awarded in whole or in part, the Commonwealth shall have the

right to duplicate, use, or disclose all proposal data submitted by vendors in response to this RFP as a matter of public record. Although the Commonwealth recognizes the vendor's possible interest in preserving selected data which may be part of a proposal, the Commonwealth must treat such information as provided by the Kentucky Open Records Act, KRS 61.870 et sequitur.

Informational areas which normally might be considered proprietary shall be limited to **individual personnel data, customer references, selected financial data, formulae, and financial audits** which, if disclosed, would permit an unfair advantage to competitors. If a proposal contains information in these areas that a vendor declares proprietary in nature and not available for public disclosure, the **vendor shall declare in the Transmittal Letter [see Section 60.6 (A)] the inclusion of proprietary information and shall noticeably label as proprietary each sheet containing such information. Proprietary information shall be submitted under separate sealed cover marked "Proprietary Data"**. Proposals containing information declared by the vendor to be proprietary, either in whole or in part, outside the areas listed above may be deemed non-responsive to the RFP and may be rejected.

40.30 Contract Claims

The Parties acknowledge that KRS 45A.225 to 45A.290 governs contract claims.

40.31 Limitation of Liability

The liability of the Commonwealth related to contractual damages is set forth in KRS 45A.245

40.32 Discrimination (Effective April 8, 2015)

Discrimination (because of race, religion, color, national origin, sex, sexual orientation, gender identity, age, or disability) is prohibited. This section applies only to contracts utilizing federal funds, in whole or in part. During the performance of this contract, the contractor agrees as follows:

1. The contractor will not discriminate against any employee or applicant for employment because of race, religion, color, national origin, sex, sexual orientation, gender identity, or age. The contractor further agrees to comply with the provisions of the Americans with Disabilities Act (ADA), Public Law 101-336, and applicable federal regulations relating thereto prohibiting discrimination against otherwise qualified disabled individuals under any program or activity. The contractor agrees to provide, upon request, needed reasonable accommodations. The contractor will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, national origin, sex, sexual orientation, gender identity, age or disability. Such action shall include, but not be limited to the following; employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensations; and selection for training, including apprenticeship. The

- contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this non-discrimination clause.
2. The contractor will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to race, religion, color, national origin, sex, sexual orientation, gender identity, age or disability.
 3. The contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice advising the said labor union or workers' representative of the contractor's commitments under this section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment. The contractor will take such action with respect to any subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions, including sanctions for noncompliance.
 4. The contractor will comply with all provisions of Executive Order No. 11246 of September 24, 1965 as amended, and of the rules, regulations and relevant orders of the Secretary of Labor.
 5. The contractor will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, as amended, and by the rules, regulations and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations and orders.
 6. In the event of the contractor's noncompliance with the nondiscrimination clauses of this contract or with any of the said rules, regulations or orders, this contract may be cancelled, terminated or suspended in whole or in part and the contractor may be declared ineligible for further government contracts or federally-assisted construction contracts in accordance with procedures authorized in Executive Order No. 11246 of September 24, 1965, as amended, and such other sanctions may be imposed and remedies invoked as provided in or as otherwise provided by law.
 7. The contractor will include the provisions of paragraphs (1) through (7) of section 202 of Executive Order 11246 in every subcontract or purchase order unless exempted by rules, regulations or orders of the Secretary of Labor, issued pursuant to section 204 of Executive Order No. 11246 of September 24, 1965, as amended, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions including sanctions for noncompliance; provided, however, that in the event a contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the agency, the contractor may request the United States to enter into such litigation to protect the interests of the United States.

SECTION 50 – SCOPE OF WORK**50.1 Agencies to Be Served**

This contract shall be for use by **CHFS-DMS**. No shipments shall be made except upon receipt by vendor of an official delivery order from the using agency.

50.2 Term of Contract and Renewal Options

The initial term of the contract shall be effective **July 01, 2020** and expire **December 31, 2025**.

This contract may be renewed at the completion of the initial contract period for **five (5) additional two (2) year** periods upon the mutual agreement of the Parties. Such mutual agreement shall take the form of a contract modification as described in Section 40.8 of this RFP.

Vendors shall not be eligible to accept Medicaid members or receive monthly capitated rate payments prior to meeting all Readiness Review and Network Adequacy requirements. Awarded Vendor(s) are to meet these requirements no later than April 1, 2020. Failure to meet the requirements by this date may result in cancellation of the awarded contract.

At the end of the contract, the vendor shall provide all agency data in a form that can be converted to any subsequent system of the agency's choice. The vendor shall cooperate to this end with the vendor of the agency's choice.

The Commonwealth reserves the right not to exercise any or all renewal options. The Commonwealth reserves the right to extend the contract for a period less than the length of the above-referenced renewal period if such an extension is determined by the Commonwealth Buyer to be in the best interest of the Commonwealth.

The Commonwealth reserves the right to renegotiate any terms and/or conditions as may be necessary to meet requirements for the extended period. In the event proposed revisions cannot be agreed upon, either party shall have the right to withdraw without prejudice from either exercising the option or continuing the contract in an extended period.

50.3 Basis of Price Revisions

PRICE ADJUSTMENTS: Unless otherwise specified, the prices established by the contract resulting from this solicitation shall remain firm for the contract period subject to the following:

CMS Approval: The capitation payment rates established by the Contract are subject to the approval of the Center for Medicare and Medicaid Services (CMS). If CMS rejects any component of the rates, DMS will work with its actuaries to develop and certify new rates to CMS for approval. Those new rates, shall be reconciled retroactively to the beginning of the rate period certified to CMS.

50.4 Notices

After the award of contract, all programmatic communications with regard to day-to-day performance under the contract are to be made to the agency technical contact(s) identified during the negotiation phase of this procurement. After the award of contract, all communications of a contractual or legal nature are to be made to the Commonwealth Buyer.

50.5 Subcontractors

The contractor is permitted to make subcontract(s) with any other party for furnishing any of the work or services herein. The contractor shall be solely responsible for performance of the entire contract whether or not subcontractors are used. The Commonwealth shall not be involved in the relationship between the prime contractor and the subcontractor. Any issues that arise as a result of this relationship shall be resolved by the prime contractor. All references to the contractor shall be construed to encompass both the contractor and any subcontractors of the contractor.

50.6 Transition of MCOs

An MCO currently contracting with the Commonwealth in the Managed Care Program that remains with the Managed Care Program shall not have its current membership reassigned on July 1, 2020. If an MCO currently contracting with the Commonwealth in the Managed Care Program does not continue with the Managed Care Program its membership shall be reassigned as indicated below:

The Department shall follow the steps below for the purpose of equitable distribution.

- A. All managed care Enrollees of a Medicaid family will be assigned to the same MCO.
- B. Continuity of Care – The Department will use Claims history to determine the most recent, regularly visited Primary Care Providers (PCP). The top three (3) PCP providers for each Enrollee shall be considered. This determination will be based on the last twelve (12) months of history with relative weights based on the time period of the visits. The weight shall be one (1) thru three (3) with three (3) being assigned to visits in the most recent four (4) months; one (1) being assigned to visits in the earliest four-month period, and two (2) being assigned to the visits in the middle four (4)-month period. Next, each Enrollee's top three (3) PCP Providers shall be

- matched against the provider network of the Medicaid Region's MCOs and a "MCO network suitability score" shall be assigned to each family Enrollee.
- C. In order to give due consideration to children and individuals with specialized health care needs it is important that all family Enrollees are not treated equally in developing the family unit's overall MCO score. The ratio between the numbers of children eligible for managed care versus the number of adults eligible for managed care is almost 1.9 to 1. Therefore, the "MCO network suitability score" for a child shall be further multiplied by a factor of 1.9. Similarly, individuals with special health care needs (identified as SSI Adults and SSI Children) shall have their score adjusted by a factor of 1.6 which represents the relative cost of these individuals relative to the cost of adults over the age of eighteen (18). In the case of SSI Children both the child factor (1.9) and the special needs factor (1.6) shall be applied. After these adjustments, each family Enrollee's individual "MCO network suitability score" shall be added together to determine the family unit's "MCO network suitability score."
- D. The family shall be assigned to the MCO with the highest "MCO network suitability score" unless that MCO has exceeded its maximum threshold of 100,000 members. If the maximum threshold has been exceeded, the family shall be assigned to the MCO with next highest score, which has not exceeded its threshold.
- E. In scenarios where multiple MCOs have the same score for the family "MCO network suitability score" and all MCOs are above the minimum threshold, the family shall be assigned to the MCO with the lowest enrollment.

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Medicaid Managed Care Organization (MCO) - All Regions

V. APPROVALS

This Contract is subject to the terms and conditions as stated. By executing this Contract, the parties verify that they are authorized to bind this agreement and that they accept the terms of this Agreement.

This Contract may be executed electronically in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same Contract.

This Contract is invalid until properly approved and executed by the Finance and Administration Cabinet.

Aetna Better Health of Kentucky Insurance Company, d/b/a Aetna Better Health of Kentucky, Inc. ("Contractor", "Vendor", or "Aetna")

DocuSigned by:




11/25/2019 | 11:58 AM PST

0146A0FC706A425
Randy Hyun, President

Date

Approved by the Cabinet for Health and Family Services

DocuSigned by:

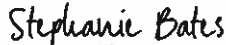


11/25/2019 | 11:19 AM EST

41A8DFE70753450
Matthew Kleinert, Special Assistant
Office of Legal Services

Date

DocuSigned by:



11/25/2019 | 12:24 PM PST

B78CCE6153DA194
Stephanie Bates, Deputy Commissioner
Department for Medicaid Services

Date

DocuSigned by:



11/25/2019 | 1:07 PM PST

D34FE52AED20486
Adam Meier, Cabinet Secretary

Date

Approved by the Finance and Administration Cabinet



Joan Graham, Executive Director
Office of Procurement Services

11/26/19

Date

MEDICAID MANAGED CARE CONTRACT

BETWEEN

**THE COMMONWEALTH OF KENTUCKY
ON BEHALF OF**

**THE CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES**

AND

CONTRACTOR

MEDICAID MANAGED CARE CONTRACT

BETWEEN

***THE COMMONWEALTH OF KENTUCKY
ON BEHALF OF***

***THE CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES***

AND

CONTRACTOR

ATTACHMENT F - Draft Medicaid Managed Care Contract and Appendices

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Preamble

This Contract is entered into among the Commonwealth of Kentucky, Finance and Administration Cabinet (“FAC”), and the awarded vendor listed on this Contract’s cover page (“Contractor”).

WHEREAS, the Kentucky Department for Medicaid Services (DMS) (“Department”) within the Cabinet for Health and Family Services is charged with the administration of the Kentucky Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended (the “Act”), and the statutes, laws, and regulations of Kentucky; and the Kentucky Children’s Health Insurance Program (KCHIP) in accordance with the requirements of the Title XXI of the Social Security Act, as amended, and

WHEREAS, the Contractor is eligible to enter into a risk contract in accordance with Section 1903(m) of the Act and 42 C.F.R. 438.6, is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. 438.2, and **Contractor** is an Insurer under Subtitle 3 of the Kentucky Insurance Code with a health line of authority; and

WHEREAS, the parties are entering into this agreement regarding services for the benefit of Enrollees residing in the Commonwealth and, the Contractor has represented that the Contractor will exercise appropriate financial responsibility during the term of this Contract, including adequate protection against the risk of Insolvency, and that the Contractor can and shall provide quality services efficiently, effectively and economically during the term of this Contract, and further the Contractor shall monitor the quality and provision of those services during the term of this Contract, representations upon which FAC and the Department rely in entering into this Contract;

WHEREAS, DMS and Contractor agree that the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (hereinafter referred to as "CMS") must approve this Contract as it relates to Kentucky SKY as a condition precedent to its becoming effective for any purpose;

NOW THEREFORE, in consideration of the monthly payment of predetermined Capitated Rates by the Department, the assumption of risk by the Contractor, and the mutual promises and benefits contained herein, the parties hereby agree as follows:

1.0 DEFINITIONS

1.1 General Definitions

Abuse means Provider Abuse and Recipient Abuse, as defined in KRS 205.8451.

ACA Expansion Enrollees means individuals less than 65 years of age with income below one hundred thirty eight percent (138%) of the federal poverty level and former foster children up to the age of twenty-six (26) and who were not previously eligible under Title XIX of the Social Security Act prior to the passage of the Affordable Care Act (ACA).

Adverse Benefit Determination means, as defined in 42 C.F.R. 438.400(b), the following:

- A. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit;
- B. Reduction, suspension, or termination of a service previously authorized by the Department, its agent or Contractor;
- C. Denial, in whole or in part, of payment for a service;
- D. Failure to provide services in a timely manner, as defined by Department;
- E. Failure of an MCO or Prepaid Health Insurance Plan (PHIP) to act within the timeframes required by 42 C.F.R. 438.408(b);
- F. For a resident of a rural area with only one MCO, the Denial of a Medicaid Enrollee's request to exercise his or her right, under 42 C.F.R. 438.52(b)(2)(ii), to obtain services outside a Contractor's Network; or
- G. Denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Affiliate means an entity that directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the entity specified.

Affordable Care Act means the Patient Protection and Affordable Act (PPACA), P.L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010.

Allowed Medical Expenses equals incurred medical Claims plus expenses for activities that improve health care quality (as defined in 45 C.F.R. 158.150).

Appeal means a request for review of an Adverse Benefit Determination, or a decision by the Contractor related to Covered Services, services provided or the payment for a service.

Automatic Assignment (or Auto-Assignment) means the:

- A. Enrollment of an eligible person, for whom Enrollment is mandatory, in a MCO chosen by the Department or its Agent; or
- B. The assignment of a new Enrollee to a PCP chosen by the MCO, pursuant to the provisions of this Contract.

Behavioral Health Services means clinical, rehabilitative, and support services in inpatient and outpatient settings to treat a mental illness, emotional disability, or substance use disorder.

Behavioral Health Services Organization means an entity that is licensed as a behavioral health services organization pursuant to 902 KAR 20:430.

Business Associate means parties authorized to exchange electronic data interchange (EDI) Transactions on the Trading Partner's behalf, as defined by HIPAA.

Business Day means "working day" or Monday through Friday except for state holidays.

Cabinet means the Cabinet for Health and Family Services.

Capitation means a Contractual arrangement through which a Contractor agrees to provide Covered Services to Enrollees for a fixed amount per member per month (PMPM).

Capitation Payment means a payment that the Commonwealth makes to the Contractor on behalf of each Enrollee for the provision of Covered Services. This payment is made regardless of whether the Enrollee receives Covered Services during the period covered by the payment. Payments are contingent upon the availability of appropriated funds.

Capitation Rate(s) means the fixed amount to be paid monthly to the Contractor by the Commonwealth for Enrollees enrolled based on such factors as the Enrollee's aid category, age, gender and service.

Care Coordination is a process that actively and effectively links an Enrollee, in a timely and integrated manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified.

Care Plan means written documentation of decisions made in advance of care provided, based on a comprehensive Enrollee Needs Assessment of an Enrollee's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Enrollee and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes. Case Management is distinguished from Disease Management by its intensity and a holistic focus on all of an Enrollee's disease(s), condition(s), and related needs.

Centers for Medicare and Medicaid Services (CMS) is the U.S. Department of Health and Human Services, formerly the Health Care Financing Administration, which is responsible for Medicare and Medicaid.

Children with Special Health Care Needs means Enrollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health

and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) is an Act that reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It ensures that a State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.

Claim means any 1) bill for services, 2) line item of service, or 3) all services for an Enrollee within a bill.

Clean Application as used in KRS 205.532 to 205.536 means a credentialing application submitted by a provider to a Credentialing Verification Organization (CVO) that is complete and does not lack any required substantiating documentation.

Clinical Laboratories Improvement Amendments of 1988 (CLIA) is federal legislation as found at Section 353 of the federal Public Health Services Act (42 U.S.C. §§ 201, 263a) and regulations promulgated hereunder.

Close of Business means 5:00 p.m. Eastern Time Zone.

Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for TANF and disabled Medicaid Enrollees.

Commonwealth means the Commonwealth of Kentucky.

Community Mental Health Center (CMHC) is a board or a nonprofit organization providing a regional community health program operated pursuant to KRS Chapter 210 for individuals who have mental health disorders, substance use disorders, intellectual and/or developmental disabilities and may provide primary care.

Condition is a disease, illness, injury, or disorder, of biological, cognitive, or psychological basis for which evaluation, monitoring and/or treatment are indicated.

Contract means this Contract between FAC and the Contractor and any amendments, including, corrections or modifications thereto incorporating and making a part hereof the documents described in **Section 40.1 "Documents Constituting Contract"** of this Contract.

Contract Term means the term of this Contract as set forth in **Section 7.1 "Term."**

Contractor's Network means collectively, all of the Providers that have contracts with the Contractor or any of the Contractor's Subcontractors to provide Covered Services to Enrollees.

Court-Ordered Commitment means an involuntary commitment of an Enrollee to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.

Covered Services means services that the Contractor is required to provide under this Contract, as identified in this Contract.

Credentialing Application Date as used in KRS 205.532 to 205.536 means the date that a CVO receives a Clean Application from a provider.

Credentialing Verification Organization (CVO) as used in KRS 205.532 to 205.536 means an organization that gathers data and verifies the credentials of providers in a manner consistent with federal and state laws and the requirements of the National Committee for Quality Assurance (NCQA). A CVO is:

- A. An organization designated by the Department pursuant to subsection (3) (a) of KRS 205.532 to 205.536; and
- B. Any bona fide, nonprofit, statewide, health care provider trade association, organized under the laws of Kentucky, that has an existing contract with the Department or a Managed Care Organization (MCO) contracted with the Department to perform credentialing verification activities for its Enrollees, providers who are employed by its Enrollees, or providers who practice at the Enrollees' facilities.

Critical Access Hospital means a health care facility designation of the federal CMS that provides for cost-based reimbursement for inpatient services.

Day means a calendar day unless otherwise noted.

Decertification means any time the certification of any level of care in a hospital or residential facility is no longer authorized.

Delivery Payment means a one-time payment to the Contractor for the delivery of a newborn. This payment is in addition to the Capitation Payment for the newborn.

Denial means the termination, suspension or reduction in the amount, scope or duration of a Covered Service or the refusal or failure to provide a Covered Service, or the refusal or failure to pay for a service already rendered.

Department means the Department for Medicaid Services (DMS) within the Cabinet, or its designee.

Department for Aging and Independent Living (DAIL) is the department within the Cabinet which oversees the administration of statewide programs and services on behalf of Kentucky's elders and individuals with disabilities.

Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is the department within the Cabinet that oversees the administration of statewide programs and services for individuals with mental health disorders, substance use disorders, intellectual disabilities, or developmental disabilities.

Department for Community Based Services (DCBS) is the department within the Cabinet that oversees the eligibility determinations for the DMS and the management of the Foster Care program. DCBS has offices in every county of the Commonwealth.

Department of Insurance (DOI) is the department within the Public Protection Cabinet which regulates the Commonwealth's insurance market, licenses agents and other insurance professionals, monitors the financial condition of companies, educates consumers to make wise choices, and ensures that Kentuckians are treated fairly in the marketplace.

Department for Medicaid Services (DMS) means the single state agency that submits to the CMS the state plan for the medical assistance program, and administers the program in accordance with the provisions of the state plan, the requirements of Title XIX of the Social Security Act, and all applicable Federal and state laws and regulations.

Discharge Planning means a comprehensive evaluation of the Enrollee's health needs and identification of the services required to facilitate appropriate care following discharge from an institutional clinical setting or residential placement, or the transition between levels of care.

Disenrollment means an action taken by the Department to remove an Enrollee's name from the HIPAA 834 following the Department's receipt and approval of a request for Disenrollment or a determination that the Enrollee is no longer eligible for Enrollment.

Drug Formulary/Preferred Drug List (PDL) means a list of prescription drugs, both generic and brand name, used to identify drugs with status (preferred or non-preferred) that offer the greatest overall value based on efficacy, safety and cost-effectiveness.

Dual Eligible Enrollee means an Enrollee who is simultaneously eligible for Medicaid and Medicare benefits.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services mean comprehensive and preventive health care services for children who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Special Services means necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses, and conditions identified by EPSDT screening services for children who are enrolled in Medicaid, whether or not such services are covered under the State Medicaid Plan.

Effective Date means the operational start date of the Contract when Enrollees begin receiving services from the Contractor.

Emergency Behavioral Health Disorder Services or Care means an emergent situation in which the Enrollee is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition rendering the Enrollee unmanageable and unable to cooperate in treatment.

Emergency Medical Condition is defined in 42 USC 1395dd (e) and 42 C.F.R. 438.114 and means:

- A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in
 1. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 2. Serious impairment of bodily functions, or
 3. Serious dysfunction of any bodily organ or part; or
- B. With respect to a pregnant woman having contractions:
 1. That there is an inadequate time to effect a safe transfer to another hospital before delivery, or
 2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services or Emergency Care means covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

Encounter means a service or item provided to a patient through the healthcare system that includes but are not limited to:

- A. Office visits;
- B. Surgical procedure;
- C. Radiology, including professional and/or technical components;
- D. Prescribed drugs including mental/behavioral drugs;
- E. Durable Medical Equipment (DME);
- F. Transportation;
- G. Institutional stays;
- H. EPSDT screening; or
- I. A service or item not directly provided by the Plan, but for which the Plan is financially responsible. An example would include an Emergency Service provided by an Out-of-Network Provider or facility.

Encounter File means an electronically formatted record of multiple Encounters using data elements as established by the Department.

Encounter Technical Workgroup means a workgroup composed of representatives from Contractor, the Department, the Fiscal Agent, and External Quality Review Organization (EQRO).

Encounter Void means an accepted or Erred Encounter Record that has been removed from all Encounter Records.

Enrollee means an individual as defined in 42 CFR § 438.2 and is interchangeable with Member and Recipient.

Enrollee Listing Report means the HIPAA 834 transaction file which indicates Contractor's Enrollees and any new, terminated and changed Enrollees and the HIPAA 820 transaction file which indicates the Capitation Payment for Contractor's Enrollees, as reconciled against one another.

Enrollee Needs Assessment is used to identify a person's specific health conditions, functional status, social determinants, accessibility needs and other characteristics as well as personal strengths, resources and abilities. The Enrollee Needs Assessment performed by an individual or a team of specialists and may involve family, or other significant people to inform care planning and the level of required services and supports.

Enrollment means an action taken by the Department to add an Enrollee's name to the HIPAA 834 following approval by the Department of an eligible Enrollee to be enrolled.

Erred Encounter means an Encounter that has failed to satisfy one or more requirements for valid submission.

Erred Encounter File means an Encounter File that is rejected by the Department because it has failed to satisfy the requirements for submission.

Execution Date means the date upon which this Contract is executed by FAC, the Department, and the Contractor. The Contract is considered executed as of the date of final approval in the Kentucky electronic Management Administrative and Reporting System (eMARS) and posting to the Commonwealth's eProcurement website.

Expedited Authorization Request as defined in KRS 205.534 means a request for authorization or preauthorization where the provider determines that following the standard timeframe could seriously jeopardize an Enrollee's life or health, or ability to attain, maintain, or regain maximum function. A request for authorization or preauthorization for treatment of an Enrollee with a diagnosis of substance use disorder is considered an Expedited Authorization Request.

External Quality Review Organization (EQRO) refers to a vendor and its affiliates, with which the Commonwealth may contract as established under 42 C.F.R. 438, Subpart E.

Family Planning Services means counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy.

Federally Qualified Health Center (FQHC) means a facility that meets the requirements of Social Security Act at 1905(l)(2).

Fee-For-Service is a traditional indemnity health care delivery system in which payment is made to a health care provider after a service is rendered and billed.

Fiscal Agent means the agent contracted by the Department to audit Provider Claims: process and audit Encounter data; and, to provide the Contractor with eligibility, provider, and processing files.

Foster Care is defined in **Section 1.3 “Kentucky SKY Definitions.”**

Fraud means any act that constitutes Fraud under applicable federal law or KRS 205.8451-KRS 205.8483.

FTE means full-time equivalent for an employee, based on forty (40) hours worked per week.

Grievance means the definition established in 42 C.F.R. 438.400.

Grievance and Appeal System means a comprehensive system that includes a grievance process, an appeal process, and access to the Commonwealth's fair hearing system.

Health Care Effectiveness Data and Information Set (HEDIS™) means a national performance improvement tool developed by the National Committee for Quality Assurance (NCQA) and used to measure performance across six domains of care.

Health Information means any Health Information provided and/or made available by the Department to a Trading Partner, and has the same meaning as the term “Health Information” as defined by 45 C.F.R. Part 160.103.

Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the implementing regulations (45 C.F. R. Sections 142, 160, 162, and 164), all as may be amended.

Health Maintenance Organization (HMO) is a licensed entity in the Commonwealth pursuant to KRS 304.38, et seq.

Health Risk Assessment (HRA) refers to a standardized screening tool used by the Department's contracted MCOs to collect information on an Enrollee's health status, including mental health and substance use disorders(s). Additionally, other information that is collected includes, but is not limited to Enrollee demographics, personal and family medical history, and lifestyle. The Contractor shall use the assessment to identify need for health, behavioral health or community services and

to determine when to conduct a more comprehensive Enrollee Needs Assessment to identify Enrollees who are in need of care management.

HHS Transaction Standard Regulation means 45 C.F.R., at Title 45, Parts 160 and 162, as may be amended.

HIPAA 820 means a transaction file prepared by the Department that indicates Enrollee's capitated payment.

HIPAA 834 means a transaction file prepared by the Department that indicates all Enrollees enrolled.

Homeless Person, when used in the context of **Section 22.5 "Outreach to Homeless Persons,"** means one who lacks a fixed, regular or nighttime residence; is at risk of becoming homeless in a rural or urban area because the residence is not safe, decent, sanitary or secure; has a primary nighttime residence at a publicly or privately operated shelter designed to provide temporary living accommodations; has a primary nighttime residence at a public or private place not designed as regular sleeping accommodations; or is a person who does not have access to normal accommodations due to violence or the threat of violence from a cohabitant.

Individual Education Plan (IEP) means Medically Necessary services for an eligible child coordinated between the schools and the Contractor that complement school services and promote the highest level of function for the child.

Individuals with Disabilities Education Act (IDEA) is a law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to eligible infants, toddlers, children and youth with disabilities.

Individuals with Special Healthcare Needs (ISHCN) are Enrollees who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISHCN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these Enrollees so the MCO can facilitate access to appropriate services.

Insolvency means the inability of the Contractor to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities. "Liabilities," for purposes of the definition of Insolvency, shall include, but not be limited to, Claims payable required by the Kentucky Department of Insurance pursuant to Kentucky statutes, laws or regulations.

Institution for Mental Disease (IMD) is defined by 42 C.F.R. 435.1010.

Insurer is an Insurer under Subtitle 3 of the Kentucky Insurance Code with a health line of authority.

I/T/U means ("I") Indian Health Service, ("T") Tribally operated facility/program, and ("U") Urban Indian clinic.

Kentucky HEALTH refers to the Section 1115 Demonstration Waiver known as Kentucky Helping to Engage and Achieve Long Term Health (HEALTH).

Kentucky HEALTH Business Requirements refer to the technical and operational guidelines and documents, provided to the contractor by the Department, which outline how the various Kentucky

HEALTH information systems, including the Contractor's, are required to operate and interface with each other. This includes, but is not limited to, the Kentucky HEALTH High Level Requirements document, Detailed Design documents, Invoicing and Payment Reporting Guides, Special Terms and Conditions (STCs), and Companion Guides.

Kentucky Health Information Exchange (KHIE) means the secure electronic information infrastructure created by the Commonwealth for sharing health information among health care providers and organizations and offers health care providers the functionality to support meaningful use and a high level of patient-centered care.

Legal Entity means any form of corporation, insurance company, Limited Liability Company, partnership, or other business entity recognized as being able to enter into contracts and bear risk under the laws of both the Commonwealth and the United States.

Managed Care Organization (MCO) means an entity for which the Commonwealth has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

Marketing means any communication from or on behalf of the Contractor, that can reasonably be interpreted as intended to influence the beneficiary to enroll with the MCO, or either to not enroll in or to disenroll from another MCO as defined by 42 C.F.R. 438.104.

Maximum Allowable Cost (MAC) means the upper limits that a plan will pay for generic drugs and brand name drugs that have generic version available (multi-source brands).

Medical Home means a person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers, and where appropriate, the individual's family and other supports.

Medicaid Region means one of eight multi-county Regions within Kentucky.

Medical Loss Ratio (MLR) means the proportion of premium revenues spent on clinical services and quality improvement as defined in 42 C.F.R. 438.4 – 438.8 and subsequent CMS guidance and further specified by the Department.

Medical Record means a single complete record that documents all of the treatment plans developed for, and medical services received by, the Enrollee including inpatient, outpatient, referral services and Emergency Care whether provided by Contractor's Network or Out of Network Providers.

Medically Necessary or Medical Necessity means Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Miles, unless otherwise noted, means the distance traveled using public roadways.

Modified Adjusted Gross Income (MAGI) means the calculation under the ACA used to determine income eligibility for Medicaid based upon federal income tax rules which include family size and household income based on the tax filing unit.

National Correct Coding Initiative (NCCI) means CMS developed coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits.

National Provider Identifier (NPI) is a unique identification number for covered health care providers as required under HIPAA.

Net Capitation Payment equals earned premiums minus federal, state and local taxes and licensing or regulatory fees.

Network Provider (or Provider) means any provider, group of providers, or entity under contract with the Contractor or the Contractor's Subcontractor that provides Covered Services to Enrollees.

Non-covered Services means health care services that the Contractor is not required to provide under the terms of this Contract.

Office of Attorney General (OAG) The Attorney General is the chief law officer of the Commonwealth of Kentucky and all of its departments, commissions, agencies, and political subdivisions, and the legal adviser of all state officers, departments, commissions, and agencies.

Office of Inspector General (OIG) is Kentucky's regulatory agency for licensing all health care agencies in the Commonwealth. The OIG is responsible for the prevention, detection and investigation of Medicaid Fraud, Waste, Abuse and mismanagement.

Office for Children with Special Health Care Needs (OCSHN) is a Title V agency which provides specialty medical services for children with specific diagnoses and health care services needs that make them eligible to participate in Commission sponsored programs, including provision of Medical care.

Out-of-Network Provider means any person or entity that has not entered into a participating provider agreement with the Contractor or any of the Contractor's Subcontractors for the provision of Covered Services.

Overpayment means any payment made to a provider by the Contractor to which the provider is not entitled.

Person-Centered Recovery Planning (PCRP) means a collaborative process resulting in a recovery oriented behavioral health treatment plan needed for maximum reduction of mental disability and restoration of a recipient to his/her best possible functional level.

Point-of-Sale (POS) means state-of-the-art, online and real-time rules-based Claims processing services with Prospective Drug Utilization Review including an accounts receivable process.

Population Health Management (PHM) Program means a model of care as aligned with the National Committee of Quality Assurance's (NCQA) defined program that supports defined populations across the care continuum, promoting healthy behaviors and targeted interventions for those identified at risk or who have chronic conditions. The PHM Program supports Enrollees to maintain or improve physical health and behavioral health and to consider and address functional needs and social determinants of health.

Post Stabilization Services means Covered Services, related to an Emergency Medical Condition, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 438.114(e) to improve or resolve the Enrollee's condition.

Prepayment Review means a specific review of identified Claims or services or types of Claims or services prior to determination and payment in order to prevent improper payments due to a

sustained or high level of payment error or resulting from an analysis that identifies a problem related to possible Fraud, Waste, and/or Abuse.

Presumptive Eligibility means eligibility granted for Medicaid Covered Services as specified in administrative regulation as a qualified individual based on an income screening performed by a qualified provider.

Prevalent Non-English Language means any non-English language spoken by five (5) percent or more of the population in Kentucky and any non-English language spoken by five (5) percent or more of the population in a county served by the Contractor.

Primary Care Provider (PCP) means a licensed or certified health care practitioner that functions within the provider's scope of licensure or certification, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or health clinic (including an FQHC, FQHC look-alike, primary care center, or RHC), has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals, and for an Enrollee who has a gynecological or obstetrical health care needs, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

Prior Authorization means the Contractor's act of authorizing specific services before they are rendered.

Program Integrity means the process of identifying and referring any suspected Fraud or Abuse activities or program vulnerabilities concerning the health care services to the Cabinet's Office of the Inspector General.

Prospective Drug Utilization Review (ProDUR) means a monitoring system that screens prescription drug Claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse, as required by 42 C.F.R. 438.3(s) and complies with 1927(g) and 42 C.F.R. part 456, subpart K.

Protected Health Information (PHI) means individual patient demographic information, Claims data, insurance information, diagnosis information, and any other care or payment for health care that identifies the individual (or there is reasonable reason to believe could identify the individual), as defined by HIPAA.

Psychiatric Residential Treatment Facility (PRTF) means a separate, standalone facility providing a range of comprehensive long-term, intensive treatment for children and youth under age twenty-one (21) years on an inpatient basis under the direction of a physician. The facilities provide a more highly structured environment than can be provided in a Qualified Residential Treatment Program, Residential Placement, and in the home and serves as a community-based alternative to hospitalization. The facilities also serve children and youth who are transitioning from hospitals, but who not ready to live at home or in a foster home. (42 CFR Parts 441 and 483, and 902 KAR 20:320 and 902 KAR 20:330)

Quality Improvement (QI) means the process of assuring that Covered Services provided to Enrollees are appropriate, timely, accessible, available, and Medically Necessary and the level of performance of key processes and outcomes of the healthcare delivery system are improved through the Contractor's policies and procedures.

Quality Management means the integrative process that links knowledge, structure and processes together throughout the Contractor's organization to assess and improve quality.

Rate Area means one of two geographic areas composed of Medicaid Regions for which Rate Cells are developed. Rate Area A is comprised of Medicaid Region 3. Rate Area B is comprised of Medicaid Regions 1, 2, 4, 5, 6, 7, and 8.

Rate Cell means covered eligibility categories segmented into sub-groups based on an analysis of similarities of the per capita costs, age, and gender of various populations.

Rate Group means Rate Cell level information aggregated into eight (8) larger but similarly characterized groups including 1) Families and Children – Child, 2) Families and Children – Adult, 3) SSI without Medicare Adult, 4) SSI Child and 5) Foster Care Child, 6) Dual Eligibles, 7) ACA MAGI Adults, and 8) ACA Former Foster Care Child.

Recipient is interchangeable with "Enrollee."

Retrospective Drug Utilization Review (RetroDUR) means a process that involves ongoing and periodic examination of pharmacy Claims data to identify patterns of Fraud, Abuse, gross overuse, or medically unnecessary care and implements corrective action when needed, as required by 42 C.F.R. 438.3(s) and complies with 1927(g) and 42 C.F.R. part 456, subpart K.

Risk Adjustment is a method for determining adjustments to the PMPM rate that accounts for variation in health risks among participating Contractors when determining Capitation Rates.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a Rural Health Clinic under 1861(aa)(1) of the Social Security Act and approved for participation in the Kentucky Medicaid Program.

Serious Emotional Disorder (SED) means a child with a clinically significant Condition as described in KRS 200.503.

Service Authorization Request means an Enrollee's request for the provision of a service.

Service Location means any location at which an Enrollee may obtain any Covered Services from the Contractor's Network Provider.

Serious Mental Illness (SMI) means a major mental illness or disorder (but not a primary diagnosis of Alzheimer's disease or dementia) as included in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM), under: schizophrenia spectrum and other psychotic disorders; bipolar and related disorders; depressive disorders; or post-traumatic stress disorders and has documented history indicating persistent disability and significant impairment in major areas of community living; and has clinically significant symptoms for at least two years or has been hospitalized for mental illness more than once within the two (2) past years; and has significant impairment that impedes functioning in two (2) or more major areas of living and is unlikely to improve without treatment, services and/or supports.

Sister Agency means agencies or departments within the Cabinet of Health and Family Services.

Specialty Care means any service provided that is not provided by a PCP.

State means the Commonwealth of Kentucky.

State Fair Hearing means the administrative hearing provided by the Cabinet pursuant to KRS Chapter 13B and contained in 907 KAR 17.010.

Subcontract means any agreement entered into, directly or indirectly, by a Contractor to delegate the responsibility of any major service or group of services, including administrative functions or Covered Services, specifically related to securing or fulfilling the Contractor's obligations under this Contract. Administrative functions are any requirements under this Contract other than the direct provision of services to Enrollees such as, but not limited to, utilization or medical management, Claims processing, Enrollee grievances and appeals, and the provision of data or information necessary to fulfill Contractor obligations.

Subcontractor means any individual or entity other than a Provider, Physician Health Organization, or Network Provider, with which Contractor has entered into a written agreement for the purpose of fulfilling a Contractor's obligations under an MCO Contract.

Supplemental Security Income (SSI) is a program administered by the Social Security Administration (SSA) that pays benefits to disabled adults and children who have limited income and resources. SSI benefits are also payable to people sixty-five (65) and older without disability who meet the financial limits.

Symmetrical Risk Corridor means the same size corridors of risk sharing percentages above and below a target amount designed to limit exposure to unexpected expenses.

Taxonomy codes reference codes designed to categorize the type, classification, and/or specialization of health care providers. Health care providers must select the relevant code(s) when applying for a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES).

Teaching Hospital means a hospital providing the services of interns or residents-in-training under a teaching program approved by the appropriate approving body of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of interns or residents-in-training in the field of dentistry in a general or osteopathic hospital, the teaching program shall have the approval of the Council on Dental Education of the American Dental Association. In the case of interns or resident-in-training in the field of podiatry in a general or osteopathic hospital, the teaching program shall have the approval of the Council on Podiatry Education of the American Podiatry Association.

Third-Party Liability/Resource means any resource available to an Enrollee for the payment of expenses associated with the provision of Covered Services, including but not limited to, Medicare, other health insurance coverage or amounts recovered as a result of settlement, dispute resolution, award or litigation. Third Party Resources do not include amounts that are exempt under Title XIX of the Social Security Act.

Trading Partner means a provider or a health plan that transmits health information in electronic form in connection with a Transaction covered by 45 C.F.R. Parts 160 and 162, or a Business Associate authorized to submit health information on the Trading Partner's behalf, as defined by HIPAA.

Transaction means the exchange of information between two (2) parties to carry out financial or administrative activities related to health care as defined by 45 C.F.R. Part 160.103, as defined by HIPAA.

Urgent Care means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

Utilization Management (UM) is a service performed by the Contractor which seeks to ensure that Covered Services provided to Enrollees are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established or administered by DMS.

Utilization Review (UR) is the evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and ambulatory review, pre-certification, prospective review, concurrent review, second opinions, care management, Discharge Planning, or retrospective review.

Waste means generally, but is not limited to, the overutilization or inappropriate utilization of services or misuse of resources, and typically is not a criminal or intentional act.

Women, Infants and Children (WIC) means a federally-funded health and nutrition program for women, infants, and children.

1.2 Kentucky HEALTH Definitions

Ad Hoc Invoice means invoicing done outside of the Batch Invoicing of actively eligible and enrolled Kentucky HEALTH Enrollees on the fifteenth day of each month. Ad Hoc Invoicing shall be completed within three (3) Business Days of the Contractor's receipt of the applicable HIPAA 834 record.

Alternative Benefit Plan (ABP) means the benefit package provided to ACA Expansion Enrollees which is developed by the Department in accordance with 42 CFR Part 440, Subpart C.

Batch Invoicing or Batch Invoice means invoicing of actively eligible and enrolled Kentucky HEALTH Enrollees on the fifteenth day of each month for the next coverage month.

Benefit Year means the time period of January 1 through December 31 of each calendar year.

Community Engagement (CE) refers to the Kentucky HEALTH initiative whereby non-exempt Enrollees shall complete at least eighty (80) hours per month of qualifying activities to maintain eligibility. Community Engagement qualifying activities are defined separately. This initiative shall be marketed as the Partnering to Advance Training and Health (PATH) program.

Community Engagement Qualifying Activities refer to activities deemed to meet the Community Engagement requirement of eighty (80) hours per month. Such activities include volunteering, caregiving, education, job training, employment, or participation substance use disorder treatment activities.

Community Engagement Suspension means the penalty applied to Kentucky HEALTH Enrollees who do not complete their required Community Engagement hours. Enrollees in a Community Engagement Suspension remain enrolled in Kentucky HEALTH, but not eligible for benefits during the suspension period.

Conditionally Eligible Enrollee means an applicant who has been determined to meet all Kentucky HEALTH eligibility criteria, but who has not made an initial premium payment or otherwise cleared a penalty in order to start coverage. Conditionally Eligible Enrollees are not eligible to receive Kentucky HEALTH benefits.

Copayment Plan is the cost sharing plan for ACA Expansion Enrollees, Parent and Caretaker Relatives, and TMA Enrollees at or below one hundred percent (100%) FPL who fail to make required Kentucky HEALTH premium payments. Enrollees in the Copayment Plan do not have access to a My Rewards Account, and are charged copayments for Covered Services in accordance with the Kentucky Medicaid State Plan.

Cost Sharing Exempt refers to Kentucky HEALTH Enrollees who are excluded from the requirement or option to contribute toward the cost of their health coverage. It includes Pregnant Women and Kentucky HEALTH Children.

Cost Sharing Optional refers to Kentucky HEALTH Enrollees who are not required to contribute toward the cost of their health coverage as a condition of eligibility. It includes Former Foster Youth to age 26 and Medically Frail Individuals. These Enrollees can choose to make monthly Kentucky HEALTH premium payments in order to gain access to a My Rewards Account.

Cost Sharing Required includes ACA Expansion Enrollees, Parent and Caretaker Relatives, and TMA Enrollees who are required to contribute to the cost of their coverage via monthly premium payments or copayments for every Kentucky HEALTH covered benefit received.

Debt means any unpaid premium amounts the Contractor may collect from an Enrollee. Payment of Debt is neither a condition of eligibility nor required to cure a Non-Payment Penalty.

Deductible Account is state-funded administrative tracking account in the amount of one thousand dollars (\$1,000.00) designed to expose Kentucky HEALTH Enrollees to the cost of healthcare, designed to encourage them to be active consumers by evaluating cost and quality of care. It is funded with State dollars, not with Contractor or Enrollee dollars. The first one thousand dollars (\$1,000.00) of non-preventive services received by Enrollees within a benefit year are tracked against the Deductible Account and documented on a monthly statement sent to Enrollees. Half of the remaining Deductible Account balance at the end of the benefit year (up to five hundred dollars [\$500.00]) is eligible to be rolled over into the My Rewards Account.

Deemed Newborns are children enrolled in Kentucky HEALTH who meet the requirements described in 42 CFR §435.117.

Fast Track Payment means a Department-determined advance premium dollar amount that applicants may opt to pay to expedite Kentucky HEALTH coverage to the first day of the month in which the payment is made, which may be as early as the first day of the month of application.

Former Foster Youth are Kentucky HEALTH Enrollees who are under age twenty-six (26) and were in Foster Care under the responsibility of the State or a Tribe within Kentucky or another State and enrolled in Medicaid on the date of attaining age eighteen (18) or such higher age as the State elected.

Head of Household refers to the individual who initiates Medicaid application on behalf of a MAGI household. The Head of Household is not always enrolled in Kentucky HEALTH or with the Contractor. Kentucky HEALTH premium invoices are sent to the Head of Household, identified by the Cabinet on the HIPAA 834, unless otherwise requested by the household.

Integrated Eligibility and Enrollment System (IEES) means the information technology system utilized by the Cabinet to integrate eligibility and enrollment determination functions for all State-administered health and human services programs.

KCHIP Enrollee means a child enrolled in the Kentucky Children's Health Insurance Program.

Kentucky HEALTH Children means Deemed Newborns as described at 42 CFR §435.117 and infants and children under age nineteen (19) as described at 42 CFR §435.118. It does not include KCHIP Enrollees.

Kentucky HEALTH Enrollee means an Enrollee who is enrolled in one of the following eligibility groups: (i) ACA Expansion Enrollee; (ii) Parent and Caretaker Relative; (iii) TMA; (iv) Pregnant Women; (v) Former Foster Youth; (vi) Kentucky HEALTH Children; and (vii) KCHIP.

Medically Frail means an ACA Expansion Enrollee, Parent and Caretaker Relative or TMA Enrollee who, in accordance with 42 CFR §440.315(f), and Department developed criteria, has a disabling mental disorder (including serious mental illness), chronic substance use disorder, serious and complex medical condition, or a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living. Enrollees who meet the definition of Medically Frail shall not be subject to (i) Community Engagement requirements; (ii) mandatory cost sharing through premiums or copayments; or (iii) enrollment in the ABP.

Medically Frail Identification Tools mean the Department-defined processes established to determine an individual's Medically Frail status in accordance with 42 CFR §440.315(f).

My Rewards Account is an account available to Kentucky HEALTH Enrollees, other than Kentucky HEALTH Children and KCHIP Enrollees. Enrollees, with the exception of Pregnant Women, shall make their required premium payment contribution to have an active My Rewards Account. Enrollees can accrue funds into their My Rewards Accounts by completing Department-approved activities such as completion of healthy activities or preventive services. Funds in the My Rewards Account can be utilized to purchase Department defined services not otherwise available through the Enrollee's covered benefit package.

Non-Payment Penalty refers to a six (6)-month penalty period applied to Cost-Sharing Required Enrollees who fail to make timely premium payments. Individuals at or below one hundred percent (100%) FPL and subject to a Non-Payment Penalty are enrolled in the Copayment Plan. Individuals above one hundred percent (100%) FPL and subject to a Non-Payment Penalty are suspended from eligibility for Kentucky HEALTH. A twenty-five dollar (\$25) My Rewards Account deduction is also applied.

Parent and Caretaker Relative means a Kentucky HEALTH Enrollee who meets the requirements at 42 CFR §435.110.

Past Due means the total amount that an Enrollee is required to pay either to avoid a Non-Payment Penalty or to end a Non-Payment Penalty prior to the expiration of the six (6)-month penalty period; it does not include Debt.

Possibly Medically Frail refers to the output of the Medically Frail Identification Tool which requires additional information through the Provider Attestation for determination of Medically Frail status.

Potentially Medically Frail refers to Kentucky HEALTH Enrollees who have been identified as requiring determination of Medically Frail status via the Medically Frail Identification Tool.

Pregnant Women are Kentucky HEALTH Enrollees who meet the requirements at 42 CFR §435.116.

Premium Plan is the cost sharing plan Kentucky HEALTH Enrollees are defaulted to as of implementation enrolled in upon initial application, and continuously enrolled in as long as they

make their required monthly premium payments. Enrollees in the Premium Plan do not incur any other cost sharing for their healthcare coverage, and have access to a My Rewards Account.

Provider Attestation refers to the Department's designated form for completion by Medicaid Providers to document the clinical assessment of an Enrollee's Medically Frail status.

Provider Attestation Scoring Tool refers to the Department defined processes to score the results of a Provider Attestation for purposes of determining an Enrollee's Medically Frail status.

Random Control Trial (RCT) means the evaluation of the Kentucky HEALTH program in which Enrollees otherwise eligible for Kentucky HEALTH are allocated at random to a control group through which the policies and procedures of Kentucky HEALTH are not applied.

Re-Entry Course is an educational course, identified by the Department, required for Kentucky HEALTH Enrollees in a suspension or penalty status to end the applicable suspension or penalty and gain early re-entry into Kentucky HEALTH coverage.

Special Terms and Conditions (STC) refers to the agreement between CMS and the State regarding the requirements and assurances that govern the operation of Kentucky HEALTH.

Transitional Medical Assistance (TMA) means a Kentucky HEALTH Enrollee who meets the requirements of Section 1925 of the Social Security Act.

Voluntary Withdrawal Penalty is a six (6) month penalty period applied to Kentucky HEALTH Enrollees who disenroll from the program without cause. Individuals in this penalty period are not eligible to re-enroll in Kentucky HEALTH until the six (6) month period expires, unless early re-entry requirements are met.

1.3 Kentucky SKY Definitions

Adoption Assistance (AA) means the program established by the Adoption Assistance and Children Welfare Act of 1980 (P.L. 96-272) that provides financial and medical benefits to adoptive families who adopt children with special needs up to eighteen (18) years of age. There are three (3) categories of adoption assistance: (1) monthly adoption assistance payments; (2) Medicaid benefits; and (3) non-recurring adoption assistance such as adoption fees, court costs, attorney fees and other expenses

Adoption Assistance Enrollee (AA Enrollee) means an Enrollee receiving Adoption Assistance and enrolled in Kentucky SKY.

Adoptive Parent is an adult who provides a child a permanent home through a court process that, once final, names the adoptive parents as the child's legal parent.

Adverse Childhood Experiences (ACEs) are stressful or traumatic events, including abuse (sexual, physical or emotional), domestic violence, neglect (physical and emotional), divorce, financial hardship, household mental illness or substance use, incarceration of a parent. ACEs are a significant risk factor for substance use disorders and other health related issues over the life span of an individual.¹

Assessment Team (AT) consists of persons representing various disciplines associated with key

¹ <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences>

components of the Foster Care assessment process. The purpose of the AT meetings is to review the outcome and recommendations related to the assessment of the FC Enrollee and family. The disciplines which may participate as part of the AT should include, but are not limited to the following:

- A. Legal custodian (DCBS professionals);
- B. Individual conducting the Trauma Assessment;
- C. School system representative with direct knowledge of the educational status of the child;
- D. Medical health provider with direct knowledge of the medical and dental status of the Foster Care Enrollee;
- E. Representative from the appropriate court system if the child had any court or law enforcement involvement including local law enforcement officials or a Court Appointed Special Advocate (CASA);
- F. A Mental Health representative with direct knowledge of the mental health or substance use issues affecting the child or family;
- G. Foster Parent(s) or Out of Home Placement provider where the child resided during the assessment process with direct knowledge of the child's behavior and activity during the assessment; and
- H. Any other individual having appropriate information directly related to the FC Enrollee's case.

The AT meeting is coordinated and facilitated by the Care Coordinator.

Care Coordination Team (CCT) means a team of Kentucky SKY Contractor professionals with the following responsibilities:

- A. Coordination of care and services for each Kentucky SKY Enrollee in collaboration with the Department, DCBS and DJJ; and
- B. Development of business processes and workflows in collaboration with the Department, DCBS, and DJJ, including those related to the transmission of Kentucky SKY Enrollee information.

Care Coordinator means the lead member of the Care Coordination Team and who serves as the key point of contact between the Kentucky SKY Contractor and the Department, DCBS, and DJJ, the Kentucky SKY Enrollees, Adoptive Parent(s), Caregivers, Fictive Kin, and Providers. The qualifications of the Care Coordinator will be based on the individual needs of the Kentucky SKY Enrollees. The Care Coordinator is responsible for convening Assessment Team meetings.

Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate Quality Improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS tool facilitates the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

Community Districts are the areas of the Commonwealth which DJJ divided into four (4) districts: East, Central, Southeast, and West.

Court Appointed Special Advocate (CASA) is a trained volunteer who is appointed by a judge to represent the best interest of an abused or neglected child in the court system.

Crisis occurs when an individual presents with a sudden, unanticipated or potentially dangerous Behavioral Health Condition, episode or behavior.

Crisis Intervention Services are those services provided to an Enrollee for the purpose of stabilizing or preventing a Crisis, determining services needed, and assisting the individual in

receiving the least restrictive, most effective treatment available. Crisis Intervention Services are immediate and unscheduled Behavioral Health Services that focus on intervention, de-escalation, stabilization and referral to needed follow-up services. These services include mobile crisis stabilization and in-home services.

Dental Provider (Dentist) is a licensed dentist who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required general dental services to Kentucky Care Enrollees, including EPSDT services. A Dentist shall include general dental practitioners provided that the Dentist is able and willing to carry out all Dentist responsibilities in accordance with these Contract provisions and licensure requirements. The Dentist is responsible for coordinating referrals, as needed, with Dental Specialty Providers and all subsequent dental care.

Department for Community Based Services (DCBS) is the department within the Cabinet that oversees the eligibility determinations for the Department and the management of the Foster Care program.

Department of Juvenile Justice (DJJ) is the Department within the Kentucky Justice and Public Safety Cabinet responsible for prevention programs for at-risk youth in communities all over the Commonwealth, including court intake, pre-trial detention, residential placement and treatment services, probation, community aftercare and reintegration programs, as well as the confinement of youth awaiting adult placement or court. DJJ provides case management to coordinate services and supervision for the youth and family unit for cases that are probated, committed or sentence to DJJ. Components of DJJ case management include assessment, case planning, resource linkage, monitoring, documentation, advocacy, promoting family strengths, and engaging the family.

Division of Protection and Permanency (Protection and Permanency) is the DCBS division that:

- A. Coordinates the Commonwealth's child welfare and violence prevention efforts;
- B. Contracts with vendors that provide a variety of services statewide and for specific service regions to enhance family violence prevention and intervention services;
- C. Provides consultative services and technical assistance to local child protective services offices regarding child and adult protection cases; and
- D. Coordinates permanency services including the coordination of state efforts to recruit and certify adoptive homes for children in Foster Care.

DJJ Children's Benefit Worker is a DJJ professional responsible for the following:

- A. Serves as an intermediate contact for Managed Care Organizations to address service eligibility;
- B. Drafts correspondence regarding youth benefits to county attorneys and Managed Care Organizations, as needed;
- C. Reviews court and other state agency benefit systems documents to determine Title IV-E eligibility for youth committed to DJJ; and
- D. Other responsibilities defined by DJJ.

DJJ Commitment means an order of the court which places a child under the custodial control or supervision of the Kentucky Justice and Public Safety Cabinet, Department of Juvenile Justice, or another facility or agency until the child attains the age of eighteen (18) unless otherwise provided by law.

DJJ Community Services Case Plan means a written document that builds a plan for supervision and services which targets the risk and need factors identified in the youth's Criminogenic Needs Questionnaire (Needs-Q) and Risk and Criminogenic Needs Assessment (RCNA) and involves the

youth, family, service providers, and natural supports. The plan shall include the goals to be pursued, the specific roles of the participants in carrying out the plan, and the specific timetable for completion of the plan.

DJJ Detention means the safe and temporary custody of a juvenile who is accused of conduct subject to the jurisdiction of the court who requires a restricted or closely supervised environment for his or her own or the community's protection.

DJJ Enrollee means a Dually Committed Youth enrolled in Kentucky SKY.

DJJ Residential Services Individualized Treatment Plan means a written document that takes into consideration the severity of the current offense, the risk and need factors identified in the youth's needs assessment, and any additional assessments which identify the treatment goals to be pursued, specifies the roles of the participants in carrying out the plan, and specifies a timetable for completion of the plan.

DJJ Residential Treatment Facility means a facility or group home with more than eight (8) beds designated by DJJ for the treatment of children.

DJJ Social Service Clinician is a DJJ professional who provides intensive social work services and social services to complex cases:

- A. Provides intensive Case Management services to juveniles and their families with complex multiple issues;
- B. Conducts risk and needs assessment on all probated, committed or sentenced youth to assist with treatment planning;
- C. Prepares treatment plans, aftercare plans and case reviews;
- D. Completes court reports and other reports as needed;
- E. Maintains contact with juveniles and families while youth are in placement;
- F. Participates in case conferences;
- G. Conducts case reviews on all juveniles residing with a parent or care giver; and
- H. Other responsibilities defined by DJJ.

DJJ Social Service Specialist is a DJJ professional who provides consultative services to DJJ Social Service Workers and DJJ Social Service Clinicians:

- A. Provides Case Management for probated, committed or sentenced youth and carries a specialized caseload;
- B. Prepares case plans and aftercare plans;
- C. Participates in case conferences and other meetings pertaining to treatment; and
- D. Other responsibilities defined by DJJ.

DJJ Social Worker (Levels I and II) is a DJJ professional responsible for providing social work services and/or counseling to juvenile offenders and their families:

- A. Provides beginning level Case Management services to assigned probated, committed or sentenced juveniles and their families;
- B. Conducts risk and needs assessment for the purpose of treatment planning and aftercare planning;
- C. Completes court reports, treatment plans, aftercare plans, case/phase reviews and other reports as part of Case Management services;
- D. Participates in case conferences and maintains contact with the youth in placement;
- E. Responsible for making referrals for services; and
- F. Other responsibilities defined by DJJ.

Dually Committed Youth means a youth committed to and under the custodial care of both the Department of Juvenile Justice and the Department for Community Based Services through an order of the court. The following are two primary scenarios for Dually Committed Youth:

- A. Youth in DCBS custody that incur public offense charges and are adjudicated and dually committed to DJJ. In this scenario, DJJ takes the primary lead in placement to address delinquency issues. Once the youth is released from the DJJ facility, DCBS has the primary role in securing a placement for ongoing dependency, neglect and/or abuse issues.
- B. Youth can be committed to DJJ initially and receive treatment without DCBS involvement. If dependency, neglect and/or abuse issues are identified during the DJJ Commitment, DJJ will initiate a referral to DCBS causing the youth to become dually committed to DCBS. The DJJ referral will identify reasons why the youth cannot return home or whether the youth has access to a home or relative after release from a DJJ facility.

Family First Prevention Services Act (FFPSA) was passed by Congress in 2018 and restructured federal child welfare funding, particularly Title IV-E and Title IV-B of the Social Security Act. FFPSA seeks to reduce entry in Foster Care, promote in-home parenting skill training, increase access to substance abuse and mental health services, and limit the placement of children in congregate care.

Family Services Office Supervisor (FSOS) is a DCBS professional who plans, assigns, supervises and evaluates employees responsible for providing family-based services, intake services and/or recruitment and certification services to eligible clients. The full job description for this position can be found at [Family Services Office Supervisor](#).

Fictive Kin refers to individuals who are not related by birth, adoption, or marriage to a child, but who have an emotionally significant relationship with the child. These individuals take on the characteristics of a family relationship and/or an alternate caregiver. Fictive Kin would be one placement option available in addition to a relative Caregiver, Foster Home, residential care facility, emergency shelter, or child care institution.

Former Foster Youth Enrollee means individuals who are under age twenty-six (26) and were in Foster Care under the responsibility of the State or a Tribe within Kentucky or another State and enrolled in Medicaid on the date of attaining age eighteen (18) or such higher age as the State elected.

Foster Care (FC) means the twenty-four (24) hour temporary care for children placed away from their parents or guardians and for whom the Title IV-E agency (Department for Community Based Services) has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives or Fictive Kin, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Foster Care Caregiver means the DCBS-authorized caretaker for a Foster Care Enrollee who may be the Foster Care Enrollee's Foster Parent(s), relative(s), Fictive Kin, or twenty-four (24)-hour childcare facility staff.

Foster Care Enrollee (FC Enrollee) means an Enrollee in Foster Care and enrolled in Kentucky SKY.

Foster Parent means a substitute caregiver who assumes the daily caretaking responsibilities for children in DCBS custody who have been placed in their home.

Guardian means an individual appointed by the court to be responsible for a minor if a parent is unable to care for a child due to death, incarceration, or physical or mental incapacity. A parent may be able to designate this guardian according to Kentucky guardianship law if the parent is

capable of making a reasonable choice. A child may also nominate someone to be his or her guardian if the child is fourteen (14) years of age or older and capable of making a reasonable nomination.

High Fidelity Wraparound is an evidence-based approach to Behavioral Health Services designed to meet needs that are prioritized by the youth and family, improve their ability and confidence to manage their own services and supports, develop or strengthen their natural supports, and integrate the work of all child and family service systems and natural supports into one individualized plan.

Individual Health Plan (IHP) means the plan developed for a Medically Complex Child to assess the needs of the child and is updated every six (6) months. An IHP meeting is convened every three (3) months within the Service Region to assess the ongoing needs of the Medically Complex Child and evaluate whether the child's needs continue to warrant a Medically Complex Child designation. The Medically Complex Liaison, Kentucky SKY Contractor, Providers, and others who are involved in the child's medical care attend the IHP meeting.

Interstate Compact on Adoption and Medical Assistance (ICAMA) ensures the continued provision of all of the benefits of an adoption subsidy agreement, regardless of the state of residence of the child, including medical assistance mandated by adoption agreements. ICAMA provides that the state where the adoptive family resides will furnish Medicaid program services to the child.

Interstate Compact on the Placement of Children (ICPC) means the uniform law enacted by all fifty (50) states, the District of Columbia and the U.S. Virgin Islands to ensure protection and services to children who are placed across state lines for Foster Care, temporary placement for services in residential treatment facilities between party states, or as a preliminary to adoption.

Kentucky SKY is the Commonwealth's Medicaid risk-based managed care delivery program for Foster Care Enrollees, Former Foster Care Youth Enrollees, Adoption Assistance Enrollees, and JJ Enrollees.

Kentucky SKY Enrollee means an Enrollee who is enrolled in one of the following eligibility groups: (i) Foster Care Child, (ii) Former Foster Care Youth, and (iii) Adoption Assistance Child. Dually Committed Youth and children eligible pursuant to ICPC and ICAMA are included in the Foster Care Child group.

Kentucky SKY Contractor is the sole Managed Care Organization providing Covered Services to Kentucky SKY Enrollees.

Medical Support Section operates within the Division of Protection and Permanency and consists of physical and mental health professionals that provide consultation to assist regional DCBS staff in safeguarding children and vulnerable adults as well as assisting families. In addition to other responsibilities, the Medical Support Section:

- A. Determines eligibility for the designation of Medically Complex Children;
- B. Visits Medically Complex Children to assist local DCBS staff in ensuring that medical needs are being met;
- C. Participates in the initial development and subsequent quarterly reviews of each Medically Complex Child's Individual Health Plan; and
- D. Provides support and training for Medically Complex Liaisons.

Medically Complex or Medically Complex Child(ren) pursuant to 922 KAR 1:350 means a child considered for possible Medically Complex designation if the child has a medical Condition

diagnosed by a physician which includes:

- A. Significant medically oriented care needs related to a serious illness or condition diagnosed by a health professional that may become unstable or change abruptly resulting in a life-threatening event;
- B. A chronic condition that is expected to be life-long and progressive and to require extensive services;
- C. An acute, time-limited condition requiring additional oversight; or
- D. A severe disability that requires the routine use of medical devices or assistive technology to compensate for the loss of a vital body function needed to participate in activities of daily living and significant and sustained care to avert death or further disability.

Medically Complex Liaison means the DCBS professional responsible for assisting the Kentucky SKY Contractor with arranging the initial Individual Health Plan meeting for the Medically Complex Child within thirty (30) days of the Medically Complex determination.

Neonatal Abstinence Syndrome means is a group of problems that occur in a newborn who was exposed to addictive drugs, including opiates, while in the mother's womb.

Nurse Case Manager (NCM) is responsible for assisting Kentucky SKY Enrollees identified as Medically Complex or requiring Chronic Condition Services in obtaining Medically Necessary Services, health-related services and coordinating their clinical care needs.

Parent means a parent by blood, marriage, or adoption and also means a legal guardian, or other person standing in place of the parent and who is the subject of the DCBS reunification plan.

Peer Support Services means an evidence-based model of care involving a qualified peer support specialist, a person with "lived experience," who supports individuals with mental health issues, trauma, and substance use disorders.

Peer Support Specialist means an individual who has successfully completed the initial and ongoing training approved by DBHDID under Kentucky statute and regulation. Peer Support Services can be provided by an adult Peer Support Specialist, youth Peer Support Specialist, or family Peer Support Specialist.

Qualified Residential Treatment Program (QRTP) is model under the Family First Prevention Services Act reimbursed through Title IV-E. The QRTP must include a trauma-informed treatment model designed to meet the emotional and behavioral needs of youth as identified by an assessment within thirty (30) days of the youth's placement. The model facilitates outreach and engagement of family members in the youth's treatment plan, provides Discharge Planning and family-based aftercare for at least six (6) months. The residential facility must have registered nursing staff and other licensed clinical staff, on-site if required by the facility's treatment model, and must be available twenty-four (24) hours a day, seven (7) days a week. The residential facility must be licensed by the state and accredited by at least one of the following: the Commission on Accreditation of Rehabilitation Facilities, Joint Commission, or the Council on Accreditation.

Regional Juvenile Detention Facility is the building and its premises used for the confinement of a child under the custodial control or supervision of the Justice and Public Safety Cabinet, Department of Juvenile Justice, or another facility or agency, until the child attains the age of eighteen (18) unless otherwise provided by law.

Residential Placement is an Out of Home Placement setting designed to meet the needs of children and youth in DCBS custody with behavioral, emotional and mental health needs that prevent them from being able to reside in a less structured family home setting. Residential

Placement offers a structured physical environment and a treatment program designed to help children improve their ability to function in multiple areas of life and is less restrictive than a PRTF.

Service Plan is an individualized plan developed with and for a Foster Care Enrollee or Adoption Assistance Enrollee which includes, but is not limited to, the following:

- A. Summary of current medical and social needs and concerns;
- B. Short and long term needs and goals;
- C. A treatment plan to address the Foster Care Enrollee or Adoption Assistance Enrollee; and
- D. A description of who will provide such services.

The Service Plan form is found in the DCBS SOP Manual.

Service Regions are the counties of the Commonwealth which DCBS divided into nine (9) Service Areas: Cumberland Region, Eastern Mountain Region, Jefferson Region, The Lakes Region, Northeastern Region, Northern Bluegrass Region, Salt River Trail Region, Southern Bluegrass Region, and Two Rivers Region.

Service Region Administrator is a DCBS professional who provides management for the supervision, development and implementation of child protective services, adult protective and permanency services, and/or the Kentucky Transitional Assistance Program, food stamp benefits and child support. The full job description for this position can be found at [Service Region Administrator](#).

Service Region Administrator Associate is a DCBS professional who provides administrative support services to a Service Region Administrator in developing, implementing, and monitoring regional plans and initiatives. The full job description for this position can be found at [Service Region Administrator Associate](#).

Service Region Clinical Associate is a DCBS professional who provides complex casework consultation to DCBS staff who are engaged in the provision of services leading to stability, safety, permanency, self-sufficiency and well-being to families and children, and directs corrective actions in cases with deficits in assessment and case planning. The full job description for this position can be found at [Service Region Clinical Associate](#).

Social Determinants of Health - Conditions in which people are born, grow, live, work and age that shape health. Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to healthy food choices, access to transportation, social support networks and connection to culture, as well as access to health care are all determinants of health.

Social Service Specialist is a DCBS professional who provides consultative services to families, DCBS staff throughout a Service Area for program specialties such as Foster Care, child/adult protective services, Adoption Assistance, juvenile justice, and services to children/individuals with special health care needs. Other responsibilities include reviewing and analyzing complex cases and participate in case conferences. The full job description for this position can be found at [Social Service Specialist](#).

Social Service Worker I (SSW) is a DCBS professional who provides family or community based, preventive services including, but not limited to, child protection, Foster Care, adult protection, juvenile justice, guardianship services, and Adoption Assistance. Other responsibilities include interviewing clients, investigating complaints of abuse/neglect of children, making home visits, assessing the need for services, and providing on going family based services. Further, this position develops service objectives and Service Plans, makes appropriate referrals, provides and

coordinates needed services. The full job description for this position can be found at [Social Service Worker](#).

Standards of Practice Manual (SOP Manual) is a DCBS tool documenting policies, procedures and forms applicable to children and youth in Foster Care and Adoption Assistance. The Standards of Practice Manual is located at <http://manuals.sp.chfs.ky.gov/Pages/index.aspx>.

Substance Exposed Infant (SEI) means a child under the age of twelve (12) months who is subjected to or in the presence of an individual whose use of legal or illegal substances creates an environment which places the child at risk of serious harm. This definition includes fetal alcohol syndrome which is a range of disorders and abnormalities that occur in a child as the result of alcohol exposure during the mother's pregnancy.

The Workers Information System (TWIST) is a statewide automated child welfare information system operated by the Cabinet supporting the business requirements of the Department of Community Based Services. TWIST is a central repository for documenting adult and child protection cases, and provides data collection and reporting capabilities to measure outcomes and performance.

Therapeutic Foster Care is a care program for children and youth who need therapeutic intervention for behavioral or emotional issues in the least restrictive environment in which these needs can be met outside a residential or psychiatric treatment facility.

Title IV-B of the Social Security Act addresses the provision of child welfare services that can be used for prevention of and response to child abuse and neglect. It does so by funding services and programs which protect and promote the welfare of all children, prevent the neglect, abuse, or exploitation of children; and support at-risk families through services which allow children, where appropriate, to remain with their families or return to their families in a timely manner.

Title IV-E of the Social Security Act provides for federal payments to states for Foster Care maintenance and adoption assistance payments made on behalf of certain eligible children. The objectives are:

- A. To improve the quality of care provided to children in substitute care;
- B. To reduce the number of children who are removed from their own homes for placement in substitute care. Substitute care includes foster family, group home and institutional care;
- C. To return children from substitute care to their homes as soon as conditions in the home permit; and
- D. To facilitate the adoption or other permanent placement for those children who cannot be returned to their own homes.

There are two major components of Title IV-E: eligibility and reimbursability. Eligibility does not automatically confer federal benefits. The reimbursability criteria shall be met for a state to receive federal support for the child.

Trauma means those "experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being."²

Trauma-informed is an approach to the delivery of behavioral health services that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and

² https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/key_terms.html

populations. According to the Substance Use and Mental Health Services Administration (SAMHSA), there are “four key elements of a trauma-informed approach: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; (3) responding by putting this knowledge into practice; and (4) resisting retraumatization.”³

Trauma-informed Care is an approach to engaging people that recognizes the potential presence of trauma symptoms and acknowledges the role that trauma may play in an individual’s life ⁴ According to the National Council for Behavioral Health, there are seven (7) domains of trauma-informed care: “early screening and assessment, consumer-driven care and services, nurturing a trauma-informed and responsive workforce, evidence-based and emerging best practices, creating safe environments, community outreach and partnership building, and ongoing performance improvement and evaluation”.⁵

2.0 ABBREVIATIONS AND ACRONYMS

AA - Adoption Assistance

ABP - Alternative Benefit Plan

ACA - Affordable Care Act

ADA - American Dental Association

AHRQ - Agency for Health Care Research and Quality

AIDS - Acquired Immune Deficiency Syndrome

APRN - Advanced Practice Registered Nurse

A/R - Accounts Receivable

AT - Assessment Team

BBA - Balanced Budget Act

BH - Behavioral Health

BIN - NCPDP Processor ID Number

CAHPS - Consumer Assessment of Health Care Providers and Systems

CANS - Child and Adolescent Needs and Strengths

CAP - Corrective Action Plan

³ https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/key_terms.html

⁴ Harris, M. and Fallot, R. D., "Using trauma theory to design service systems," *New Directions for Mental Health Services*, Vol. 2001, No. 89, Spring 2001.

⁵ <https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/>

CASA - Court Appointed Special Advocate

CCD - Continuity of Care Document

CCT - Care Coordination Team

CE - Community Engagement

C.F.R. - Code of Federal Regulations

CHFS - Cabinet for Health and Family Services

CMHC - Community Mental Health Center

CMS - Centers for Medicare and Medicaid Services

CMS-416 - Centers for Medicare and Medicaid Services-416 (form)

CMS-1500 - Centers for Medicare and Medicaid Services-1500 (form)

COB - Coordination of Benefits

COPD - Chronic Obstructive Pulmonary Disease

CPT - Current Procedural Terminology

DEA - Drug Enforcement Administration

DIVERTS - Direct Intervention: Vital Early Responsive Treatment Systems

DJJ - Department of Juvenile Justice

DSH - Disproportionate Share Hospital

DSM-V - Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

EEO - Equal Employment Opportunity

EHR - Electronic Health Records

EPSDT - Early and Periodic Screening, Diagnostic and Treatment

EQR - External Quality Review

EQRO - External Quality Review Organization

FAC - Finance and Administration Cabinet

FC - Foster Care

FFPSA - Family First Prevention Services Act

FFS - Fee-For-Service

FPL - Federal Poverty Level

FQHC - Federally Qualified Health Center

FSOS - Family Services Office Supervisor

FTE - Full-time Equivalent

HANDS - Kentucky Health Access Nurturing Development Services

HCPCS - Health Care Common Procedure Coding System

HEDIS™ - Health Care Effectiveness Data and Information Set

HHS - The United States Department for Health and Human Services

HIPAA - Health Insurance Portability and Accountability Act

HIV - Human Immunodeficiency Virus

HRA - Health Risk Assessment

HTTP - Hyper Text Transport Protocol or Hyper Text Transfer Protocol

ICAMA - Interstate Compact on Adoption and Medical Assistance

ICD-10-CM - International Classification of Diseases, Tenth Revision, Clinical Modification

ICF-IID - Intermediate Care Facility for Individuals with Intellectual Disabilities

ICN – Internal Control Number

ICPC - Interstate Compact on the Placement of Children

IHP - Individualized Health Plan

KAR - Kentucky Administrative Regulation

KCHIP - Kentucky Children’s Health Insurance Program

KRS - Kentucky Revised Statute

LPN - Licensed Practical Nurse

MAC - Maximum Allowable Cost

MAGI - Modified Adjusted Gross Income

MBHO - Managed Behavioral Healthcare Organization

MCE - Managed Care Entity

MCO - Managed Care Organization

MDT - Multidisciplinary Team

MIS - Management Information System

MLR - Medical Loss Ratio

MMIS - Medicaid Management Information System

NAS - Neonatal Abstinence Syndrome

NCCI - National Correct Coding Initiative

NCM - Nurse Case Manager

NCPDP - National Council for Prescription Drug Programs

NCQA - National Committee for Quality Assurance

NDC - National Drug Code

NEMT - Non-Emergency Medical Transportation

NPI - National Provider Identifier

OBRA - Omnibus Budget Reconciliation Act

OSCAR - Online Survey Certification and Reporting

PA - Prior Authorization

PATH - Partnering to Advance Training and Health

PCN - Processor Control Number

PCP - Primary Care Provider

PCRPP - Person-Centered Recovery Planning

PDL - Preferred Drug List

PMPM - Per Member Per Month

POS - Point of Sale

ProDUR - Prospective Drug Utilization Review

PRTF - Psychiatric Residential Treatment Facility

P&T - Pharmacy and Therapeutics Committee

QAPI - Quality Assessment and Performance Improvement

QRTP - Qualified Residential Treatment Program

R/A - Remittance Advice

RAC - Recovery Audit Contractor

RetroDUR - Retrospective Drug Utilization Review

RFP - Request for Proposal

RHC - Rural Health Clinic

RN - Registered Nurse

SDOH - Social Determinants of Health

SOBRA - Sixth Omnibus Budget Reconciliation Act

SOP - Standards of Practice Manual

SRCA - Service Region Clinical Associate

SSI - Supplemental Security Income

SSW - Social Service Worker

STC - Special Terms and Conditions

TANF - Temporary Assistance for Needy Families

TMA - Transitional Medical Assistance

TTY-TTD - TeleTypewriter-Telecommunications Device for the Deaf

TPL - Third Party Liability

UB-92 - Universal Billing 1992 (form)

UB-04 - Universal Billing 2004 (form)

UCF - Universal Claim Form

UM - Utilization Management

URAC - Utilization Review Accreditation Commission

USC - United States Code

VPN - Virtual Private Network

WIC - Women, Infants and Children

WS-Security - Web Services-Security

3.0 CONTRACTOR TERMS

3.1 Contractor Representations and Warranties

The Contractor represents and warrants that the following are true, accurate and complete statements of fact as of the Execution Date and that the Contractor shall take all actions and fulfill all obligations required so that the representations and warranties made in this Contract shall remain true, accurate and complete statements of fact throughout the term of the Contract.

3.2 Organization and Valid Authorization

The Contractor is a Legal Entity duly organized, validly existing and in good standing under the laws of the Commonwealth, and is in full compliance with all material Commonwealth requirements and all material municipal, Commonwealth and federal tax obligations related to its organization as a Legal Entity. The obligations and responsibilities set forth in this Contract have been duly authorized under the terms of the laws of the Commonwealth and the actions taken are consistent with the Articles of Incorporation and By-laws of Contractor.

This Contract has been duly authorized and validly executed by individuals who have the legal capacity and authorization to bind the Contractor as set forth in this Contract. Likewise, execution and delivery of all other documents relied upon by FAC and the Department in entering into this Contract have been duly authorized and validly executed by individuals who have the legal capacity and corporate authorization to represent the Contractor.

3.3 Licensure of the Contractor

The Contractor has a valid license to operate as an HMO or Insurer, issued by DOI. There are no outstanding unresolved material Appeals or Grievances filed against Contractor with DOI. The Contractor has timely filed all reports required by DOI and DOI has taken no adverse action against Contractor of which FAC has not been notified.

As an HMO or Insurer under Subtitle 3 of the Kentucky Insurance Code with a health line of authority, and regardless of the non-applicability of any other provision of the Kentucky Insurance Code or any legal authority cited herein, pursuant to this Contract the Contractor agrees to be subject to a one percent (1%) annual assessment on Capitation Payments that follow the provisions of any broad based assessment within state law including but not limited to the Governor's Enacted Budget, KRS 304.17B-021 or KRS 142.316, subject to the approval of CMS. The one percent (1%) assessment is a component of the Capitation Rates as contained in **Appendix A "Capitation Payment Rates."** On or about March 1st of each year, the Department

shall notify the Contractor in writing that the annual assessment is due and the Contractor shall have thirty (30) calendar days to remit payment in full to the Department. In the event the assessment is increased, the increase shall be provided for in an amended Capitation Rate. If CMS fails to approve this component of the rates, or if the assessment is otherwise deemed non-collectable, the Capitation Payment rates shall be adjusted to remove that component from the Capitation Rate.

3.4 Fiscal Solvency

As of the Execution Date, Contractor's statutory surplus is at or above the Regulatory Action Level as defined in the risk-based capital regulations applicable to designated HMO or Insurer's licenses in the Commonwealth. The Contractor is not aware of any impending changes to its financial structure that could adversely impact its compliance with these requirements or its ability to pay its debts as they come due generally. The Contractor has not filed for protection under any Commonwealth or federal bankruptcy laws. None of the Contractor's property, plant or equipment has been subject to foreclosure or repossession within the preceding ten (10)-year period, and the Contractor has not had any debt called prior to expiration within the preceding ten (10)-year period.

3.5 Licensure of Providers

Prior to the start date of operations and at all times during the period of the Contract, the Contractor shall ensure that each provider, including individuals and facilities and their staff, providing health care services to Enrollees is validly licensed or, where required, certified to provide those services in the Commonwealth or the state in which services are provided, including certification under CLIA, if applicable. Each provider in has a valid Drug Enforcement Agency ("DEA") registration number, if applicable. Each provider shall have a valid NPI and Taxonomy, if applicable.

3.6 Ownership or Controlling Interest/Fraud and Abuse

Neither the Contractor nor any individual who has a controlling interest or who has a direct or indirect ownership interest of five percent (5%) or more of the Contractor, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over the Contractor or who directly or indirectly conducts the day-to-day operation of the Contractor) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to Fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

Contractor shall require by contract that neither any Provider of health care services in the Contractor's Network, nor any individual who has a direct or indirect ownership or controlling interest of five percent (5%) or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over the Provider or who directly or indirectly conducts the day-to-day operation of the Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to Fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from

participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

The Contractor shall certify its compliance with 42 C.F.R. 438.610(a), (b) and (c) and have processes and/or procedures in place to ensure ongoing compliance throughout the life of the Contract.

3.7 Compliance with Federal Law

- A. The Contractor shall be prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):
 - 1. Furnished by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX of the Social Security Act or Sections 1128, 1128A, 1156, or 1842(j)(2), [203] of the Social Security Act;
 - 2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);
 - 3. Furnished by an individual or entity to whom the Department has suspended payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the Department determines there is good cause not to suspend such payments;
 - 4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
 - 5. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; or
 - 6. For home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.
- B. The Capitation Payment provided by this Contract shall not be paid to the Contractor if it could be excluded from participation in Medicare or Medicaid for any of the following reasons:
 - 1. The Contractor is controlled by a sanctioned individual;
 - 2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act;
 - 3. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, Utilization Review, medical social work, or administrative services, with one of the following:
 - a. Any individual or entity excluded from participation in Federal health care programs.
 - b. Any entity that would provide those services through an excluded individual or entity.
- C. Prohibited Affiliations.
 - 1. The Contractor shall not:
 - a. Knowingly have a director, officer, or partner who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs;
 - b. Knowingly have a person with ownership of more than five percent (5%) of the managed care entity's (MCE's) equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs; or
 - c. (Knowingly have an employment, consulting, or other agreement with an individual

- or entity for the provision of MCE contract items or services who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs.
2. The Contractor shall provide written disclosure to the Department of any director; officer; partner; Subcontractor, Network Provider; individual or entity with an employment, consulting, or other agreement; or any affiliation with a person or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
 3. If the Department learns that the Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department shall notify CMS of the noncompliance; may continue this Contract unless CMS directs otherwise; shall not renew or extend this Contract unless CMS provides to the Department a written statement describing compelling reasons that exist for renewing or extending the agreement.
- D. The Contractor shall report to the Department and, upon request, to the Secretary of HHS, the Inspector General of the HHS, and the U. S. Comptroller General a description of transactions between the Contractor and a party in interest (as defined in Section 1318(b) of such Social Security Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the Contractor and such a party; (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; (iii) Any lending of money or other extension of credit between the Contractor and such a party. The Contractor shall make any reports of transactions between the Contractor and parties in interest that are provided to the Department, or other agencies available to Enrollees upon reasonable request.
- E. The Contractor shall disclose to the Department any persons or corporations with an ownership or control interest in the Contractor that has direct, indirect, or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity; owns five percent (5)% or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets; is an officer or director of the Contractor organized as a corporation, or is a partner of the Contractor organized as a partnership.

The disclosure shall contain: the name and address (The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address; date of birth and Social Security Number (in the case of an individual); other tax identification number (in the case of a corporation); whether the control interest in the Contractor or the Contractor's Subcontractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; the name of any other Medicaid provider or Fiscal Agent in which the person or corporation has an ownership or control interest and the name, address, date of birth, and Social Security Number of any managing employee of the Contractor.

3.8 Pending or Threatened Litigation

All material threatened or pending litigation against the Contractor or its Affiliates has been disclosed in writing to FAC prior to the Execution Date. For purposes of this Section, litigation is material if a final finding of liability against the Contractor or its Affiliate(s), would create a substantial likelihood that the Contractor's ability to perform its obligations under this Contract would be significantly impaired. Any new material litigation filed against the Contractor or its Affiliates after the Execution Date will be disclosed in writing to FAC within ten (10) Business Days of receipt by the Contractor of notice new pending litigation. For purposes of this Section the term "litigation" shall mean any formal judicial or administrative proceeding.

4.0 CONTRACTOR FUNCTIONS

4.1 Performance Standards

The Contractor shall perform or cause to be performed all of the Covered Services and shall develop, produce and deliver to the Department all of the statements, reports, data, accounting, Claims and documentation described and required by the provisions of this Contract, and the Department shall make payments to the Contractor on a capitated basis as described in this Contract. The Contractor acknowledges that failure to comply with the provisions of this Contract may result in the Commonwealth taking action pursuant to **Sections 39.1 through 39.13 “Remedies for Violation, Breach, or Non-Performance of Contract.”** The Contractor shall meet the applicable terms and conditions imposed upon Medicaid managed care organizations as set forth in 42 United States Code Section 1396b(m), 42 C.F.R. 438 et seq., 907 KAR Title 17, other related managed care regulations and the 1915 Waiver, as applicable.

4.2 Administration and Management

The Contractor shall be responsible for the administration and management of all aspects of the performance of all of the covenants, conditions and obligations imposed upon the Contractor pursuant to this Contract. No delegation of responsibility, whether by Subcontract or otherwise, shall terminate or limit in any way the liability of the Contractor to the Department for the full performance of this Contract.

The Contractor agrees that its administrative costs shall not exceed ten percent (10%) of the total Medicaid managed care contract cost. Administrative costs are those costs consistent with DOI annual financial filings that are included in the line for “GAO” which is generally referred to as General, Administrative, and Overhead expenses.

4.3 Delegations of Authority

If the Contractor delegates responsibilities to a Subcontractor, the Contractor shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230(b) and 42 CFR 434.6. The Contractor shall ensure that the Subcontractor is in compliance with all Medicaid laws and regulations including applicable subregulatory guidance and contract provisions.

The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor in compliance with 42 C.F.R. 438.230. Before any delegation, the Contractor shall evaluate the prospective Subcontractor’s ability to perform the activities to be delegated. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.

The Department has the right to approve or deny delegation to any Subcontractor.

See **Section 6.0 “Subcontracts”** for subcontracting requirements.

4.4 Approval of Department

The Contractor shall submit provider or Enrollee materials, information, or documents to the Department and all such submissions will be reviewed by the Department (i) during Readiness Review; (ii) within thirty (30) days for standard submissions or (iii) five (5) Business Days for expedited submissions. The Contractor shall not use or distribute such materials with Enrollees or Providers until such time that Department approval has been received.

Written material submitted to the Department for review and approval shall be considered received for review beginning with the date that the Department acknowledges to the Contractor receipt of the submission. Such acknowledgment may be demonstrated by evidence of a return receipt if sent via U.S. Mail, a delivery receipt if sent via e-mail, or the signature of a Cabinet for Health and Family Services employee taking receipt of the submission in the case of hand-delivery, including overnight mail or courier delivery.

No materials will be considered approved unless such approval is sent to the Contractor in writing by the Department.

General health education materials do not require prior approval by the Department. However, the Contractor shall ensure such materials are in compliance with this Contract and state and federal regulations and laws. The Contractor shall be subject to penalties for materials found to be non-compliant as set forth in **Appendix B "Remedies for Violation, Breach, or Non-Performance of Contract."**

4.5 No Third Party Rights

This Contract does not, nor is it intended to, create any rights, benefits or interest to any Enrollee, provider, PHO, provider network, Subcontractor, delegated Subcontractor, supplier, corporation, partnership or other organization of any kind.

5.0 CONTRACTOR CONFORMANCE WITH APPLICABLE LAW, POLICIES AND PROCEDURES

5.1 Department Policies and Procedures

The Contractor shall comply with the applicable policies and procedures of the Department, specifically including without limitation the policies and procedures for MCO services, and all policies and procedures applicable to each category of Covered Services as required by the terms of this Contract. In no instance may the limitations or exclusions imposed by the Contractor with respect to Covered Services be more stringent than those specified in the applicable Department's policies and procedures without the approval of the Department. The Department shall provide reasonable prior written notice to Contractor of any material changes to its policies and procedures, or any changes to its policies and procedures that materially alter the terms of this Contract.

5.2 Commonwealth and Federal Law

At all times during the term of this Contract and in the performance of every aspect of this Contract, the Contractor shall strictly adhere to all applicable federal and Commonwealth law (statutory and case law), regulations and standards, in effect when this Contract is signed or which may come into effect or which may be amended or repealed during the term of this Contract, except where waivers of said laws, regulations or standards are granted by applicable federal or Commonwealth authority. In addition to the other laws specifically identified herein, the Contractor shall comply with the Davis-Bacon Act and the Clean Air Act and Federal Water Pollution Control Act. The Contractor agrees to comply with the terms of 45 C.F.R. 93 Appendix A, as applicable.

Any change mandated by the Affordable Care Act which pertains to Managed Care Organizations (MCO) and/or Medicaid Services shall be implemented by the Contractor without amendment to this Contract.

5.3 Nondiscrimination and Affirmative Action

During the performance of this Contract, the Contractor agrees as follows:

- A. The Contractor shall not discriminate against any employee or applicant for employment because of race, religion, color, national origin, sex, sexual orientation, gender identity or age. The Contractor further shall comply with the provision of the Americans with Disabilities Act of 1990 (Public Law 101- 336), 42 USC 12101, and applicable federal regulations relating thereto prohibiting discrimination against otherwise qualified disabled individuals under any program or activity. The Contractor shall provide, upon request, needed reasonable accommodations. The Contractor will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to their race, religion, color, national origin, sex, age or disability. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor shall post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause or its nondiscriminatory practices.
- B. The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor; state that all qualified applicants will receive consideration for employment without regard to race, religion, color, national origin, sex, sexual orientation, gender identity, age or disability.
- C. The Contractor shall send to each labor union or representative of workers with which they have a collective bargaining agreement or other contract understanding, a notice advising the said labor union or workers' representative of the Contractor's commitments under this Section, and shall post copies of the notice in conspicuous places available to employees and applicants for employment. The Contractor shall take such action with respect to any Subcontract or purchase order as FAC may direct as a means of enforcing such provisions, including sanctions for noncompliance.
- D. The Contractor shall comply with all applicable provisions and furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, as amended, and by the rules, regulations and orders of the Secretary of Labor, or pursuant thereto, and will permit access to their books, records and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations and orders.
- E. In the event of the Contractor's noncompliance with the nondiscrimination clauses of this Contract or with any of the said rules, regulations or orders, this Contract may be canceled, terminated or suspended in whole or in part and the Contractor may be declared ineligible for further government contracts or federally-assisted construction contracts in accordance with procedures authorized in Executive Order No. 11246 of September 24, 1965, as amended, and such other sanctions may be imposed and remedies invoked as provided in or as otherwise provided by law.
- F. The Contractor shall include the provision of paragraphs (1) through (7) of Section 202 of Executive Order No. 11246 in every Subcontract or purchase order unless exempted by rules, regulations or orders of the Secretary of Labor, issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, as amended, so that such provisions will be binding upon each Subcontractor or vendor. Monitoring of Subcontractor compliance with the provisions of this Contract on nondiscrimination shall be accomplished during regularly scheduled quality assurance audits. Any reports of alleged violations of the requirements of this Section received by the Contractor, together with any suggested resolution of the alleged violation proposed by the Contractor in response to the report, shall be reported to FAC within five (5) Business Days. Following consultation with the Contractor, FAC shall advise the Contractor of any further action it may deem appropriate in resolution of the violation. The Contractor will take such action with respect to any Subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions including sanctions for noncompliance; provided, however, that in the event the Contractor becomes involved in, or is threatened with, litigation with a Subcontractor as a result of such direction by the agency, the Contractor may request the United States to enter or intervene into such litigation to protect the interests of the United States. The Contractor shall comply with Title IX of the Education Amendments of 1972 (regarding education programs and activities), if applicable.

5.4 Employment Practices

The Contractor agrees to comply with each of the following requirements and to include in any Subcontracts that any Subcontractor, supplier, or any other person or entity who receives compensation pursuant to performance of this Contract, a requirement to also comply with the following laws:

- A. Title VI of the Civil Rights Act of 1964 (Public Law 88-352);
- B. Title IX of the Education Amendments of 1972 (regarding education, programs and activities);
- C. The Age Discrimination Act of 1975;
- D. The Rehabilitation Act of 1973;
- E. Rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741; and
- F. Regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112).

5.5 Governance

The Contractor shall have a governing body. The governing body shall ensure adoption and implementation of written policies governing the operation of the Contractor's plan. The administrator or executive officer who oversees the day-to-day conduct and operations of the Contractor shall be responsible to the governing body. The governing body shall meet at least quarterly, and shall keep a permanent record of all proceedings available to the Cabinet, FAC, and/or CMS upon request. The Contractor shall have written policies and procedures for governing body elections detailing, at a minimum, the following: how board members will be elected; the length of the term for board members; filling of vacancies; and notice to Enrollees.

5.6 Access to Premises

The State, CMS, HHS Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its Subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

The Contractor shall provide computer access in the event an audit, inspection, investigation or other on-site visit is conducted. The Contractor shall provide log-in credentials in order to access Contractor's Claims and customer service systems on a read-only basis. The Contractor shall provide access to a locked space and office security credentials for use during business hours. All access under this Section shall comply with HIPAA's minimum necessary standards and any other applicable Commonwealth or federal law.

In addition, upon reasonable notice, the Contractor shall allow duly authorized agents or representatives of the Commonwealth or federal government or the independent External Quality Review Organization (EQRO) access to the Contractor's premises during normal business hours, and shall cause similar access or availability to the Contractor's Subcontractors' premises to inspect, audit, investigate, monitor or otherwise evaluate the performance of the Contractor and/or its Subcontractors. The Contractor and/or Subcontractors shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

In the event right of access is requested under this Section, the Contractor or Subcontractor shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the Commonwealth, federal, or external quality

review personnel conducting the audit, investigation, or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Contractor's or Subcontractors' activities. The Contractor shall have twenty (20) Business Days to respond to any findings of an audit performed by FAC, the Department or their agent before the findings are finalized. The Contractor shall cooperate with FAC, the Department or their agent as necessary to resolve audit findings. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations.

5.7 Waivers, State Innovation Models or Other Federal Initiatives

The Contractor shall participate, upon the Department's request, in any federal waivers, grant initiatives or awards or other program changes that develop, plan, create or implement any model that includes but is not limited to integration of behavioral health and physical health, improve health care delivery, reform payment, require Enrollee engagement or improve population health outcomes. Such support may include but not be limited to collaboration with the Department and its designees in developing and implementing the identified initiatives and models, providing data or other information to inform planning and development of initiatives and models, and implementation of programmatic changes and innovations to support implementation of the initiatives and models. The Contractor shall provide reporting and data as determined or requested by the Department.

6.0 SUBCONTRACTS

6.1 Requirements

The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Enrollees or other services that involve risk-sharing, medical management, or otherwise interacting with an Enrollee or Provider, except the Contractor shall not enter into any Subcontract with Subcontractors outside of or that would be providing any services outside the United States. All subcontractors shall have and maintain Kentucky specific expertise in each content area for which they are providing services.

Subcontractors must be eligible for participation in the Medicaid program, pursuant to federal and state regulations. The Contractor shall evaluate each prospective Subcontractor's ability to perform the proposed delegated activities. The Contractor shall execute a written contractual agreement (Subcontract) between the Contractor and Subcontractor that is in a form and has content approved by the Department. Furthermore, the Contractor shall submit any change in terms or scope of a Subcontract, notice of suspension or termination of a Subcontract to the Department for review and approval. The Contractor shall submit for review to the Department a listing of Subcontractors who will support this Contract, a description and role of each Subcontractor, detail listing of services provided, all locations of operation including disclosure of any and all operations outside the United States, and a template agreement of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Enrollees, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, the Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract including the processing of Claims.

The Department's review shall ensure that all Subcontract template agreements include the following information and related requirements, at a minimum and as applicable to the given Subcontract:

- A. Identify the population covered by the Subcontract;
- B. Specify the amount, duration and delegated scope of services and reporting responsibilities of the Subcontractor, including specification that the Subcontractor shall provide information and data with the level of detail and on a timeline specified by the Contractor and Department;
- C. Require participation in meetings with the Department by staff as requested by the Department;
- D. Require ongoing and ad hoc reporting to the Department as defined and upon request. Include a statement that the Department shall have unlimited but not exclusive rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Subcontractor resulting from this Contract. However, the Department shall not disclose proprietary information that is afforded confidential status by state or federal regulations;
- E. Specify that the Subcontractor shall support the Contractor and the Department, upon request, in responding to legislative or other stakeholder requests. Support may include provision of data or other information, participation in drafting of materials or reports, or attendance in required meetings or other forums;
- F. Specify that all materials developed by the Subcontractor specific to this Contract shall include the name and logo of each Contractor for which the material is applicable. The Subcontractor shall not publish materials that are used for more than one Contractor without each Contractor being identified on the materials;
- G. Include a requirement that data and information about Covered Services and Enrollees as applicable to this Contract 1) cannot be held as proprietary unless agreed to by the Department and 2) must be made available to the Department;
- H. For Subcontractors that will contract with Providers, specify the following:
 - 1. Use of only Medicaid enrolled providers in accordance with this Contract;
 - 2. Inclusion of all requirements set forth in **Appendix C. "Required Standard Provisions for Network Provider Contracts"**; and
 - 3. Requirements to follow required policies and processes for credentialing conducted by the Credentialing Verification Organization (CVO);
- I. Specify that a Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report;
- J. Provide full disclosure of the method of compensation or other consideration to be received from the Contractor;
- K. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Enrollees of Medically Necessary Covered Services;
- L. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;
- M. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;
- N. Specify that the Subcontractor where applicable, agrees to timely submit Encounter Records in the format specified by the Department so that the Contractor can meet the specifications required by this Contract;
- O. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of FAC and the Department, applicable subregulatory guidance and contract provisions, and all standards governing the provision of Covered Services and information to Enrollees, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of FAC, the Department, the Office of the Inspector General, the Attorney

- General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination;
- P. Require participation in readiness reviews as requested by the Department, including submission of requested materials, participation in meetings, and onsite reviews;
 - Q. Provide for Contractor to conduct ongoing monitoring of the Subcontractor's performance of the full scope of required services and the quality of services rendered to Enrollees in accordance with the terms of this Contracts, including those with accreditation. The Subcontract shall include the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; requirement for formal review according to a periodic schedule consistent with industry standards, but no less than annually. As requested, the Contractor shall provide results of the review to the Department;
 - R. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action. The Contractor shall inform the Department of any required corrective actions related to Covered Services, Enrollees, or providers. The Department will determine frequency of required updates on progress of implementation of the corrective actions;
 - S. Specify the right of the state, CMS, HHS Inspector General, the Comptroller General or their designee to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, determination of amounts payable under the MCO's contract with the State, or for reasonable possibility of Fraud or similar risk;
 - T. Specify the Subcontractor will make its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to Medicaid Enrollees available;
 - U. The right to audit through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later;
 - V. Requirement that Subcontractors notify the Contractor throughout the Contract Term of any new or existing litigation;
 - W. Specify the remedies up to, and including, revocation of the Subcontract available to the Contractor if the Subcontractor does not fulfill its obligations. The Subcontractor shall also be subject to penalties as set forth in **Appendix B "Remedies for Violation, Breach, or Non-Performance of Contract."**
 - X. Contain provisions that suspected Fraud and Abuse be reported to the Contractor.
 - Y. Requirements that provide for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate and if the Subcontractor does not provide data or information upon request;
 - Z. A statement that the Subcontract may be terminated by the Contractor for convenience and without cause upon a specified number of days written notice; and
 - AA. Specify procedures and criteria for extension, renegotiation and termination.

The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the suspension or termination of any approved Subcontractors within ten (10) days following suspension or termination. All approvals required by this section are subject to **Section 4.4 "Approval of Department."**

6.2 Subcontractor Indemnity

Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Enrollee from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.

Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or Insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Enrollees to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.

6.3 Disclosure of Subcontractors

The Contractor shall inform the Department of any Subcontractor providing Covered Services for which the Subcontractor contracts a subcontractor in any transaction or series of transactions, in performance of any term of this Contract. As set forth in **Section 6.1 “Requirements,”** such arrangements require prior written consent of the Department.

6.4 Remedies

FAC and the Department shall each have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.

6.5 Capitation Agreements

The Contractor shall notify the Department of any “Capitation” agreement, including agreement changes or updates, with Subcontractors or Providers that includes the assumption of risk by the Subcontractor or Provider. The notification shall include the name of the entity, the scope of the risk, the contracting amount, and how the entity in turn pays its Subcontractors or Providers for providing Covered Services. The Contractor shall submit monthly reports of Capitation Payments made to Subcontractors, such as but not limited to a vision or pharmacy benefit manager or Providers such as Primary Care Physicians. The Contractor shall mark records it considers proprietary as such and shall defend such classification in the event an Open Records request is made concerning the proprietary record.

7.0 CONTRACT TERM

7.1 Term

The term of the Contract shall be for the period **July 1, 2020** through **December 31, 2025**. This Contract may be renewed for five (5) additional two (2) year periods upon the mutual agreement of the Parties. Such mutual agreement shall take the form of an addendum to the Contract under **Section 40.3 “Amendments.”** The Contractor shall give notice to the Commonwealth at least sixty (60) days before the end of any annual term if the Contractor does not intend to renew the Contract. The Department shall use its best efforts to provide rates for renewal terms at least ninety (90) days prior to the expiration of the current term, unless the Department elects not to renew the Contract hereunder.

Vendors shall not be eligible to accept Medicaid Enrollees or receive monthly capitated rate payments prior to meeting all Readiness Review and Network Adequacy requirements. Awarded Vendor(s) are to meet these requirements no later than April 1, 2020. Failure to meet the requirements by this date may result in cancellation of the awarded contract. At the end of the contract, the vendor shall provide all agency data in a form that can be converted to any subsequent

system of the agency's choice. The vendor shall cooperate to this end with the vendor of the agency's choice, in a timely and efficient manner.

The Commonwealth reserves the right not to exercise any or all renewal options. The Commonwealth reserves the right to extend the Contract for a period less than the length of the above-referenced renewal period if such an extension is determined by FAC and the Department to be in the best interest of the Commonwealth and agreed to by the Contractor.

The Commonwealth reserves the right to renegotiate any terms and/or conditions as may be necessary to meet requirements for the renewal period. In the event proposed terms or conditions cannot be agreed upon, subject to the notices above, either party shall have the right to withdraw without prejudice from exercising the option for a renewal.

7.2 Effective Date

This Contract is not effective and binding until approved by the Commonwealth of Kentucky. Payment under this Contract is contingent upon approval by CMS of any Waiver Amendment, State Plan Amendment and this Contract.

7.3 Social Security

The parties are cognizant that the Commonwealth is not liable for Social Security contributions pursuant to 42 U.S. Code Section 418, relative to the compensation of the Contractor for this Contract.

7.4 Contractor Attestation

The Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or Designee shall attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission. This includes Encounter data or any other data in which the contractor paid Claims.

8.0 READINESS REVIEW

8.1 Prerequisite to Enrolling Enrollees

The Department reserves the right to conduct a thorough readiness review prior to the enrollment of Medicaid Enrollees with the Contractor and its Subcontractors to ensure the Contractor and its Subcontractors are able and prepared to perform all administrative functions and to provide high quality services to Enrollees. Readiness reviews may include desk reviews of materials, policies, and procedures; systems demonstrations; onsite reviews; and interviews of staff. The Department reserves the right to also conduct onsite reviews in Subcontractor facilities. Specifically, the Department will assess the Contractor's ability and readiness to, at a minimum, meet the requirements set forth in the Contract, Commonwealth requirements, and federal requirements outlined in 42 C.F.R. 438.66.

The Department will designate a multi-disciplinary readiness review team, which may include DMS staff, sister agency representatives, and contract staff. The Department will establish and provide to the Contractor the timeline for conduct of the readiness reviews, including Contractor requirements. The Contractor and its Subcontractors shall meet all required timelines for submission of requested materials and deliverables to the Department, be responsive to questions within designated timeframes, and provide adequate space and facilities for conduct of onsite reviews. The Contractor shall include all staff and Subcontractor representatives in readiness

review meetings or onsite reviews as identified and requested by the Department.

The Department will provide the Contractor with a summary of findings and identified areas requiring remedial attention or corrective action. The Contractor shall develop a plan and relevant timelines for addressing the identified issues. The Department may conduct follow up reviews to assess the effectiveness of the Contractor's implemented plan and subsequent readiness.

A Contractor's failure to pass the readiness review or to cure the deficiencies through remedial attention or correction action may result in the assessment and payment of liquidated damages against the Contractor, delayed operations or Enrollment, and/or immediate Contract termination pursuant to **Section 39.11 "Termination for Default."**

The Department reserves the right to conduct readiness reviews at any point during the Contract Term based on implementation of programmatic or regulatory changes that result in operational changes deemed to be material by the Department.

9.0 ORGANIZATION AND COLLABORATION

9.1 Office in the Commonwealth

The Contractor shall establish and maintain an office within Kentucky, no more than eighty (80) Miles from 275 East Main Street, Frankfort, Kentucky. Such office shall be established within ninety (90) days of Contract Execution and, at a minimum, the Contractor shall locate the Executive Team in this office.

The Contractor shall also staff the following positions or equivalent to be located in and operate from within the State:

- A. Enrollee Services;
- B. Provider Services, including Provider Relations, Network Development and Enrollment;
- C. Population Health Management staff
- D. Utilization Management Director
- E. Enrollee and Provider Complaint, Grievance, and Appeal Coordinator(s)
- F. QAPI Coordinator
- G. Program Integrity Coordinator

The Contractor may opt to locate other functions outside of an eighty (80) mile radius of Frankfort, Kentucky, but shall locate such functions within the United States. The Contractor shall not provide services or functions under this Contract that are located outside of the United States. Additionally, no Claims paid by the Contractor to a Network Provider, Out-of-Network Provider, Subcontractor, or financial institution located outside of the United States shall be considered in the development of actuarially-sound Capitation Rates.

The Contractor may Subcontract for any functions with Department approval as set forth in **Section 6.0 "Subcontracts."** The Contractor shall set clear expectations that the Subcontractor is a representative of the Contractor in performance of this Contract, and the structure of the relationship and reporting lines must be clearly defined. All Subcontractors shall meet appropriate licensing and contract requirements specified in applicable State and Federal laws and regulations.

9.2 Administration/Staffing

The Contractor shall directly or indirectly provide staffing of qualified individuals for the necessary functions and positions in a sufficient number to adequately provide for the Contractor's operational

responsibilities and to support enrollment or projected enrollment. Responsibility for the functions or staff positions may be combined or divided among departments, individuals, or Subcontractors unless otherwise specified. .

The Contractor's Executive Team members are considered key personnel capable and responsible for oversight of all Contractor operations for the Kentucky account and shall have the below minimum responsibilities. All key personnel shall be dedicated full-time to this Contract and shall be available to meet at the Department's requested location within twenty-four (24) hours' notice from the Department. Should the Contractor designate additional key personnel to serve as part of its Executive Team, such individuals are subject to all requirements in this Contract specific to key personnel unless otherwise approved in writing by the Department. The Contractor shall staff the following Executive Team members or equivalents:

- A. A Chief Executive Officer (CEO), Chief Operating Officer (COO), or equivalent who shall be a full-time administrator with clear authority over the general administration and implementation of the requirements detailed in the Contract.
- B. A Chief Financial Officer who shall oversee the budget and accounting systems implemented by the Contractor.
- C. A Chief Compliance Officer who shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractors, and oversee the Contractor's compliance with the laws and requirements of the Department. The Chief Compliance Officer shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Chief Compliance Officer shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.
- D. A Medical Director who shall be a physician licensed to practice in Kentucky. The Medical Director shall oversee the Contractor's clinical functions and the Medically Frail portion of Kentucky HEALTH and be actively involved in all major health programs of the Contractor. All clinical directors, including those employed by Subcontractors, shall report to the Medical Director for all responsibilities of this Contract. The Medical Director shall also be responsible for treatment policies, protocols, Quality Improvement activities, Population Health Management activities, and Utilization Management decisions and devote sufficient time to ensuring timely medical decisions. The Medical Director shall also be available for after-hours consultation, if needed.
- E. A Pharmacy Director licensed in Kentucky who shall coordinate, manage and oversee the provision of pharmacy services to Enrollees.
- F. A Dental Director licensed to practice dentistry in Kentucky. The Dental Director shall be actively involved in all oral health programs of the Contractor and devote sufficient time to ensuring timely oral health decisions. The Dental Director shall also be available for after-hours consultation, if needed.
- G. A Behavioral Health Director who shall be a behavioral health practitioner licensed in Kentucky and actively involved in all programs or initiatives relating to behavioral health. The Behavioral Health Director shall also coordinate efforts to provide Behavioral Health Services by the Contractor or any behavioral health Subcontractors.
- H. A Provider Network Director who shall be responsible for oversight of Provider Services and Provider Network Development. The Provider Network Director shall provide oversight of required coordination with the Department's contracted Credentialing Verification Organization(s) (CVOs). The Provider Network Director shall also coordinate workforce development initiatives conducted by the Contractor and collaboratively with the Department and other contracted MCOs.
- I. A Quality Improvement Director who shall be responsible for the operation of the Contractor's Quality Improvement Program.
- J. A Population Health Management Director who shall be responsible for coordination and oversight of the Population Health Management (PHM) Program and services.

The Contractor shall also ensure that it has the appropriate, qualified staff to fill the below roles and positions, or the equivalents, as well as others identified by the Contractor as necessary to fully support Contract implementation and ongoing operations.

- A. A Management Information System Director who shall oversee, manage and maintain the Contractor Management Information System (MIS).
- B. Enrollee Services Manager and staff to coordinate all communications with Enrollees and to advocate for Enrollees. The Contractor shall provide sufficient Enrollee Services staff to respond in a timely manner to Enrollees seeking prompt resolution of problems or inquiries.
- C. Provider Services Manager and staff to coordinate network development and all communications with Contractor Providers, Out of Network Providers as applicable, and Subcontractors who are involved in clinical services. The Contractor shall provide sufficient Provider Services staffing ratios to support network development, communications and education and to respond in a timely manner to Providers seeking prompt resolution of problems or inquiries.
- D. Claims Processing staff to ensure the timely and accurate processing of Claims, including original Claims, corrected Claims, and re-submissions, and the overall adjudication of Claims, including the timely and accurate submission of Encounter data.
- E. A Utilization Management Director who shall be responsible for the operation of the Contractor's Utilization Management Program and any Subcontractors of the Contractor performing services relevant to Utilization Management.
- F. An Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for Enrollees.
- G. A Guardianship Liaison who shall serve as the Contractor's primary liaison for meeting the needs of Enrollees who are adult guardianship clients.
- H. A Program Integrity Coordinator to serve as the single point of contact with the Department whose job duties are dedicated exclusively to the coordination, management, and oversight of the Contractor's Program Integrity unit to reduce Fraud, Waste and Abuse of Medicaid services within Kentucky. The Coordinator shall facilitate timely response to Department requests for information.

The Contractor shall ensure that all staff, Providers and Subcontractors have appropriate training, education, credentials, experience, liability coverage and orientation to fulfill the requirements of their positions. The Contractor warrants and represents that all persons assigned to perform work under this Contract shall have the necessary credentials to perform the work herein. The Contractor shall ensure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice in the Commonwealth of Kentucky. On at least an annual basis, the Contractor and its Subcontractors will verify that applicable staff have all necessary current licenses that are in good standing and will provide a list to the Department of licensed staff and current licensure status.

The Contractor shall comply with all staffing/personnel obligations, including but not limited to those pertaining to security, health, and safety issues.

The Contractor shall submit the following to the Department for approval within thirty (30) days of signing the Contract, annually, prior to material revisions and upon request by the Department:

- A. A detailed staffing plan that includes activities the Contractor will conduct to fill any staffing needs to have sufficient support for Contract implementation and ongoing operations. The staffing plan must provide timelines for conduct of activities and for filling all staff positions.
- B. A current organizational chart depicting all functions including mandatory functions, number of employees in each functional department and key managers responsible for the functions.
- C. Job descriptions and required qualifications, and a description of the qualifications of each individual with key management responsibility for any mandatory function.

The Contractor shall notify the Department and FAC in writing of any change in the Executive Management key personnel, department managers, and point of contact for this Contract within three (3) Business Days of the Contractor learning of a change, including a change in duties or time commitments, resignation, or of the Contractor notifying an individual of planned changes for the key position (e.g., promotion, termination). The Commonwealth reserves the right to approve or disapprove all key personnel (initial or replacement) prior to their assignment to this Contract.

9.3 Monthly Meetings

The Contractor's Pharmacy Director, Medical Director, Quality Improvement Director, Population Health Management Director, Utilization Management Director, Dental Director and Behavioral Health Director, their designees, or other Contractor staff as requested by the Department shall meet in separate or joint monthly meetings with the Department, and other contracted MCOs like personnel to collaborate on issues, ideas and innovations for the efficient and economical delivery of quality services to the Enrollees. Sister agencies or other entities may also be included in meetings as deemed appropriate by the Department.

Meetings will be used to consider issues such as opportunities to improve health outcomes of Enrollees, addressing social determinants of health, and efforts for population health management. The Contractor shall be prepared to present best practices for topics identified by the Department as requested. Such meetings shall be conducted in compliance with applicable federal antitrust laws. The Department will establish the schedule for the meetings and may increase, cancel or reduce the meetings, as needed, with prior notice to the Contractor.

10.0 CAPITATION PAYMENT INFORMATION

10.1 Monthly Payment

On or before the eighth (8th) day of each month during the term of this Contract, the Department shall remit to the Contractor the Capitation Payment specified in **Appendix A "Capitation Payment Rates"** (subject to approval of the rates by CMS) for each Enrollee determined to be enrolled for the upcoming month. The Contractor shall reconcile the Capitation Payment against the HIPAA 820. The Contractor shall receive a full month's Capitation Payment for the month in which enrollment occurs except for an Enrollee enrolled based on a determination of eligibility due to being unemployed in accordance with 45 C.F.R. 233.100. The monthly Capitation Payment for such an Enrollee shall be pro-rated from the date of eligibility based on unemployment. The Commonwealth's payment shall conform to KRS 45A.245. Payments are contingent upon the availability of appropriated funds.

The Department reserves the right, if needed, to delay the monthly payment due on or before June 8 to on or before July 8 or the next Business Day following July 8. If such delay is contemplated, the Department shall give notice of such intent forty-five (45) days before June 8. Whether or not the Department exercises its right to delay the June Capitation Payment, the payment of all other monthly Capitation Payments shall be made on or before the eighth (8th) day of the month in which it is due.

10.2 Payment in Full

The Contractor shall accept the Capitation Payment and any adjustments made pursuant to **Section 11.2 "Rate Adjustments"** of this Contract from the Department as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated with performance of this Contract. Enrollees shall be entitled to receive all Covered Services for the entire period for which the Department has made payment. Any and all costs incurred by the Contractor in excess of the Capitation Payment shall be borne in full by the Contractor. Interest

generated through investment of funds paid to the Contractor pursuant to this Contract shall be the property of the Contractor to use for eligible expenditures under this Contract. The Contractor and Department acknowledge that contracts for Medicaid capitated rates and services are subject to approval by CMS.

The Contractor may pursue any unpaid Capitation Payment thirty (30) Business Days after when due from the Commonwealth in accordance with KRS 45A.245.

The Contractor shall report to the Department within sixty (60) calendar days when it has identified Capitation Payments or other payments in excess of amounts specified in this Contract in accordance with 42 C.F.R. 438.608(c)(3).

10.3 Payment Adjustments

The Monthly Capitation Payments shall be adjusted for a period not to exceed twenty-four (24) months prior to the Monthly Capitation Payment to reflect corrections to the Enrollee Listing Report. Payments will be adjusted to reflect the automatic enrollment of eligible newborn infants. At such time that Kentucky HEALTH is live, a delivery payment will be paid on the eighth (8th) day of the month for the previous month's claims. Claims for payment adjustments shall be deemed to have been waived by the Contractor if a payment request is not submitted in writing within twelve (12) months following the month for which an adjustment is requested. Waiver of a claim for payment shall not release the Contractor of its obligations to provide Covered Services pursuant to the Contract.

In the event that an Enrollee is eligible and enrolled, but does not appear on the Enrollee Listing Report, the Contractor may submit a payment adjustment request. The Contractor shall submit the request in accordance with **Appendix D "Reporting Requirements and Reporting Deliverables"** for automated reporting requirements.

In the event that an Enrollee is eligible and enrolled and the Contractor believes the Capitation Payment was in error due to underpayment, overpayment, or duplicate payment, the Contractor may submit a payment adjustment request. The Contractor shall submit the request in accordance with **Appendix D "Reporting Requirements and Reporting Deliverables"** for automated reporting requirements.

In the event that an Enrollee does not appear on the Enrollee Listing Report, but the Department has paid the Contractor for an Enrollee, the Department may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the Contractor.

In the event an Enrollee appears on the Enrollee Listing Report but is determined to be ineligible, the Department may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the Contractor. In such instances, for each Enrollee that is determined to be ineligible, the Contractor may recover payment from any Provider who rendered services to Enrollee during the period of ineligibility. The entity to which the Enrollee is retroactively added shall assume responsibility for payment of any services provided to Enrollees during the period of adjusted eligibility.

For cases involving Enrollee ineligibility due to Fraud, Waste, and Abuse, the Department shall only recoup the Capitation amount and the Contractor shall establish procedures pursuant to **Section 10.4 "Contractor Recoupment from Enrollee for Fraud, Waste and Abuse"** to recover paid Claims. Any adjustment by the Department hereunder for retroactive Disenrollment of Enrollees shall not exceed twelve (12) months from the effective date of Disenrollment.

10.4 Contractor Recoupment from Enrollee for Fraud, Waste and Abuse

If permitted by state and federal law, the Contractor shall request a refund from the Enrollee for all paid Claims in the event the Department has established that the Enrollee was not eligible to be enrolled through an administrative determination or adjudication of Fraud. The Contractor shall, upon receipt of a completed OIG investigation of a Contractor's Enrollee that calls for administrative recoupment, send a request letter to Enrollee seeking voluntary repayment of all Claims paid by the Contractor on behalf of Enrollee during time period Enrollee was found to be ineligible to receive services. The request letter shall include the following as provided by the Department: the reason for the Enrollee's ineligibility, time period of ineligibility, and amount paid during the period of ineligibility. The Contractor shall report, on a monthly basis, to the Commonwealth any monies collected from administrative request letters during the previous month and provide a listing of all administrative request letters sent to Enrollees(s) during the previous month. The Contractor is only required to mail the initial letter to the Enrollee requesting repayment of funds and accept repayment on behalf of the Department. The Contractor is not required to address any due process issues should those arise. The Contractor shall work with Department's agent to obtain monies collected through court ordered payments. Any outstanding payments not collected within six (6) months shall be subject to be collected by the Commonwealth and shall be maintained by the Commonwealth. The foregoing provisions shall be construed to require Contractor's reasonable cooperation with the Commonwealth in its efforts to recover payments made on behalf of ineligible persons, and shall not create any liability on the part of the Contractor to reimburse amounts paid due to Fraud that the Contractor has been unable to recover.

11.0 RATE COMPONENT

11.1 Calculation of Rates

The Capitation Rates are established in accordance with 42 C.F.R. 438. The Capitation Rates are attached as **Appendix A "Capitation Payment Rates"** and shall be deemed incorporated into this Contract and shall be binding to the Contractor and the Department, subject to CMS' approval. If CMS fails to approve any component of the rates, the Capitation Payment rates shall be adjusted to reflect that disapproval or failure to approve. DMS will work with its actuaries to develop and certify new rates to CMS for approval. Those new rates, shall be reconciled retroactively to the beginning of the rate period certified to CMS.

11.2 Rate Adjustments

Prospective adjustments to the rates may be required if there are mandated changes in Medicaid services to the managed care population provided through this Contract as a result of legislative, executive, regulatory, or judicial action. Changes, including programmatic changes, applicable to this Contract mandated by state or federal legislation, or executive, regulatory or judicial mandates, shall take effect on the dates specified in the legislation or mandate. In the event of such changes, any rate adjustments shall be made through the Contract amendment process.

The Contractor is free to negotiate provider rates and methodologies that are tied to Medicaid fee-for-service reimbursement, but such ties shall not be considered to have any direct impact on rates. Changes to fee-for-service provider reimbursement rates or methodologies which may be mandated by legislative, executive, regulatory or judicial action shall not be considered as an impact to the Contractor that must be considered in setting and/or adjusting rates unless those changes are explicitly required under this Contract.

11.3 Health Insurers' Premium Fee under the ACA

The Health Insurers' premium Fee (HIF) under the ACA is due in September each year based on

the preceding calendar year premiums each year unless otherwise modified. If the Contractor is or will be subject to the health insurer's premium fee for the Capitation Payments being made under this or a previously existing Managed Care Contract with the Commonwealth, the Commonwealth shall compensate the Contractor for that fee and for any federal taxes resulting from such compensation. To facilitate this payment, the Contractor shall provide the Department with the Insurer's Premium Fee assessment received from the Federal Government and the pro rata portion attributed to the Contractor's Capitation Payments under its Contract(s) for the preceding calendar year if available. In addition, the Contractor shall provide a certified statement from its Chief Financial Officer as to the effective Federal Tax Rate paid for the prior five (5) tax periods. These shall be submitted to the Department no later than September 1 of each year that the Insurer's premium fee is imposed. This payment method is contingent upon receipt of federal financial participation for the payment and CMS approval.

11.4 Medical Loss Ratio Adjustment

Annually on a state fiscal year basis, the total annual Capitation Payment made to the Contractor for the combined ACA and Non-ACA populations and their associated healthcare costs shall be evaluated against a ninety (90) percent Minimum Medical Loss Ratio (MLR) Requirement to determine whether a Payment Adjustment is warranted (determined pursuant to **Appendix E "Medical Loss Ratio Calculation."**) A Payment Adjustment (premium refund) shall occur if:

- A. The Contractor has a MLR of less than ninety percent (90%) but greater than or equal to eighty-six percent (86%). The Contractor shall submit a Payment Adjustment (premium refund) to the Commonwealth for seventy-five percent (75%) of the difference between the dollar amount corresponding to actual MLR and the dollar amount corresponding to a ninety percent (90%) Medical Loss Ratio.
- B. The Contractor has a MLR less than eighty six percent (86%). The Contractor shall submit a Payment Adjustment (premium refund) to the Commonwealth for the sum of: (a) seventy-five percent (75%) of the difference between the dollar amount corresponding to an eighty six percent (86%) MLR and the dollar amount corresponding to a ninety percent (90%) MLR; and (b) one hundred percent (100%) of the difference between the actual countable medical expenses for the Contractor and the dollar amount corresponding to an eighty six percent (86%) Medical Loss Ratio.

The adjustment process will begin ten (10) months after the end of each State Fiscal Year. If the Contract with the Contractor is not renewed at any time or is terminated at any time, the Medical Loss Ratio and Annual Statement will reflect an appropriately reduced number of months of experience instead of the full twelve (12) months.

As part of the financial reconciliation process described above, the Contractor shall calculate and report an MLR in a format and manner prescribed by the Department for expenses directly attributed or allocated for both the ACA and non-ACA combined annually on a state fiscal year basis. The report shall be in compliance with 42 C.F.R. 438.8(k) and shall include an attestation from the Contractor's actuary to the accuracy of the calculation in accordance with the requirements of 42 C.F.R. 438.8. The Contractor shall require Subcontractors/vendors providing Claim adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within one hundred eighty (180) days of the end of the MLR reporting period or within thirty (30) Days of Contractor's request for such information. The report, and any other information the Contractor wants to submit for consideration, shall be due to the Commonwealth thirty (30) Days after the end of the twelve (12)-month period described above.

The Commonwealth shall then determine, within thirty (30) Days of receipt of all information from all Contractors, if any adjustment is to be collected and notify the Contractor in writing. The Contractor shall then have fifteen (15) Days to review the Commonwealth's findings and remit payment to the Commonwealth. Items for reconciliation, including non-claim specific items, are

further described in **Appendix E “Medical Loss Ratio Calculation”** of this Contract. The calculation of the MLR shall comply with the requirements of 42 C.F.R. 438.8. The Contractor shall cooperate with the Department or its contractor by supplying all clarifications and answers to inquiries within the requested timeframe. If the Contractor fails to submit information or respond to a Department request regarding MLR Calculation within the requested timeframe, it shall be subject to a penalty as set forth in **Appendix B “Remedies for Violation, Breach, or Non-Performance of Contract.”**

If the Department makes a retroactive change to a Capitation Payment in a MLR reporting year that has already been submitted, upon the Department’s request, the Contractor shall recalculate the MLR for any year affected by the change and submit a new MLR report meeting the applicable requirements.

The Department may, at its discretion and subject to CMS approval, implement MLR incentive programs by which the MCO may reduce its allowable MLR.

11.5 Physician Incentive Plans

A template for any compensation arrangement between the Contractor and a physician, or physician group as that term is defined in 42 C.F.R. § 417.479(c); or between the Contractor and any other PCPs within the meaning of this Contract; or between the Contractor and any other Subcontractor (or like entity) shall be submitted to the Department for approval prior to its implementation. Approval is preconditioned on compliance with all applicable federal and Commonwealth laws and regulations and subject to **Section 4.4 “Approval of Department.”** The Contractor shall provide information to any Enrollee upon request about any Physician Incentive Plan and/or any payments to Provider made pursuant to an incentive arrangement under this Section to a provider as required by applicable state or federal law.

If a Contractor includes a Physician Incentive Plan, the activities included shall comply with requirements set forth in 42 C.F.R. 422.208 and 42 C.F.R. 422.210. The Contractor shall report disclosures to the Department for Physician Incentive Plans including the following:

- A. Whether services not furnished by a physician/group are covered by the incentive plan. No further disclosure is required if the Physician Incentive Payment does not cover services not furnished by a physician/group.
- B. The type of incentive arrangement, e.g. withhold, bonus, Capitation.
- C. Percent of withhold or bonus (if applicable).
- D. Panel size, and if patients are pooled, the approved method used.
- E. If the physician/group is at substantial financial risk, proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

11.6 Co-Payments

The Contractor shall not set co-payment amounts that exceed the Department’s Fee for Service co-payments. The co-payment requirements for the Medicaid Program can be found in 907 KAR 1:604. Any cost sharing imposed by the Contractor shall be in accordance with 42 C.F.R. §§447.50 through 447.82.

The Department will calculate payments to the Contractor as set forth in 42 CFR 447.56(d).

The actuarial value of the co-payments will be reflected in the Capitation Rate.

The Department may exclude the collection of co-payments with at least ninety (90) days written

notice to the Contractor.

12.0 RISK ADJUSTMENTS

12.1 Purpose for Risk Adjustments

Risk adjustment uses information on an Enrollee's medical conditions, as reported in Claims data, and other factors to predict health care costs and adjust payments to MCOs. Risk adjustment helps ensure payments to MCOs are more equitable and mitigates the impact of selection bias, thus protecting MCO solvency and reducing incentives for plans to avoid high-risk individuals. Risk adjustment is designed to be revenue neutral to the State.

12.2 Risk Adjustment Method

The Department will analyze the risk profile of each MCO's Enrollees using a risk adjustment model specified by the Department.

- A. Enrollees will be assigned risk scores based on attributes including, but not limited to, demographics, disease conditions, rate cell, and duration of enrollment in the study period.
- B. Not all Enrollees will be risk scored. Exclusions such as dual eligible Enrollees may exist.
- C. Each MCO's proposed base Capitation rates will be risk adjusted based on its Enrollees' risk scores relative to risk scores of other MCOs.
- D. The Department will update risk scores at least one (1) time per State Fiscal Year, either in the form of a full Enrollee re-score or an update for changes in Enrollee distributions, with all calculations including a budget neutrality adjustment.

Supplemental Pass-Through Payments and Payments related to the HIF will not be risk-adjusted.

13.0 CONTRACTOR'S FINANCIAL SECURITY OBLIGATIONS

13.1 Solvency Requirements and Protections

The Contractor shall be subject to requirements contained in KRS Chapter 304 and related administrative regulations regarding protection against Insolvency and risk-based capital requirements. In addition, pursuant to KRS 304.3-125, the Commissioner has authority to require additional capital and surplus if it appears that an Insurer is in a financially hazardous condition.

The Contractor shall cover continuation of services to Enrollees during Insolvency, for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

In the event of the Contractor's Insolvency, the Contractor shall not hold its Enrollees liable, except in instances of Enrollee Fraud:

- A. For the Contractor's debts;
- B. For the Covered Services provided to the Enrollee, for which the Department does not pay the Contractor;
- C. For the Covered Services provided to the Enrollee for which the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; and
- D. 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 Contractor provided the services directly.

13.2 Contractor Indemnity

In no event shall the Commonwealth, FAC, the Department or Enrollee be liable for the payment of any debt or fulfillment of any obligation of the Contractor or any Subcontractor to any Subcontractor, supplier, Out-of-Network Provider or any other party, for any reason whatsoever, including the Insolvency of the Contractor or any Subcontractor insolvency. The Contractor agrees that any Subcontract will contain a hold harmless provision.

The Contractor shall indemnify, defend, save and hold harmless the Commonwealth, FAC, the Department, its officers, agents, and employees (collectively, the "Indemnified Parties") from all claims, demands, liabilities, suits, judgments, or damages, including court costs and reasonable attorney fees made or asserted against or assessed to the Indemnified Parties (collectively the "Losses"), arising out of or connected in any way with this Contract or the performance or nonperformance by the Contractor, its officers, agents, employees; and suppliers, Subcontractors, or Providers, including without limitation any claim attributable to:

- A. The improper performance of any service, or improper provision of any materials or supplies, irrespective of whether the Department knew or should have known such service, supplies or materials were improper or defective;
- B. The erroneous or negligent acts or omissions, including without limitation, disregard of federal or Commonwealth law or regulations, irrespective of whether the Department knew or should have known of such erroneous or negligent acts;
- C. The publication, translation, reproduction, delivery, collection, data processing, use, or disposition of any information to which access is obtained pursuant to this Contract in a manner not authorized by this Contract or by federal or Commonwealth law or regulations, irrespective of whether the Department knew or should have known of such publication, translation, reproduction, delivery, collection, data processing, use, or disposition; or
- D. Any failure to observe federal or Commonwealth law or regulations, including but not limited to, insurance and labor laws, irrespective of whether the Department knew or should have known of such failure.

Upon receiving notice, the Department shall give the Contractor written notice of any claim made against the Contractor for which the Indemnified Parties are entitled to indemnification, so that the Contractor shall have the opportunity to appear and defend such claim. The Indemnified Parties shall have the right to intervene in any proceeding or negotiation respecting a claim and to procure independent representation, all at the sole cost and expense of the Indemnified Parties. Under no circumstances shall the Contractor be deemed to have the right to represent the Commonwealth in any legal matter without express written permission from FAC. Notwithstanding the above, Contractor shall have no obligation to indemnify the Indemnified Parties for any losses due to the negligent acts or omissions or intentional misconduct of the Indemnified Parties.

13.3 Insurance

The Contractor shall secure and maintain during the entire term of the Contract, and for any additional periods following termination of the Contract during which it is obligated to perform any obligations pursuant to this Contract, original, prepaid policies of insurance, in amounts, form and substance satisfactory to FAC, and non-cancelable except upon thirty (30) Days prior written notice to FAC, providing coverage for property damage (all risks), business interruption, comprehensive general liability, motor vehicles, workers' compensation and such additional coverage as is reasonable or customary for the conduct of the Contractor's business in the Commonwealth.

13.4 Advances and Loans

The Contractor shall not, without thirty (30) Days prior written notice to and approval by the Department, make any advances to a related party or Subcontractor. The Contractor shall not, without similar thirty (30) Day prior written notice and approval, make any loan or loan guarantee to any entity, including another fund or line of business within its organization. Such approval is subject to **Section 4.4 “Approval of Department.”** Written notice is to be submitted to the Department and if applicable to DOI. The prohibition on advances to Subcontractors contained in this subsection shall not apply to Capitation Payments or payments made by the Contractor to Contractor’s Network for provision of Covered Services.

13.5 Provider Risks

If a Provider assumes substantial financial risk for contracted services, the Contractor shall ensure that the Provider has adequate stop-loss protection. The Contractor shall provide the Department proof the Provider has adequate stop-loss coverage, including an amount and type of stop-loss.

14.0 THIRD PARTY RESOURCES

14.1 Coordination of Benefits (COB)

The Contractor shall actively pursue, collect and retain all monies available from all available resources for services to Enrollees under this Contract except where the amount of reimbursement the Contractor can reasonably expect to receive is less than estimated cost of recovery.

Cost effectiveness of recovery is determined by, but not limited to, time, effort, and capital outlay required in performing the activity. The Contractor shall specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the Contractor determines seeking reimbursement would not be cost effective. The Contractor shall provide the guidelines to the Department for review and approval.

COB collections are the responsibility of the Contractor or its Subcontractors. Subcontractors shall report COB information to the Contractor. Contractor and Subcontractors shall not pursue collection from the Enrollee but directly from the third party payer. The Contractor shall only recoup payments to providers if the third party payer is Medicare. Access to Covered Services shall not be restricted due to COB collection.

The Contractor shall maintain records of all COB collections. The Contractor shall demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for Enrollees. The Contractor shall seek information on other available resources from all Enrollees.

In order to comply with CMS reporting requirements, the Contractor shall submit a monthly COB Report for all Enrollee activity which the Department or its agent shall audit no less than every six (6) months. Additionally, Contractor shall submit a report that includes subrogation collections from auto, homeowners, or malpractice insurance, etc.

14.2 Third Party Liability

By law, Medicaid is the payer of last resort and as a result shall be used as a source of payment for Covered Services only after all other sources of payment have been exhausted. If an Enrollee has resources available for payment of expenses associated with the provision of Covered Services, other than those which are exempt under Title XIX of the Social Security Act, such resources are

primary to the coverage provided by the Contractor, pursuant to this Contract, and must be exhausted prior to payment by the Contractor. The Capitation Rate set forth in this Contract has been adjusted to account for the primary liability of third parties to pay such expenses. The Contractor shall be responsible for determining the legal liability of third parties to pay for services rendered to Enrollees pursuant to this Contract. The Contractor shall maintain a current TPL Resource File which contains the Enrollee's current TPL information including coverage that has ended for the Enrollee. The Contractor shall share TPL information with Subcontractors that are responsible for payment of Covered Services for Enrollees. The Contractor shall also provide TPL information to the Department on a monthly file.

All funds recovered by the Contractor from Third Party Resources shall be treated as income to the Contractor to be used for eligible expenses under this Contract. Except as provided in **Section 41**, the Contractor and all Providers in the Contractor's Network are prohibited from directly receiving payment or any type of compensation from the Enrollee, except for Enrollee co-pays or deductibles from Enrollees for providing Covered Services. Enrollee co-payments, co-insurance or deductible amounts cannot exceed amounts specified in 907 KAR 1:604. Co-payments, co-insurance or deductible amounts may be increased only with the approval of the Department.

42 C.F.R. 433.138 requires that as a condition of Medicaid eligibility each Enrollee will be required to:

- A. Assign, in writing, his/her rights to the Contractor for any medical support or other Third Party Payments for medical services paid for by the Contractor; and
- B. Cooperate in identifying and providing information to assist the Contractor in pursuing third parties that may be liable to pay for care and services.

42 C.F.R. 433.138 requires the Contractor be responsible for actively seeking and identifying Third Party Resources, i.e., health or casualty insurance, liability insurance and attorneys retained for tort action, through contact with the Enrollees, participating providers, and the Medicaid Agency. However, the Commonwealth may direct the Contractor to refrain from actively seeking and identifying Third Party Resources for services that are covered only by the Medicaid program, as identified by the Department.

42 C.F.R. 433.139 requires the Contractor be responsible to ensure that the Medicaid Program is the payer of last resort when other Third Party Resources are available to cover the costs of medical services provided to Medicaid Enrollees. When the Contractor is aware of other Third Party Resources, the Contractor shall avoid payment by "cost avoiding" (denying) the Claim and redirecting the provider to bill the other Third Party Resource as a primary payer. If the Contractor does not become aware of another Third Party Resource until after the payment for service, the Contractor is responsible to seek recovery from the Third Party Resource on a post-payment basis. See **Appendix F "Third Party Payments/Coordination of Benefits."** The Department or its agent will audit the Contractor's Third Party practices and collections at least every six (6) months.

The Contractor shall respond to Enrollee and provider requests for COB or TPL updates according to the following timelines:

- A. For urgent requests, within forty-eight (48) hours; or
- B. For routine requests, within three (3) Business Days.

15.0 MANAGEMENT INFORMATION SYSTEM

15.1 Contractor MIS

The Contractor shall maintain a Management Information System (MIS) that will provide support for all aspects of a managed care operation to include the following subsystems: Enrollee, Third Party Liability, provider, reference, Encounter/Claims processing, financial, utilization data/ Quality Improvement and Surveillance Utilization Review Subsystem. The Contractor will also be required to demonstrate sufficient analysis and interface capacities. The Contractor's MIS shall ensure medical information will be kept confidential at all times including but not limited to when data is moving and at rest, through security protocol, especially as that information relates to personal identifiers and sensitive services. The Contractor shall comply with 42 C.F.R. 438.242.

The Contractor shall provide such information in accordance with the format and file specifications for all data elements as specified in **Appendix G "Management Information Systems Requirements"** hereto, and as may be amended from time to time.

The Contractor shall transmit all data directly to the Department in accordance with 42 C.F.R. 438. If the Contractor utilizes Subcontractors for services, all data from the Subcontractors shall be provided to the Contractor and the Contractor shall transmit the Subcontractors' data to the Department in a format specified by the Department in accordance with 42 C.F.R. 438.

The Contractor will execute a Business Associate Agreement (BAA) in **Appendix H "Business Associates Agreement"** with the Department, pursuant to Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," that directs the federal Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information. The execution of the BAA is required prior to data exchanges being implemented.

The Contractor shall meet all system requirements, including but not limited to required testing, as directed by the Department. Upon request by the Department, the Contractor shall participate in Joint Application Development sessions for system or policy changes.

At least ten (10) Days prior to implementation, the Contractor shall notify the Department of any significant changes to the system that may impact the integrity of the data, including such changes as new Claims processing software, new Claims processing vendors and significant changes in personnel.

15.2 Contractor MIS Requirements

The Department's MIS system utilizes eight (8) subsystems to carry out the functions of the Medicaid program. The Contractor is not required to have actual subsystems as listed below, provided the requirements are met in other ways which may be mapped to the subsystem concept. The Contractor shall have the capacity to capture necessary data and provide it in formats and files that are consistent with the Commonwealth's functional subsystems as described below. The Contractor shall maintain flexibility to accommodate the Department's needs if a new system is implemented by the Commonwealth. These subsystems focus on the individual systems functions or capabilities which provide support for the following areas:

- A. Enrollee Subsystem;
- B. Third Party Liability (TPL);
- C. Provider Subsystem;
- D. Reference Subsystem;
- E. Claims Processing Subsystem (to include Encounter Data);

- F. Financial Subsystem;
- G. Utilization/Quality Improvement Subsystem; and
- H. Surveillance Utilization Review Subsystem (SURS).

The Contractor shall ensure that data received from Providers and Subcontractors is accurate and complete by conducting the following activities, at a minimum:

- A. Verifying, through edits and audits, the accuracy and timeliness of reported data;
- B. Screening the data for completeness, logic and consistency;
- C. Collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for the Department's Medicaid Quality Improvement, population health and care management efforts;
- D. Compiling and storing all Claims and Encounter data from the Subcontractors in a data warehouse in a central location in the Contractor's MIS;
- E. At a minimum, assuring edits and audits comply with NCCI;
- F. Resolving all reporting errors in transaction submission and reconciliation; and
- G. Successfully transmitting required data to the Department.

15.3 Interface Capability

The interface subsystems support incoming and outgoing data from other organizations and allow the Contractor to maintain Enrollee Enrollment information and Enrollee-related information. It might include information from secondary sources to allow the tracking of population outcome data or other population information. At a minimum, there will be a Provider, Enrollee, Encounter Record and Capitation interface. Specific requirements for the interface subsystem shall include such items as: defined data elements, formats, and file layouts including input and output job schedule with backend reporting and data reconciliation.

15.4 Access to Contractor's MIS

The Contractor shall provide the Department with log-in credentials to allow access to Contractor's Claims and customer service systems on a read-only basis at the Contractor's primary place of business during normal business hours. The Contractor shall provide the Department access to a locked space and office security credentials for use during business hours. All access under this Section shall comply with HIPAA's minimum necessary standards and any other applicable Commonwealth or federal law.

16.0 ENCOUNTER DATA

16.1 Encounter Data Submission

In accordance with the terms of this Contract and all applicable state and federal laws, the Contractor shall submit complete, accurate, and timely Encounter Data to the Department within thirty (30) Days of Claim adjudication. This includes all paid and denied Claims, corrected Claims, adjusted Claims, voided Claims, and zero dollars (\$0) paid Claims processed by the Contractor or by its Subcontractors.

The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports, and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract. The system shall be capable of following or tracing an Encounter within its system using a unique Encounter identification number for each Encounter. At a minimum, the Contractor shall electronically provide Encounter Files to the Department, on a weekly schedule. Encounter Files must follow the format, data elements and method of transmission specified by the Department. All changes to edits and processing requirements due to Federal or State law changes

shall be provided to the Contractor in writing no less than sixty (60) Business Days prior to implementation, whenever possible. Other edits and processing requirements shall be provided to the Contractor in writing no less than thirty (30) Business Days prior to implementation. The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department. The electronic test files are subject to Department review and approval before production of data. The Department will process the Encounter data through defined edit and audit requirements and reject Encounter data that does not meet its requirements. Threshold edits, those which will enable the Encounter File to be accepted, and informational editing, those which enable the Encounter to be processed, shall apply. The Department reserves the right to change the number of, and the types of edits used for threshold processing based on its review of the Contractor's monthly transmissions. The Contractor shall be given thirty (30) Business Days' prior notice of the addition/deletion of any of the edits used for threshold editing.

The Contractor's weekly electronic Encounter data submission is to include all adjudicated (paid and denied) Claims, corrected Claims and adjusted Claims processed by the Contractor. Contractor shall submit all Claims within thirty (30) Days of adjudication. Encounter File transmissions that exceed a five percent (5%) threshold error rate (total Claims/documents in error equal to or exceed five percent (5%) of Claims/documents records submitted) will be subject to penalties as provided in the Contract. Encounter File transmissions with a threshold error rate not exceeding five percent (5%) will be accepted and processed by the Department. Only those Erred Encounters will be returned to the Contractor for correction and resubmission. Denied Claims submitted for Encounter processing will not be held to normal edit requirements and rejections of denied Claims will not count towards the minimum five percent (5%) rejection.

Encounter data must be submitted in the format defined by the Department as follows:

Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 transaction 837 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version 2.2. Example transactions include the following:

1. 837I – Instructional Transactions
2. 837P – Professional Transactions
3. 837D – Dental Transactions
4. 278 – Prior Authorization Transactions
5. 835 – Remittance Advice
6. 834 – Enrollment/Disenrollment
7. 820 – Capitation
8. 276/277 Claims Status Transactions
9. 270/271 Eligibility Transactions
10. 999 – Functional Acknowledgement
11. NCPDP 2.2

Encounter corrections (Encounter returned to the Contractor for correction, i.e., incorrect procedure code, blank value for diagnosis codes) will be transmitted to the Contractor electronically for correction and resubmission. The Contractor shall have the capacity to track all Erred Encounter Records and provide a report detailing transmission reconciliation of each failed transaction or file within thirty (30) Days of the transaction or file error. Penalties will be assessed against the Contractor for each Encounter record, which is not resubmitted within thirty (30) days of the date the record is returned.

The Contractor shall use procedure codes, diagnosis codes, MS-DRG, and other codes used for reporting Encounter data in accordance with guidelines and versions of all code sets as defined by

the Department. The Contractor shall also use appropriate NPI/Provider numbers for Encounters as directed by the Department.

The Contractor shall submit corresponding data in all data fields on each Encounter File submitted to the Department. Claims shall be submitted with a current and valid date in the format identified by the applicable Encounter File submission guidelines.

Encounters submitted without dates, including those that have previously been allowed to be submitted blank, shall be populated with a valid date or the Encounter shall threshold. A complete list of field requirements at both the detail and the header levels shall be supplied by the Department.

The Encounter File will be received and processed by the Department's Fiscal Agent and will be stored in the existing MMIS.

The Contractor shall include provisions in all Subcontracts with Providers or other vendors requiring that an Encounter is reported/submitted in an accurate and timely fashion that complies with Department requirements.

The Contractor shall specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting Encounters, and a secondary contact person in the event the primary contact person is not available. The Contractor shall report the reconciliation status of failed transactions on a monthly basis.

The Contractor shall submit Encounter data after the Contract ends for services rendered during the Contract period for a sufficient time as determined by the Department to ensure timely filing and complete data.

The Department will conduct an annual validity study to determine the completeness, accuracy and timeliness of the Encounter data provided by the Contractor. Completeness will be determined by assessing whether the Encounter data transmitted includes each service that was provided. Accuracy will be determined by evaluating whether or not the values in each field of the Encounter accurately represent the service that was provided. Timeliness will be determined by assuring that the Encounter was transmitted to the Department the month after adjudication. The Department will randomly select an adequate sample which will include hospital Claims, provider Claims, drug Claims and other Claims (any Claims except in-patient hospital, provider and drug), to be designated as the Encounter Processing Assessment Sample (EPAS).

The Contractor will be responsible to provide to the Department the following information as it relates to each Claim to substantiate that the Contractor and the Department processed the Claim correctly:

- A. A copy of the Claim, either paper or a generated hard copy for electronic Claims;
- B. Data from the paid Claim's file;
- C. Enrollee eligibility/enrollment data;
- D. Provider eligibility data;
- E. Reference data (i.e., diagnosis code, procedure rates, etc.) pertaining to the Claim;
- F. Edit and audit procedures for the Claim;
- G. A copy of the remittance advice statement/explanation of benefits;
- H. A copy of the Encounter Record transmitted to the Department; and
- I. A listing of Covered Services.

The Department will review each Claim from the EPAS to determine if complete, accurate and timely Encounter data was provided to the Department. Results of the review will be provided to

the Contractor. The Contractor will be required to provide a corrective action plan to the Department within sixty (60) Days if deficiencies are found.

16.2 Encounter Technical Workgroup

The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality, and completeness of the Encounter submission.

17.0 OFFICE OF HEALTH DATA AND ANALYTICS

17.1 Kentucky Health Information Exchange

Providers who contract with The Contractor will sign a Participation Agreement with the Kentucky Health Information Exchange (KHIE) within one (1) month of contract signing. Providers will engage with KHIE for the purpose of connecting their electronic health records (EHR) system to the health information exchange to share their patient electronic records. The ultimate objective is to facilitate improved care coordination resulting in higher quality care and better outcomes. The data set required for submission is a Summary of Care Record.

Hospitals that contract with "Your MCO" will be required to also submit ADTs (Admission, Discharge, Transfer messages) to KHIE.

If the provider does not have an electronic health record they must still sign a Participation Agreement with KHIE and sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in their community of care.

The Contractor will submit a monthly report to the KY Office of Health Data and Analytics regarding the above items.

17.2 Kentucky Health Benefit Exchange

The Contractor shall develop a collaborative relationship with Enrollees of the Kentucky Health Benefit Exchange (KHBE) Consumer Assistance Program, which includes KHBE staff, Assisters, Navigators, Certified Application Counselors and Insurance Agents. The Contractor shall provide a contact person to KHBE staff for outreach and education, accessibility complaints, and Grievances and appeals as appropriate for the Medicaid responsibilities of Assisters and Navigators.

18.0 ELECTRONIC HEALTH RECORDS

The Contractor shall encourage all Providers in its Network to participate in the EHR Incentive Program, if eligible.

The Department will continue to administer the EHR Incentive Payment Program. The Department will notify the Contractor on a monthly basis which providers have received incentive payments and will continue to update the Contractor when additional payments are made. The Contractor shall comply with data requests from the Department to assist in verification that the Providers are meeting the requirements for the EHR Incentive Payment Program.

19.0 QUALITY MANAGEMENT AND HEALTH OUTCOMES

The Contractor shall support Kentucky in its goals to transform the Medicaid program to empower individuals to improve their health and engage in their healthcare and to drastically improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. To support these goals, the Contractor shall implement innovative and strategic solutions to Quality Management and improvement, and collaborate with the Department and other contracted MCOs, to develop a data-driven, outcomes-based continuous quality improvement process. The Department will work with the MCOs to develop approaches that are focused and achievable. The Contractor shall work to achieve improvements in outcomes and performance metrics as determined by the Department, and to develop a value-based payment (VBP) model.

The Contractor is accountable to the Department for the quality of care provided to Enrollees, and as such shall implement a comprehensive approach to quality measurement and improvement that complies with 42 C.F.R. 438 Subpart E, requirements of this Contract, and the Department's Quality Strategy. The Contractor shall implement a comprehensive QAPI Program in compliance with the requirements of 42 C.F.R. 438.330.

The Contractor shall provide copies of all materials and documents identified in this section that must be submitted to the Department to the Department's Division of Program Quality & Outcomes, Managed Care Oversight Quality Branch Manager.

19.1 National Committee for Quality Assurance (NCQA) Accreditation

In compliance with 42 C.F.R 438.332, the Contractor shall inform the Department of its accreditation status for its Medicaid product line within two (2) years from the Effective Date of its initial MCO Contract with the Commonwealth. The Contractor shall have NCQA accreditation.

If the Contractor holds a current NCQA accreditation status it shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Review Tool (IRT): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.

The Contractor shall authorize the accrediting entity to provide the Department a copy of its most recent accreditation review, including:

- A. Accreditation status, survey type, and level (as applicable);
- B. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
- C. Expiration date of the accreditation.

The Contractor shall provide the Department a copy of its complete survey report every (3) three years.

19.2 Quality Committees and Meetings

- A. The Contractor shall have in place an organizational Quality Improvement Committee (QIC) that shall be responsible for all quality activities. The QIC structure shall be chaired by the Contractor's Medical Director or Quality Improvement Director, be interdisciplinary and include administrative staff assigned to this Contract and Kentucky-based providers of a variety of medical disciplines including behavioral health, health professions and individual(s) with

specialized knowledge and experience with Individuals with special health care needs and/or receiving Population Health Management services.

The QIC shall analyze and evaluate the results of QM/QI activities, recommend policy decisions, ensure that providers are involved in the QM/QI program, institute needed action to address deficiencies, and ensure that appropriate follow-up occurs.

The QIC shall maintain records that document the QIC's activities, meeting minutes, findings, recommendations, actions, and results. Records shall be available for review upon Department request, during the annual on-site EQRO review, and/or for NCQA accreditation review.

The Contractor shall provide the Department's Chief Medical Officer with ten (10) Days advance notice of all regularly scheduled QIC meetings with an agenda and related meeting materials, as available, to support determination of attendance.

- B. The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Enrollees, individuals from consumer advocacy groups or the community who represent the interests of the Enrollee population. The Contractor shall also include community-based organizations on the Committee.

The Contractor shall implement innovative strategies to encourage Enrollee participation in the Committee. The Contractor may collaborate with other contracted MCOs to conduct joint QMACs, with Department approval, if doing so is found to increase Enrollee participation and input. Enrollees participating in the QMAC shall be consistent with the composition of the Enrollee population, including such factors as aid category, gender, geographic distribution, parents, as well as adult Enrollees and representation of racial and ethnic minority groups. Enrollee participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Enrollee participation.

The Contractor shall conduct at least quarterly meetings of the QMAC. Responsibilities of the QMAC shall include the following at a minimum:

- A. Providing review and comment on the following:
 - 1. Quality and access standards;
 - 2. Grievance and Appeals process and policy modifications based on review of aggregate Grievance and Appeals data;
 - 3. Enrollee Handbooks;
 - 4. Enrollee educational materials prepared by the Contractor; and
 - 5. Contractor and Department policies that affect Enrollees.
- B. Recommending community outreach activities.

The Contractor shall provide the Department with ten (10) Days advance notice of all regularly scheduled meetings of the QMAC with an agenda and related meeting materials, as available, to support determination of attendance. The Contractor shall submit meeting minutes to the Department within ten (10) Days after conduct of each meeting.

The Contractor shall submit a summary to the Department annually that includes a listing of the Enrollees participating with the QMAC, recommendations received from attendees, and information about if and how the Contractor implemented the recommendations.

- C. The Contractor shall participate in quality meetings with the Department, its designees, and other CHFS departments and/or other contracted MCOs quarterly or at a frequency otherwise determined by the Department. These meetings will be used to collaborate on quality initiatives, for MCOs to provide updates on progress of their performance improvement projects (PIPs), or other initiatives to support achievement of Department goals to improve outcomes. The Contractor shall be prepared to discuss opportunities and challenges in addressing quality, outcomes, and population health.

19.3 Quality Assurance and Performance Improvement (QAPI) Program

The Contractor shall implement and operate a comprehensive QAPI Program in compliance with the requirements of 42 C.F.R. 438.330 that focuses on health outcomes, health improvement and health-related social needs. The QAPI program shall assess, monitor, evaluate and improve the quality of care provided to Enrollees. QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Record(s), are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.

The Contractor shall integrate management activities such as Utilization Management, Risk Management, Enrollee Services, Grievances and Appeals, Population Health Management, Provider Credentialing, Ombudsman Services and Provider Services in its QAPI program.

The Contractor's QAPI program shall use as a guideline the most current NCQA Standards and Guidelines for the Accreditation of MCOs and incorporate best practices and innovations in quality assurance. The Contractor shall collaborate with Enrollees to gain input on development of the QAPI program. The Contractor shall maintain documentation of all Enrollee input, response, conduct of performance improvement activities, and feedback to Enrollees. Documentation shall be made available upon request of the Department or its contracted EQRO.

The QAPI program shall at a minimum include:

- A. Requirements set forth in the Department's Quality Strategy and in accordance with federal regulations at 42 CFR 438.330, including:
 - 1. Conducting and assessing PIPs as further described in **Section 19.6 "Performance Improvement Projects"** of this Contract;
 - 2. Collecting and submitting to the Department performance measurement data that enables the Department to calculate performance on required measures, including indication of progress on measures and related outcomes;
 - 3. Establishing mechanisms for detecting under-utilization and over-utilization of services' and
 - 4. Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs, as defined by the State.
- B. A QIC to provide oversight of QAPI functions;
- C. Methods for seeking input from and working with stakeholders, such as the Department, Enrollees, Providers, Subcontractors, other contracted MCOs, other community resources and agencies, and advocates to actively improve the quality of care provided to Enrollees;
- D. Methods for addressing Department mandated performance measures;

- E. Integration of Behavioral Health indicators into the QAPI program and a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Enrollees;
- F. Methods to collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Enrollee's overall care;
- G. Use of a health information system to support collection, integration, tracking, analysis and reporting of data analytics specific to health care outcomes and performance metrics, including stratification of findings (e.g., by Region, provider type, Enrollee populations); and
- H. Methods to evaluate data and findings reports to assess QAPI program activities, progress on objectives, identified areas for improvements and processes to implement changes, including methods for providing feedback or other information to Providers and Enrollees.

Within thirty (30) Days of Contract Execution, by each June 30, thereafter, and upon request, the Contractor shall submit a QAPI Program Plan for review and approval by the Department. The QAPI Program Plan shall include the below information, at a minimum. The Department reserves the right to designate the required format and design for the QAPI Program Plan.

- A. Detailed QAPI program description that addresses goals and objectives, all program elements, and scope of activities;
- B. Discussion of innovative approaches the Contractor will implement to support the Department in achieving improved outcomes;
- C. Detailed description of the Contractor's staffing to meet QAPI program goals and objectives, including a listing of staffing resources, roles, qualifications and experience, and total FTEs percentage of time;
- D. Description of QAPI activities to be conducted by Providers and Subcontractors, if separate from the Contractor's QAPI activities and integration of those into the overall QAPI program;
- E. Workplan that provides the scope of activities and timelines, including reporting cycles and annual evaluation;
- F. Clearly defined approaches to Quality Improvement efforts, including PIPs, that the Contractor will implement; and
- G. A process to continually evaluate the impact and effectiveness of the QAPI program, and approach to modify the QAPI Program to address deficiencies.

The Contractor shall establish new goals and objectives at least annually based on findings from QI activities and studies, survey results, Grievances and Appeals, performance measures, and EQRO findings, among other information as identified by the Department or Contractor.

19.4 Kentucky Healthcare Outcomes

The Contractor's Quality Management and performance improvement approach shall incorporate rigorous outcomes measurement against relevant targets and benchmarks. All health goals, outcomes, and indicators shall comply with Federal requirements established under 42 C.F.R. 438.240 (C) (1) and (C) (2) relating to Contractor performance and reporting. The Department will specify the required performance and outcomes measures that the Contractor shall address, including Health Care Effectiveness Data and Information Set (HEDIS™) measures and Kentucky-specific measures. Performance measures, benchmarks, and/or specifications may be modified by the Department over the course of the Contract to comply with industry standards and updates,

as well as to focus on particular outcomes. The Department will provide the Contractor with at least ninety (90) Days' notice, when possible, to make administrative changes to comply with any new measurement requirements.

- A. The Department will set specific quantitative performance targets and goals, and the Contractor shall be expected to achieve demonstrable and sustained improvement for each measure. Minimum performance levels shall be specified for each performance improvement area derived from regional or national standards or from standards established by an appropriate practice organization.
- B. The Contractor shall report activities to address the performance measures in the QAPI Plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall make comparisons across data for each measure by the Medicaid geographic regions, eligibility category, race ethnicity, gender and age to the extent such information has been provided by the Department to Contractor. The Contractor shall incorporate consideration of social determinants of health into the process for analyzing data to support population health management. Reported information may be used to determine disparities in health care. The Contractor shall submit a plan to the Department for initiatives and activities the Contractor will implement to address identified disparities.
- C. The Contractor shall continually work to improve health outcomes from year to year and sustain such improvements. The Department shall assess the Contractor's achievement of performance improvement as evidenced by health outcome measurement results on an annual basis unless otherwise specified by the Department.
- D. Where achievement is lagging in progress towards meeting performance measure targets, the Department will consider the following:
 - 1. Opportunities across MCOs to collaborate to understand challenges and work with the MCOs to identify opportunities to coordinate efforts to work towards improvement. The Contractor shall actively participate in collaborative efforts, including providing data and other materials to help inform options.
 - 2. Need for the Contractor to develop and implement a corrective action plan that addresses the lack of achievements and identifies steps that will lead toward improvements. The Contractor shall submit the plan to the Department within thirty (30) Calendar Days of receipt of notification of required corrective action.
 - 3. Implementation of penalties, as deemed appropriate by the Department due to Contractor failure to make improvements. See **Appendix B "Remedies for Violation, Breach, or Non-Performance of Contract"** for information about penalties.

19.5 Reporting HEDIS™ Performance Measures

The Contractor shall collect and report HEDIS™ data annually, including separate data for the KCHIP population. After completion of the Contractor's annual HEDIS™ data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31.

In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format to the Department. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.

For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor

shall make comparisons across each measure by Medicaid Region, Medicaid eligibility category, race, ethnicity, gender and age.

Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS™ reported measures and Kentucky-specific measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement corrective action. The Contractor shall have sixty (60) Days to review and respond to the Department's performance report.

The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractors submitted Encounter data. The Contractor shall have sixty (60) Days to review and respond to findings reported as a result of these activities.

19.6 Performance Improvement Projects (PIPs)

The purpose of health care quality performance improvement projects (PIPs) is to assess and improve processes, and thereby outcomes, of care for Enrollees. For these projects to achieve real improvements and for interested parties to have confidence in the reported improvements, the Contractor shall follow CMS protocol when designing, conducting, and reporting on PIPs in a methodologically sound manner.

The Contractor shall comply with 42 C.F.R. 438.330(d) to conduct PIPs which focus on both clinical and non-clinical areas. PIPs focused on clinical areas as designated by the Department may address preventive and chronic health care needs of the whole Enrollee population and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special health care needs, race, ethnicity, gender and age. PIPs focused on non-clinical areas as designated by the Department may address issues such as improving the quality, availability, and accessibility of services provided by the Contractor to Enrollees and Providers. Such aspects of service should include, but not be limited to availability, accessibility, cultural competency of services, and complaints, grievances, and Appeals.

The Department and its contracted EQRO shall determine PIP focus areas, and the Contractor shall implement PIPs as follows to achieve significant improvements that are sustained over time, in health outcomes and Enrollee satisfaction:

- A. The Contractor shall design and implement PIPs that are focused on areas of concern to conduct on an ongoing basis.
- B. The Department will work with the EQRO and the MCOs to identify regionally based collaborative PIPs that would be feasible and impactful for the Kentucky healthcare community. All parties will work together to develop strategies and detailed processes for implementing and coordinating efforts for regional collaborative PIPs. To support a collaborative process, the Contractors shall perform the following activities:
 1. Define the scope of the PIP, identify target populations, set improvement goals, and define comprehensive interventions;
 2. Coordinate with existing State or MCO initiatives, as applicable;
 3. Support development of meeting agenda topics, writing quarterly reports, and identifying subject matter experts who should attend meetings based on the agenda items, and writing quarterly reports upon Department request.
 4. Provide adequate funding and staffing resources to execute the PIP.
 5. Evaluate the successes and challenges of interventions on an ongoing basis, and provide quarterly progress reports and an annual findings report to the Department.

DMS will give final approval for the collaborative PIP design and establish required timelines for ongoing meetings and coordination among the involved parties.

- C. As required by the Department, the Contractor shall implement an additional PIP if findings from an EQR review or audit indicate need or if directed by CMS. The Contractor shall assist the Department by supplying readily available data, soliciting input and supporting clinicians.
- D. Implement PIPs as identified and requested for conduct by CMS.

The Contractor's PIPs shall include the following elements:

- A. Measurement of performance using objective quality indicators and measures and minimum performance levels as defined collaboratively by the Department, the EQRO, and Contractor prior to commencement of each PIP. In determining indicators and measures, the Department and Contractor shall work to confirm they are not misaligned with those being used in other projects and that they are measurable and can be tracked. The Department shall have final decision and approval of required indicators and data definitions of each;
- B. Implementation of interventions to achieve improvement in the access to and quality of care;
- C. Evaluation of the effectiveness of the interventions based on the performance measures; and
- D. Planning and initiation of activities for increasing or sustaining improvement.

The Contractor shall be committed to ongoing collaboration for service and clinical care improvements through efforts such as development of best practices, use of Encounter data-driven performance measures and establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection. The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies, community-based health and social agencies and health care delivery systems to achieve improvements in priority areas. Linkages with local public health agencies is essential for achievement of public health objectives. Evidence of adequate partnerships should include formal documentation of meetings, input from stakeholders and shared responsibility in the design and implementation of PIP activities.

The Contractor shall complete each PIP in a period determined by the Department to allow information on the success of the project in the aggregate to produce new information on quality of care each year. Each PIP will use a study period approved by the Department.

The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Enrollees, identify areas for potential improvement, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions.

The Contractor shall participate in the quarterly quality meetings or more frequent meetings with the Department to review progress in achieving the identified goals and targeted improvements for the PIP focus areas. The Department may request ad-hoc meetings as it deems necessary to, for example, address areas of non-compliance. The Department will provide the Contractor with reasonable advance notice of meetings, generally at least five (5) Business Days when possible. The Contractor shall provide to the Department, no later than fourteen (14) Business Days prior to each quarterly meeting, an electronic report detailing the Contractor's progress, successful strategies, and challenges in achieving improvements.

The Contractor shall report the status and results of all required PIPs to the Department as required in 42 C.F.R. 438.330(c)(3) with sufficient detail for the Department to evaluate the reliability and

validity of the data and the conclusions drawn. The Contractor's final report shall follow a format as approved by the Department, and must provide detailed information that addresses all items, as applicable, that are outlined in the CMS Protocol for Performance Improvement Projects, PIP Review Worksheet.

The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement.

While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

19.7 Department for Public Health Initiatives

The Contractor is encouraged to work with the Department for Public Health to support efforts to improve public health outcomes and to support the Department for Public Health's key priorities, which include but are not limited to diabetes, obesity, cardiovascular disease, lung cancer, and substance use disorder. The Contractor is encouraged to work with the Department for Public Health to identify opportunities for the Contractor to collaborate and participate in initiatives such as, but not limited to, the following: the Diabetes Self-Management Program and the Diabetes Prevention and Control Program, and the Tobacco Prevention and Cessation Program.

19.8 Quality Management and Performance Improvement Monitoring and Evaluation

The Contractor, through the QAPI program, shall monitor and evaluate progress in improving the quality of health care and outcomes on an ongoing basis and provide updates to the Department on progress during quality meetings and at the Department's request on an ad hoc basis. Health care needs such as preventive care, acute or chronic physical or behavioral conditions, social determinants of health and high volume, high risk, and special health care needs populations shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines.

The Contractor's Quality Management and performance improvement activities shall demonstrate the linkage of quality initiatives and projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified through performance metrics (e.g., annual HEDIS™ indicators), results of consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by the Department or an accreditation body.

The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues. The Contractor shall collaborate with existing provider Quality Improvement activities and, to the extent possible, align with those activities to reduce duplication and to maximize outcomes.

Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee. Areas identified for improvement shall be tracked and corrective actions taken as indicated. The effectiveness of corrective actions shall be monitored until problem resolution occurs. The Contractor shall perform reevaluations to ensure that improvement is sustained.

The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Enrollees. The Contractor shall modify as necessary, the QAPI program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the

needs of Enrollees. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Enrollees. The Contractor shall submit this report as specified by the Department. The Department shall give the Contractor advance notice of the due date of the annual QAPI report. The Department may require interim reports more frequently than annually to demonstrate Contractor progress.

19.9 Value-based Payment

The Contractor shall collaborate with the Department and other MCOs to implement a Value-Based Payment (VBP) model that aligns incentives for Enrollees, Providers, the Contractors, and the Commonwealth to achieve the Medicaid program's overarching goals for improvement in quality and healthcare outcomes. The impact of initiatives will be measured in terms of access, outcomes, quality of care, and savings.

The Contractor shall work collaboratively with the Department and other MCOs to develop, implement, and execute the VBP model, for which the Department has final approval on design. The Contractor shall provide staffing, including Executive Team members such as the Chief Medical Officer, to attend planning meetings on a schedule defined by the Department and to provide expertise and input on the design, priorities, and initiatives to implement the models. Initiatives shall include an approach to incentivize Providers to participate, and to support Providers in learning about opportunities under the model and their roles in achieving goals. The Contractor may also implement strategies and incentives to encourage Enrollees' participation in addressing their own health needs which may in turn support achievement of identified performance measures.

The Department will finalize performance measures and related targets that the Contractor shall achieve under the VBP model based on the Department's goals for the Medicaid program to support achieved healthcare outcomes and achieve savings. The Department will also determine payment strategies for the Contractor's achievement levels of the required targets such as incentive payments and withholds. The Contractor shall develop initiatives it will implement to achieve the performance measure targets. The Department may also specify required initiatives for the Contractor and other contracted MCOs to implement, which may coordinate with PIPs and focused studies. All contracted MCOs are encouraged to collaborate on initiatives, interventions, and solutions to be implemented.

The Department reserves the right to modify the performance measures during the Contract Term. For any performance measures, the Department and the Contractor shall agree to the methodology for quantifying the Contractor's success in achieving targets and related incentives.

When the VBP model is implemented, the Contractor shall review and provide real-time information focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis and submit reports annually based on agreed upon reporting requirements. The Contractor shall highlight status and progress of initiatives, as well as successes and challenges. The Department will make the final decision as to data and information to be reported to the Department by the Contractor. The Contractor and the Department shall use findings to identify additional opportunities for improvement to the model and need for modification of priorities, measures, and targets.

19.10 Conduct of Surveys

The Contractor shall conduct an annual survey of Enrollees' and Providers' satisfaction with the quality of services provided and their degree of access to services. The Enrollee satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children with a separate sample and survey for CHIP Enrollees, administered by an NCQA certified survey vendor. The Contractor shall provide a copy of the current CAHPS survey tool to the Department. Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services. To meet the provider satisfaction survey requirement, the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool within thirty (30) Days of signing the Contract, annually and prior to any revisions.

The Department shall review and approve any survey instruments and shall provide a written response to the Contractor within thirty (30) Days of receipt. The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting surveys, the targeted audience, the number and percentage of stakeholders, Providers or Enrollees to be surveyed, response rates, and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned. All survey results must be reported to the Department, and upon request, disclosed to Enrollees.

19.11 Quality Rating System

The Department shall monitor for CMS development of a Medicaid Managed Care Quality Rating System to determine whether it will adopt the CMS system or develop its own. The Department shall implement CMS's Medicaid Managed Care Quality Rating System or develop its own within three (3) years of the date of a final notice published in the Federal Register. When implemented, the Contractor shall comply with requirements specified by the Department.

20.0 UTILIZATION MANAGEMENT

The Contractor may establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as Medical Necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose, 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 Family Planning Services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning.

20.1 Utilization Management Program

The Contractor shall implement a Utilization Management (UM) Program that meets the requirements set forth in this section and that is documented in a plan as defined in KRS 304.17A-600. The UM program, processes and timeframes shall be in accordance with 42 C.F.R. 456, 42 C.F.R. 431, 42 C.F.R. 438. If the Contractor utilizes a private review agent, as defined in KRS 304.17A-600, the agent shall comply with all applicable requirements of KRS 304.17A-600 to 304.17A-633, as applicable. The Medical Director and Behavioral Health Director shall supervise the UM Program and shall be accessible and available for consultation as needed.

The Contractor shall implement innovative and effective Utilization Management processes to

ensure a high quality, clinically appropriate yet highly efficient and cost-effective delivery system. The Contractor shall continually evaluate the cost and quality of medical services delivered by Providers. The Contractor shall apply objective and evidence-based criteria that take the individual Enrollee's circumstances when determining the Medical Necessity of health care services.

The Contractor shall have a written plan for the UM program that details the program structure and, if delegated, includes a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities. The UM Program and Review Plan shall comply with KRS 304.17A-600 and include the following information, at a minimum:

- A. Scope of the program;
- B. The processes and information sources used to determine service coverage;
- C. List which services require PCP Referral; which services require Prior Authorization and how requests for initial and continuing services are processed;
- D. Written policies and procedures to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review, approve, or deny the provision of services, as needed, including those specific to the EPSDT program;
- E. Policies and procedures to evaluate discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;
- F. Written policies and procedures for monitoring to ensure clinically appropriate overall continuity of care;
- G. Written policies to ensure the coordination of services:
 - 1. Between settings of care, including appropriate Discharge Planning for short-term and long-term hospital and institutional stays;
 - 2. With the services the Enrollee receives from any other MCO;
 - 3. With the services the Enrollee receives in FFS; and
 - 4. With the services the Enrollee receives from community and social support providers.
- H. Written policies and procedures that explain how Prior Authorization data shall be incorporated into the Contractor's overall Quality Improvement Plan;
- I. Education plan for UM Program staff in the application of related policies and use of designated criteria in making UM decisions;
- J. Written policies and procedures for complying with the Mental Health Parity And Addiction Equity Act (MHPAEA);
- K. Mechanisms to identify or detect under-utilization and over-utilization of services; and
- L. Description of evaluation approach of Enrollee satisfaction (using the CAHPs survey) and Provider satisfaction with the UM program as part of its satisfaction surveys, and how the Contractor will use results.

Nothing in this section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures in so far as that decision is accompanied by the clinical rationale for such a decision.

Network Providers may participate in UM activities to the extent that there is not a conflict of interest. The Contractor shall have UM Policies and Procedures that define when such a conflict may exist and remedies.

The Contractor shall include in each Subcontract that, consistent with 42 C.F.R. Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to an Enrollee.

The Contractor shall submit the UM Program description to the Department for approval within thirty (30) Days of signing the Contract annually and at any time when making material revisions.

The Contractor shall evaluate the UM program annually, including an assessment of the effectiveness in improving clinical and service outcomes. The evaluation shall include assessment of UM activities conducted by Subcontractors. The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Contractor's Medical Director and Behavioral Health Director prior to submission to the Department. The Contractor shall provide findings of the evaluation to the Department, including a discussion of changes, if any, the Contractor plans to make to the program to address challenges or increase effectiveness.

20.2 Utilization Management Committee

The Contractor shall establish an internal UM Committee, including Kentucky-based provider representation, that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization, patterns of care, and key utilization indicators. The Contractor's Medical Director shall chair or co-chair the UM Committee report findings to the Quality Improvement Committee. The UM Committee shall review, at a minimum:

- A. The need for and approval of any changes in UM policies, standards, and procedures, including approval and implementation of clinical guidelines, and approving and monitoring the UM program description and work plan.
- B. Grievances and Appeals (including expedited Appeals and State Fair Hearings) related to UM activities to determine any needed policy changes.

20.3 Clinical Practice Guidelines

The Contractor shall develop or adopt practice guidelines that are disseminated to Providers, and, upon request, to Enrollees and Potential Enrollees. The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals; consider the needs of Enrollees; developed or adopted in consultation with contracting health professionals, and reviewed and updated periodically.

20.4 Medical Necessity Criteria

The Contractor shall have a comprehensive UM Program that reviews services for Medical Necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health. The Contractor shall comply with federal and state regulations when selecting Medical Necessity criteria. The Contractor shall adopt Interqual or MCG (Milliman) as the primary medical/surgical criteria for Medical Necessity except that the Contractor shall utilize the American Society of Addiction Medicine (ASAM) for substance use. If Interqual or MCG does not cover a Behavioral Health Service, the Contractor shall adopt the following standardized tools for Medical Necessity determinations:

- A. For adults: Level of Care Utilization System (LOCUS)
- B. For children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII)

If it is determined that a Medical Necessity criteria named in this section is not available or is not specifically addressed for a service or for a specific population, the Contractor shall submit its proposed Medical Necessity criteria to the Department for approval subject to **Section 4.4 "Approval of Department."** CMS recognized guidelines, LCDs and NCDs, may be utilized by all MCOs when other criteria do not specifically address the provider request. There must be written policies for applying the criteria based on an assessment of the local delivery system. The Department may also, at its discretion, require the use of other criteria it creates or identifies for

services or populations not otherwise covered by the named criteria in this section. Criteria must be based on established scientific evidence which should be specifically referenced in documentation, and strive to incorporate local factors such as Kentucky's demography, epidemiology or provider network attributes. The Contractor shall implement such criteria within ninety (90) Days of receipt of notice from the Department.

The Contractor's Medical Necessity criteria will be transparent and meet all relative documentation requirements as required by the Department, the Kentucky Department of Insurance, CMS or other relevant regulatory agencies. Criteria shall be readily available for review by DMS or the public by request and on the Contractor's website.

The Contractor and Subcontractors responsible for service authorization decisions shall have in place written policies, procedures and mechanisms to ensure consistent application of review criteria for the processing of requests for initial and continuing authorization of services. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.

The Contractor shall have a review body that includes representation by Kentucky licensed health care professionals that review Medical Necessity criteria at least annually. The Contractor shall annually attest to the criteria being used by the Contractor and Subcontractors for Medical Necessity decisions.

The Contractor shall resubmit criteria approved under a prior contract, if applicable, to the Department for review and approval to ensure compliance with the requirements of this Contract.

20.5 Service Authorization

The Contractor may place limits on a service in accordance with federal regulations and requirements of this Contract as set forth in this section and **Section 30.1 "Medicaid Covered Services."** Such limitations and authorization requirements shall be included in the UM Program description as set forth in **Section 20.0 "Utilization Management"**. The Contractor shall submit requests to implement new or change existing authorization requirements to the Department for review and approval prior to implementation of the change.

In accordance with KRS 205.5591, the Contractor shall not require the following specific to telehealth services:

- A. Require Prior Authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;
- B. Demonstration that it is necessary to provide services to an Enrollee through telehealth; and
- C. Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services.

For the processing of requests for initial and continuing authorizations of services, the Contractor shall consult with the requesting Provider for medical services when appropriate. Decisions to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by a physician who has appropriate clinical expertise in treating the Enrollee's medical or behavioral condition or disease. The clinical reason for the Denial, in whole or in part, specific to the Enrollee shall be cited. Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed.

The Department shall provide a common Prior Authorization Form for all Contractors and Subcontractors as applicable to utilize for a Provider to initiate the Prior Authorization process. The

Contractor shall give the Provider the option to use the common form or the Contractor specific form. The Contractor's Prior Authorization process shall be fully automated and comply with provisions of this Contract. The Contractor's Prior Authorization requirements shall comply with all state and federal requirements including but not limited to the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. 438.910(d).

20.6 Service Review and Authorization Timeframes

The Contractor shall make Prior Authorization determinations in a timely and consistent manner so that Enrollees with comparable medical needs receive comparable and consistent levels, amounts, and duration of services as supported by the Enrollee's medical condition, records, and previous affirmative coverage decisions. Unless otherwise specified, the Contractor shall meet, and shall require Subcontractors to meet, the following timelines for conduct of Medical Necessity and service authorization reviews:

- A. Complete the review process for a standard Prior Authorization request within two (2) Business Days of receiving the request. The timeframe for a standard authorization request may be extended up to fourteen (14) Days if the Provider or Enrollee requests an extension, or if the Contractor justifies, in writing, to the Department a need for additional information and how the extension is in the Enrollee's best interest.
- B. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, complete an expedited authorization decision within twenty-four (24) hours and provide notice as expeditiously as the Enrollee's health condition requires;
- C. A request for authorization or preauthorization for treatment of an Enrollee with a diagnosis of substance use disorder shall be considered an Expedited Authorization Request by the provider and the Contractor;
- D. Complete post-service (retrospective) review requests within fourteen (14) Days or, if the Enrollee or the Provider requests an extension or the Contractor justifies in writing to the Department a need for additional information and how the extension is in the Enrollee's interest, may extend up to an additional fourteen (14) Days.
- E. Upon request of an Enrollee or Provider, provide written confirmation of the Contractor's decision within three (3) Business Days, providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Enrollee Rights and Responsibilities.

20.7 Adverse Benefit Determination Related to Requests for Services and Coverage Denials

The Contractor shall provide the Enrollee written notice that meets the language and formatting requirements for Enrollee materials, of any Adverse Benefit Determination (not limited to service authorization actions) within the timeframes for each type of Adverse Benefit Determination pursuant to 42 C.F.R. 438.210(d) and in compliance with 42 C.F.R. 438.404 and other provisions of this Contract. The notice must explain:

- A. The Adverse Benefit Determination the Contractor has made or intends to make;
- B. The reason(s) for the Adverse Benefit Determination in clear, non-technical language that is understandable by a layperson;
- C. Specific and detailed information as to why the service did not meet Medical Necessity, if the action related to a Denial, in whole or in part, of a service is due to a lack of Medical Necessity;
- D. The federal or state regulation supporting the action, if applicable;
- E. The 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 Adverse Benefit Determination, including Medical Necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

- F. The Enrollee's right to Appeal including information on exhausting the Contractor's one level of Appeal as required by 42 C.F.R. 438.402(b);
- G. Procedures for exercising Enrollee's rights to Appeal or file a Grievance;
- H. Circumstances under which the Appeal process can be expedited and how to request it;
- I. The Enrollee's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services;
- J. The Enrollee's right to request a State Fair Hearing after receiving notice that the Adverse Benefit Determination is upheld;

Notices to Enrollees shall:

- A. Be available in English, Spanish, and each Prevalent Non-English Language;
- B. Be available in alternative formats for persons with special needs; and
- C. Be easily understood in language and format.

The Contractor shall give notice as follows at a minimum:

- A. Within ten (10) Days of an Adverse Benefit Determination when the Adverse Benefit Determination is a termination, suspension or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to five (5) Days if Enrollee Fraud or Abuse has been determined.
- B. By the date of the Adverse Benefit Determination for the following situations:
 - 1. In the death of an Enrollee;
 - 2. A signed written Enrollee statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this will be the result of supplying that information);
 - 3. The Enrollee's admission to an institution where he or she is ineligible for further services;
 - 4. The Enrollee's address is unknown and mail directed to him or her has no forwarding address;
 - 5. The Enrollee has been accepted for Medicaid services outside of Kentucky;
 - 6. The Enrollee's physician prescribes the change in the level of medical care;
 - 7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions;
 - 8. The safety or health of individuals in the facility would be endangered, the Enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Enrollee's urgent medical needs, or an Enrollee has not resided in a nursing facility for thirty (30) Days.
- C. On the date of the Adverse Benefit Determination when the Adverse Benefit Determination is a Denial of payment.
- D. As expeditiously as the Enrollee's health condition requires and within State-established timeframes . If the Contractor extends the timeframe for an appeal or expedited appeal, and the extension was not at the request of the Enrollee, the Contractor shall make reasonable efforts to give the Enrollee prompt oral notice of the delay; give the Enrollee written notice within two (2) Days, 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 resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.
- E. For expedited authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than two (2) Business Days after receipt of the request for service.
- F. On the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a Denial and is thus an Adverse Benefit Determination.

As set forth in KRS 205.534, upon the request of a Medicaid Provider, provide at no cost to the provider, all documents, records, and other information relevant to an adverse payment or coverage determination, the Contractor shall inform a Medicaid Provider of the determination with sufficient detail of the reason(s) therefore and the Provider's right to request and receive at no cost to the Provider, all documents, records, and other information related to the determination

20.8 Court-Ordered Evaluations and Services

In the event an Enrollee requires Medicaid covered Services ordered by a State or federal court, the Contractor shall fully comply with all court orders while maintaining appropriate UM practices. See **Appendix I "Covered Services"** for additional requirements.

The Contractor shall maintain and operate a formalized Discharge Planning Program that includes a comprehensive evaluation of the Enrollee's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

21.0 MONITORING AND OVERSIGHT

21.1 Monitoring Requirements

The Department is responsible for monitoring and oversight of the Contractor for compliance with the provisions of this Contract and applicable federal and State laws and regulations. The Department and its representatives will conduct ongoing monitoring and oversight through activities such as but not limited to the following:

1. Tracking and/or auditing or reviewing Contractor activities, materials, and records developed under the Contract, which may include periodic medical audits and audits or review of Appeals, enrollments, disenrollments, termination of providers, utilization and financial records;
2. Reviewing management systems and procedures;
3. Conducting periodic reviews of the Contractor's Provider Network to confirm adequacy and to ensure that providers excluded from Medicaid participation are excluded from the Contractors Provider Network;
4. Reviewing Contractor reports for progress, successes, trends, and challenges or problems;
5. Conducting random inspections of Contractor and Subcontractor facilities; and
6. Providing feedback to the Contractor about findings, and requiring corrective actions, as determined necessary by the Department.

The Contractor shall fully cooperate with monitoring and oversight activities. The Contractor shall participate in scheduled meetings, respond to Department inquiries and findings from monitoring and oversight activities, respond to requests for corrective action plans, provide reports on the timeline required by and as requested by the Department, among other activities as deemed necessary by the Department. See **Section 37.0 "Contractor Reporting Requirements."** Cooperation in Contract monitoring and provision of documents during Contract monitoring shall be at no additional cost to the Department.

The Contractor is responsible for the faithful performance of the Contract and shall have internal monitoring procedures and processes to ensure compliance. The Contractor shall provide oversight of its Subcontract(s) and shall have internal monitoring procedures and processes to ensure Subcontractor compliance. The Contractor shall ensure that all Subcontractor(s) work for the purpose of fulfilling a Contractor's obligation under this Contract.

21.2 External Quality Review

Section 1902(a)(30)(c) of Title XIX of the Social Security Act, requires the Commonwealth to acquire an independent external review body for the purpose of performing an annual review of the quality of services provided by an MCO under contract with the Commonwealth, including the evaluation of quality outcomes and timeliness of access to services. Requirements relating to the External Quality Review (EQR) are further defined and described under 42 C.F.R. 438, Subpart E. The results of EQR are made available, upon request, to specified groups and to interested stakeholders. The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Part 438.

The Contractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 C.F.R. 438, Subpart E. These protocols guide the independent external review of quality outcomes and timeliness of and access to services provided by a Contractor providing Medicaid services.

In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 C.F.R. 438.360.

21.3 EQR Administrative Reviews

The Contractor shall assist the EQRO in completing all Contractor reviews and evaluations in accordance with established protocols previously described. The Contractor shall assist the Department and the EQRO in identification of Provider and Enrollee information required to carry out annual, external independent reviews of the quality outcomes, and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and Subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.

21.4 EQR Performance

If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:

- A. Assign a staff person(s) to conduct follow-up concerning review findings;
- B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan;
- C. Submit a corrective action plan in writing to the EQRO and Department within ten (10) Business Days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification;
- D. Demonstrate how the results of the EQR are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this Contract; and
- E. If Contractor disagrees with the EQRO's findings, submit its position to the Commissioner of the Department whose decision is final.

22.0 ENROLLEE SERVICES

22.1 Required Functions

The Contractor shall have an Enrollee Services function that includes a call center which is staffed

and available by telephone Monday through Friday 7:00 am to 7:00 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer for all Contractor programs with the exception of behavioral health which is addressed in **Section 33.6 “Behavioral Health Services Hotline.”**

If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately.

The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses, and registered nurses.

The Contractor shall self-report their prior month performance in the three (3) areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their Enrollee services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.

Appropriate foreign language and/or oral interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education and otherwise comply with 42 C.F.R. 438.10(d). Enrollee written materials shall be provided and printed in English, Spanish, and each Prevalent Non-English Language. Oral interpretation shall be provided for all non-English languages. The Contractor staff shall be able to respond to the special communication needs of the disabled, blind, deaf, and aged, and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.

The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to an Enrollee's records when written Enrollee consent is provided.

The Contractor's Enrollee Services function shall also be responsible for:

- A. Ensuring that Enrollees are informed of their rights and responsibilities;
- B. Ensuring each Enrollee is free to exercise his or her rights without the Contractor or its Providers treating the Enrollee adversely;
- C. Guaranteeing each Enrollee's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;
- D. Collecting updated demographic information for Enrollees, including address, phone numbers, etc.;
- E. Monitoring the selection and assignment process of PCPs;
- F. Identifying, investigating, and resolving Enrollee Grievances about health care services;
- G. Assisting Enrollees with filing formal Appeals regarding plan determinations;
- H. Providing each Enrollee with an identification card that identifies the Enrollee as a participant with the Contractor, unless otherwise approved by the Department;
- I. Explaining rights and responsibilities to Enrollees or to those who are unclear about their rights or responsibilities including reporting of suspected Fraud and Abuse;

- J. Explaining Contractor's rights and responsibilities, including the responsibility to ensure minimal waiting periods for scheduled Enrollee office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;
- K. Providing within five (5) Business Days of the Contractor being notified of the enrollment of a new Enrollee, by a method that will not take more than three (3) Days to reach the Enrollee, and whenever requested by the Enrollee, guardian or authorized representative, an Enrollee Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);
- L. Explaining or answering any questions regarding the Enrollee Handbook;
- M. Facilitating the selection of or explaining the process to select or change PCPs through telephone or face-to-face contact where appropriate. The Contractor shall assist Enrollees to make the most appropriate PCP selection based on previous or current PCP relationship, providers of other family Enrollees, medical history, language needs, provider location and other factors that are important to the Enrollee. The Contractor shall notify Enrollees within thirty (30) Days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) Days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) Days prior to the effective date of involuntary termination if their PCP leaves the Program and assist Enrollees in selecting a new PCP;
- N. Facilitating direct access to specialized providers in the circumstances of:
 - 1. Enrollees with long-term, complex health conditions;
 - 2. Aged, blind, deaf, or disabled persons; and
 - 3. Enrollees who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the PCP or by the specialty physician being permitted to serve as the PCP.
- O. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;
- P. Providing Enrollees with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;
- Q. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Enrollees under age eighteen (18); childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in **Appendix I "Covered Services"** of this Contract;
- R. Facilitating access to Behavioral Health Services and pharmaceutical services;
- S. Facilitating access to the services of public health departments, Community Mental Health Centers (CMHCs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), the Office for Children with Special Health Care Needs and charitable care providers, such as Shriners' Hospital for Children;
- T. Assisting Enrollees in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to PCPs or referrals to specialty providers, the Enrollee Services staff function shall document and refer such problems to the designated Enrollee Services Manager for resolution;
- U. Assisting Enrollees in obtaining transportation for both emergency and appropriate non-emergency situations;
- V. Handling, recording and tracking Enrollee Grievances properly and timely and acting as an advocate to ensure Enrollees receive adequate representation when seeking an expedited Appeal;
- W. Facilitating access to Enrollee Health Education Programs;
- X. Assisting Enrollees in completing the Health Risk Assessment (HRA) as outlined in **Appendix I "Covered Services"** upon any telephone contact; and referring Enrollees to the appropriate areas to learn how to access the health education and prevention opportunities available to

- them including referral to the Population Health Management (PHM) Program; and
- Y. The Enrollee Services staff shall be responsible for making an annual report to management about any changes needed in Enrollee services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.

22.2 Enrollee Handbook

The Contractor shall publish an Enrollee Handbook and make the handbook available to Enrollees upon enrollment, to be delivered to the Enrollee within five (5) Business Days of Contractor's notification of Enrollee's enrollment.

With the exception of a new Enrollee assigned to the Contractor, the Contractor is in compliance with this requirement if the Enrollee's handbook is:

- A. Mailed within five (5) Business Days by a method that will not take more than three (3) Days to reach the Enrollee;
- B. Provided by email after obtaining the Enrollee's agreement to receive the information by email;
- C. Posted on the Contractor's website and the Contractor advises the Enrollee in paper or electronic form that the information is available on the internet and includes the internet address, provided that Enrollee's with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
- D. Provided by any other method that can reasonably be expected to result in the Enrollee receiving that information.

For any new Enrollee assigned to the Contractor, the Contractor shall mail a hard copy of the Enrollee Handbook within five (5) Business Days of notification of the assignment.

The Enrollee Handbook shall be available in English, Spanish, and each Prevalent Non-English Language. The Enrollee Handbook shall be available in a hardcopy format as well as an electronic format online. The electronic format shall be readily accessible, placed in a location on the website that is prominent and easily accessible, can be electronically retained and printed. The information shall be available in paper form without charge upon request within five (5) Business Days.

The Enrollee Handbook shall follow the model Enrollee Handbook provided to the Contractor by the Department after Contract execution. The handbook shall meet the requirements of 42 CFR 438.10(c)(4)(ii), 42 CFR 438.10, and 42 CFR 438.62(b)(3).

The handbook shall be written at the sixth (6th) grade reading comprehension level and shall include at a minimum the following information:

- A. Information as required by the Department in the model Enrollee Handbook;
- B. The Contractor's Network of Primary Care Providers, including a list of the names, telephone numbers, and service site addresses of PCPs available in the network listing. The network listing may be combined with the Enrollee Handbook or distributed as a stand-alone document;
- C. How to access a list of Network Providers for Covered Services in paper form, upon request, or electronic form containing information required in 42 C.F.R. 438.10(h);
- D. Any restrictions on an Enrollee's freedom of choice among Network Providers;
- E. The procedures for selecting a PCP and scheduling an initial health appointment or requesting a change of PCP and specialists; reasons for which a request may be denied; and reasons a Provider may request a change;
- F. The availability of oral interpretation services for all languages, written translations in English, Spanish, and each Prevalent Non-English Language as well as for the top fifteen (15) non-English languages as released by the U.S. Department of Health and Human Services, Office

- for Civil Rights, alternative formats, and other auxiliary aids and services as well as how to access those services;
- G. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Enrollee Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;
 - H. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage, including those due to moral or religious objections, and a notice stating that the Contractor shall be liable only for those services authorized by the Contractor;
 - I. Enrollee rights and responsibilities including reporting suspected Fraud and Abuse and the elements specified in 42 C.F.R. 438.100;
 - J. Procedures for obtaining Emergency Care and non-emergency care after hours, what constitutes an Emergency Medical Condition, the fact that a Prior Authorization is not required for Emergency Services and the right to use any hospital or other setting for Emergency Care. For a life-threatening situation, instruct Enrollees to use the Emergency Medical Services available or to activate Emergency Medical Services by dialing 911;
 - K. Procedures for obtaining transportation for both emergency and non-emergency situations;
 - L. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;
 - M. Procedures for arranging EPSDT for persons under the age of twenty-one (21) years;
 - N. Procedures for obtaining access to Long Term Care Services;
 - O. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;
 - P. A list of direct access services that may be accessed without the authorization of a PCP;
 - Q. Information about how to access care before a PCP is assigned or chosen;
 - R. An Enrollee's right to obtain a second opinion in or out of the Contractor's Provider network and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;
 - S. Procedures for obtaining Covered Services from non-Network Providers;
 - T. Procedures and timelines for filing a Grievance or Appeal. This shall include the title, address and telephone number of the person responsible for processing and resolving Grievances and Appeals, the availability of assistance in the filing process, the right of the Enrollee to a State Fair Hearing and that benefits will continue while under appeal if MCO decision is to reduce or terminate services;
 - U. Information about the Cabinet for Health and Family Services' independent ombudsman program for Enrollees;
 - V. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;
 - W. Information on the availability of health education services;
 - X. Any cost sharing imposed;
 - Y. How to exercise an advance directive;
 - Z. Information deemed mandatory by the Department; and
 - AA. The availability of Population Health Management (PHM) Program services provided by the Contractor.

The Contractor's Quality and Access Committee shall review and approve the Enrollee Handbook. The Contractor shall review the Enrollee Handbook at least annually for updates as necessary to maintain accuracy, particularly with regard to the list of participating providers, Covered Services and any service not covered by the Contractor because of moral or religious objections. The Department may also request updates to the Enrollee Handbook at any time to address issues such as changes in state or federal regulations. The Contractor shall communicate any changes to Enrollees in written form as least thirty (30) Days before the intended effective date of the change. Revision dates shall be added to the Enrollee Handbook so that it is evident which version is the most current.

The Contractor shall submit its Enrollee Handbook, and any subsequent changes throughout the

Contract Term, to the Department for review and approval. Changes shall be approved by the Department prior to printing or distribution. The Department has the authority to review the Contractor's Enrollee Handbook at any time.

22.3 Enrollee Education and Outreach

The Contractor shall develop, administer, implement, monitor and evaluate an Enrollee and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Enrollees. The Outreach Program shall encourage Enrollees and community partners to use the information provided to best utilize services and benefits.

Creative methods should be used to reach Contractor's Enrollees and community partners. These must include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.

The Contractor shall submit an annual outreach plan to the Department for review and approval subject to **Section 4.4 "Approval of Department."** The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.

22.4 Cultural Consideration and Competency

The Contractor shall participate in the Department's effort 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, disabilities and regardless of gender, sexual orientation or gender identity. The Contractor shall address the special health care needs of its Enrollees needing culturally sensitive services. The Contractor shall conduct ongoing training of staff in the areas of cultural competency development, cultural sensitivity, and unconscious bias. The Contractor shall incorporate in policies, administration and service practice the values of the following: recognizing the Enrollee's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Enrollee's cultural background. The Contractor shall communicate such policies to Subcontractors and include requirements in Subcontracts to ensure Subcontractor implementation of such policies.

22.5 Outreach to Homeless Persons

The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence. The plan shall include:

- A. Utilizing existing community resources such as shelters and clinics; and
- B. Face-to-face encounters.

The Contractor shall not differentiate services for Enrollees who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.

22.6 Enrollee Information Materials

All written materials provided to Enrollees that are critical to obtaining services, including, at a minimum, Marketing materials, new Enrollee information, provider directories, handbooks, Denial and termination notices, and grievance and appeal information shall comply with 42 C.F.R. 438.10(d) and 45 C.F.R. 92 unless otherwise specifically addressed in this Contract. The information shall at a minimum:

- A. Be written at a sixth (6th) -grade reading level determined by Flesch-Kincaid and use easily understood language and format;
- B. Be published in at least a twelve (12) point font size, and available in large print in a font size no smaller than eighteen (18) point, except font size requirements shall not apply to Enrollee Identification Cards;
- C. Comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).
- D. Be available through auxiliary aids and services, upon request of the Enrollee at no cost;
- E. Be available in alternative formats, upon request of the Enrollee at no cost;
- F. Be available in English, Spanish, and each Prevalent Non-English Language;
- G. Be provided through oral interpretation services for any language;
- H. Include taglines in the top fifteen (15) non-English languages as released by the U.S. Department of Health and Human Services Office of Civil Rights, as well as large print, explaining the availability of written translation or oral interpretation and the toll-free telephone number of the Contractor's entity providing those services and how to request services.

Written materials provided to Enrollees, including forms used to notify Enrollees of Contractor actions and decisions, with the exception of written materials unique to individual Enrollees, unless otherwise required by the Department shall be submitted to the Department for review and, approval prior to publication and distribution to Enrollees such approval by the Department shall be subject to **Section 4.4 "Approval of Department."**

22.7 Information Materials Requirements

The Contractor shall notify all Enrollees of their right to request and obtain the information listed herein at least once a year and within a reasonable time after the Contractor receives from the Department notice of the Enrollee's Enrollment. Any change in the information listed herein shall be communicated at least thirty (30) Days before the intended effective date of the change.

- A. Names, locations, telephone numbers of, and non-English languages spoken by, Providers in the Contractor's Network, including identification of Providers that are not accepting new patients. This includes, at a minimum, information on PCPs, specialists, and hospitals;
- B. Any restrictions on the Enrollee's freedom of choice among network Providers;
- C. Any changes in Covered Services by the Contractor due to moral or religious objections and how to obtain the service;
- D. Enrollee rights and protections, as specified in 42 C.F.R. §438.100;
- E. Information on the right to file grievances and Appeals and procedures as provided in 42 C.F.R. §§438.400 through 438.424 and 907 KAR 17:010, including: requirements and timeframes for filing a grievance or Appeal; availability of assistance in the filing process; toll-free numbers that the Enrollee can use to file a grievance or an Appeal by phone; that when requested benefits can continue during the grievance or Appeal; and that the Enrollee may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee;
- F. Information on a State fair hearing including the right to hearing; method for obtaining a hearing; and rules that govern representation at the hearing;
- G. The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled;
- H. Procedures for obtaining benefits, including authorization requirements;

- I. The extent to which, and how, Enrollees may obtain benefits, including Family Planning Services, from Out-of-Network Providers;
- J. The extent to which, and how, after-hours and emergency coverage are provided, including:
 - 1. What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Services, with reference to the definitions in 42 C.F.R. §438.114(a) and 907 KAR 3:130;
 - 2. The fact that Prior Authorization is not required for Emergency Services;
 - 3. The process and procedures for obtaining Emergency Services, including use of the 911-telephone system;
 - 4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;
 - 5. The fact that, subject to the provisions of this section, the Enrollee has a right to use any hospital or other setting for Emergency Care.
- K. The post-stabilization care services rules set forth at 42 C.F.R. §422.113(c);
- L. The Contractor's policy on referrals for Specialty Care and for other benefits not furnished by the Enrollee's PCP;
- M. Cost sharing, if any;
- N. How and where to access any benefits that are available under the State plan but are not covered under the Contract;
- O. Any Appeal rights made available to Providers to challenge the failure of the Contractor to cover a service;
- P. Advance directives, as set forth in 42 C.F.R. §438.6(i)(2);
- Q. Upon request, information on the structure and operation of the Contractor and physician incentive plans; and
- R. An Enrollee's right to request and receive a copy of his or her Medical Records and request that the records be amended or corrected.

22.8 Advance Medical Directives

The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 - 311.643 and 42 C.F.R. Part 489, Subpart I and 42 C.F.R. 422.128, and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Enrollees to initiate directions about their future medical care in those circumstances where Enrollees are unable to make their own health care decisions. The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Enrollees and shall notify all Enrollees of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Enrollee Services staff on informing Enrollees about Advance Medical Directives. PCPs have the responsibility to discuss Advance Medical Directives with adult Enrollees at the first medical appointment and chart that discussion in the Medical Record of the Enrollee.

22.9 Enrollee Rights and Responsibilities

The Contractor shall have written policies and procedures that are in compliance with Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R. part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972; Titles II and III of the Americans with Disabilities Act; Section 1557 of the ACA and 42 C.F.R. 438.100, and designed to protect the rights of Enrollees and enumerate the responsibilities of each Enrollee. A written description of the rights and responsibilities of Enrollees shall be included in the Enrollee information materials provided to new Enrollees. The Contractor shall provide a copy of these policies and procedures to all of the Contractor's Network Providers to whom Enrollees may be referred. In addition, the Contractor shall provide these policies and procedures to any Out-of-Network Provider upon request from the Provider.

The Contractor's written policies and procedures that are designed to protect the rights of Enrollees, in accordance with federal and state law, shall include, without limitation, the right to:

- A. Respect, dignity, privacy, confidentiality, accessibility and nondiscrimination;
- B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;
- C. Consent for or refusal of treatment and active participation in decision choices;
- D. Ask questions and receive complete information relating to the Enrollee's medical condition and treatment options, including Specialty Care;
- E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and request a State Fair Hearing from the Contractor and/or the Department;
- F. Timely access to care that does not have any communication or physical access barriers;
- G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;
- H. Assistance with Medical Records in accordance with applicable federal and state laws;
- I. Timely referral and access to medically indicated Specialty Care;
- J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
- K. Receive information in accordance with 42 C.F.R. 438.10;
- L. Be furnished health care services in accordance with 42 C.F.R. Part 438; and
- M. Any American Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or an I/T/U PCP shall be allowed to receive services from that provider if part of Contractor's Network.

The Contractor shall also have policies addressing the responsibility of each Enrollee to:

- A. Become informed about Enrollee rights;
- B. Abide by the Contractor's and Department's policies and procedures;
- C. Become informed about service and treatment options;
- D. Actively participate in personal health and care decisions, practice healthy lifestyles;
- E. Report suspected Fraud and Abuse; and
- F. Keep appointments or call to cancel.

22.10 Enrollee Choice of MCO

The Department will enroll and disenroll eligible Enrollees in conformance with this Contract. The Contractor is not allowed to induce or accept Disenrollment from an Enrollee. The Contractor shall direct the Enrollee to contact the Department for Enrollment or Disenrollment questions.

The Department makes no guarantees or representations to the Contractor regarding the number of eligible Enrollees who may ultimately be enrolled with the Contractor or the length of time any Enrollee may remain enrolled with the Contractor.

The Department will electronically transmit to the Contractor new Enrollee information monthly and will electronically transmit demographic changes regarding Enrollees daily.

22.11 Identification Cards

The Contractor shall issue an identification card for every Enrollee assigned to it. The Identification card will also include the PCP, if applicable, and the Enrollee's Identification Number. If the same card is used for pharmacy Claims processing, the card shall include the Claims processor information as specified in **Section 31.0 "Pharmacy Benefits."**

23.0 ENROLLEE SELECTION OF PRIMARY CARE PROVIDER (PCP)

23.1 Enrollees Not Required to Have a PCP

Dual Eligible Enrollees and Enrollees who are presumptively eligible, are not required to have a Primary Care Provider (PCP).

23.2 Enrollee Choice of Primary Care Provider

Enrollees shall choose or have the Contractor select a PCP for their medical home. The Contractor shall have two processes in place for Enrollees to choose a PCP:

- A. A process for Enrollees who have SSI coverage but are not Dual Eligible Enrollees; and
- B. A process for other Enrollees.

23.3 Enrollees without SSI

An Enrollee without SSI shall be offered an opportunity to: (1) choose a new PCP who is affiliated with the Contractor's Network or (2) stay with their current PCP as long as such PCP is affiliated with the Contractor's Network. Each Enrollee shall be allowed to choose his or her Primary Care Provider from among all available Contractor Network Primary Care Providers and specialists as is reasonable and appropriate for Enrollee.

The Contractor shall have procedures for serving Enrollees from the date of notification of Enrollment, whether or not the Enrollee has selected a PCP. The Contractor shall send Enrollees a written explanation of the PCP selection process within ten (10) Business Days of receiving Enrollment notification from the Department, either as a part of the Enrollee Handbook or by separate mailing. Enrollees will be asked to select a PCP by contacting the Contractor's Enrollee Services department with their selection. The written communication shall include the timeframe for selection of a PCP, an explanation of the process for assignment of a PCP if the Enrollee does not select a PCP and information on where to call for assistance with the selection process.

An Enrollee shall be allowed to select, from all available, but not less than two (2) PCP in the Contractor's Network.

The Contractor shall assign the Enrollee to a PCP:

- A. Who has historically provided services to the Enrollee, meets the PCP criteria and participates in the Contractor's Network;
- B. If there is no such PCP who has historically provided services, the Contractor shall assign the Enrollee to a PCP, who participates in the Contractor's Network and is within thirty (30) Miles or thirty (30) minutes from the Enrollee's residence in accordance with the accessibility standards set forth in Section 28.4 "**Provider Network Access and Adequacy.**" The assignment shall be based on the following:
 - 1. The need of children and adolescents to be followed by pediatric or adolescent specialists;
 - 2. Any special medical needs, including pregnancy;
 - 3. Any language needs made known to the Contractor; and
 - 4. Area of residence and access to transportation.

The Contractor shall monitor and document in a quarterly report to the Department the number of eligible individuals that are assigned a PCP. The Contractor shall notify the Enrollee, in writing, of the PCP assignment, including the Provider's name, and office telephone number. The Contractor

shall make available to the PCP a roster on the first day of each month of Enrollees who have selected or been assigned to his/her care.

If the Contractor assigns the Enrollee a PCP prior to offering the Enrollee the process above for self-selection, then in the event the Contractor receives a request from the Enrollee within thirty (30) Days for a reassignment, the reassignment shall be retroactively effective to the date of the Enrollee's assignment to the Contractor.

23.4 Enrollees who have SSI and Non-Dual Eligibles

An Enrollee who has SSI but is not a Dual Eligible Enrollee shall be offered an opportunity to: (1) choose a new PCP who is affiliated with the Contractor's Network or (2) stay with their current PCP as long as such PCP is affiliated with the Contractor's Network. Each Enrollee shall be allowed to choose his or her Primary Care Provider from among all available Contractor Network Primary Care Providers and specialists as is reasonable and appropriate for Enrollee.

The Contractor shall send Enrollees information regarding the requirement to select a PCP, or one will be assigned to them according to the following:

- A. Upon Enrollment, the Enrollee shall receive a letter requesting them to select a PCP. This letter may be included in the Enrollee Welcome Kit. After thirty (30) Days, if the Enrollee has not selected a PCP, the Contractor shall send a second letter requesting the Enrollee to select a PCP. If the Enrollee does not select a PCP within thirty (30) Days of the second notice, the Contractor shall send a third notice to the Enrollee.
- B. At the end of the third thirty (30) Day period, if the Enrollee has not selected a PCP, the Contractor shall select a PCP for the Enrollee and send a card identifying the PCP selected for the Enrollee and informing the Enrollee specifically that the Enrollee can contact the Contractor and make a PCP change.

If the Contractor assigns the Enrollee a PCP prior to offering the Enrollee the process above for self-selection, then in the event the Contractor receives a request from the Enrollee for a PCP reassignment within thirty (30) Days of the Auto-Assignment, the reassignment shall be retroactively effective to the date of the Enrollee's assignment to the Contractor.

23.5 Selection Procedures for Guardianship

DAIL staff are authorized to apply for Medicaid on behalf of guardianship clients (DAIL) through an expedited application process agreed on by the Department and DAIL.

Adult guardianship clients may move frequently from one placement to another. The parties agree that the following procedures will be used to determine the residence of these Enrollees for the purpose of maintaining a PCP selection. In addition to a change in the county of residence, adult guardianship clients may change PCP selections at any time.

For Enrollees who are in adult guardianship status, the county of residence shall be where the Enrollee is living. Brief absences, such as for respite care or hospitalization, not to exceed one month, do not change the county of residence.

23.6 Primary Care Provider (PCP) Changes

The Contractor shall have written policies and procedures for allowing Enrollees to select or be assigned to a new PCP when such a change is mutually agreed to by the Contractor and Enrollee, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an

Appeal. The Contractor shall allow Enrollees to select another PCP within ten (10) Days of the approved change or the Contractor shall assign a PCP to the Enrollee if a selection is not made within the time frame. Pursuant to 42 C.F.R. 438.52, for Enrollees in a designated rural area in which only the Contractor provides services, the restrictions on changing PCPs cannot be more restrictive than for Enrollee Disenrollment as outlined in **Section 26.13 "Enrollee Request for Disenrollment."**

An Enrollee shall have the right to change the PCP ninety (90) Days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Enrollee's Contractor. The Enrollee may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Enrollee to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Enrollee and/or the PCP are no longer located in the same Medicaid Region.

The Enrollee shall also have the right to change the PCP at any time for cause. Good cause includes the Enrollee was denied access to needed medical services; the Enrollee received poor quality of care; and the Enrollee does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Enrollee's request, the assignment will occur no later than the first day of the second month following the month of the request.

PCPs shall have the right to request an Enrollee's disenrollment from his/her practice and to be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship; Enrollee has not utilized a service within one (1) year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year; or inability to meet the medical needs of the Enrollee.

PCPs shall not have the right to request an Enrollee's disenrollment from their practice for the following: a change in the Enrollee's health status or need for treatment; an Enrollee's utilization of medical services; an Enrollee's diminished mental capacity; or, disruptive behavior that results from the Enrollee's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Enrollee or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.

The initial PCP shall serve until the new PCP begins serving the Enrollee, barring ethical or legal issues. The Enrollee has the right to file a grievance regarding such a transfer.

The PCP shall make the request for change to the Contractor in writing. The Enrollee may request a PCP change in writing, face to face or via telephone.

24.0 ENROLLEE GRIEVANCES AND APPEALS

24.1 General Requirements

The Contractor shall have an organized grievance system that shall include- a grievance process, an Appeals process, and access for Enrollees to a State Fair Hearing pursuant to KRS Chapter 13B and 42 C.F.R. 438 Subpart F. The Department shall provide a standardized form for Contractors to utilize for an Enrollee to begin the Contractor's grievance and Appeal process.

24.2 Enrollee Grievance and Appeal Policies and Procedures

The Contractor shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Enrollees. The Grievance and Appeal Process shall address Enrollees' oral and written grievances. The Grievance and Appeal Process

shall be approved in writing by the Department prior to implementation and shall be conducted in compliance with the notice, timelines, rights and procedures in 42 C.F.R. 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. If federal law and regulation and state law and regulation conflict, federal law and regulation preempts unless the state has been given specific discretion. Grievance and Appeal policies and procedures shall include, but not be limited to:

- A. Provide the Enrollee the opportunity to present evidence, testimony and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals and expedited Appeals as specified in 42 C.F.R. 438.408(b) and (c);
- B. Provide the Enrollee and the Enrollee's representative 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 Contractor, or at the direction of the Contractor, in connection with the Appeal of the Adverse Benefit Determination. This information shall be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe for Appeals as specified in 42 C.F.R. 438.408(b) and (c);
- C. 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;
- D. Consider the Enrollee, the Enrollee's representative, or the legal representative of the Enrollee's estate as parties to the Appeal;
- E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;
- F. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Enrollees who file a grievance or Appeal;
- G. Ensure that a grievance or an Appeal is disposed of and notice given as expeditiously as the Enrollee's health condition requires but not to exceed thirty (30) Days from its initiation. If the Contractor extends the timeline for an Appeal not at the request of the Enrollee, the Contractor shall make reasonable efforts to give the Enrollee prompt oral notice of the delay and shall give the Enrollee written notice, within two (2) Days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file another grievance if he or she disagrees with that decision. Additionally, if the Contractor fails to resolve an Appeal within this thirty (30) Day timeframe, the Enrollee is deemed to have exhausted the Contractor's internal Appeal process and may initiate a State Fair Hearing;
- H. Ensure individuals and subordinates of individuals who make decisions on grievances and Appeals were not involved in any prior level of review;
- I. If the grievance or Appeal involves a Medical Necessity determination, Denial or expedited resolution or clinical issue, ensure that the grievance and Appeal is heard by health care professionals who have the appropriate clinical expertise;
- J. Process for informing Enrollees, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Enrollees upon Enrollment; and by providing it to all Subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;
- K. Provide assistance to Enrollees in filing a grievance if requested or needed including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability;
- L. Include assurance that there will be no discrimination against an Enrollee solely on the basis of the Enrollee filing a grievance or Appeal;
- M. Include notification to Enrollees in the Enrollee Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, Appeals and hearings;
- N. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;
- O. Provide for an Appeal of a grievance decision if the Enrollee is not satisfied with that decision;
- P. Provide for continuation of services, in accordance with 42 C.F.R. 438.420, while the Appeal is pending;

- Q. Provide expedited Appeals relating to matters which could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function;
- R. Provide that oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals to establish the earliest possible filing date for the Appeal and must be confirmed in writing;
- S. Not require an Enrollee or an Enrollee's representative to follow an oral request for an expedited Appeal with a written request;
- T. Inform the Enrollee of the limited time to present evidence and allegations of fact or law in the case of an expedited Appeal;
- U. Acknowledge receipt of each grievance and Appeal;
- V. Provide written notice of the Appeal decision in a format and language that, at a minimum, meet the standards described in 42 C.F.R. 438.10 and for notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice;
- W. Provide for the right to request a hearing under KRS Chapter 13B;
- X. Allows a Provider or a representative to file a grievance or Appeal on the Enrollee's behalf as provided in 907 KAR 17.010; and
- Y. Notifies the Enrollee that if a Service Authorization Request is denied and the Enrollee proceeds to receive the service and Appeal the Denial, if the Appeal is in the Contractor's favor, that the Enrollee may be liable for the cost as allowed by 42 C.F.R. 438.420(d).

If the Contractor continues or reinstates the Enrollee's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

- A. The Enrollee withdraws the Appeal or request for a State Fair Hearing;
- B. The Enrollee does not request a State Fair Hearing with continuation of benefits within ten (10) Days from the date the Contractor mails an adverse appeal decision; or
- C. A State Fair Hearing decision adverse to the Enrollee is made.

All grievance or Appeal files shall be maintained in a secure and designated area and be accessible to the Department, its designee, or CMS upon request, for review. Grievance or Appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

The Contractor shall have procedures for assuring that files contain sufficient information, as outlined at 42 C.F.R. 438.416, to identify the grievance or Appeal, the date it was received, the nature of the grievance or Appeal, notice to the Enrollee of receipt of the grievance or Appeal, all correspondence between the Contractor and the Enrollee, the date the grievance or Appeal is resolved, the resolution, the notices of final decision to the Enrollee, and all other pertinent information. Documentation regarding the grievance shall be made available to the Enrollee, if requested.

24.3 State Fair Hearings for Enrollees

An Enrollee shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. The Contractor, the Enrollee, or the Enrollee's representative or legal representative of the Enrollee's estate shall be parties to the hearing as provided in 907 KAR 17:010(5). An Enrollee may request a State Fair Hearing if he or she is dissatisfied with an Adverse Benefit Determination that has been taken by the Contractor within one hundred and twenty (120) Days of the final appeal decision by the Contractor as provided for in 42 C.F.R. 438.408. An Enrollee may request a State Fair Hearing for an Adverse Benefit Determination taken by the Contractor that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. The standard timeframe for reaching a decision in a State Fair Hearing is found in KRS Chapter 13B.

Failure of the Contractor to comply with the State Fair Hearing requirements of the Commonwealth and federal Medicaid law in regard to an Adverse Benefit Determination made by the Contractor or to appear and present evidence shall result in an automatic ruling in favor of the Enrollee.

The Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but not later than seventy-two (72) hours from the date the Contractor receives notice reversing the determination, if the services were not furnished while the Appeal was pending and the State Fair Hearing results in a decision to reverse the Contractor's decision to deny, limit, or delay services. The Contractor shall pay for disputed services received by the Enrollee while the Appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services.

The Department shall provide for an expedited State Fair Hearing within three (3) Days of a request for an Appeal that meets the requirements of an expedited appeal after a Denial by the Contractor.

25.0 MARKETING

25.1 Marketing Activities

The Contractor shall submit any Marketing plans and all Marketing materials related to the Medicaid managed care program to the Department and shall obtain the written approval of the Department prior to implementing any Marketing plan or arranging for the distribution of any Marketing materials to potential Enrollees. The Contractor shall abide by the requirements in 42 C.F.R. 438.104 regarding Marketing activities. The Contractor shall establish and at all times maintain a system of control over the content, form, and method of dissemination of its Marketing and information materials or any Marketing and information materials disseminated on its behalf or through its Subcontractors. The Contractor shall provide Marketing materials in English, Spanish, and each Prevalent Non-English Language. The Marketing plan shall include methods and procedures to log and resolve Marketing Grievances. The Contractor shall conduct mass media advertising directed to Enrollees in the entire state pursuant to the Marketing plan.

Marketing by mail, mass media advertising and community oriented Marketing directed at potential Enrollees shall be allowed, subject to the Department's prior approval. The Contractor shall be responsible for all costs of mailing, including labor costs.

Any Marketing materials referring to the Contractor must be approved in writing by the Department prior to dissemination, including mailings sent only to Enrollees. The Contractor shall engage only in Marketing activities that are pre-approved in writing by the Department. The Contractor shall require its Subcontractors to submit any Marketing or information materials which relates to this Contract prior to disseminating same. The Contractor shall be responsible for submitting such Marketing or information materials to the Department for approval. The Department shall have the same approval authority over such Subcontractor materials as over Contractor materials. The Contractor shall correct problems and errors subsequently identified by the Department after notification by the Department. Any approval required by **Section 25.1 "Marketing Activities"** shall be subject to **Section 4.4 "Approval of Department."**

The Contractor is responsible for ensuring any Enrollee gift card or value added benefit meets the requirements of Social Security Act §1128A, the Contract and any other applicable federal and state laws. Approval of these benefits by the Department shall not be construed as superseding federal or state law.

25.2 Marketing Rules

The Contractor shall abide by the requirements in 42 C.F.R. Section 438.104 regarding Marketing activities. Face to face Marketing by the Contractor directed at Enrollees or potential Enrollees is strictly prohibited. In developing Marketing materials such as written brochures, fact sheets, and posters, the Contractor shall abide by the following rules:

- A. No Marketing materials shall be disseminated through the Contractor's Provider network. If the Contractor supplies branded health education materials to its Provider network, distribution shall be limited to the Contractor's Enrollees and not available to those visiting the Provider's facility. Such branded health education materials shall not provide Enrollment or Disenrollment information. Any violation of this section shall be subject to the maximum sanction contained in **Section 39.4 "Penalties for Failure to Correct;"**
- B. No fraudulent, misleading, or misrepresentative information shall be used in the Marketing materials;
- C. No offers of material or financial gain shall be made to potential Enrollees as an inducement to select a particular provider or use a product;
- D. No offers of material or financial gain shall be made to any person for the purpose of soliciting, referring or otherwise facilitating the Enrollment of any Enrollee;
- E. No direct or indirect door-to-door, telephone, email, texting or other cold-call Marketing activities;
- F. All Marketing materials comply with information requirements of 42 C.F.R. 438.10; and
- G. No materials shall contain any assertion or statement (whether written or oral) that CMS, the federal government, the Commonwealth, or any other similar entity endorses the Contractor.

The following are inappropriate Marketing activities, and the Contractor shall not:

- A. Provide cash to Enrollees or potential Enrollees, except for stipends, in an amount approved by the Department and reimbursement of expenses provided to Enrollees for participation on committees or advisory groups;
- B. Provide gifts or incentives to Enrollees or potential Enrollees unless such gifts or incentives: (1) are also provided to the general public; (2) do not exceed ten dollars per individual gift or incentive; and (3) have been pre-approved by the Department;
- C. Provide gifts or incentives to Enrollees unless such gifts or incentives: (1) are provided conditionally based on the Enrollee receiving preventive care or other Covered Services; (2) are not in the form of cash or an instrument that may be converted easily to cash; and (3) have been pre-approved by the Department;
- D. Seek to influence a potential Enrollee's Enrollment with the Contractor in conjunction with the sale of any private insurance;
- E. Induce providers or employees of the Department to reveal confidential information regarding Enrollees or otherwise use such confidential information in a fraudulent manner; or
- F. Threaten, coerce or make untruthful or misleading statements to potential Enrollees or Enrollees regarding the merits of Enrollment with the Contractor or any other plan.

26.0 ENROLLEE ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

26.1 Eligibility Determination

The Department shall have the exclusive right to determine an individual's eligibility for the Medicaid Program and eligibility to become an Enrollee of the Contractor. Such determination shall be final and is not subject to review or Appeal by the Contractor. Nothing in this section prevents the Contractor from providing the Department with information the Contractor believes indicates that the Enrollee's eligibility has changed.

26.2 Assignments of New Enrollees

Due consideration shall be given to the following when making assignments for Enrollees who do not select an MCO when enrolling:

- A. Keeping the family together - Assign Enrollees of a family to the same MCO;
- B. Continuity of Care - Preserve the family's pre-established relationship with providers to the extent possible;
- C. Robust MCO Competition - equitable distribution of the participants among the MCOs.

If the Contractor was participating in the Managed Care Program as an MCO prior to entering into this Contract, its current Enrollment shall not be reassigned on July 1, 2020. If an MCO currently contracting with the Commonwealth in the Managed Care Program does not continue with the Managed Care Program, its membership shall be equitably reassigned.

The Department shall follow the steps below for the purpose of equitable distribution.

- A. All managed care Enrollees of a Medicaid family will be assigned to the same MCO.
- B. Continuity of Care – The Department will use Claims history to determine the most recent, regularly visited Primary Care Providers (PCP). The top three (3) PCP providers for each Enrollee shall be considered. This determination will be based on the last twelve (12) months of history with relative weights based on the time period of the visits. The weight shall be one (1) thru three (3) with three (3) being assigned to visits in the most recent four (4) months; one (1) being assigned to visits in the earliest four-month period, and two (2) being assigned to the visits in the middle four (4)-month period. Next, each Enrollee's top three (3) PCP Providers shall be matched against the provider network of the Medicaid Region's MCOs and a "MCO network suitability score" shall be assigned to each family Enrollee.
- C. In order to give due consideration to children and individuals with specialized health care needs it is important that all family Enrollees are not treated equally in developing the family unit's overall MCO score. The ratio between the numbers of children eligible for managed care versus the number of adults eligible for managed care is almost 1.9 to 1. Therefore, the "MCO network suitability score" for a child shall be further multiplied by a factor of 1.9. Similarly, individuals with special health care needs (identified as SSI Adults and SSI Children) shall have their score adjusted by a factor of 1.6 which represents the relative cost of these individuals relative to the cost of adults over the age of eighteen (18). In the case of SSI Children both the child factor (1.9) and the special needs factor (1.6) shall be applied. After these adjustments, each family Enrollee's individual "MCO network suitability score" shall be added together to determine the family unit's "MCO network suitability score."
- D. The family shall be assigned to the MCO with the highest "MCO network suitability score" unless that MCO has exceeded its maximum threshold. Two maximum thresholds are defined for each Medicaid Region: Families and Children, and Others. If the family unit has both categories of individuals, then both thresholds shall apply. In a scenario where the applicable threshold(s) are exceeded, the family shall be assigned to the MCO with next highest score. If a tie exists between two eligible MCOs, see the following step used.
- E. In scenarios where multiple eligible MCOs have the same score for the family "MCO network suitability score", the MCOs which are under the minimum threshold shall be given preference, until the MCO reaches the minimum threshold.
- F. In scenarios where multiple MCOs have the same score for the family "MCO network suitability score" and all MCOs are above the minimum threshold, the family shall be assigned on a rotation basis.

26.3 General Enrollment Provisions

The Department shall notify the Contractor of the Enrollees to be enrolled with the Contractor. The

Contractor shall provide for a continuous open enrollment period throughout the term of the Contract for newly eligible Enrollees. The Contractor shall not discriminate against potential Enrollees on the basis of an individual's health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of an Enrollee's health status, need for health services, race, color, religion, sex, sexual orientation, gender identity, disability or national origin.

The Department shall be responsible for the Enrollment. The Department shall develop an Enrollment packet to be sent to potential Enrollees. The Contractor shall have an opportunity to review and comment on the information to be included in the Enrollment packet, and may be asked to provide material for the Enrollment packet.

Enrollees, during the first ninety (90) Days after the effective date of initial Enrollment, whether the Enrollee selected the Contractor or was assigned through an automatic process, the Enrollee shall have the opportunity to change their Contractor and once a year thereafter in accordance with 42 C.F.R. 438.

26.4 Enrollment Procedures

Each Enrollee shall be provided a Kentucky Medicaid Enrollee Identification Card by the Contractor.

Within five (5) Business Days after receipt of notification of new Enrollee Enrollment, the Contractor shall send a confirmation letter to the Enrollee by a method that shall not take more than three (3) Days to reach the Enrollee. The confirmation letter shall include at least the following information: the effective date of Enrollment; Site and PCP contact information; how to obtain referrals; the role of the Contractor; the benefits of preventive health care; an overview of the Population Health Management (PHM) Program; Enrollee identification card; copy of the Enrollee Handbook; and list of Covered Services. The identification card may be sent separately from the confirmation letter as long as it is sent within five (5) Business Days after receipt of notification of new Enrollee enrollment.

26.5 Enrollment Levels

The Contractor shall accept all Enrollees, regardless of overall plan enrollment. Enrollment shall be without restriction and shall be in the order in which potential Enrollees apply or are assigned. The Contractor shall maintain staffing and service delivery network necessary to adhere to minimum standards for Covered Services.

Enrollees may voluntarily choose a Contractor. Enrollees who do not select a Contractor shall be assigned to a Contractor by the Department. The Department reserves the right to re-evaluate and modify the Auto-Assignment algorithm anytime for any reason, provided however, the Department shall provide written notice to Contractor of any modification of the Auto-Assignment algorithm before the implementation of such modification.

The Department may develop specific limitations regarding Enrollee enrollment with the Contractor to take into consideration quality, cost, competition and adverse selection.

26.6 Enrollment Period

Enrollment begins at 12:01 a.m. on the first day of the first (1st) calendar month for which eligibility is indicated on the eligibility file (HIPAA 834) transmitted to the Contractor, and shall remain until the Enrollee is disenrolled in accordance with Disenrollment provisions of this Contract. Applicable

state and federal law determines Membership for newborns. Membership begins on day of application for Enrollees who are presumptive eligible.

The Contractor shall be responsible for the provision and costs of all Covered Services beginning on or after the beginning date of Enrollment. In the event an Enrollee entering is receiving Medically Necessary Covered Services the day before Enrollment, the Contractor shall be responsible for the costs of continuation of such Medically Necessary Covered Services, without any form of prior approval and without regard to whether such services are being provided within or outside the Contractor's Network until such time as the Contractor can reasonably transfer the Enrollee to a service and/or Network Provider without impeding service delivery that might be harmful to the Enrollee's health.

26.7 Enrollee Eligibility File (HIPAA 834)

The Department shall electronically transmit to the Contractor a HIPAA 834 transaction file daily to indicate new, terminated and changed Enrollees and a monthly listing of all Contractor's Enrollees. The Department shall submit with the monthly HIPAA 834 transaction file, a reconciliation of Enrollment information pursuant to policies and procedures determined by the Department. The Department shall send the first Enrollment data to Contractor in HIPAA 834 format.

All Enrollments and Disenrollments shall become effective on the dates specified on the HIPAA 834 transaction files and shall serve as the basis for Capitated Payments to the Contractor.

The Contractor shall be responsible for promptly notifying the Department of Enrollees of whom it has knowledge were not included on the HIPAA 834 transaction file and shall have been enrolled with the Contractor. Should the Contractor become aware of any changes in demographic information the Contractor shall advise the Enrollee of the need to report information to the appropriate source, i.e. the DCBS office or the Social Security Administration. The Contractor shall not attempt to report these types of changes on behalf of the Enrollee, but shall monitor the HIPAA 834 for appropriate changes. In the event that the change does not appear on the HIPAA 834 within sixty (60) Days, Contractor shall report the conflicting information to the Department. The Department shall evaluate and address the inconsistencies as appropriate.

26.8 Persons Eligible for Enrollment and Retroactivity

To be enrolled with a Contractor, the individual shall be eligible to receive Medicaid assistance under one of the aid categories defined below:

Eligible Enrollee Categories

- A. Temporary Assistance to Needy Families (TANF);
- B. Children and family related;
- C. Aged, blind, and disabled Medicaid only;
- D. Pass through;
- E. Poverty level pregnant women and children, including Presumptive Eligibility;
- F. Aged, blind, and disabled receiving State Supplementation;
- G. Aged, blind, and disabled receiving Supplemental Security Income (SSI);
- H. Under the age of twenty-one (21) years and in an inpatient psychiatric facility;
- I. Children under the age of eighteen (18) who are receiving adoption assistance and have special needs;
- J. Dual eligibles;
- K. Disabled Children;
- L. Foster Care Children;
- M. Adults ages nineteen (19) to sixty-four (64) with income under one hundred thirty eight percent

(138%) of the Federal Poverty Level; or
N. Former Foster Care Children up to age twenty-six (26).

Enrollees eligible to enroll with the Contractor will be enrolled beginning with the first day of the application month with the exception of (1) newborns who are enrolled beginning with their date of birth and (2) presumptively eligible (PE) Enrollees who are eligible on their day of eligibility determination and (3) unemployed parent program Enrollees who are enrolled beginning with the date the definition of unemployment or underemployment in accordance with 45 C.F.R. 233.100 is met. Presumptively Eligible Enrollees will be added to the Contractor's Enrollee Listing Report with an Enrollment date equal to the eligibility date described in (2) above.

The Contractor shall also be responsible for providing coverage to individuals who are retroactively determined eligible for Medicaid. Retroactive Medicaid coverage is defined as a period of time up to three (3) months prior to the application month. The Contractor shall cover all Medically Necessary services provided the Enrollee during the retroactive coverage without a Prior Authorization. The Contractor shall allow a provider to submit a Claim outside of the timely filing period when the provider is notified after the end of the Contractor's timely filing period of a retroactive change in MCO by receipt of a recoupment letter, and the Contractor shall not deny the Claim based on timely filing.

The Contractor is not responsible for retroactive coverage for SSI Enrollees who are newly enrolled. The Department shall be responsible for previous months or years in situations where an individual appealed a SSI Denial, and were subsequently approved as of the original application date and was not already assigned to the Contractor.

26.9 Newborn Infants

Newborn infants of non-presumptive eligible Enrollees shall be deemed eligible for Medicaid and automatically enrolled with the Contractor as individual Enrollees for sixty (60) Days. The hospital shall request Enrollment of a newborn at the time of birth, as set forth by the Department. Deemed eligible newborns are auto enrolled in Medicaid and Enrollment is coordinated within the Cabinet. The delivery hospital is required to enter the birth record in the birth record system called KY CHILD (Kentucky's Certificate of Live Birth, Hearing, Immunization, and Lab Data). That information is used to auto enroll the deemed eligible newborn within twenty-four (24) hours of birth. The Contractor is required to use the newborn's Medicaid ID for any costs associated with child.

26.10 Dual Eligibles

The Contractor shall utilize the HIPAA 834 to identify Enrollees who are Dual Eligible within the MMIS. The Contractor and Medicare Providers shall work together to coordinate the care for such Enrollees in order to reduce over utilization and duplication of services and cost.

26.11 Persons Ineligible for Enrollment

Enrollees who are not eligible to enroll in the Managed Care Program are defined below:

INELIGIBLE ENROLLEE CATEGORIES

- A. Individuals who shall spend down to meet eligibility income criteria;
- B. Individuals currently Medicaid eligible and have been in a nursing facility for more than thirty (30) Days*;
- C. Individuals determined eligible for Medicaid due to a nursing facility admission including those individuals eligible for institutionalized hospice;

- D. Individuals served under the Supports for Community Living, Michele P, home and community-based, or other 1915(c) Medicaid waivers;
- E. Qualified Medicare Beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs) or Qualified Disabled Working Individuals (QDWIs);
- F. Timed limited coverage for illegal aliens for Emergency Medical Conditions;
- G. Working Disabled Program;
- H. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);
- I. Individuals who are eligible for the Breast or Cervical Cancer Treatment Program; and
- J. Individuals otherwise eligible while incarcerated in a correction facility.

* The Contractor shall not be responsible for an Enrollee's nursing facility costs during the first thirty (30) Days; however, if an Enrollee is admitted to a nursing facility, the Contractor shall be responsible for covering the costs of health services, exclusive of nursing facility costs, provided to the Enrollee while in the nursing facility until the Enrollee is either discharged from the nursing facility or disenrolled from the Contractor (effective as is administratively feasible). Contractor costs may include those of physicians, physician assistants, APRNs, or any other medical services that are not included in the nursing home facility per diem rate. In no event shall Contractor be responsible for covering the costs of such health services after the Enrollee's thirtieth (30th) Day in the nursing facility, and the monthly Capitation Payment for such an Enrollee shall be prorated based upon the days of eligibility. This also applies to an Enrollee receiving hospice services who is transferred into a nursing facility.

The Contractor shall not be responsible for 1915(c) Waiver Services furnished to its Enrollees.

26.12 Reenrollment

An Enrollee whose eligibility is terminated because the Enrollee no longer qualifies for medical assistance under one of the aid categories listed in **Section 26.8 "Persons Eligible for Enrollment and Retroactivity"** or otherwise becomes ineligible may apply for reenrollment in the same manner as an initial Enrollment.

An Enrollee previously enrolled with the Contractor shall be automatically reenrolled with the Contractor if eligibility for medical assistance is re-established within two (2) months of losing eligibility. The Contractor shall be given a new Enrollment date once an Enrollee has been reinstated.

Reenrollment that is more than two (2) months after losing eligibility shall be treated as a new Enrollment for all purposes.

The Contractor shall provide reasonable modifications to the annual redetermination process to beneficiaries with disabilities protected by the Americans with Disabilities Act of 1990 (Public Law 101-336), 42 USC 12101, and applicable Federal regulations relating thereto prohibiting discrimination against otherwise qualified disabled individuals under any program or activity; Section 504 of the Rehabilitation Act. The Contractor shall provide reasonable modifications to the obligation to report a change in circumstance for any beneficiary with a disability.

26.13 Enrollee Request for Disenrollment

An Enrollee may request Disenrollment only with cause pursuant to 42 C.F.R. 438.56.

The Enrollee shall submit a written or oral request to request Disenrollment to either the Contractor or the Department giving the reason(s) for the request. If submitted to the Contractor, the Contractor shall transmit the Enrollee's request to the Contract Compliance Officer of the Department. If the Disenrollment request is not granted, the Enrollee may request a State Fair

Hearing. The Department shall notify all Enrollees of their Disenrollment rights at least annually no less than sixty (60) Days before the start of each Enrollment period.

26.14 Contractor Request for Disenrollment

The Contractor shall recommend to the Department Disenrollment of an Enrollee when the Enrollee pursuant to 42 C.F.R. 438.56:

- A. Is found guilty of Fraud in a court of law or administratively determined to have committed Fraud related to the Medicaid Program;
- B. Is abusive or threatening as defined by and reported in Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers to either Contractor, Contractor's agents, or providers;
- C. Is admitted to a nursing facility for more than thirty-one (31) Days;
- D. Is incarcerated in a correctional facility;
- E. No longer qualifies for Medical Assistance under one of the aid categories listed in **Section 26.8 "Persons Eligible for Enrollment or Retroactivity;"** or
- F. Cannot be located.

All requests by the Contractor for the Department to disenroll an Enrollee shall be in writing and shall specify the basis for the request. If applicable, the Contractor's request shall document that reasonable steps were taken to educate the Enrollee regarding proper behavior, and that the Enrollee refused to comply. The Contractor may not request Disenrollment of an Enrollee based on an adverse change in the Enrollee's health, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

26.15 Effective Date of Disenrollment

Disenrollment shall be effective on the first day of the calendar month for which the Disenrollment appears on the HIPAA 834 transaction file. Requested Disenrollment shall be effective no later than the first (1st) day of the second (2nd) month following the month the Enrollee or the Contractor files the request. If the Department fails to make a determination within the timeframes the Disenrollment shall be considered approved.

26.16 Continuity of Care upon Disenrollment

The Contractor shall take all reasonable and appropriate actions necessary to ensure the continuity of an Enrollee's care upon Disenrollment. Such actions shall include: assisting in the selection of a new Primary Care Provider, cooperating with the new Primary Care Provider in transitioning the Enrollee's care, and making the Enrollee's Medical Record available to the new the Primary Care Provider, in accordance with applicable state and federal law. The Contractor shall be responsible for following the Transition/Coordination of Care Plan contained in **Appendix J "Transition/Coordination of Care Plan"** whenever an Enrollee is transferred to another MCO.

26.17 Death Notification

The Contractor shall notify the Department or Social Security Administration in the appropriate county, within five (5) Business Days of receiving notice of the death of any Enrollee.

26.18 Enrollee Address Verification

The Department reserves the right to disenroll an Enrollee from the Medicaid program if the Department is unable to contact the Enrollee by first class mail and after the Contractor has been notified and is unable to provide the Department with a valid address. The Enrollee shall remain disenrolled until either the Department or the Contractor locates the Enrollee and eligibility is reestablished.

27.0 PROVIDER SERVICES

27.1 Required Functions

The Contractor shall maintain a Provider Services function that is responsible for the following services and tasks:

- A. Enrolling, credentialing and recredentialing of Providers and coordination of these responsibilities with the Department's Credentialing Verification Organization(s) (CVOs) when contracted;
- B. Providing Provider Service representatives who respond to provider requests and inquiries within two (2) Business Days of a request;
- C. Performance review of Providers;
- D. Establishing and operating a Provider Call Center;
- E. Assisting Providers with:
 - 1. Enrollee Enrollment status questions;
 - 2. Prior Authorization and referral procedures, including consulting with a requesting Provider on authorization decisions, when appropriate;
 - 3. Claims submissions and payments;
 - 4. Coordination of care for child and adult Enrollees with complex and/or chronic conditions.
- F. Handling, recording and tracking Provider Grievances and Appeals properly and timely while ensuring no punitive action is taken against a Provider who either requests an expedited resolution or supports an Enrollee's Appeal;
- G. Developing, distributing, and maintaining a Provider manual;
- H. Developing and maintaining provider services webpages within the Contractor's website;
- I. Developing, conducting, and assuring Provider orientation and ongoing education;
- J. Encouraging and coordinating the enrollment of Primary Care Providers in the Department for Public Health and the Department for Medicaid Services Vaccines for Children Program. This program offers certain vaccines free of charge to Medicaid Enrollees under the age of twenty-one (21) years. The Contractor is responsible for reimbursement of the administration fee associated with vaccines provided through the program; and
- K. Providing necessary technical support to Providers who experience unique problems with certain Enrollees in their provision of services.

27.2 Provider Services Call Center

The Contractor shall operate a toll-free provider call center that meets standards as determined by the Department. The Contractor may decide to use this toll-free line or operate separate toll-free lines for Claims resolution and Utilization Management and Prior Authorization calls; however, staffing shall be adequate to ensure qualified and timely responses. Additionally, the Contractor shall operate phone lines as defined in this Contract for pharmacy and Behavioral Health Services.

Provider Services shall be staffed, at a minimum, Monday through Friday 8:00 am – 6:00 pm Eastern Standard Time, including federal holidays. Staff members shall be available to speak with providers any time during open hours. The Contractor shall have an automated system during non-business hours with sufficient capacity for all callers to leave messages. All messages shall be

returned on the next Business Day.

The Contractor shall have policies and procedures for operation of the provider call center that address staffing requirements and ratios, orientation and education of call center staff, hours of operation, performance standards, and methods the Contractor will implement to monitor calls and comply with standards. For common topics, the Contractor shall develop scripts for use by call center staff in providing consistent responses to provider inquiries.

The Contractor's call center systems shall have the capability to track and report call management metrics. The Contractor shall meet the following performance standards as measured by monthly averages for the Provider Services and pharmacy call centers:

- A. Call abandonment rate of less than five percent (5%);
- B. Eighty percent (80%) of calls are answered by a live voice within thirty (30) seconds, and the remaining twenty percent (20%) are answered by a representative with an additional thirty (30) seconds. "Answer" is defined as response to each caller who requests to speak to a live representative;
- C. Blocked call rate, or a call that was not allowed into the system, that does not exceed one percent (1%);
- D. Accurate response to call center phone inquiries by call center representatives is ninety percent (90%) or higher; and
- E. One hundred (100) percent of call center open inquiries are resolved within seventy-two (72) hours.

Additionally, the Contractor shall ensure that voice messages left during non-business hours are returned within one (1) Business Day.

Provider Services staff shall be instructed to follow all contractually-required provider relation functions including, policies, procedures and scope of services.

27.3 Provider Services Website

The Contractor shall provide and maintain a website that includes webpages specifically for providers to use to access current program information and provider specific information. The website shall have an interactive function that allows for the following:

- A. Capabilities for providers to submit inquiries and receive responses within one (1) Business Day of receipt; and
- B. Capabilities for Providers to file grievances, Appeals, and supporting documentation electronically in an encrypted format which complies with Federal and State law and allows a Medicaid provider to review the current status of a matter relating to a grievance or an Appeal filed concerning a submitted Claim; and
- C. Other portals, as determined by the Vendor (e.g., for processing Claims).

The Contractor shall refer any inquiries to the Department that are not within the Contractor's scope of services.

The Contractor shall provide the following information on its Provider Services webpages, at a minimum:

- A. Contact information for Contractor call center(s) and hotline(s);
- B. Searchable Provider Manual;
- C. Searchable Provider Directory;
- D. Current and clearly defined Prior Authorization requirements.
- E. Pharmacy Preferred Drug List (PDL) and pharmacy conditions for coverage and utilization limits;
- F. Enrollee rights and responsibilities;

- G. Information about KHIE;
- H. What's New updates; and
- I. Links to other websites such as CHFS, DMS, and the CVO(s).

The Contractor shall review and update its website monthly or more frequently as needed to ensure information is accurate and up to date. The Contractor shall submit to the Department for prior approval all materials that it will post on its website and screenshots for any webpage changes unless otherwise agreed to in writing by both parties. Excluding upgrades which support the ordinary operation, administration, and maintenance of the website and as otherwise agreed upon by both parties, the Contractor shall not modify the website prior to receipt of Department approval.

27.4 Provider Manual and Communications

The Contractor shall prepare and issue a Provider Manual(s), including any necessary specialty manuals (e.g., Behavioral Health) to all network Providers. For newly contracted Providers, the Contractor shall issue copies of the Provider Manual(s) within five (5) Business Days from inclusion of the Provider in the network or provide online access to the Provider Manual and any changes or updates. All Provider Manuals shall be available in hard copy format upon request of the Provider and/or online.

The Contractor shall submit to the Department for approval the Provider Manual, including any provided by a Subcontractor for direct services, and any updates to the Provider Manual, prior to publication and distribution to Providers. Such approval is subject to **Section 4.4 "Approval of Department."**

The Provider Manual and updates shall serve as a source of information to Providers regarding the following and other topics as identified by the Contractor:

- A. Provider rights and responsibilities;
- B. Covered Services;
- C. Enrollee rights and responsibilities and cost-sharing requirements;
- D. Information for PCPs about Advance Medical Directives and their responsibilities for informing Enrollees;
- E. Contractor's Policies and Procedures;
- F. Information for accessing the Contractor and program materials through the Contractor's call center(s), toll-free hotlines, and website;
- G. Provider credentialing and recredentialing;
- H. Provider and Enrollee Grievances and Appeals process;
- I. Claims submission process and requirements;
- J. Provider Program Integrity requirements and reporting suspected Fraud and Abuse;
- K. Utilization Management and Prior Authorization procedures;
- L. Medicaid federal and state laws and regulations;
- M. Overview of the QAPI program;
- N. Overview of value-based payment (VBP) models, when implemented; and
- O. Standards for preventive health services.

The Contractor shall prepare and issue provider communications as necessary to inform providers about Contractor's policies, initiatives or other information. The Department shall approve prior to distribution provider communications only if they change or amend the way the Contractor conducts business with the provider or when there are material changes to the Medicaid managed care program (e.g., changes to federal and state laws, provider notification of a rate change). Such approval is subject to **Section 4.4 "Approval of Department."**

27.5 Provider Orientation and Education

The Contractor shall conduct initial orientation for all Providers within thirty (30) Days after the Contractor places a newly contracted Provider on an active status. The Contractor shall ensure that all Providers receive initial and ongoing orientation to operate in full compliance with the Contract and all applicable Federal and Commonwealth requirements. The Contractor shall use reasonable efforts to ensure that all Providers receive targeted education for specific issues identified by the Contractor and/or the Department.

The Contractor shall develop and submit to the Department a Provider orientation and education plan that includes orientation and education methods, topics, and dates for completion of activities and educational workshops or other types of training sessions. The Contractor shall submit the plan to the Department within sixty (60) Days of contract execution, when material changes are made, and annually.

The Contractor shall ensure that Provider education includes:

- A. Contractor coverage requirements for Medicaid services, including information about Prior Authorization requirements, EPSDT preventive health screening services and EPSDT special services;
- B. Contractor policies and procedures, Contractor administrative clinical practices, and updated information when modifications to existing services occur;
- C. Medicaid policies and procedures, including state and federal mandates and any new policies and procedures;
- D. How to report suspected Fraud and Abuse, and annually addressing Fraud, Waste, and Abuse with Providers;
- E. Medicaid populations and eligibility;
- F. Standards for preventive health services;
- G. Telehealth services;
- H. Special needs of Enrollees in general that affect access to and delivery of services, including those Enrollees set forth in **Section 42.0 "Kentucky SKY Program"**, if applicable;"
- I. Advance Medical Directives;
- J. Claims submission and payment requirements;
- K. Special health/care management programs in which Enrollees may enroll;
- L. Provider role in Population Health Management (PHM) program;
- M. Cultural sensitivity;
- N. Responding to needs of Enrollees with SUD or behavioral health, developmental, intellectual and physical disabilities;
- O. Integrated healthcare, addressing Social Determinants of Health, and population health management initiatives;
- P. Reporting of communicable disease;
- Q. The Contractor's QAPI program, the EQRO, and the Provider's role in impacting quality and healthcare outcomes, including ongoing education about QAPI program findings and interpretation of data when deemed necessary by the Contractor or Department;
- R. Medical records review; and;
- S. Value-based payment.

The Contractor shall develop, implement, and conduct ongoing educational programs for the Kentucky Medicaid Pharmacy Provider community. These educational initiatives shall include, but not be limited to:

- A. Provider letters and bulletins;
- B. PDL drug changes and distribution;
- C. POS messaging;
- D. Training sessions, webinars, quarterly newsletters, and other training activities as requested by the Department;

- E. Billing instructions and Claim resolution;
- F. Website postings of the PDL; and
- G. PA processes and procedures.

The Contractor shall maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written or electronic evidence of training of each Provider and their staff.

27.6 Provider Educational Forums

The Contractor shall participate in any Medicaid Provider Educational Forums designated by the Department to be held throughout the State as enhanced education efforts related to Medicaid managed care. The Contractor shall remit to the Department Twenty Thousand (\$20,000) Dollars at the start of each fiscal year under this Contract to support this outreach effort.

27.7 Provider Credentialing and Recredentialing

The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), KRS 205.560(12), 907 KAR 1:672 or other applicable state regulations and federal law until such time that the Department contracts with a Credentialing Verification Organization (CVO) to perform such services. The Contractor shall document the procedure it will implement, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Enrollees. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J "Credentialing Process."**

The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) Days of receipt of all relative information from the Provider, or within forty-five (45) Days if the Provider is providing substance use disorder services. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J "Credentialing Process."**

If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor shall use the format provided in **Appendix J "Credentialing Process"** to transmit the listed provider enrollment data elements to the Department. The Contractor shall generate and electronically submit a Provider Enrollment Coversheet for each provider to the Department.

The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.

The Contractor shall provide a credentialing process whereby the Provider is only required to complete one credentialing process that applies to the Contractor and any or all of its Subcontractors, if one credentialing process meets NCQA requirements.

27.8 Transition to a Credentialing Verification Organization (CVO)

In compliance with KRS 205.532, the Department will contract with one or more CVOs to conduct enrollment, credentialing, and recredentialing services for the Medicaid managed care program. This section sets forth requirements the Contractor must meet at such time that the CVO contract(s) are effective and operational.

Each provider seeking to be enrolled in Medicaid and credentialed with the Department and the Contractor shall submit a single credentialing application to the designated CVO or organization

meeting the requirements of KRS 205.532(1)(c)2, if applicable. The Contractor shall comply with and take all necessary actions to implement the requirements of 2018 Ky.Acts Ch. 69 and all other applicable Federal and State laws.

The Contractor shall work with any identified CVO designated by the Department. The Contractor shall have a documented process that addresses the following at a minimum:

- A. Referral of providers to the CVO to complete credentialing prior to contracting with the Contractor, and to provide information to Network Providers about the re-credentialing process.
- B. Methods for receiving verified credentialing packets from the CVO;
- C. Determining whether the Contractor will contract with the provider within thirty (30) Days of receipt of the verified credentialing packet from the CVO;
- D. Within ten (10) Days of an executed contract with a provider, ensuring that any of the Contractor's internal processing systems are updated to include the accepted provider contractor and the provider as a participating provider;
- E. Notifying the provider if additional time beyond the required ten (10) Days is needed to load and configure the provider contract, which time shall not exceed an additional fifteen (15) Days;
- F. Working with the CVO as needed when a re-evaluation of provider documentation is determined as necessary to maintain participation status.
- G. Meeting with the Department and/or the CVO monthly during implementation activities, quarterly during ongoing operations, or at a different frequency as requested by the Department, Contractor, or CVO about the credentialing process.

The Contractor shall accept provider credentialing and verified information from the Department, or the Department's contracted CVO, and shall not request a provider to submit additional credentialing information without the Department's written prior approval. The Contractor is not prohibited from collecting additional information to inform the Contractor's contracting process.

Nothing in this section requires the Contractor to contract with a provider if the Contractor and provider do not agree on the terms and conditions for participation.

A provider's Claims become eligible for payment as of the date of the provider's Credentialing Application Date. The Contractor shall not require a provider to Appeal or resubmit any Clean Claim submitted during the time period between the provider's Credentialing Application Date and the Contractor's completion of its credentialing process.

A university hospital, as defined in KRS 205.639, may perform the activities of a CVO for its employed physicians, residents, and mid-level practitioners where such activities are delineated in the hospital's contract with the Contractor. The provisions of KRS 205.532 (3), (4), (5), and (6) with regard to payment and timely action on a credentialing application shall apply to a credentialing application that has been verified through a university hospital.

27.9 Provider Maintenance of Medical Records

The Contractor shall require Providers to maintain Enrollee Medical Records on paper or in an electronic format. Enrollee Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The Medical Record shall be signed by the provider of service.

The Enrollee's Medical Record is the property of the Provider who generates the record. However, the Contractor shall require that each Enrollee or his/her representative is entitled to one free copy of his/her Medical Record. Additional copies shall be made available to Enrollees at cost. Medical records shall generally be preserved and maintained by the Provider for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e., immunization and tuberculosis records are required to be kept for a person's lifetime).

The Contractor shall ensure that the PCP maintains a primary Medical Record for each Enrollee, which contains sufficient medical information from all providers involved in the Enrollee's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:

- A. Enrollee/patient identification information, on each page;
- B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;
- C. Date of data entry and date of Encounter;
- D. Provider identification by name;
- E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;
- F. Past medical history, including serious accidents, operations, illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e., documentation of chickenpox);
- G. Identification of current problems;
- H. The consultation, laboratory, and radiology reports filed in the Medical Record shall contain the ordering provider's initials or other documentation indicating review;
- I. Documentation of immunizations pursuant to 902 KAR 2:060;
- J. Identification and history of nicotine, alcohol use or substance abuse;
- K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;
- L. Follow-up visits provided secondary to reports of emergency room care;
- M. Hospital discharge summaries;
- N. Advanced Medical Directives, for adults;
- O. All written Denials of service and the reason for the Denial; and
- P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.

An Enrollee's Medical Record shall include the following minimal detail for individual clinical Encounters:

- A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;
- B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits;
- C. Plan of treatment including:
 - 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills;
 - 2. Therapies and other prescribed regimen; and
 - 3. Follow-up plans including consultation, referrals and directions, including time to return.

An Enrollee's Medical Record shall include at a minimum for hospitals and mental hospitals:

- A. Identification of the Enrollee;

- B. Physician name;
- C. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 42 C.F.R. 456.172 (mental hospitals) or 42 C.F.R. 456.70 (hospitals));
- D. Initial and subsequent continued stay review dates (described under 42 C.F.R. 456.233 and 42 C.F.R. 465.234 (for mental hospitals) and 42 C.F.R. 456.128 and 42 C.F.R. 456.133 (for hospitals));
- E. Reasons and plan for continued stay if applicable;
- F. Other supporting material appropriate to include;
- G. For non-mental hospitals only:
 1. Date of operating room reservation; and
 2. Justification of emergency admission if applicable.

27.10 Provider Grievances and Appeals

The Contractor shall have in place a provider grievance and appeals process, distinct from that offered to Enrollees. The Contractor shall process provider grievances and appeals promptly, consistently, fairly, and in compliance with state and federal law and Department requirements. The Contractor shall submit its Provider Grievances and Appeals Policy and Procedures to the Department for review ninety (90) Days after Contract execution. The Contractor shall submit changes to the Policy and Procedures to the Department for review prior to implementation of such changes.

The Contractor shall allow for Providers to have the right to file an internal appeal with the Contractor regarding Denial of the following:

- A. A health care service;
- B. Claim for reimbursement;
- C. Provider payment;
- D. Contractual issues.

Appeals received from Providers that are on the Enrollee's behalf for denied services with requisite consent of the Enrollee are deemed Enrollee appeals and not subject to this Section. See **Section 24.0 "Enrollee Grievances and Appeals"** for requirements for Enrollee appeals.

The Contractor's Provider Grievance and Appeals Policy and Procedures shall include the following, at a minimum:

- A. A grievance process for providers to submit complaints or disputes for which remedial action is not requested to the Contractor and that requires use of a standard Department provided Provider Grievance Form by the Contractor to initiate its Provider grievance process;
- B. An appeals process for providers to raise challenges to specific Contractor decisions that includes:
 1. A committee to review and make decisions on provider appeals. The committee must consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal;
 2. Written notification to the Provider regarding a Denial;
 3. Right to request an external third party review of Contractor decisions after the internal process has been exhausted.
- C. Requirements for recording all grievances and appeals filed by a provider to include the date filed, type of issue, identification and contact of the individual filing the grievance or appeal, identification of the individual recording the grievance or appeal, disposition of the grievance or appeal, corrective action required and date resolved;
- D. Requirements that any form of correspondence with the provider about the appeal be directed

- to the designee who filed the appeal.
- E. Process for ongoing review and monitoring of types of grievances and appeals submitted and their resolutions for use in determining if additional provider education or changes to MCO operations is necessary to address trends;

The Contractor shall resolve Provider grievances or appeals and provide written notification of the resolution that is received by the Provider within thirty (30) Days. If the grievance or appeal is not resolved within thirty (30) Days, the Contractor shall request a fourteen (14) Day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall submit Provider Grievances and Appeals reports as required in **Appendix D "Reporting Requirements and Reporting Deliverables."**

A Provider who has exhausted the Contractor's internal appeal process shall have a right to a final Denial, in whole or in part, by the Contractor to an external independent third party in accordance with applicable state laws and regulations including Denials, in whole or in part, involving Emergency Services. The Contractor shall provide written notification to the Provider of its right to file an appeal. A Provider shall have a right to Appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation. If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) Days unless the Final Order designates a different timeframe.

27.11 Other Related Processes

The Contractor shall provide information specified in 42 C.F.R. 438.10(g)(2)(XI) about the Enrollee Grievance and Appeal System to all service providers and Subcontractors at the time they enter into a contract.

27.12 Release for Ethical Reasons

The Contractor shall not require Providers to perform any treatment or procedure that is contrary to the Provider's conscience, religious beliefs, or ethical principles in accordance with 42 C.F.R. 438.102.

The Contractor shall have a referral process in place for situations where a Provider declines to perform a service because of ethical reasons. The Enrollee shall be referred to another Provider licensed, certified or accredited to provide care for the individual service, or assigned to another PCP licensed, certified or accredited to provide care appropriate to the Enrollee's medical condition.

A release for ethical reasons only applies to Contractor's Network Providers; it does not apply to the Contractor.

The Contractor shall not prohibit or restrict a Provider from advising an Enrollee about his or her health status, medical care or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.

28.0 PROVIDER NETWORK

28.1 General Provisions

The Contractor shall develop a robust Provider Network that is adequate to deliver Covered

Services as described in this Contract to meet the healthcare needs of all Enrollees. The Contractor shall demonstrate that its Provider Network meets the Department's availability and access requirements set forth in **Section 28.0 "Provider Network,"** to ensure adequate and appropriate provision of services to Enrollees in urban and non-urban areas and which may include the use of telehealth when appropriate to the condition and needs of the Enrollee. The Contractor shall also demonstrate the extent to which it has included Network Providers who have traditionally provided a significant level of care to Medicaid Enrollees.

The Contractor's Provider Network shall support the Department's quality and health outcomes goals and requirements. The Department may request information about value-based payment arrangements the Contractor includes in its provider contracts. The Contractor shall have Network Providers of sufficient types, numbers, specialties, and sub-specialties to ensure quality and access to health care services.

The Contractor shall develop a Provider Network that complies with KRS 304.17A-515, 42 C.F.R. 438.206 and other state and federal regulations as applicable. When establishing and maintaining a Provider Network, the Contractor shall consider the anticipated Medicaid enrollment; the expected utilization of services given the characteristics and health care needs of the specific Medicaid populations enrolled with the Contractor; the numbers and types (their training, experience, and specialization) of Providers required to provide the necessary Medicaid services; the numbers of Network Providers who are not accepting new Medicaid patients; and the geographic location of Network Providers and its Enrollees, considering distance, travel time, the means of transportation ordinarily used by its Enrollees, and whether the location provides physical access for its Enrollees with disabilities.

28.2 Network Providers to Be Contracted

The Contractor shall develop and maintain a Provider Network that includes providers from throughout the Kentucky provider community and may include providers in bordering states as described in this subsection. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 or as amended and KRS 304.17A-270.

The Contractor shall contract with providers who are willing to meet the terms and conditions for participation established by the Contractor, including, but not limited to the following provider types:

- A. Hospitals and ambulatory surgical centers
- B. Physicians, advanced practice registered nurses, physician assistants, and family planning providers
- C. Free standing birthing centers, primary care centers, local health departments, home health agencies, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHC), and private duty nursing agencies
- D. Behavioral health and substance abuse providers
- E. Opticians, optometrists, audiologists, hearing aid vendors, and speech language pathologists
- F. Physical therapists, occupational therapists, and chiropractors
- G. Dentists
- H. Pharmacies and durable medical equipment suppliers
- I. Podiatrists
- J. Renal dialysis clinics
- K. Transportation providers
- L. Laboratory and radiology providers
- M. Individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and EPSDT Special Services

The Contractor may also contract with other providers that meet the credentialing requirements to the extent necessary to provide Covered Services to Enrollees. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. When the Department's contracted CVO(s) are operational, the Contractor shall also coordinate with the CVO(s), as determined appropriate, to conduct this process.

28.2.1 Hospitals

The Contractor shall have a comprehensive network of hospitals such that they are available and geographically accessible to all Enrollees. This includes, but is not limited to acute care, rehabilitation, psychiatric, and tertiary care facilities, as well as facilities with neo-natal, intensive care, burn, and trauma units. The Contractor shall also include in its Network all Critical Access Hospitals (CAHs). The Contractor shall contract with at least one (1) Teaching Hospital.

28.2.2 Primary Care Providers

The Contractor shall have an adequate number of accessible Primary Care Providers (PCPs) in its network, including family practice and general practice physicians, internists, obstetricians and gynecologists, and pediatricians. Primary care physician residents may function as PCPs. The PCP shall serve as the Enrollee's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Enrollee. Although PCPs are given this responsibility, the Contractor shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.

Specialty providers may serve as PCPs under certain circumstances, depending on the Enrollee's needs, including for an Enrollee who has a gynecological or obstetrical health care need, a disability, or chronic illness. The decision to utilize a specialist as the PCP shall be based on agreement among the Enrollee or family, the specialist, and the Contractor's medical director. The Enrollee has the right to Appeal such a decision in the formal Appeals process.

The Contractor shall monitor a PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:

- A. Maintaining continuity of the Enrollee's health care;
- B. Making referrals for Specialty Care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's Network;
- C. Maintaining a current Medical Record for the Enrollee, including documentation of all PCP and Specialty Care services;
- D. Discussing Advance Medical Directives with all Enrollees as appropriate;
- E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of twenty-one (21) years;
- F. Documenting all care rendered in a complete and accurate Medical Record that meets or exceeds the Department's specifications;
- G. Arranging and referring Enrollees when clinically appropriate, to behavioral health providers; and
- H. Maintaining formalized relationships with other PCPs to refer their Enrollees for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.

The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in the Contractor's Network and that the unacceptable arrangements are not implemented:

- A. Acceptable:
 1. Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;
 2. Office phone is answered after hours by a recording directing the Enrollee to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and
 3. Office phone is transferred after office hours to another location where someone shall answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.
- B. Unacceptable:
 1. Office phone is only answered during office hours;
 2. Office phone is answered after hours by a recording that tells Enrollees to leave a message;
 3. Office phone is answered after hours by a recording that directs Enrollees to go to the emergency room for any services needed; and
 4. Returning after-hours calls outside of thirty (30) minutes.

28.2.3 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

The Contractor shall contract with at least one (1) FQHC and one (1) RHC for each Medicaid Region where available.

If the Contractor is not able to reach agreement on terms and conditions with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Enrollees without contracting with these specified providers. Such approval is subject to **Section 4.4 “Approval of Department.”**

28.2.4 Department for Public Health

The Department for Public Health contracts with the local health departments and serves an important role in promoting population health and the provision of safety net services in the Commonwealth. The Contractor shall offer a participation agreement to the Department for Public Health for local health department services. Such participation agreement shall include, but not be limited to, the following provisions:

- A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360; and
- B. Provide reimbursement at rates commensurate with those provided under Medicare.

If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department for approval, documentation which describes the good faith contracting attempts and supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Enrollees without contracting with these specified providers. Such approval is subject to **Section 4.4 “Approval of Department.”**

28.2.5 Family Planning Services

The Contractor shall contract with Network Providers who are qualified by experience and training to provide Family Planning Services.

28.2.6 Behavioral Health and Substance Use Disorders

The Contractor shall maintain a comprehensive network of behavioral health and substance abuse

providers to provide out-patient (including intensive home services), intensive out-patient, substance abuse residential, Case Management, mobile crisis, residential crisis stabilization, assertive community treatment, and peer support services, including:

- A. Psychiatrists, Psychologists, and Licensed Clinical Social Workers;
- B. Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, and Licensed Clinical Alcohol and Drug Counselors;
- C. Targeted Case Managers and Certified Family, Youth and Peer Support Providers;
- D. Behavioral Health Multi-Specialty Groups and Behavioral Health Services Organizations;
- E. Chemical Dependency Treatment Centers;
- F. Psychiatric Residential Treatment Facilities (PRTFs) and Residential Crisis Stabilization Units;
- G. Community Mental Health Centers (CMHCs);
- H. Multi-Therapy Agencies providing physical, speech and occupational therapies, which include Comprehensive Outpatient Rehabilitation Facilities, Special Health Clinics, Mobile Health Services, Rehabilitation Agencies and Adult Day Health Centers; and
- I. Other independently licensed behavioral health professionals.

28.2.7 Dental Providers

The Contractor shall enroll providers of dental services in accordance with 907 KAR 1:026.

28.2.8 Clinical Laboratory Improvement Amendments (CLIA) Requirements

The Contractor shall maintain a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Enrollees.

Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the CASPER/QIES file provided by CMS for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.

28.2.9 Pharmacies

The Contractor shall maintain a comprehensive network of pharmacies that ensures pharmacies are available and geographically accessible to all Enrollees.

28.2.10 Telehealth

The Contractor may use telehealth as a tool for facilitating access to needed services in a clinically appropriate manner that are not available within the Contractor's Provider Network and in accordance with KRS 205.559 and KRS 205.5591.

Telehealth providers must be licensed in Kentucky to receive reimbursement for telehealth services under Medicaid.

The Contractor shall not:

- A. Require a Medicaid provider to be physically present with an Enrollee, unless the provider determines that it is Medically Necessary to perform those services in person;
- B. Require a Medicaid provider to be employed by another provider or agency to provide telehealth services that would not be required if that service were provided in person;
- C. Require a Provider to be part of a telehealth network.

The Contractor shall have and implement policies and procedures that follow all federal and state security and procedure guidelines. The policies and procedures shall incorporate the Department's

policies and procedures for the proper use and security for telehealth, including but not limited to confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology.

The Contractor may leverage telehealth in its Request for Exception to the Department's network adequacy standards, as appropriate and approved by the Department. The Contractor may not consider access to telehealth providers for meeting network adequacy standards, unless approved by the Department as part of an exception to network requirements.

28.2.11 Transportation Services

The Department contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery to provide non-emergency medical transportation (NEMT) services to select Medicaid Enrollees. NEMT services do not include emergency ambulance and non-emergency ambulance stretcher services. The Contractor shall contract with providers of transportation of an emergency nature, including emergency ambulance and ambulance stretcher services.

28.2.12 Charitable Providers

The Contractor may include any charitable providers that serve Enrollees within a Medicaid Region, provided that such providers meet credentialing standards.

28.2.13 Bordering State Providers

The Contractor may include providers located within fifty (50) Miles of the Kentucky border. Border providers may be in Missouri, Illinois, Indiana, Ohio, West Virginia, Virginia, and Tennessee. Border providers that the Contractor includes in its network must be enrolled in Kentucky Medicaid and have a signed agreement with the Contractor. The Contractor shall follow all Kentucky Medicaid enrollment rules when contracting bordering state providers.

28.2.14 Out-of-Network Providers

If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Enrollee for as long as Contractor is unable to provide the services in accordance with 42 C.F.R. 438.206.

The Department will provide the Contractor with an expedited enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only.

28.3 Additional Network Providers Requirements

The Contractor shall attempt to contract with the following providers:

- A. Teaching Hospitals;
- B. The Office for Children with Special Health Care Needs;
- C. Community Mental Health Centers; and
- D. Pediatric Prescribed Extended Care Providers.

If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department for approval, documentation which describes the good faith contracting attempts and supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Enrollees without contracting with these specified providers. Such approval is subject to **Section 4.4 "Approval of Department."**

The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.

28.4 Provider Network Access and Adequacy

The Contractor shall meet the Provider Network access and adequacy standards consistent with KRS 304.17A-515 and established by the Department as described in this section, unless otherwise approved by the Department in accordance with the requirements set forth in **Section 28.0 "Provider Network."** Any exceptions shall be justified and documented by the Contractor in accordance with **Section 28.9 "Exceptions to Provider Network."** Significant changes in Contractor's Network composition that reduce Enrollee access to services may be grounds for Contract termination.

The Department may amend these standards as deemed appropriate throughout the Contract Term. The Contractor shall comply with modified standards as directed, but with no less than a ninety (90) Day prior notice unless other timing is required by federal or state regulation.

The Contractor shall make available and accessible facilities, Service Locations, and personnel sufficient to provide Covered Services consistent with the requirements specified in this subsection.

Consistent with KRS 304.17A-515, the Contractor shall have a Provider Network that meets the following accessibility requirements:

- A. For urban areas, a Provider Network that is available to all Enrollees within thirty (30) Miles or thirty (30) minutes of each Enrollee's place of residence or work, to the extent that services are available;
- B. For areas other than urban areas, a Provider Network that makes available PCP services, hospital services, and pharmacy services within thirty (30) minutes or thirty (30) Miles of each Enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all Enrollees within fifty (50) minutes or fifty (50) Miles of each Enrollee's place of residence or work, to the extent those services are available.

In addition, the Contractor shall meet the following as required by the Department:

- A. Enrollee to PCPs ratios shall not exceed 1500:1 FTE Provider for children under twenty-one (21) and adults;
- B. Specific to voluntary family planning, counseling and medical services as soon as possible within a maximum of thirty (30) Days. If not possible to provide complete medical services to Enrollees less than eighteen (18) years of age on short notice, counseling and a medical appointment as immediately as possible and within ten (10) Days;
- C. Appointment and wait times shall not exceed thirty (30) Days from date of an Enrollee's request for routine and preventive services and forty-eight (48) hours for Urgent Care:
 1. PCPs for both adults and pediatrics;
 2. Specialists designated by the Department including sufficient adult specialists to meet the needs of Enrollees twenty-one (21) years of age and older and pediatric specialists to meet the needs of Enrollees under age twenty-one (21);
 3. General and pediatric dental services;
 4. General vision services; and
 5. Laboratory and radiology services.
- D. If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for Specialty Care, any such appointment shall be made within thirty (30) Days for routine care or forty-eight (48) hours for Urgent Care;
- E. Emergency medical and Behavioral Health Services shall be made available and accessible to Enrollees twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any

provider in the Contractor's Network shall be made available and accessible within forty-eight (48) hours of request; and

- F. Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is most suitable for the type of injury, illness, or condition, regardless of whether the facility is in Contractor's Network.

The Contractor shall monitor usage of Emergency Rooms in each Medicaid Region by Enrollees for non-emergent visits, and provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Enrollees to reduce unnecessary Emergency Room visits. .

The Contractor shall develop and provide GeoAccess reports to the Department in accordance with **Appendix D "Reporting Requirements and Reporting Deliverables"** and as directed by the Department. The Contractor shall utilize the most recent GeoAccess program versions available and update periodically and on a timeline defined by the Department. The Contractor shall use GeoCoder software along with the GeoAccess application package.

The Contractor shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider location. For purposes of this requirement, a Full-Time Provider location is defined as a location operating for sixteen (16) or more hours in an office location each week. For Providers who have more than one (1) office, the Contractor must indicate each location by a separate record in the Provider file and divide the capacity of the Provider by the number of locations. For example, if the Provider capacity is one hundred fifty (150), and the Provider has two (2) offices, each office would have a capacity of seventy five (75). The "individual capacity" option should be used when reporting PCPs.

For calculating distance (Miles), the Contractor shall use the maximums for the amount of time it takes an Enrollee using usual travel means in a direct route to travel from place of residence or work to the Provider's location. The Department recognizes that when using NEMT services, transportation may not always follow direct routes due to multiple passengers.

28.5 Provider Network Plan

The Contractor shall develop and submit to the Department a Provider Network Plan that demonstrates the Contractor's capacity to serve its anticipated enrollment in consideration of all required provider types and in accordance with **Section 28.4 "Provider Network Access and Adequacy,"** Commonwealth and federal law, and the terms of the Contract. The Contractor shall submit to the Department for approval the Provider Network Plan with ongoing updates as follows:

- A. Thirty (30) Days after Contract Execution;
- B. Annually;
- C. Within thirty (30) Days of a significant change in the Contractor's Provider network that impacts network adequacy or the ability to provide services in a Medicaid Region (e.g., addition or loss of a large provider group); and
- D. At other times as requested by the Department during Readiness Review and throughout the Contract Term.

The Provider Network Plan shall address the following at a minimum:

- A. Overall approach, including:
 - 1. Activities to establish and maintain a Provider Network that meets the standards set forth in **Section 28.4 "Provider Network Access and Adequacy,"** including a description of the Provider Network and factors and criteria the Contractor used to select Providers and build the Provider Network (e.g., objective quality standards);

2. Process and methodology to understand the distribution of Enrollee health care needs against available Providers and Provider capacity to serve those needs;
 3. Methods to ensure that the Provider Network addresses the needs of all Enrollees, including those with limited English proficiency or illiteracy;
 4. Methods to ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities;
 5. Methods to support and sustain Network Providers, including hospitals, in Non-urban and other traditionally underserved areas;
 6. A quantifiable and measurable process for monitoring and assuring the sufficiency of the Provider Network to meet the health care needs of all Enrollees on an ongoing basis;
 7. Methods the Contractor will implement when it or its Network Providers fail to comply with **Section 28.4 “Provider Network Access and Adequacy;”** and
 8. Methods the Contractor will use to analyze access to specific provider types upon request of the Department.
- B. Quality assurance standards, consistent with the Department’s Quality Strategy and requirements, which must be adequate to identify, evaluate, and remedy problems relating to access, continuing care, and quality care;
- C. Demonstration of level of compliance with the following:
1. Appropriate range of preventive, primary care, and specialty services, that is adequate for the anticipated number of Enrollees by Medicaid Region;
 2. A Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Medicaid Enrollees in the Medicaid Region.
- D. Documentation to support information in the Provider Network Plan (e.g., GeoAccess reports showing geographical location by provider type in relationship to Enrollees’ locations and other data as agreed upon with the Department).

28.6 Provider Contracting

The Contractor shall offer to contract with providers in writing. All Network Provider contracts shall include the standard provisions set forth in **Appendix C “Required Standard Provisions for Network Provider Contracts.”** Neither the Contractor nor its Subcontractors shall require a Provider to participate exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 C.F.R. Part 438 to provide Enrollees with continuity of care and choice.

The Contractor shall ensure that all Network Providers have knowingly and willfully agreed to participate in the Contractor’s Network. The Contractor shall not acquire established networks without contacting each individual provider to ensure knowledge of the requirements of this Contract and the provider’s complete understanding and agreement to fulfill all terms of the Provider Network Contract. The Department reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and onsite visits to Providers, the existence of a direct relationship between the Contractor and the Providers.

The Contractor shall not require practitioners, as a condition of contracting, to agree to participate or accept other products offered by the Contractor nor shall the Contractor automatically enroll the provider in any other product offered by the Contractor.

Providers shall meet the credentialing standards described in **Section 27.7 “Provider Credentialing and Recredentialing”** of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor’s Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor is responsible for confirming all Network Providers are credentialed and enrolled in the Kentucky Medicaid Program. The Contractor may include Providers in its Provider Network who

do not provide services to the Medicaid fee-for-service population; however, such Providers must be enrolled with the Kentucky Medicaid program.

The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Provider Network. The policies and procedures shall not discriminate against Providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification. The Contractor shall ensure that no incentive is provided, monetary or otherwise, to Providers for withholding Medically Necessary services from Enrollees.

The Contractor shall also make reasonable efforts to recruit providers based on Enrollee requests. When Enrollees ask to receive services from a provider not currently enrolled in the Contractor's Network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.

The Contractor shall send all newly contracted Providers a written network participation welcome letter that includes a contract effective date for which Providers are approved to begin providing medical services to Enrollees. The welcome letter shall also provide orientation information as set forth in **Section 27.5 "Provider Orientation and Education."**

The Contractor shall provide written notice to providers not accepted into the Provider Network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Provider Network if the provider has active sanctions imposed by Medicare, Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active Fraud investigation involving the provider or the provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of its credentialing process to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.

28.7 Medicaid Providers Files

The Department will provide the Contractor with access to the Department's Medicaid provider master file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract developed by the Department. The Contractor shall use the Medicaid provider master file to obtain the ten (10)-digit provider number assigned to a medical provider by the Kentucky Medicaid Program, the provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent. The Contractor shall transmit a file of provider data specified in this Contract for all credentialed Network Providers on a monthly basis and when any information changes.

28.8 Providers Not Participating in Medicaid Fee-for-Service

A provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation with the Contractor's Provider Network but must be enrolled in the Kentucky Medicaid Program. If a potential provider has not had a Medicaid number assigned, the provider shall apply for enrollment with the Department and meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. Upon request of a provider, the Contractor shall provide support to the provider in submission of required materials to the Department for processing of the enrollment. When the Contractor has submitted the required data in the transmission of the provider file indicating inclusion in the Contractor's Network,

the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two (2) weeks of transactions being accepted, suspended or denied.

All documentation regarding a provider's qualifications and services provided shall be available for review by the Department or its agents when needed for the enrollment process at the Contractor's offices during business hours upon reasonable advance notice.

28.9 Exceptions to Provider Network Requirements

Network adequacy measures the Contractor's ability to deliver the Covered Services required under the terms of the Contract by providing reasonable access to a sufficient number of primary care, specialty, and other types of providers. Recognizing conditions exist in the Commonwealth that may create challenges in meeting network adequacy requirements (e.g., workforce shortages for specific provider types in specific counties, not all counties in Kentucky have a PCP or hospital, etc.), the Department will permit the Contractor to request exceptions to Provider Network requirements.

The Department will grant exceptions based on the evidence presented by the Contractor and exceptions granted will generally be time limited. The Contractor shall partner with the Department and other contracted MCOs to understand the health needs of Kentucky and to develop innovative solutions to develop or foster provider capacity or otherwise meet the healthcare needs of Enrollees and the requirements of this Contract.

In accordance with 42 CFR 438.68(d)(1), the Contractor may request Department approval for an exception to meeting Provider Network adequacy standards in a specific Region for a specific provider type. Requests must be made in writing and include the following:

- A. Description of the Region(s) and specific provider type(s) for which the exception is being made;
- B. Justification for the exception request;
- C. Description of the Contractor's efforts to negotiate with providers in good faith, including detailed information about providers who have been contacted, challenges in contracting, and ongoing efforts to contract;
- D. Description of how the Contractor will provide adequate services to meet the needs of Medicaid Enrollees for the specific Region and provider type; and
- E. A detailed plan to address Enrollees' needs and to remedy the Provider Network deficiency, including an estimated timeline to close the network gap.

The Department will review the exception request and respond as set forth in **Section 4.4 "Approval of Department."** The Department's response will request additional information or issue a decision of approval or Denial based on the evidence presented by the Contractor and other information as identified by the Department. If approved, the Department will include in its notice to the Contractor a specified timeframe for which the approval is granted. The Contractor shall provide updates on implementation of its plan to remedy the network deficiency on a frequency and in the detail required by the Department in the approval notice.

Forty-five (45) Days before an exception is set to expire, the Contractor shall submit a new request for the exception or inform the Department the exception is no longer needed. Should the Department receive information at any time to question the exception, the Department may deem the Contractor to be out of compliance.

28.10 Termination of Network Providers

- A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare, Medicaid, or KCHIP program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Enrollees.

The Department reserves the right to direct the Contractor to terminate or modify any Provider agreement when the Department determines it to be in the best interest of the Commonwealth. The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three (3) Business Days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.

- B. The Contractor shall notify the Department via e-mail of a Provider termination from the Contractor's Network within three (3) Business Days for any of the following reasons:
 - 1. Adverse Medicare Action;
 - 2. Adverse Action on Professional License;
 - 3. Deceased;
 - 4. Professional License Surrender; or
 - 5. Other State Medicaid Adverse Action.
- C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with the Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement. The Contractor shall notify the Department via e-mail of such a Provider termination within three (3) Business Days.
- D. When a Provider elects to terminate its contract with the Contractor, the Contractor shall notify the Department via e-mail of such a Provider termination within three (3) Business Days of the contract termination date.
- E. The Contractor shall survey all Providers who choose to exit the network and use results of Provider exit surveys to improve Provider retention and recruitment. The Contractor shall provide the Department with the Provider exit survey template for review and approval prior to use and for any subsequent changes. The Contractor shall provide the Department with survey results upon request.

Contractor notifications to the Department about a Provider termination shall contain the reason, a brief description of the Provider's actions and/or applicable information leading to termination, the NPI, Medicaid ID, Entity Name, Provider Type (two digit) and complete mailing address. The Contractor shall send the e-mail notification to the DMS Commissioner's Office, Division of Program Quality and Outcomes, and the Division of Program Integrity, and any applicable designee(s). The Contractor notification to the Department shall provide assurances of how the Contractor will maintain network adequacy and access to care despite the Provider termination.

For any terminations, the Contractor shall notify Enrollees who have received a service from the terminating Provider within the previous six (6) months. Such notice shall be mailed within fifteen (15) Days of the action taken if it is a PCP and within thirty (30) Days for any other Provider. As applicable, the notice shall include:

- A. If the terminated provider was a contracted PCP, information about selecting or being Auto-Assigned to a new PCP and how the Contractor will assist the Enrollee to transition care to the newly assigned PCP;
- B. If the terminated provider was a specialist, information about how the Contractor will assist the Enrollee to transition care to another specialist.

28.11 Provider Electronic Transmission of Data

The Contractor shall submit information, including any additions or changes to the Provider Network, to demonstrate that the Contractor has an adequate network that meets the Department's standards as set forth in **Section 28.4 "Provider Network Access and Adequacy."** **Appendix L "MCO Provider Network File Layout"** contains the file layouts, data element definitions, and other information relevant to maintenance of the provider file by Contractor. The Contractor shall work collaboratively with the Department to ensure that the Contractor's file and submitted data complies with the requirements of this Contract. Additionally, the Contractor shall notify the Department, in writing, of any anticipated network changes that may impact Provider Network standards as defined herein.

The Contractor shall update this information to reflect changes in the Contractor's Provider Network monthly. Unless the request is as a result of a determination under **Section 28.13 "Monitoring Compliance with Network Adequacy and Access Requirements"** that the Contractor is not in compliance with the access standards, the Contractor shall have thirty (30) Days to produce documentation on changes to its Network.

Encounter Records containing provider numbers that are not on the Medicaid master provider file will not be accepted.

28.12 Maintaining Current Provider Network Information for Enrollees

In addition to providing changes to the Provider Network to the Department, the Contractor shall ensure that all changes to the Provider Network, including updates to the Provider Directory maintained on the Contractor's website, are communicated to Enrollees within fifteen (15) Days of the change if it is a PCP and within thirty (30) Days of the change for any other Provider. The Contractor shall update a paper Provider Directory at least monthly.

In accordance with 42 C.F.R. 438.10(h), the Provider Directory shall include the following for physicians, hospitals, pharmacies, and behavioral health providers:

- A. Provider's name and any group affiliation;
- B. Street address(es);
- C. Telephone number(s);
- D. Website URL, as appropriate;
- E. Specialty(ies), as appropriate;
- F. Whether the Provider is accepting new Enrollees;
- G. 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 rooms, and equipment.
- I. Information for Providers with telehealth capabilities and presentation sites.

28.13 Monitoring Compliance with Network Adequacy and Access Requirements

The Contractor shall monitor Provider compliance with access requirements, including but not limited to appointment and wait time standards set forth in **Section 28.4 "Provider Network Access and Adequacy"** and take corrective action for failure to comply. The Contractor shall conduct monitoring such as surveys and office visits to monitor compliance with appointment waiting time standards and shall report findings and corrective actions to the Department in accordance with **Section 37.0 "Contractor Reporting Requirements."**

The Department will monitor the Contractor's compliance with Provider Network requirements and standards on an ongoing basis. The Department will use data from the Contractor's monthly provider file, Geographic Access data reports, enrollment data, and other required Contractor reporting to verify compliance with the Provider Network requirements. The Department will monitor that the Contractor has a sufficient number and distribution of Providers for each provider type. The Department or its Agent may also periodically phone Providers to confirm the Provider is contracted with the Contractor. The Department will also monitor data such as provider satisfaction survey findings, complaints and appeals data for indications that problems exist with access to Providers. Providers in the Contractor's Network who are not accepting Enrollees shall not be included in assessment of network adequacy and access.

If at any time, the Contractor or the Department determine that the Contractor's Provider Network is not adequate to comply with the standards specified in **Section 28.4 "Provider Network Access and Adequacy"** for ninety-five percent (95%) of its Enrollees, the Contractor or Department shall notify the other and within fifteen (15) Business Days the Contractor shall submit a corrective action plan to remedy the deficiency.

Corrective action plans for lack of network adequacy shall include, at a minimum, the following:

- A. A summary of the deficiency, including provider type, number of additional full-time equivalent (FTE) providers needed to resolve the deficiency, and the Medicaid Region(s) in which the deficiency exists;
- B. Specific actions and a timeline by which the Contractor anticipates addressing the deficiency;
- C. A list of providers with name, location, and expected date of provider agreement execution with whom the Contractor is currently negotiating a provider agreement and, the number of FTEs that will be addressed by contracting with the provider;
- D. If the Contractor is not in negotiations with providers to help resolve the deficiency, a detailed account of attempts to secure an agreement with each provider that would resolve the deficiency. This shall include the provider name(s), address(es), date(s) contacted, and a detailed explanation as to why the Contractor is unable to secure an agreement (e.g., lack of provider willingness to participate in the Medicaid program, provider prefers to limit access to practice, rate requests, etc.);
- E. A listing of Out-of-Network Providers, including name and location, who are being used to provide the deficient specialty provider services and the rates the Contractor is currently paying these Out-of-Network Providers;
- F. Documentation of how these arrangements are communicated to the Enrollee; and
- G. Documentation of how these arrangements are communicated to the PCPs.

The Contractor shall also develop and maintain a contingency plan in the event that a large Provider of services collapses or is otherwise unable to provide needed services.

The Department will review all corrective action plans and contingency plans and determine, based on the actions proposed by the Contractor, available data, and the supply of providers available to Medicaid Enrollees, whether the plan will be accepted. See **Section 39.3 "Requirement of Corrective Action."**

29.0 PROVIDER PAYMENT PROVISIONS

29.1 Claims Payments

The Contractor shall accept only the uniform Claim forms submitted from providers that have been approved by the Department and completed according to Department guidelines. The Contractor shall accept Claims submitted directly to the Contractor by the Provider. The Contractor shall ensure that payments are made to the appropriate provider.

29.2 Prompt Payment of Claims

In accordance with 42 C.F.R. 447.46, the Contractor shall comply with the timely Claims payment requirements of 42 C.F.R. 447.45. The Contractor shall consider timely claims filing to be within three-hundred sixty five (365) Days of the date of service. The Contractor shall implement Claims payment procedures that ensure ninety percent (90%) of all Provider Claims, including to I/T/Us, for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) Days of the date of receipt of such Claims and that ninety-nine percent (99%) of all Claims are processed within ninety (90) Days of the date of receipt of such Claims. In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and KRS 304.99-123, as may be amended. The Contractor shall provide to each Medicaid Provider the opportunity for an in-person meeting with a representative of the Contractor on any Clean Claim that remains unpaid in violation of KRS 304.17A-700 to 304.17A-730; and on any Claim that remains unpaid for forty-five (45) Days or more after the date on which the Claim is received by the Contractor and that individually, or in the aggregate, exceeds twenty five hundred dollars (\$2,500.00).

The Contractor shall reprocess Claims that are incorrectly paid or denied in error, in compliance with KRS 304.17A-708. The Contractor shall not require a Medicaid Provider to rebill or resubmit such a Claim to obtain correct payment, and no Claim shall be denied for timely filing if the Claim was timely submitted.

The date of receipt is the date the MCO receives the Claim, as indicated by its date stamp on the Claim or other notation as appropriate to the medium used to file a Claim and the date of payment is the date of the check or other form of payment.

The Contractor shall notify the requesting provider of any decision to deny a Claim or to authorize a service in an amount, duration, or scope that is less than requested. Notifications shall include reason for the Denial, and contact information for submission of Claims denied because a Subcontractor should have been billed. This information shall also be provided in the denying entity is a Subcontractor.

Any conflict between federal law and Commonwealth law will default to the federal law unless the Commonwealth requirements are stricter.

29.3 Payment to Out-of-Network Providers

The Contractor shall reimburse Out-of-Network Providers in accordance with **Section 29.1 "Claims Payments"** for the following Covered Services:

- A. Specialty care for which the Contractor has approved an authorization for the Enrollee to receive services from an Out-of-Network Provider;
- B. Emergency Care that could not be provided by the Contractor's Network Provider because the time to reach the Contractor's Network Provider would have resulted in risk of serious damage to the Enrollee's health;
- C. Services provided for family planning;
- D. Services for children in Foster Care, if applicable; and
- E. Pharmacy services.

The above listed Covered Services shall be reimbursed at no more than one hundred percent (100%) of the Medicaid fee schedule/rate unless the Covered Service falls under the EPSDT benefit.

29.4 Payment to Providers for Serving Dual Eligible Enrollees

The Contractor shall coordinate benefits for Dual Eligible Enrollees by paying the lesser amount of:

- A. The Contractor's allowed amount minus the Medicare payment, or
- B. The Medicare co-insurance and deductible up to Contractor's allowed amount.

In the event that Medicaid does not have a price for codes included on a crossover Claim then the entire Medicare coinsurance and deductible shall be paid by the Contractor. The Contractor shall further assist Dual Eligible Enrollees in coordination of benefits required under **Section 4.3 "Delegations of Authority."**

29.5 Payment of Federally Qualified Health Centers ("FQHC") and Rural Health Clinics ("RHC")

The Contractor is responsible to reimburse, by making payments directly to FQHCs and RHCs, no less than the amount established under Kentucky's prospective payment system (PPS) rate for the federally certified facilities.

The Contractor shall report to the Department within forty-five (45) Days of the end of each quarter the total amount paid to each FQHC and RHC per month. The report shall include the provider number, name, total number of paid Claims per month, total amount paid by Contractor, and any adjustments. If the Contractor fails to submit the information within the required timeframe, there shall be a penalty of five hundred dollars (\$500) per day until the information is received.

29.6 Office for Children with Special Health Care Needs

The Care Management and Care Coordination needs of the medically complex children serviced by the Office for Children with Special Health Care Needs, here after referred to as "the Office", must be recognized by the Contractor in that a special payment rate shall be developed for the Office by a process of negotiation between the Contractor and the Office. The rate to be established shall be not less than seventy-eight percent (78%) of the Medicaid allowable cost based on the most recent available cost report of the Office and shall be subject to negotiation at annual intervals.

29.7 Payment of Teaching Hospitals

In establishing payments for Teaching Hospitals in the Contractor's Network, the Contractor shall recognize total costs for graduate medical education at state owned or operated Teaching Hospitals, including adjustments required by KRS 205.565.

29.8 Intensity Operating Allowance

The Department and the Contractor acknowledge and agree that Contractor is subject to the legislatively mandated intensity operating allowance and hospital rate increase. The Contractor shall receive Capitation Payments that reflect these mandated items. (See 907 KAR 10:830)

29.9 Urban Trauma

The Contractor shall agree that payment for Urban Trauma Center amount is contingent upon the Commonwealth's receipt of the necessary state matching funds from the Urban Trauma Provider to support such payment and shall so do in a manner necessary to meet all federal requirements governing such transactions. (See 907 KAR 10:830)

29.10 Critical Access Hospitals

The Contractor shall reimburse Critical Access Hospitals at rates that are at least equal to those established by CMS for Medicare reimbursement to a Critical Access Hospital in accordance with 907 KAR 10:815.

29.11 Supplemental Payments

The Department and Contractor recognize the Department's desire to provide enhanced reimbursement to provider entities through supplemental payments in order to preserve the ability of the provider entities to provide essential services to Commonwealth residents.

Supplemental payments in addition to adjudicated Claims payments are made to a number of specified provider entities. Those categories of providers receiving supplemental payments are as follows:

- A. Intensity Operating Allowance for Pediatric Teaching hospitals;
- B. A State Designated Urban Trauma Center;
- C. State Owned or Operated University Teaching Hospital Faculty; and
- D. Psychiatric Access Supplement to a Designated Psychiatric Hospital.

Descriptions of these payments are found in other sections of the Contract. State owned or operated university Teaching Hospitals include a hospital operated by a related party organization as defined in 42 C.F.R. 413.17, which is operated as part of an approved School of Medicine or Dentistry.

Supplemental payments will be made in accordance with 42 C.F.R. 438.6(d). The Department will make payments to the Contractor, through the monthly Capitation Payment in accordance with **Appendix A "Capitation Payment Rates"** for the supplemental payments the Contractor shall pay the specified providers. The Department will notify the Contractor of the amount of the monthly supplemental payment. Contractor shall make monthly supplemental payments to the specified providers on or before the last Business Day of the month of service for which Capitation is paid. Six (6) months following the end of this Contract, the Department or its designee will reconcile the supplemental payments between the Department and the Contractor based on Total Enrollee Months during the Contract period. The Department will make a final supplemental payment or recoup payments from the Contractor as determined by the reconciliation. The Contractor shall pay any additional funds due the specified providers or recoup from the providers based on the Department's determination.

The Contractor agrees, upon the request of the Department, to submit to the Department Claims-level cost data for payment verification purposes. Contractor will work with the Department to ensure that information is provided to allow for provider entities to remit the state matching portion of the payments to the Department, as applicable.

29.12 Independence of Provider Reimbursement Rates and Methodologies

Unless explicitly stated elsewhere in this Contract, the Department does not direct the Contractor's expenditures for services provided under this Contract, and reimbursement rates and methodologies for services provided under this Contract are at the sole discretion of the Contractor.

29.13 Notice to Providers on Change of Reimbursement

The Contractor shall give at least thirty (30) Days written notice to Providers prior to any change in

payment structure or reimbursement amount. The written notice must contain clear and detailed information about the change. The changes shall not be retroactive.

30.0 COVERED SERVICES

30.1 Medicaid Covered Services

The Contractor shall provide Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program, and for Enrollees under the age of twenty-one (21) as set forth in 42 C.F.R. 441 Subpart B; that are reasonably expected to achieve the purpose for which the services are furnished; enables the Enrollee to achieve age-appropriate growth and development; and enables the Enrollee to attain, maintain, or regain functional capacity. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition.

The Contractor shall provide, or arrange for the provision of Covered Services to Enrollees in accordance with the state Medicaid plan, state regulations, and policies and procedures applicable to each category of Covered Services.

The Contractor shall ensure that the care of new Enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Enrollees receiving health care under fee for service prior to Enrollment in the Plan. **Appendix I “Covered Services”** shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Enrollees. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in the State Medicaid Plan, applicable administrative regulations governing Kentucky Medicaid services and individual Medicaid program services manuals incorporated by reference in the administrative regulations.

After the Execution Date, to the extent a new or expanded Covered Service is added by the Department to Contractor’s responsibilities under this Contract, (“New Covered Service”) the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted, if necessary, accordingly to **Sections 11.2 “Rate Adjustments” and 40.3 “Amendments”** The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) Days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.

The Contractor may provide, or arrange to provide, services in addition to the services described above provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.

For any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.

The Contractor shall not prohibit or restrict a Provider from advising an Enrollee about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.

If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Enrollee for as long as Contractor is unable to provide the services in accordance with 42 C.F.R. 438.206. The Contractor shall coordinate with Out-of-Network Providers with respect to payment. The Contractor will ensure that cost to the Enrollee is no greater than it would be if the services were provided within the Contractor's Network.

An Enrollee who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.

30.2 Direct Access Services

The Contractor shall make Covered Services available and accessible to Enrollees as specified in this Contract. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When an Enrollee wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.

The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by an Enrollee for the following services within the Contractor's Network:

- A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;
- B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;
- C. Voluntary family planning in accordance with federal and state laws and judicial opinion;
- D. Maternity care for Enrollees under eighteen (18) years of age;
- E. Immunizations to Enrollees under twenty-one (21) years of age;
- F. Sexually transmitted disease screening, evaluation and treatment;
- G. Tuberculosis screening, evaluation and treatment;
- H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;
- I. Chiropractic services;
- J. For Enrollees with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs; and
- K. Women's health specialists.

The Contractor shall ensure direct access and may not restrict the Enrollee's access to services in accordance with 42 C.F.R. 438 and applicable state statutes and regulations.

30.3 Second Opinions

At the Enrollee's request, the Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions, within the Contractor's Network, or arrange for the Enrollee to obtain a second opinion outside the network

without cost to the Enrollee. The Contractor shall inform the Enrollee, in writing, at the time of Enrollment of the Enrollee's right to request a second opinion.

30.4 Telehealth

Covered Services shall be delivered via telehealth according to Kentucky regulations and statutes.

30.5 Billing Enrollees for Covered Services

The Contractor and its Providers and Subcontractors shall not bill an Enrollee for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this Contract. Any Provider who knowingly and willfully bills an Enrollee for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.

However, if an Enrollee agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Enrollee. The standard release form signed by the Enrollee at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Enrollee in the absence of a knowing assumption of liability for a Non-Medicaid Covered Service. The form or other type of acknowledgement relevant to Medicaid Enrollee liability must specifically state the services or procedures that are not covered by Medicaid.

30.6 Referrals for Services Not Covered by Contractor

When it is necessary for an Enrollee to receive a Medicaid service that is outside the scope of the Covered Services provided by the Contractor, the Contractor shall refer the Enrollee to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Enrollees for Non-Covered Services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Enrollees in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval subject to **Section 4.4 "Approval of Department."**

30.7 Interface with State Behavioral Health Agency

- A. The Contractor's Behavioral Health Director or designee shall meet with the Department and DBHDID no less than quarterly to discuss State Mental Health Authority and Single State (substance abuse) Agency (SSA) protocols, rules and regulations including but not limited to:
 - 1. Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) operating definitions;
 - 2. Other priority populations;
 - 3. Targeted Case Management, Community Support Associate, and Peer Support provider certification training and process;
 - 4. Satisfaction survey requirements;
 - 5. Priority training topics (e.g., trauma-informed care, suicide prevention, co-occurring disorders, evidence-based practices);
 - 6. Behavioral health Services hotline; and
 - 7. Behavioral health crisis services (referrals; emergency, urgent and routine care).
- B. The Contractor shall coordinate:
 - 1. Enrollee education process for individuals with Serious Mental Illnesses (SMI) and children and youth with serious emotional disturbances (SED) with the Department.

- Contractor will provide the Department and DBHDID with proposed materials and protocols.
2. With the Department, DBHDID and CMHCs a process for integrating Behavioral Health Services' hotlines with processes planned by the Contractor to meet system requirements.
 3. With the Department on establishing collaborative agreements with state operated or state contracted psychiatric hospitals, as well as with other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use.

30.8 Provider-Preventable Diseases

The Contractor shall not pay a Provider for provider-preventable conditions that meet the following criteria:

- A. Is identified in the State Medicaid plan;
- B. Has been found by the Department, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
- C. Has a negative consequence for the Enrollee;
- D. Is auditable; and
- E. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

The Contractor shall require all Providers to report provider-preventable conditions associated with Claims for payment or Enrollee treatments for which payment would otherwise be made. The Contractor shall report all identified provider-preventable conditions in a form or frequency as specified by the Department.

30.9 Mental Health Parity

The Contractor and its providers must comply with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Contractor and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

30.10 Institutions for Mental Disease (IMD) Expansion

In accordance with 42 C.F.R. 438.3(e)(2), the Contractor may cover services or settings in lieu of services or settings covered under the State Plan, including an inpatient stay in an IMD for psychiatric or substance use disorder, for Enrollees aged twenty-one (21) through sixty-four (64) for a short term stay up to the number of days permitted by CMS.

- A. The services and settings will be reimbursable and subject to the requirements of 42 C.F.R. Part 438.
- B. Per 42 C.F.R. 438.3(e)(2)(ii), the Contractor may not require an Enrollee to receive services in an IMD.
- C. The Contractor shall track the number of days of the Enrollee's stay in an IMD during a calendar month. If the Enrollee's stay exceeds fifteen (15) Days in a given month, the Contractor shall notify the Department within five (5) Business Days.
- D. The Enrollee will remain in the Contractor's plan. For months when the Enrollee's stay exceeds fifteen (15) Days, the Contractor will receive a pro-rated Capitation Payment for the

days the Enrollee is not in the IMD. The rate to be paid for the days in the IMD shall be at the Contractor's negotiated rate between the Contractor and the provider.

31.0 PHARMACY BENEFITS

This section provides requirements specifically related to the Contractor's administration of pharmacy benefits and related pharmacy services including but not limited to Claims processing, pharmacy provider payments, Preferred Drug List (PDL) development, Prior Authorization reviews and appeals, maximum allowable cost schedule development, Prospective Drug Utilization Reviews, Retrospective Drug Utilization Reviews, physician administered drug list, and provision of pharmacy utilization data and reports.

31.1 Pharmacy General Requirements

The Contractor shall administer pharmacy benefits and related pharmacy services either directly or through a pharmacy benefit manager or administrator or the like Subcontractor in accordance with this section, other requirements specified in this Contract, and in accordance with all applicable State and Federal laws and regulations.

31.2 Covered Outpatient Drugs

- A. The Contractor shall ensure access to all Medically Necessary covered outpatient drugs consistent with Section 1927 of the SSA and as amended regardless of the Contractor's PDL status of the covered outpatient drug.
- B. The Contractor may only exclude drug categories permitted under Section 1927(d) of the SSA.
- C. The Contractor's PDL cannot be more restrictive than the FFS coverage of outpatient drugs.
- D. Only drugs included in the Medicaid Drug Rebate Program (MDRP) shall be considered by the Department during the capitation rate setting process.

31.3 Physician Administered Drugs

- A. The Contractor shall develop and maintain the physician administered drug list.
- B. The Contractor shall be responsible for reimbursement of physician administered drugs and biologics.
- C. Claims for drug products obtained and/or administered in an office/clinic or other non-institutional setting and processed via Contractor's medical benefit shall contain a valid eleven (11)-digit National Drug Code (NDC) and other necessary information such as a Healthcare Common Procedure Coding System (HCPCS) codes and appropriate billable units for the actual drug and quantity administered.

31.4 Preferred Drug List

The Contractor is permitted to maintain a PDL and the Contractor may utilize Prior Authorization and other appropriate Utilization Management mechanisms in a manner set forth in the Act, the Code of Federal Regulations, and this Contract. The Contractor's PDL shall follow the general and minimum requirements herein:

- A. The PDL shall:
 - 1. Only exclude coverage of drugs or drug categories as permitted under Section 1927(d) of the SSA as amended.
 - 2. Be developed under the advisement of a Pharmacy and Therapeutics Committee.
 - 3. Not be constructed for the sole purpose to deny coverage of any Medicaid covered outpatient drug.

4. Be reviewed such that all represented therapeutic classes are reviewed at a minimum on an annual basis.
 5. Drugs and/or drug formulations that are new to market must be reviewed within seventy-five (75) days of market availability.
- B. If the PDL prefers generic equivalents, Contractor shall provide a brand name exception process for prescribers to pursue when brand name products are requested by the prescriber due to Medical Necessity.
 - C. The Contractor shall publish and make available the PDL as follows:
 1. Provide a hard copy of the PDL upon the request of an Enrollee or a Provider.
 2. Provide an electronic copy to Providers and Enrollees on the Contractor's web site in a format as specified in 42 C.F.R. 438.10. It shall include the PDL status (preferred, non-preferred), an indication if Prior Authorization is required, and information necessary to initiate a request for Prior Authorization or access to a non-preferred drug.
 3. Update the PDL no less than quarterly throughout the year and shall reflect changes such as, new drugs, the status of a drug (preferred/non-preferred) and an indicator if Prior Authorization is required.
 - D. If DMS, at any point through the duration of this contract, elects to move to a single uniform PDL for all Medicaid beneficiaries, the Contractor must abide by the discretion of DMS to the extent of the PDL and its implementation to its members.

31.5 Alignment of Clinical Criteria and Pharmacy Based Programs and Initiatives

The Contractor shall, when and as directed by the Department, align with Department sponsored clinical criteria, pharmacy based programs and other initiatives.

- A. The Contractor shall align its criteria and processes and comply with such requirements no later than thirty (30) Days after written notification is sent to the Contractor from the Department.
- B. Any systems or policy and process changes required to implement new alignment requirements shall be made at no cost to the Department.

31.6 Reimbursement Rates and Dispensing Fees

- A. The Department shall have the ability to set, create, or approve, and may change at any time for any reason, reimbursement rates between the Contractor or a pharmacy benefit manager or administrator or the like Subcontractor and a pharmacy Provider, or an entity which contracts on behalf of a pharmacy.
- B. Reimbursement rates shall include dispensing fees which take into account applicable CMS guidance and any DMS requirements.
- C. The Contractor shall require its pharmacy benefit manager or administrator or the like subcontracted by the Contractor to notify the Department directly or through the Contractor no less than thirty (30) Days in advance of any proposed change of over five percent (5%) in the product reimbursement rates for a pharmacy Provider licensed in the state.
- D. The Department may disallow such a change by notifying the Contractor at any time prior to the implementation date of the change. If the Department disallows the proposed change, the Contractor shall require its subcontracted pharmacy benefit manager or administrator or the like to reprocess all affected Claims without undue delay at the old reimbursement rate.
- E. Beginning on the Effective Date of this Contract and pursuant to 18 RS HB 200, Medicaid Benefits, section (16), the Contractor shall comply and ensure that any Subcontractor engaged to reimburse for drug products through POS/retail Claims complies with all dispensing fee requirements set by this Contract. The Contractor shall or shall cause and ensure its subcontracted agent or entity to pay an additional dispensing fee of two dollars (\$2.00) without reduction of any kind or for any reason. This additional dispensing fee amount shall be in addition to the dispensing fee remitted to pharmacies for POS/retail Claims as calculated or determined by contractual provisions negotiated directly with the dispensing pharmacy or any entity who contracts on behalf of the dispensing pharmacy whether negotiated by the

Contractor, any subcontracted pharmacy benefit manager or administrator or the like.

31.7 Pharmacy and Therapeutics Committee

The Contractor shall utilize a P&T committee that as part of its composition includes at least one (1) Kentucky licensed physician and one (1) Kentucky licensed pharmacist who currently provides services to Kentucky Medicaid recipients. The P&T shall meet at least quarterly and make recommendations to the Contractor for changes to the PDL.

31.8 Pharmacy Claims Payment Administration

The Contractor shall:

- A. Ensure the Point of Sale (POS) system satisfies the following functional and informational requirements:
 - 1. Provide POS function for Claims submissions by pharmacies twenty-four (24) hours per day, seven (7) Days per week, except for Department-approved, scheduled downtime.
 - 2. Provide the ability to apply an Internal Control Number (ICN) to each Claim and its supporting documentation, regardless of submission format, to tracking Claims, conduct research, perform reconciliations, and for audit purposes.
 - 3. Ensure the system is capable of adding, changing, or removing Claim adjudication processing rules to accommodate State and Federal required changes to the pharmacy program within thirty (30) Days, unless otherwise approved.
- B. Process, adjudicate, and pay pharmacy Claims, including voids and full or partial adjustments, via an online, real-time POS system by:
 - 1. Using the specified current National Council for Prescription Drug Program (NCPDP) format. Required updates to this format shall be implemented at no cost to the Department;
 - 2. Identifying and denying Claims that contain invalid Provider numbers including where the Taxonomy/National Provider Identifier (NPI) or Provider number is missing or is invalid.
 - 3. Identifying any liable third party, and ensuring that Medicaid is the appropriate payer of last resort. The term "pay" means either send the Provider cash or cash equivalent in full satisfaction of the clean Claim, or give the Provider a credit against any outstanding balance owed by that Provider to the Contractor.
 - 4. The term "clean Claim" means a properly completed paper or electronic Claim submitted in compliance with NCPDP standards and approved for payment.
 - 5. Resubmission of a Claim with further information and/or documentation shall constitute a new Claim for purposes of establishing the time frame for Claims processing.
 - 6. Contractor shall pay the Claim or advise the Provider that the Claim submitted is denied and specify all reasons for the Denial.
- C. The Contractor shall provide the ability to process Claims on batch electronic media and paper Claims submitted directly for processing. Paper Claims may include, but not limited to, those submitted in situations when an Enrollee has to visit an out-of-network pharmacy in an emergency. Paper Claims shall be submitted on the NCPDP Universal Claim Form version D.0. The Contractor shall:
 - 1. Process and adjudicate paper Claims within ten (10) Days of receipt;
 - 2. Assign ICNs to all batch Claims within twenty-four (24) hours of receipt;
 - 3. Maintain electronic backup of batch Claims for the duration of the Contract; and
 - 4. Adjudicate electronic batch Claims through the same processing logic as the POS Claims.
- D. The Contractor shall notify the Department in writing no later than one (1) Day from discovery of any POS processing and/or Claims adjudication issue that is or has the potential to significantly impact processing time for Claims submissions, Claims adjudication, Claims adjudication accuracy, and/or continuity of Enrollee drug therapy. A significant impact means for this purpose a threshold of one hundred (100) or more Enrollees' Claims are impacted by

the issue. Notification shall be followed by a written explanation of the root cause and corrective and future preventive action.

- E. The Contractor shall establish a unique Medicaid-specific Processor Identification (BIN)/Issuer Identification Number (IIN), Processor Control Number (PCN), and Group Number combination for POS pharmacy Claims processing, to ensure Medicaid Claims are not the same as Contractor's commercial and/or Medicare Part D business lines. The BIN/IIN and PCN number shall appear on all Enrollees' identification cards along with the toll free phone number for pharmacy provider assistance as well as Enrollee assistance.

31.9 Drug Utilization Review (DUR) Program

The Contractor shall operate a drug utilization review (DUR) program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K.

As part of its DUR activities, the Contractor shall work collaboratively with the Department on related pharmacy initiatives such as the universal policy implementations, the pharmacy lock-in program, buprenorphine provider programs, and other initiatives as identified by DMS.

The Contractor shall provide a detailed description of its drug utilization review program activities to the Department on an annual basis. The actual date shall be determined by the Department and in sufficient time to gather the information necessary to comply with and time submit the CMS Annual DUR report. The Contractor shall provide all data necessary for appropriate CMS Annual DUR Report submissions including, but not limited to, completing the Contractor's portion of the actual annual report template furnished by CMS and within the requested timeframe. At the request of DMS, quarterly written reports of DUR activities shall be provided to the Department.

31.10 Pharmacy Drug Rebate Administration

Pursuant to the Affordable Care Act and 42 C.F.R. 438.3(s), CMS requires States to collect CMS level rebates on all Medicaid MCO utilization.

- A. The Contractor shall be required to report timely drug utilization data that is necessary for the Department to bill manufacturers for rebates in accordance with section 1927 (b) (1) (A) of the SSA and any Kentucky supplemental rebate program no later than forty-five (45) Days or as required by the Department after the end of each quarterly rebate period. The Contractor shall transmit a file according to Department specifications, and shall fully cooperate with Department and Department's contractors to ensure file transmissions are complete, accurate and delivered by the specified deadlines.
- B. Covered outpatient or prescribed drugs adjudicated by the Contractor, including but not limited to diabetic testing supplies, insulin, and those drug products administered by network Providers in an office/clinic or other non-institutional setting, are subject to the same manufacturer rebate requirements as Kentucky Medicaid FFS outpatient drugs. The Contractor must provide utilization information as required by DMS which includes but may not be limited to: the total number of units of each dosage form dispensed or administered, strength, date of service (date dispensed or administered), paid date (actual date Claim was paid), and NDC of the covered outpatient drug, and amount paid by the Contractor's plan.
- C. The Contractor shall submit this NDC level information on drugs, biologics, and other Provider administered products as directed by DMS, including, but not limited to drug codes (e.g., J-Code/Q-Code/A-Code), units and conversions consistent with federal and Department requirements.
- D. The Contractor shall assist and provide detailed Claim information requested by the Department or Department contractors to support rebate dispute and resolution activities. The Department or its designated contractor shall provide Contractor's Claim-level detail to

manufacturers to assist in dispute resolutions. However, the Contractor shall assist the Department fully in resolving drug rebate disputes with the manufacturer upon the request of the Department.

31.11 340B Transactions

- A. The Contractor shall submit all drug Encounters including physician administered drugs, with the exception of in-patient hospital drug Encounters, to the Department pursuant to the requirements of this Contract.
- B. The Contractor shall maintain the systems capability and methodology to appropriately identify 340B Claims in real time, prospectively, and retrospectively.
- C. The Contractor shall support all Department-based efforts and initiatives for 340B Claim identification at a Claim-level of detail, including the utilization of the NCPDP field(s) designed for this purpose.
- D. The Contractor shall require pharmacy Providers or processing vendors to identify 340B purchased drugs on Claims in accordance with Department requirements.
- E. The Contractor shall not reimburse a 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities, and shall not assess any fee, charge-back, or other adjustment upon the 340B entity on the basis that the 340B entity participates in the program set forth in 42 U.S.C. §256b.
- F. For Enrollees eligible to receive drugs subject to an agreement under 42 U.S.C. § 256b, the Contractor shall not discriminate against a 340B entity in a manner that prevents or interferes with the Enrollee's choice to receive such drugs from the 340B entity.

The Department shall deliver notice of billing guide changes to Contractor as necessary and with implementation deadlines. If program changes occur, these shall be at no cost to the Department.

31.12 Pharmacy Prior Authorizations

The Contractor shall conduct a Prior Authorization (PA) program that complies with the requirements of section 1927(d)(5) of the SSA and with Department requirements, as if such requirements apply to the Contractor instead of the Department.

The Contractor's PA program shall ensure there is no undue disruption of an Enrollee's access to care; shall prevent penalization of the Provider or Enrollee, financially or otherwise, for such PA requests or approvals; and shall incorporate the minimum requirements described herein:

- A. Clinical PA review criteria shall be evidence-based, and follow best clinical practice standards, and/or other national standards.
- B. Pharmacy Prior Authorization Denials must be made by a registered pharmacist or physician.
- C. A physician peer review shall be available upon a physician's request for any Denial made at a pharmacist review level.
- D. PA determinations including those from escalated reviews shall be made and communicated to the requesting Provider within twenty-four (24) hours from the initial request including weekends in compliance with the provisions of OBRA 1990 mandate, Section 1927 of the Social Security Act, and other federal regulations.
- E. All PA activities and decisions shall be documented in Contractor's online pharmacy case management system. This information shall be available for immediate review at the Department's request or other timeframe as specified by the Department.
- F. In the event a prescription is for a drug awaiting PA and the Contractor cannot reach the prescribing physician, and when the dispensing pharmacist, using reasonable clinical judgment, deems it necessary to avoid imminent harm or injury to the Enrollee, a seventy-two (72) hour emergency supply shall be permitted. If the physician prescribed an amount of drug

that is more than a seventy-two (72) hour supply but is packaged so that it must be dispensed intact, the pharmacist may dispense the packaged drug, and Contractor shall pay for this quantity even if it exceeds a calculated seventy-two (72) hour supply.

- G. Contractor's PA process shall include procedures for Enrollee appeals and grievances submitted by the Enrollee or the prescriber authorized to act on behalf of the Enrollee related to PAs denied after the final escalated review. Contractor's procedures for PA related appeals and grievances shall be in accordance with "**Section 24.2 Enrollee Grievance and Appeal Policies and Procedures**" and "**Section 27.10 Provider Grievances and Appeals**" of this Contract.

The Department shall provide a universal Prior Authorization form for the Contractor to utilize for a Provider to initiate the pharmacy Prior Authorization process. The Contractor shall give the Provider the option to use the designated Kentucky Medicaid pharmacy universal form or a DMS approved Contractor specific form. Although the Contractor may seek additional information before making determination on a particular Prior Authorization request, all such information shall be requested from the Provider by way of a supplemental Prior Authorization information sheet that does not duplicate information found on the Kentucky Medicaid universal pharmacy Prior Authorization form. The Contractor shall not deny a Prior Authorization request submitted on the designated universal pharmacy Prior Authorization form and require the provider to submit the Contractor specific form but rather shall suspend the request while awaiting a supplemental information sheet.

31.13 Maximum Allowable Cost

The Contractor shall establish and maintain a generic drug Maximum Allowable Cost (MAC) program to promote generic utilization and cost containment. However, the Contractor and any pharmacy benefit manager or administrator or like Subcontractor shall comply with all maximum allowable cost laws and administrative regulations promulgated by DOI, the Department, or otherwise promulgated by State or federal law.

31.14 PBM Pricing Transparency

The Contractor shall:

- A. Disclose all contract terms it has with its contracted PBM;
- B. Utilize a pass-through pricing model in which there is no difference in the PBM to pharmacy and MCO to PBM reported payment amounts;
- C. Provide any and all Claims -level detail that provides the basis for comparing the actual amount paid to pharmacies to the amount that the PBM charged the MCO for the transaction; and
- D. No additional direct or indirect remuneration fees or any membership fees or the like may be imposed on a pharmacy as a condition of Claims payment or network inclusion. No additional retrospective remuneration models including Generic Effective Rates (GERs) shall be permitted. However, nothing shall preclude the reprocessing of Claims due to Claims adjudication errors of the Contractor or its agent.

31.15 Pharmacy Call Center Services

In addition to any other Provider Services required herein, the Contractor shall operate a toll-free pharmacy call center twenty-four (24) hours a day, seven (7) days per week for access by Providers.

The Department may monitor the call center through review of statistical reports, telephone calls, or onsite visits. The Contractor shall have a tracking system that retains information collected on each call and that is retrievable using personal information for the individual from whom the call

was received. The information shall be provided to the Department upon request.

The Contractor shall provide a pharmacy call center quality assurance program subject to the Department's approval with monitoring results made available to the Department on a monthly basis.

31.16 Kentucky Pharmacy Director Workgroup

Pursuant to **Section 9.3 "Monthly Meetings"** and as directed by the Department, Contractor's Pharmacy Director shall meet monthly with the Department and other Contractors' like personnel to discuss issues for the efficient and economical delivery of pharmacy services to Enrollees. This collaborative meeting of pharmacy directors shall be referred to as the Kentucky Medicaid Pharmacy Director Workgroup.

31.17 Pharmacy Benefit Manager or Administrator Reporting Requirements

The Contractor shall comply with all pharmacy benefit reporting requirements and ad hoc requests for reports and data of this Contract, the Department and those set forth by applicable statutory or regulatory authority. At the request of the Department, the Contractor shall provide both summary and detailed reports. Detailed reports shall include Claim level details at the Department's request. If the Contractor Subcontracts any part of its pharmacy benefit administration to a pharmacy benefit manager or administrator or the like, then the Contractor shall ensure and be held responsible for such contracted entity's failure or non-compliance with any pharmacy benefit reporting requirements set forth by this Contract, the Department or applicable regulatory authority.

The Contractor shall, at a minimum, deliver or cause to be delivered through its agent or contracted entity to the Department no later than August 15th of each contracting year, reports and information required through KRS 205.647 and additional reports and information requested by the Department.

32.0 SPECIAL PROGRAM REQUIREMENTS

32.1 EPSDT Early and Periodic Screening, Diagnostic and Treatment

The Contractor shall provide all Enrollees under the age of twenty-one (21) years, except those eligible pursuant to 907 KAR 4:030, EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the time-frames required by the terms of this Contract as indicated in **Appendix L "EPSDT."** The Contractor shall comply with 907 KAR 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program. Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:

- A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034, and who are supported by adequately equipped offices to perform EPSDT services.
- B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with Enrollees and their families who are eligible for EPSDT services [(i.e. Medicaid eligible persons who are under the age of twenty-one (21))] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Enrollee's right to access these services. Enrollees and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial Enrollment and annually thereafter where Enrollees have not accessed services during the year.

- C. Provide EPSDT services to all eligible Enrollees in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in **Appendix M "EPSDT."**
- D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary Care Provider assigned to each eligible Enrollee shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.
- E. Provide all needed diagnosis and treatment for eligible Enrollees in accordance with 907 KAR 1:034. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment and or Out-of-network Providers shall provide treatment if the service is not available within the Contractor's Network.
- F. Provide EPSDT Special Services for eligible Enrollees, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in **Appendix M "EPSDT."**
- G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Enrollees are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.
- H. Establish and maintain an effective and ongoing Enrollee Services function for eligible Enrollees and their families to provide education and counseling with regard to Enrollee compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Enrollees or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Enrollees and their families when recommended assessments and treatment are not received. This function should be aligned with the Contractor's Population Health Management (PHM) Program.
- I. Maintain a consolidated record for each eligible Enrollee, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.
- J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible Enrollees with behavioral health or developmentally disabling conditions. Coordination procedures shall be established for other services needed by eligible Enrollees that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's Individual Education Plan at school, WIC, Head Start, DCBS, etc.
- K. Participate in any state or federally required chart audit or quality assurance study.
- L. Maintain an effective education/information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Enrollees which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.
- M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.
- N. Provide an EPSDT Coordinator staff function with adequate staff or Subcontract personnel to serve the Contractor's enrollment or projected enrollment.

32.2 Dental Services

Except as provided in **Section 41.0 “Kentucky HEALTH Policies and Performance Requirements”** of this contract, the Contractor shall provide preventive and primary care dental services for oral health conditions and illness in a timely manner on an emergent, Urgent Care or non-urgent care basis in accordance with 42 C.F.R. 438. Covered dental services shall be provided in accordance with 907 KAR 1:026.

The Contractor shall establish written policies and procedures to ensure the timely provision of services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided to fee-for-service Medicaid Enrollees. The Contractor shall assess the oral health of Enrollees and develop a plan for improving oral health in Enrollees, particularly in children and persons with special health care needs.

The Contractor shall have ultimate responsibility for the provision of dental services and shall oversee and coordinate the delivery of or access to all Enrollee health information and other data relating to dental services, as requested by the Department.

The Contractor will also provide for adherence to standards of care based on established clinical criteria and evidence based science.

The Contractor shall determine the Medical Necessity criteria to be used in the provision of dental services which shall be submitted to the Department for approval in accordance with **Section 4.4 “Approval of Department.”**

32.3 Emergency Care, Urgent Care and Post Stabilization Care

Emergency Care as defined in 42 USC 1395dd and 42 C.F.R. 438.114 shall be available to Enrollees twenty-four (24) hours a day, seven (7) days a week. Urgent Care services shall be made available within forty-eight (48) hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 C.F.R. 422.113(c) and 438.114(e).

The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) Days to notify the Contractor of the Enrollee's screening and treatment before refusing to cover the Emergency Services based on a failure to notify. An Enrollee who has an Emergency Medical Condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending Provider determines that the Enrollee is sufficiently stabilized for transfer or discharge.

32.4 Out-of-Network Emergency Care

The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network in compliance with 42 C.F.R. 438.114.

Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid Fee-For-Service rate as required by Section 6085 of the Deficit Reduction Act of 2005. For services provided by non-contracting hospitals, this amount must be less any payments for indirect costs of medical education and direct costs of graduate medical education that would have been included in Fee-For-Service payments.

32.5 Maternity Care

When a woman has entered prenatal care before enrolling with the Contractor, the Contractor shall make every effort to allow her to continue with the same prenatal care provider throughout the entire pregnancy. Contractor shall also establish procedures to ensure either prompt initiation of prenatal care or continuation of care without interruption for women who are pregnant when they enroll. The Contractor shall provide maternity care that includes prenatal, delivery, and postpartum care as well as care for conditions that complicate pregnancies. All newborn Enrollees newborn screening shall be covered as specified in the Commonwealth of Kentucky metabolic screen.

32.6 Voluntary Family Planning

The Contractor shall ensure direct access for any Enrollee to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in **Appendix I “Covered Services”** to this Contract. The Contractor may not restrict an Enrollee’s choice of his or her provider for Family Planning Services. The Contractor must ensure access to any qualified provider of Family Planning Services without requiring a referral from the PCP. See **Section 28.4 “Provider Network Access and Adequacy”** for allowable wait times for appointments.

The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Enrollees less than eighteen (18) years of age pursuant to Title X, 42 C.F.R. 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et seq., KRS 202A, and KRS 214.185.

All information shall be provided to the Enrollee in a confidential manner. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will ensure the Enrollee’s privacy.

32.7 Nonemergency Medical Transportation

The Department contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery to provide non-emergency medical transportation (NEMT) services to select Medicaid Enrollees. Through the NEMT program, certain eligible Enrollees receive safe and reliable transportation to Medicaid Covered Services. The Department shall continue to provide NEMT services for Medicaid Enrollees except as provided in **Section 41.0 “Kentucky HEALTH Policies and Performance Requirements.”** The Contractor shall provide educational materials regarding the availability of transportation services and refer Enrollees for NEMT. NEMT services do not include emergency ambulance and non-emergency ambulance stretcher services. Transportation of an emergency nature, including ambulance stretcher services is the responsibility of the Contractor.

32.8 Pediatric Interface

School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.

Preventive and remedial care services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician’s Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child’s IEP should not be duplicated. However, in situations where a child’s course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered

Services to eligible Enrollees.

Services provided under the Kentucky Health Access Nurturing Development Services (HANDS) shall be excluded from Contractor coverage.

Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.

32.9 Pediatric Sexual Abuse Examination

The Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Enrollees at the request of the DCBS.

32.10 Lock-In Program

The Contractor shall develop a program to address and contain Enrollee over utilization of services, for pharmacy and non-emergent care provided in an emergency setting. The program shall include:

- A. Criteria for identification and enrollment of an Enrollee in the lock-in program;
- B. Methods the Contractor will implement to support Enrollees to understand and access appropriate utilization of services, such as Care Coordination, care management and education;
- C. Methods the Contractor will implement to address Enrollees who refuse to participate in the lock-in program or to engage with the Contractor on identified support methods;
- D. Length of enrollment in the program and ongoing assessment process;
- E. Approach to tracking outcomes of the program and using findings to adjust the program and Enrollee supports as needed.

The Contractor shall submit its lock-in program description to the Department for approval subject to **Section 4.4 “Approval of Department.”**

33.0 BEHAVIORAL HEALTH SERVICES

33.1 Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) Responsibilities

The Department works collaboratively with Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to ensure that Medicaid Enrollees receive quality Behavioral Health Services.

The Contractor shall use evidence-based practices (EBPs) that meet the standards of national models in all behavior health services. The Contractor shall comply with standards identified in the “Interoperability Standards Advisory—Best Available Standards and Implementation Specifications” (ISA) and 45 CFR 170 Subpart B in complying with the Commonwealth’s behavioral health policies.

33.2 Requirements for Behavioral Health Services

The Contractor shall engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Enrollees with SMI and SED, including Enrollees with co-occurring developmental

disabilities, substance use disorders and smoking cessation.

The Contractor in its design and operation of Behavioral Health Services shall incorporate these core values for Medicaid Enrollees:

- A. Enrollees have the right to retain the fullest control possible over their behavior health treatment. Behavioral Health Services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare.
- B. The Contractor shall provide the most normative care in the least restrictive setting and serve Enrollees in the community to the greatest extent possible.
- C. The Contractor shall measure Enrollees' satisfaction with the services they receive.
- D. The Contractor's Behavioral Health Services shall be trauma-informed, recovery and resiliency focused.

33.3 Covered Behavioral Health Services

The Contractor shall ensure the provision of all Medically Necessary Behavioral Health Services for Enrollees. These services are described in **Appendix I "Covered Services."** All Behavioral Health Services shall be provided in conformance with the access standards established by the Department. When assessing Enrollees for Behavioral Health Services, the Contractor and its providers shall use the most current version of DSM classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM. Providers shall document DSM diagnosis and assessment/outcome information in the Enrollee's Medical Record.

33.4 Behavioral Health Provider Network

The Contractor shall provide access to Psychiatrists, Psychologists, and other Behavioral Health Service providers. Community Mental Health Centers (CMHCs) shall be offered participation in the Contractor provider network. Other eligible providers of Behavioral Health Services include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations, Licensed Clinical Social Workers, and other independently licensed behavioral health professions. To the extent that non-psychiatrists and other providers of Behavioral Health Services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.

33.5 Enrollee Access to Behavioral Health Services

The Contractor shall ensure accessibility and availability of qualified providers to all Enrollees. The Contractor shall maintain an adequate network that provides continuum of care to ensure the Enrollee has access to care at the appropriate level. The Contractor shall ensure that upon decertifying an Enrollee at a certain level of care, there is access to Providers for continued care at a lower level, if such care is determined Medically Necessary. The Contractor shall coordinate and collaborate with Providers on discharge plans and criteria.

The Contractor shall maintain an Enrollee education process to help Enrollees know where and how to obtain Behavioral Health Services. The Enrollee Manual shall contain information for Enrollees on how to direct their behavioral health care, as appropriate.

The Contractor shall permit Enrollees to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Enrollee with information on accessible in-network Providers with relevant experience.

33.6 Behavioral Health Services Hotline

The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) Days a year, toll-free throughout the Commonwealth. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies. Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face-to-face Emergency Services shall be available twenty-four (24) hours a day, seven (7) Days a week. The Behavioral Health Services Hotline shall not be answered by any automated means.

The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs:

- A. Ninety-nine percent (99%) of calls are answered by the fourth ring;
- B. No incoming calls receive a busy signal;
- C. The call abandonment rate is seven percent (7%) or less; and
- D. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 Emergency Services.

The Contractor shall operate one hotline to handle emergency and crisis calls. The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Enrollee. Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Enrollees, including the interpretive services required for effective communication.

The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs.

The Contractor shall conduct ongoing quality assurance to ensure these standards are met.

The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.

If the Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractor is responsible for all reasonable costs incurred by the Department or its authorized agent(s) relating to such monitoring.

The Contractor shall also contribute to a statewide emergency Behavioral Health hotline in an amount equal to their proportional share of Medicaid Enrollees per Contract year.

33.7 Coordination between the Behavioral Health Provider and the PCP

The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such contract provisions and screening and evaluation procedures shall be submitted to the Department for approval. Such approval is subject to **Section 4.4 "Approval of Department."**

The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination

and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs. Such approval is subject to **Section 4.4 “Approval of Department.”** The Contractor shall require that Behavioral Health Service Providers refer Enrollees with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Enrollee's or the Enrollee's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.

The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of an Enrollees' behavioral health status to the PCP, with the Enrollee's or the Enrollee's legal guardian's consent. This requirement shall be specified in all Provider Manuals.

33.8 Follow-up after Hospitalization for Behavioral Health Services

The Contractor shall require, through Provider contract provision, that all Enrollees receiving inpatient Behavioral Health Services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) Days from the date of discharge. The Contractor shall ensure that Behavioral Health Service Providers contact Enrollees who have missed an appointment within twenty-four (24) hours to reschedule appointments.

33.9 Court-Ordered Psychiatric Services

The Contractor must provide inpatient psychiatric services to Enrollees under the age of twenty-one (21) and over the age of sixty-five (65) who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.

The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for Enrollees under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

33.10 Continuity of Care Upon Discharge from a Psychiatric Hospital

- A. The Contractor shall coordinate with providers of Behavioral Health Services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and Discharge Planning, treatment objectives and projected length of stay for Enrollees committed by a court of law and/or voluntarily admitted to the state psychiatric hospital. The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their Medicaid Region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to ensure continuity of care for successful transition back into community-based supports. In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.
- B. The Contractor shall ensure Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive Case Management services as Medically Necessary to Enrollees with SMI and co-occurring conditions who are

discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Enrollees with SMI. The Case Manager and other identified Behavioral Health Service providers shall participate in Discharge Planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate Discharge Planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Enrollee's behavioral and physical health needs, including psychosocial rehabilitation and health promotion. Appropriate follow up by the Behavioral Health Service Provider shall occur to ensure the community supports are meeting the needs of the Enrollee discharged from a state operated or state contracted psychiatric hospital. The Contractor shall ensure the Behavioral Health Service Providers assist Enrollees in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.

33.11 Program and Standards

Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Enrollees use physical and behavioral health systems simultaneously. The Contractor shall:

- A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including Emergency Behavioral Health Services, (i.e., Suicide Prevention and community crisis stabilization);
- B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;
- C. Identify a method to evaluate the continuity and coordination of care, including Enrollee-approved communications between behavioral health care providers and Primary Care Providers;
- D. Protect the confidentiality of Enrollee information and records; and
- E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.

The Department shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.

33.12 NCQA/MBHO Accreditation Requirements

The Contractor shall demonstrate to the Department its compliance with NCQA/MBHO accreditation requirements by meeting the following standards:

- A. The availability of behavioral healthcare practitioners and providers within its network;
- B. The development of preventive behavioral health programs;
- C. The development of Self-Management Tools for Use by Enrollees;
- D. The establishment of a Complex Case Management Program that addresses the needs of adults with SMI, children with SED and other high risk groups with co-occurring conditions;
- E. The adoption of Clinical Practice Guidelines specific to the needs of behavioral health clients;
- F. The establishment of a process for Data Collection and Integration between the Contractor and the MBHO;
- G. Identify and report on critical Performance Measures that are specific to behavioral health Enrollees;
- H. Establish a written program description for the MBHO's Utilization Management Program; and
- I. Establish a process for collaboration between behavioral healthcare and medical care.

33.13 Coordination and Collaboration with Behavioral Health Providers

The Contractor shall identify and develop community alternatives to inpatient hospitalization for those Enrollees who are currently receiving inpatient psychiatric facility services and could be discharged from the facility if an appropriate treatment alternative were made available in the community. In the event that the Contractor does not provide and cover an appropriate community alternative, the Contractor shall remain financially responsible for the continued inpatient care of these individuals until the Contractor ensures availability and access to an appropriate community provider.

34.0 POPULATION HEALTH MANAGEMENT PROGRAM Population Health Management Program

34.1 Program Overview

The Department is working to transform the Medicaid program to drastically improve outcomes for a variety of healthcare conditions and to empower individuals to improve their health and engage in their healthcare. To support these goals, the Contractor shall implement an innovative Population Health Management (PHM) Program to improve the health of Enrollees through an innovative, person-centered approach that addresses medical and non-medical drivers of health while reducing inappropriate utilization and costs. Person-centered supports will focus on the whole person, addressing physical health, behavioral health, functional, and social needs.

To drive improved outcomes for its Enrollees, the Contractor shall establish and operate an integrated Population Health Management (PHM) Program that incorporates components of NCQA's PHM Model. The Department may elect to require the Contractor to attain NCQA PHM Accreditation.

The Contractor shall implement a PHM Program that supports Enrollees across the care continuum, promoting healthy behaviors and self-management as well as providing Care Coordination and Complex Care Management as needed and supported by evidence-based medicine and national best practices.

The Contractor shall submit its written PHM Program Plan to the Department for review and approval within thirty (30) Days of Contract Execution, annually, and prior to implementing any material revisions. The PHM Program Plan must address all program elements set forth in this Section and others based on the specific components of the Contractor's Program. The Department encourages the Contractor to incorporate innovations into its PHM Program that will have the highest potential for success within the Kentucky healthcare landscape, therefore, the Contractor may also submit alternative approaches and innovations to the Department for review and approval.

In alignment with NCQA's PHM Model, the Contractor shall implement a PHM Program that incorporates the below three risk levels, at a minimum, in the most cost-effective manner possible.

- A. **Health Promotion and Wellness.** The Contractor shall provide wellness and prevention support to Enrollees with little or no risk factors. The Contractor shall provide services and supports to encourage Enrollees in becoming proactive participants in their health and well-being and that promote healthy lifestyles.

The Contractor is encouraged to test and evaluate cost-effective Enrollee health promotion and wellness strategies, from high-touch, personal interactions to technology-based solutions. The Contractor shall collaborate with the Department and other entities such as the Department for Public Health on joint preventive health and wellness initiatives, as appropriate.

- B. **Management of Chronic Conditions.** The Contractor shall provide Care Coordination support to Enrollees who have been identified as having emerging risk factors and/or one (1) targeted chronic condition. The Contractor shall provide services to Enrollees that aim to reduce healthcare costs and improve quality of life for Enrollees who have a chronic condition through integrative care. Care Coordination should help Enrollees to address potential co-morbidities or other complications and help to avoid complications.
- C. **Complex Care Management** provides support to Enrollees with complex clinical, behavioral, functional and/or social needs, who have the highest risk factors such as multiple conditions, or multiple medications, served within multiple systems and often have the highest costs. Required interventions are more intensive.

The Contractor shall develop strategies and interventions to help manage the needs of these Enrollees, such as development of a person-centered Care Plan, coordination of care to address all required needs and to support the Enrollee in obtaining the required care, and telephonic and face-to-face engagement with Enrollees as deemed necessary by the Care Plan. The Contractor shall assign care managers to these individuals to support implementation of the Care Plan and to facilitate receipt of necessary care and services.

Enrollees will have the option to participate in the Contractor's PHM Program based on the Contractor's identification of each individual Enrollee's needs for support. While the Contractor may not mandate participation, the Contractor shall implement innovative strategies to attain high levels of Enrollee participation.

For all risk levels, the Contractor's PHM Program Plan shall provide information about the following at a minimum:

- A. Description of PHM Program tools the Contractor will use to identify Enrollees and their identified risk levels, as well as tools the Contractor will use to support services provided;
- B. Templates for PHM Program tools, where applicable (e.g., Health Risk Assessment, Enrollee Needs Assessment, Care Plans)
- C. Risk stratification methodology, including types of data used;
- D. Services and information available to Enrollees within the risk level, including service tiers if applicable;
- E. Description of the care planning process;
- F. Stakeholder engagement strategies, including those for Enrollees, Providers, community resources and social services agencies;
- G. Methods the Contractor will implement to engage Enrollees and encourage participation;
- H. Methods for information exchange, as applicable;
- I. Frequency of provision of services;
- J. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.);
- K. Description of staffing, including qualifications;
- L. If applicable, value-based payment (VBP) or incentive models included in Provider agreements to support involvement in the PHM Program; and
- M. Methods for evaluating success of services provided.

34.2 Conditions and Populations

The Department has identified the below conditions and populations as priority for the PHM Program. The Contractor shall implement interventions that focus on Enrollees who have a priority condition identified by the Department, but should also identify additional conditions or populations of focus based on the Contractor's Enrollee population. The Department may also adjust this listing as needs are addressed, or as additional needs are identified.

- A. Population health condition priorities, include:
 1. Asthma;

2. Heart disease;
 3. Diabetes;
 4. Obesity;
 5. Tobacco use;
 6. Cancer;
 7. Infant mortality;
 8. Low birth weight
 9. Behavioral health and substance use disorder; and
 10. Others as determined by the Contractor and/or the Department.
- B. Population priorities, include:
1. Adults and Children with Special Health Care Needs, as set forth in **Section 35.0 “Enrollees with Special Health Care Needs”**
 2. High-risk pregnant women as determined by providers
 3. Other populations as determined by the Contractor and/or the Department.

34.3 Population Health Management Program Tools

The Contractor shall use a variety of tools to support identification of and care for Enrollees for the PHM Program. The Contractor shall use the tools identified in this section, but is encouraged to use others as it deems appropriate to support implementation of its program to address Enrollee needs in a cost-effective manner.

A. Risk Stratification and Service Tiers

The Contractor shall implement a risk stratification methodology to determine risk of its overall population and to identify individual Enrollee risk levels. The Contractor’s methodology should include use of integrated data to support identification of an Enrollee’s need for specific services.

The Contractor may develop tiers of services within each risk level to address Enrollees with varying levels and intensity of care needs.

The Contractor shall conduct risk stratification on an ongoing basis on a schedule that is documented in the Contractor’s PHM Program Plan.

B. Health Risk Assessments (HRA)

The Contractor shall utilize a standardized Health Risk Assessment (HRA) tool, as designated by the Department, to determine an Enrollee’s general needs for participation in the PHM Program and to identify Enrollees who may require an Enrollee Needs Assessment. Information to be collected shall include demographic information, current physical health and behavioral health status. As part of the HRA process, the Contractor shall explain the purpose to Enrollees and available PHM Program services should they be determined in need of such services.

The Contractor shall conduct HRAs as follows:

1. Initial HRAs, including mental health and substance use disorders screenings, of new Enrollees who have not been enrolled with the Contractor in the prior twelve (12) month period, for the purpose of assessing the Enrollees’ health care needs within thirty (30) Days of Enrollment or earlier if the Enrollee is identified via other information or self identifies as having specific health care or social needs.
2. Within thirty (30) Days of Enrollment if the Contractor has a reasonable belief an Enrollee is pregnant. If determined pregnant, the Contractor shall refer the Enrollee for appropriate prenatal care.
3. Annually to assess Enrollee's for any new health care or social needs.
4. At other times as deemed appropriate by the Contractor or the Department.

The Contractor shall make all reasonable efforts in accordance with this Contract to contact Enrollees in person, by telephone, email or by mail to complete the HRA. "Reasonable effort" is defined as making at least three (3) attempts to contact the Enrollee with at least one (1) of those attempts by telephone. The three attempts by the Contractor may not be within the same day. Should the Contractor not have a usable telephone number for an Enrollee, the Contractor shall contact the Enrollee's PCP or other health care providers, if applicable, to try to obtain a usable number.

C. Enrollee Needs Assessments

For Enrollees identified through HRA completion, referral, risk scoring and stratification, or other methods as determined by the Contractor as potentially in need of a higher level of PHM Program services, the Contractor shall conduct a comprehensive Enrollee Needs Assessment to determine the Enrollee's PHM Program service needs.

The Enrollee Needs Assessment shall at a minimum assess the following:

1. Enrollee's immediate, current and past health care, mental health and SUD needs;
2. Psychosocial, functional, and cognitive needs;
3. Social Determinants of Health, including employment and housing status;
4. Ongoing conditions or needs that require treatment or care monitoring;
5. Current care being receiving, including health care services or other care management;
6. Current medications, prescribed and taken;
7. Support network, including caregivers and other social supports; and
8. Other areas as identified by the Contractor or Department.

The Contractor shall complete the Enrollee Needs Assessment with the Enrollee and/or designated representative via telephone, in person at a location that meets the Enrollee's needs, or by other methodologies as the Contractor deems appropriate for differing Enrollee demographics or needs. The Contractor shall make all reasonable efforts in accordance with this Contract to complete the Enrollee Needs Assessment within thirty (30) Days of identifying an Enrollee in potential need of care management services, or within an earlier timeframe for Enrollees identified as having more immediate needs. "Reasonable effort" is defined as making at least three (3) attempts to contact the Enrollee with at least one (1) of those attempts by telephone. The three attempts by the Contractor may not be within the same day. Should the Contractor not have a usable telephone number for an Enrollee, the Contractor shall contact the Enrollee's PCP or other health care providers, if applicable, to try to obtain a usable number.

Based on the Contractor's findings, the Contractor shall make a determination as to the Enrollee's need for care management services, as well as the intensity of services required. The Contractor shall have a process for determining level, or tier, of services the Enrollee requires based on the Enrollee's level of risk.

The Contractor shall share the findings of the Enrollee Needs Assessment with the Enrollee, the Enrollee's PCP or other referring provider, and other care management team members within fourteen (14) Days of completion and as consented to by the Enrollee to the extent required by law. Findings shall include the Contractor's recommendation for receipt of PHM Program services.

If the Enrollee Needs Assessment findings indicate that services are not necessary for the Enrollee, the Contractor shall document the decision and basis for the decision.

The Contractor shall re-assess Enrollees identified as potentially needing PHM Program services as follows:

1. When the Enrollee's circumstances or needs change (e.g., new diagnosis, inpatient admission, homelessness, etc.);

2. At least annually;
3. At the Enrollee's request; and
4. Upon referral from a provider, care giver, or social services agency

34.4 Care Planning

For Enrollees identified as needing Care Plans, the Contractor shall use a collaborative multidisciplinary team to develop an individualized and person-centered Care Plan with the Enrollee receiving care management services. The Contractor shall assign a care manager to the Enrollee who will facilitate development of the care team and Care Plan, which may include members such as the following based on the Enrollee's needs: the Enrollee and/or caretakers, the PCP, a behavioral health provider, specialists, nutritionists, and or pharmacy providers.

The Contractor shall use innovative strategies and solutions to address person-centered goals and outcomes. The Care Plan shall be developed in accordance with 42 C.F.R. 438.208. An Enrollee's Care Plan, at a minimum, shall include:

- A. Appropriate medical, behavioral, and social services and be consistent with the PCP's medical diagnosis and clinical treatment plan;
- B. Person-centered goals, objectives and desired wellness, health, functional, and quality of life outcomes for the Enrollee and how services are intended to help achieve these goals;
- C. Description of Enrollee's psychosocial needs including any housing or financial assistance needs; how such needs will be addressed to ensure the Enrollee's ability to live safely in the community;
- D. Social, educational, and other services needed by the Enrollee;
- E. Enrollee risk factors and measures in place to minimize them; and
- F. Planned Interventions.

The Contractor shall ensure each Care Plan is documented and made available to the Enrollee and the multi-disciplinary care team, including the Enrollee's PCP as appropriate. The care manager shall provide a copy of the completed Enrollee Needs Assessment and Care Plan to the Enrollee and any other providers authorized to deliver services to or for the benefit of the Enrollee and as documented in the Care Plan.

A Care Plan will be routinely updated and incorporate input from the multidisciplinary care team and the Enrollee in accordance with the Contractor's policies and procedures.

34.5 Coordination with Women, Infants and Children (WIC)

The Contractor shall comply with Section 1902(a)(11)(C) of the Social Security Act which requires coordination between Medicaid MCOs and WIC. This coordination includes the referral of potentially eligible women, infants and children to the WIC program and the provision of medical information by providers working within Medicaid managed Care Plans to the WIC program if requested by WIC agencies and if permitted by applicable law. Typical types of medical information requested by WIC agencies include information on nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, prematurity, infants of mothers with a SUD or other drug addiction, developmental disabilities or intellectual disabilities, AIDS, allergy or intolerance that affects nutritional status and anemia.

34.6 Program Evaluation

The Contractor shall conduct ongoing review of its PHM Program and report to the Department on a monthly, quarterly, or annual basis based on agreed upon performance measures and targets and reporting requirements. The Contractor shall highlight status and progress of its PHM Program services in achieving improved outcomes, as well as lessons learned, challenges, and strategies

the Contractor is implementing to address the challenges. The Department will make the final decision as to data and information to be reported to the Department by the Contractor. The Contractor and the Department shall use findings to identify additional opportunities for improvement to the model and need for modification of priorities, measures, and targets.

35.0 ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

35.1 Individuals with Special Health Care Needs (ISHCN)

Individuals with Special Health Care Needs (ISHCN) are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.

As per the requirement of 42 C.F.R. 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Enrollees with these multiple and complex physical and behavioral health care needs are further identified. The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Enrollees for the purpose of screening and identifying ISHCN's. The Contractor shall assess each Enrollee identified as ISHCN to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals. The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations:

- A. Children in/or receiving Foster Care or adoption assistance, if applicable. See **Section 42 “Kentucky SKY Program”** for additional information;
- B. Blind/Disabled Children under age nineteen (19) and Related Populations eligible for SSI;
- C. Adults over the age of sixty-five (65);
- D. Homeless (upon identification);
- E. Individuals with chronic physical health illnesses;
- F. Individuals with chronic behavioral health illnesses;
- G. Children receiving EPSDT Special Services; and
- H. Children receiving services in a Pediatric Prescribed Extended Care facility or unit.

The Contractor shall develop and distribute to ISHCN Enrollees caregivers, parents and/or legal guardians, information and materials specific to the needs of the Enrollee, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and /or caregivers in understanding their chronic illness.

The Contractor shall have in place policies governing the mechanisms utilized to identify, screen and assess individuals with special health care needs. The Contractor will produce a treatment plan for Enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.

The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.

35.2 DAIL: Adult Guardianship Clients

Enrollees who are adult guardianship clients shall be identified as ISHCN. The Contractor shall attempt to obtain the service plan which will be completed by DAIL. The service plan will be used

by DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in Case Management. The Contractor shall be responsible for the ongoing Care Coordination of these Enrollees whether or not enrolled in Case Management to ensure access to needed social, community, medical and Behavioral Health Services. A monthly report of Adult Guardianship Cases shall be sent to Department thirty (30) Days after the end of each month.

The Contractor shall develop and implement policies and procedures to ensure access to Care Coordination for all DAIL clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DAIL population.

Each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Enrollee. If the service plan identifies the need for Case Management, the Contractor shall work with Guardianship staff and/or the Enrollee, as appropriate, to determine what level of Case Management is needed.

35.3 Legal Guardians

The Contractor shall permit a parent, custodial parent, person exercising custodial control or supervision, or an agency with legal responsibility for a child by virtue of voluntary commitment or emergency or temporary custody orders to act on behalf of an Enrollee under the age of eighteen (18), potential Enrollee or former Enrollee for purposes of selecting a PCP, filing Grievances or Appeals, and otherwise acting on behalf of the child in interactions with the Contractor.

A legal guardian of an adult Enrollee appointed pursuant to KRS 387.500 to 387.800 shall be allowed to act on behalf of a ward as defined in that statute, and a person authorized to make health care decisions pursuant to KRS 311.621, et seq. shall be allowed to act on behalf of an Enrollee, prospective Enrollee or former Enrollee. An Enrollee may represent her/himself, or use legal counsel, a relative, a friend, or other spokesperson.

35.4 Enrollees with SMI Residing in Institutions or At Risk of Institutionalization

The Contractor shall participate in transition planning and continued Care Coordination for Enrollees with SMI who are transitioning from licensed Personal Care Homes, psychiatric hospitals, or other institutional settings to integrated, community based housing. The Contractor shall perform a comprehensive physical and behavioral health assessment designed to support the successful transition to community based housing within fourteen (14) Days of the transition. To perform such assessment, the Contractor shall review the Enrollee's Person-Centered Recovery Plan and level of care determination developed by the provider agency in tandem with Contractor's routine UM procedures. The Contractor shall provide services that are recommended in the Person-Centered Recovery Plan and that meet Medical Necessity criteria.

36.0 PROGRAM INTEGRITY

The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 C.F.R. 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing Fraud, Waste and Abuse requirements. The Contractor shall have sufficient investigatory capacity necessary to comply with all applicable requirements and standards under the Contract as well as all federal and state requirements and standards to detect Fraud, Waste and Abuse. The Department has defined minimums standards for the Contractor's Program Integrity Unit (PIU) as follows:

- A. Identification of a minimum of two percent (2%) in provider Overpayments and prepayment cost avoidance on Report 64;

- B. Conducting a minimum of three (3) on-site visits per quarter;
- C. Attending any training or meeting given by the Commonwealth;
- D. Collecting outstanding debt owed to the Department;
- E. Respond to informational or reporting requests timely;
- F. Requesting permission to administratively collect Overpayments in excess of five hundred dollars (\$500);
- G. Ensuring formal case tracking and case management of provider and Enrollee cases;
- H. Maintain two (2) full-time investigators with a minimum of three (3) years Medicaid Fraud, Waste and Abuse investigatory experience located in Kentucky dedicated one hundred percent (100%) to the Kentucky Medicaid Program, and notification to the Department's Program Integrity Director if there is any absence or vacancy that is more than thirty (30) Days with a contingency plan to remain compliant with the other contract requirements in the interim; and
- I. Meeting the requirements of **Appendix M "Program Integrity Requirements."**

36.1 Program Integrity Plan

The Contractor shall develop in accordance with the Contract requirements in this Section and **Appendix N "Program Integrity Requirements,"** a Program Integrity plan for the Commonwealth of Kentucky of internal controls and policies and procedures for preventing, identifying and investigating Enrollee and provider Fraud, Waste and Abuse. If the Department changes its Program Integrity activities, the Contractor shall have up to three (3) months to provide a new or revised program. This plan shall include, at a minimum:

- A. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the contract as well as all federal and state requirements and standards;
- B. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors;
- C. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under this Contract;
- D. Effective training and education for the Contractor's Compliance Officer, senior management, employees, Subcontractors, providers, and Enrollees for the federal and state standards and requirements under the contract, including:
 - 1. Training and education regarding Fraud, Waste, and Abuse; and
 - 2. Detailed information about the False Claims Act (FCA), rights of employees to be protected as whistleblowers, and other federal and state laws described in Section 1902 of the Act (42 USC 1396a(a)(68));
- E. Effective lines of communication between the Compliance Officer and the Contractor's employees;
- F. Enforcement of standards through written and well-publicized disciplinary guidelines;
- G. Written procedures and an operational system that include but are not limited to the following:
 - 1. Routine internal monitoring and auditing of Enrollee, provider and compliance risks by dedicated staff for the Contractor and any Subcontractor;
 - 2. Prompt investigation, response and development of corrective action initiatives to compliance risks or issues as they are raised or identified in the course of self-evaluation or audit, including coordination with law enforcement agencies for suspected criminal acts, to reduce potential recurrence and ensure ongoing compliance under the contract;
 - 3. Provision for immediate notification to the Department's Program Quality & Outcomes Division Director and Program Integrity Division Director should any employee of the Contractor, Subcontractors or agents seek protection under the False Claims Act;
 - 4. Provision for prompt reporting to the Department of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, in a manner as

- determined by the Department;
5. Prompt referral of any potential Fraud, Waste, or Abuse that the Contractor identifies to the Department's Program Integrity unit or any potential Fraud directly to the state Medicaid Fraud Control Unit in the form of an investigative report or in another manner as prescribed by the Department;
 6. Provision for Network Providers to report and return to the Contractor any Overpayment within sixty (60) Days of identification, and to notify Contractor in writing of the reason for the Overpayment;
 7. Suspension and escrow of payments to a Network Providers for which the Department has notified the Contractor that there is a credible allegation of Fraud in accordance with 42 C.F.R. 455.23 and report payment suspension information quarterly in a manner determined by the Department;
 8. Prompt notification to the Department when it receives information about a change in an Enrollee's circumstances that may affect the Enrollee's eligibility including changes in the Enrollee's residence or the death of the Enrollee;
 9. Notification to the Department when it receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor;
 10. Method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers have been delivered to Enrollees and the application of such verification processes on a regular basis;
 11. Ensure all of Contractor's Network Providers are enrolled with the Department consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. 455;
 12. An accounts receivable process to collect outstanding debt from Enrollees or providers and provide monthly reports of activities and collections to the Department in a manner determined by the Department;
 13. An Appeal process;
 14. Process for card sharing cases;
 15. Tracking the disposition of all Enrollee and provider cases (initial and preliminary) as well as case management that allows for ad hoc reporting or case status; and
 16. A Prepayment Review process in accordance with this contract.
- H. Contractor shall be subject to on-site review; and comply with requests from the Department to supply documentation and records;
 - I. Contractor shall comply with the expectations of 42 C.F.R. 455.20 by employing a method of verifying with Enrollee whether the services billed by provider were received by randomly selecting a minimum sample of five hundred (500) Claims on a monthly basis;
 - J. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the Overpayments identified and collected;
 - K. The Contractor shall follow cases from the time they are opened until they are closed following written protocol regarding submission of investigative reports to the Department;
 - L. Contractor shall notify Department within fifteen (15) Business Days in a manner determined by the Department of any provider placed on Prepayment Review related to Fraud, Waste and Abuse. The information shall include at a minimum the following:
 1. Case Number;
 2. Provider Name;
 3. Medicaid Provider ID;
 4. NPI;
 5. Summary of Concern; and
 6. Date action taken.

The Contractor shall submit an annual listing of providers that were under Prepayment Review during the state fiscal year in a manner determined by the Department; and

- M. The Contractor shall attend any training given by the Commonwealth, Department, its Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.

The plan shall be made available to the Department for review and approval subject to **Section 4.4 "Approval of Department."**

36.2 Prepayment Review

The Contractor shall have written, policies, procedures and standards of conduct for a Prepayment Review process in accordance with the requirements of this contract, and should perform a review when there is a sustained or high level of payment error or data analysis identifies a problem area related to possible Fraud, Waste and Abuse. Any request for a Prepayment Review process outside of the scope of Fraud, Waste and Abuse as prescribed in this Section shall be submitted in writing to the Director of the Division of Program Quality Outcomes for approval with copy to the Director of the Division of Program Integrity.

The Contractor shall have discretion on when to utilize Prepayment Review, but should consider such review due to a high volume of services, high cost, dramatic change in frequency of use, high risk problem-prone area, complaints, or if the Department or any other federal or state agency has identified a certain vulnerability in a service area. The Contractor shall not use Prepayment Review to hold Claims for an indefinite period of time. The Contractor shall review the documentation submitted within a reasonable amount of time but not to exceed thirty (30) Days from the date of the request to determine whether the Claim should be paid. Claims under Prepayment Review are not subject to prompt payment or timely filing requirements.

Notice shall be sent to the provider in writing on or before the date a Prepayment Review is started. The written notice shall contain the following:

- A. Specific reason for the review;
- B. Complete description of the specific documentation needed for the review and method of submission;
- C. Timeframe for returning the documentation, and information that the Claim will be denied if documentation is not returned timely;
- D. Length of time the Prepayment Review will be conducted if the Contractor has determined one at its discretion;
- E. Contact information if there are questions related to the Prepayment Review; and
- F. Information on how the provider may request removal of a Prepayment Review.

The Contractor shall ensure the documentation is readily available in the investigative progression from referral (external or internal) to closure and ensure the investigation meets Departmental requirements as well as the requirements of case tracking, case management and reporting.

The Provider shall be given forty-five (45) Days to submit documents in support of Claims under Prepayment Review. The Contractor shall deny Claims for which the requested documentation was not received by day forty-six (46). The Contractor shall deny a Claim when the submitted documentation lacks evidence to support the service or code. The Contractor shall follow Contract Provision 27.10 for any Appeals related to the prepayment process. The Contractor may extend the length of a Prepayment Review when it is determined necessary to prevent improper payments. If the provider has sustained a ninety percent (90%) error free Claims submission rate to the Contractor for forty-five (45) Days the Contractor must request express permission to continue Prepayment Review from the Director of Program Integrity (or designee) and the Director of Program Quality and Outcomes (or designee).

36.3 Report of Suspected Fraud, Waste or Abuse

If the Contractor fails to properly report a case of suspected provider Fraud, Waste or Abuse to the Department before the suspected Fraud, Waste or Abuse is identified by the Commonwealth, its designees, the United States or private parties acting on behalf of the United States, any portion of the funds related to Fraud or Abuse recovered by the Commonwealth or designees shall be retained by the Commonwealth or its designees.

36.4 Audit by Department or its Designee

If the Department performs or contracts with an entity that performs audits of Claims paid by the Contractor and identifies an Overpayment, then the Department shall send notice to the Contractor and collect and retain any Overpayment. The Contractor shall remit the amount or balance of the provider Overpayment within ninety (90) Days of notification by the Department unless otherwise notified in writing by the Department or contracted entity. The Contractor may request an extension of the remittance with justification to the Department's Program Integrity Director prior to the deadline. Failure to remit an amount within the timeframe will result in a five hundred dollar (\$500.00) penalty per incident.

36.5 Contractor Dispute of Audit by Department or its Designee

The Contractor shall have thirty (30) Days to dispute an Overpayment identified by the Department, in writing to the Department's Program Integrity Director, or the Department's designee, within thirty (30) calendar days of receiving notice of the identified Overpayment. Failure of the Contractor to meet contractual, state or federal requirements will not be an acceptable basis for Overpayment disputes. The Department will have the sole discretion to uphold or overturn, or amend, an identified Overpayment disputed by the Contractor. The Contractor shall be notified of the decision of the Department in writing within ninety (90) Days of receipt.

37.0 CONTRACTOR REPORTING REQUIREMENTS

37.1 General Reporting and Data Requirements

The Contractor shall comply with all reporting requirements of the Contract and in compliance with 42 C.F.R. 438.604.

Appendix D "Reporting Requirements and Reporting Deliverables" sets forth minimum and preliminary reporting requirements to which the Contractor must agree. However, the Department recognizes that MCOs have comprehensive and sophisticated data analytics capabilities and reporting systems. After Contract Execution and prior to Readiness Reviews, the Contractor agrees to participate in a collaborative process with the Department and other MCOs to establish a reporting package for which reports address the following at a minimum:

- Detailed reporting specifications and consistent data definitions for all required reports.
- Reports that provide statistical information in a format for which trends can be identified.
- Detailed analysis by the Contractor, where applicable, for identified trends and patterns of change, outliers, successes, risks, and mitigation strategies. Such analysis will include narrative summary of findings and the Contractor's interpretations of the data.

This process will result in identification of a detailed and comparable reporting package and timeframes for submission that the Contractor and other MCOs will use without modification. While the Department is not requiring use of standardized reporting templates, and the Contractor may use their own, reported data must be comparable across MCOs for comparison purposes and to

be able to understand outcomes and progress for Kentucky's Medicaid managed care program.

The Contractor shall recommend other reporting that it generates for internal use that would also be useful for the Department to review. For example, the MCOs may have pre-existing dashboards containing critical information assembled from the many MCO operational areas. The Department may use the dashboards to follow program trends, set program goals, identify Quality Improvement strategies, and monitor delivery system changes to improve health outcomes.

The Department reserves the right to modify the above described process should the Department and MCOs not come to agreement on standardized data definitions, reporting specifications, and submission timeframes. In the event this occurs, the Department will set forth prescriptive requirements for all MCOs to follow.

The Contractor shall support the Department in providing required and ad hoc reporting to CMS or other state or federal agencies.

The Department may require the Contractor to prepare and submit ad hoc reports. The Department will make every effort to give the Contractor reasonable notice that is no less than five (5) Business Days prior to the required submission date based on the nature of the requested report. Timeframes for notice may vary for requests for information from entities such as legislative bodies, CMS, or other federal agencies. .

37.2 Reporting Requirements and Standards

The Department has final approval for all reporting requirements, specifications, data definitions, and submission timeframes. The Contractor shall comply with the reporting requirements set forth in this Contract, including providing such additional data and reports as may be reasonably requested by the Department. The Contractor shall verify and ensure the accuracy, completeness and timely submission of each report, data and other information provided to the Department. All required information shall be fully disclosed in a manner that is responsive and without material omission.

The Contractor shall respond to any Department request for information or documents within the timeframe specified by the Department in its request. Such request may also apply to information from Subcontractors. If the Contractor or Subcontractor is unable to respond within the specified timeframe, the Contractor shall immediately notify the Department in writing and shall include an explanation for the inability to meet the timeframe and a request for approval of an extension of time. The Department may approve, within its sole discretion, any such extension of time upon a showing of good cause by the Contractor. To avoid delayed responses by Contractor caused by a high volume of information or document requests by the Department, the Parties shall devise and agree upon a functional method of prioritizing requests so that urgent requests are given appropriate priority.

The Department reserves the right to modify the form, nature, content, instructions and timetables for the collection and reporting of data throughout the Contract Term, including modification to **Appendix D "Reporting Requirements and Reporting Deliverables"** and the required reporting package. Any requested modification will take cost into consideration.

37.3 Reporting Requirements for Specific Operational Areas

In addition to the reporting package to be developed collaboratively and **Appendix D "Reporting Requirements and Reporting Deliverables"** below are additional reporting requirements for specific operational areas. The Department may amend these requirements over the course of the Contract Term and as needed, based on collaboration with the MCOs.

37.3.1 Paid Claims Report

The Contractor shall provide a paid Claims report, in a manner and format as required by the Department, to each of Contractor's Network hospitals as outlined in **Appendix O "Paid Claims Listing Requirements."** See **Appendix B "Remedies for Violation, Breach, or Non-Performance of Contract"** for information about penalties for failure to provide the paid Claims listing.

37.3.2 COB Reporting Requirements

The Contractor shall submit a monthly Coordination of Benefits Report for all Enrollee activity to comply with CMS reporting requirements. Additionally, the Contractor shall submit a report that includes subrogation collections from auto, homeowners, or malpractice insurance, etc.

37.3.3 Enrollment Reconciliation

The Contractor shall reconcile each Enrollee payment identified in a HIPAA 820 transaction with information contained in the HIPAA 834 transaction. The Contractor shall submit all requested corrections to the Department within forty-five (45) Days of receipt of HIPAA 820 transaction. Adjustments shall be made to the next HIPAA 820 transaction and/or next available HIPAA 834 transactions to reflect corrections.

37.3.4 Telehealth Reporting

The Contractor shall supply information and data on telehealth services to support the Department in providing an annual report to the Legislature as required under KAR 205.559. Information and data provided by the Contractor shall be sufficient to enable the Department to analyze and report on the following:

- A. The economic impact of telehealth services on the Medicaid budget, including any costs or savings as a result of decreased transportation expenditures and office or emergency room visits;
- B. The quality of care as a result of Telehealth Consultations; and
- C. Any other issues deemed relevant by the CHFS.

In addition to the analysis required under KAR 205.557, the Contractor shall report sufficient telehealth cost information to enable the Department to report to compare telehealth reimbursement and delivery among all managed care partnerships or other entities under contract with the Cabinet for the administration or provision of the Medicaid program.

37.3.5 Grievance and Appeal Reporting Requirements

The Contractor shall submit reports of Enrollee Grievances and Appeals and their disposition as described in **Appendix D "Reporting Requirements and Reporting Deliverables."**

The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.

37.4 EPSDT Reports

The Contractor shall submit Encounter Files to the Department's Fiscal Agent for each Enrollee who receives EPSDT Services. This Encounter File shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes.

37.5 Financial Reports

Financial reports demonstrate the Contractor's ability to meet its commitments under the terms of this Contract. The Contractor and its Subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the Contractor and its Subcontractors and the Contractor and the Department. These transactions shall include, but not be limited to, Claims payment, refunds and adjustment of payments.

The Contractor shall file, in the form and content prescribed by the National Association of Insurance Commissioners (NAIC), within one hundred and twenty days (120) Days following the end of each fiscal year an annual audited financial statement that has been prepared by an independent Certified Public Accountant on an accrual basis, in accordance with generally accepted or statutory accounting principles as established by the American Institute of Certified Public Accountants.

The Contractor shall also file, within seventy-five (75) Days following the end of each fiscal year, certified copies of the annual statement and reports as prescribed and adopted by the DOI. The Department may request information in the form of a consolidated financial statement.

The Contractor shall file within sixty (60) Days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the NAIC.

The Contractor shall file with FAC and the Department, within seven (7) Days after issuance, a true, correct and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the DOI.

The Department has the right to insist on an audit of paid claim costs, other costs including administrative costs, revenue, and membership reported in MRTs, at the expense of the Contractor. The Contractor will have sixty (60) Days to supply the audit report to the Department.

37.6 Ownership and Financial Disclosure

The Contractor agrees to comply with the provisions of 42 C.F.R. 455.104. The Contractor shall provide true and complete disclosures of the following information to FAC, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) Days following the date of each written request for such information:

- A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;
- B. The name of any other entity receiving reimbursement through the Medicare or Medicaid

- programs in which a person listed in response to subsection (a) has an ownership or control interest;
- C. The same information requested in subsections (A) and (B) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than twenty five thousand dollars (\$25,000) during the immediately preceding twelve (12)-month period;
 - D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five (5)-year period;
 - E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;
 - F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies and
 - G. The Contractor shall notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the Contract that may be impacted by the change in ownership including management and staff.

The Department shall review the ownership and financial disclosures submitted by the Contractor and any Subcontractor.

37.7 Record System Requirements

The Contractor shall maintain or cause to be maintained detailed records relating to the operation including but not limited to the following:

- A. Administrative costs and expenses incurred pursuant to this Contract;
- B. Enrollee enrollment status;
- C. Provision of Covered Services;
- D. All relevant medical information relating to individual Enrollees for the purpose of audit, evaluation or investigation by the Department, the Office of Inspector General, the Attorney General and other authorized federal or state personnel;
- E. Quality Improvement and utilization;
- F. All financial records, including all financial reports required under **Section 37.4 "Financial Reports"** of this Contract and A/R activity, rebate data, DSH requests and etc.;
- G. Performance reports to indicate Contractor's compliance with Contract requirements;
- H. Fraud and Abuse;
- I. Enrollee/Provider satisfaction; and
- J. Managerial reports.

All records shall be maintained and available for review by authorized federal and state personnel during the entire term of this Contract and for a period of ten (10) years after termination of this Contract, except that when an audit has been conducted, or audit findings are unresolved. In such case records shall be kept for a period of ten (10) years in accordance with 42 C.F.R. 438.2 and 907 KAR 1:672, or as amended or until all issues are finally resolved, whichever is later.

38.0 RECORDS MAINTENANCE AND AUDIT RIGHTS

38.1 Medical Records

Enrollee Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The Medical Record shall be signed by the provider of service.

The Contractor shall have Medical Record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Enrollee information from unauthorized disclosure as set forth in **Section 38.2 "Confidentiality of Records"** and **Appendix Q "CHFS Security Requirements."**

The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.

The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Enrollees by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when an Enrollee changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Enrollees sign a release of Medical Records before a Medical Record transfer occurs.

The Contractor shall have a process to systematically review provider Medical Records to ensure compliance with the Medical Records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established Medical Records standards and goals.

The Contractor shall develop methodologies for assessing performance/compliance to Medical Record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:

- A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;
- B. Allow for the tracking and trending of individual and plan wide provider performance over time;
- C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and
- D. Include mechanism for detecting instances of over-utilization, under-utilization, and mis-utilization.

38.2 Confidentiality of Records

The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 C.F.R. Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in **Section 40.15 "Health Insurance Portability and Accountability Act."**

The Contractor shall have written policies and procedures for maintaining the confidentiality of Enrollee information consistent with applicable laws. Policies and procedures shall include but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Enrollee for any needed follow-up and limitations on telephone or mail contact to the home.

The Contractor on behalf of its employees, agents and assignees, shall sign a confidentiality agreement.

Except as otherwise required by law, regulations, or this Contract, access to such information shall be limited by the Contractor and the Department, to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including but not limited to the U.S. Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of Attorney General, and such others as may be required by the Department.

Any data, information, records or reports which may be disclosed to the Department by the Contractor pursuant to the express terms of this Contract shall not be disclosed or divulged by the Department in whole or in part to any other third person, other than expressly provided for in this Contract, or the Kentucky Open Records Act, KRS 61.870-61.882. The Department and the Contractor agree that this confidentiality provision will survive the termination of this Contract.

Proprietary information, which consists of data, information or records relating to the Contractor, its Affiliates' or subsidiaries' business operations and structure, sales methods, practices and techniques, advertising, methods and practices, provider relationships unless otherwise expressly provided for in this Contract, non-Medicaid Enrollee or Enrollee lists, trade secrets, and the Contractor's, its Affiliates' or subsidiaries' relationships with its suppliers, providers, potential Enrollees or Enrollees and potential providers, is supplied under the terms of this Contract based on the Department's representation that the information is not subject to disclosure, except as otherwise provided by the Kentucky Open Records Act, KRS 61.870-61.882 or 200 KAR 5:314. The Contractor understands that it must designate information it has which it considers proprietary so that the Department or FAC may claim the proprietary information exemption to KRS 61.878(1)(c) if a request for such information is made. The Contractor also understands that it shall be responsible for defending its Claim that such designated information is proprietary before any applicable adjudicator.

Any requests for disclosure of information received by the Contractor pursuant to this section of the Contract shall be submitted to and received by the Department's Contract Compliance Officer within twenty-four (24) hours as specified in **Section 40.16 "Notices"** of this Contract, and no information for which an exemption from disclosure exists shall be disclosed pursuant to such a request without prior written authorization from the Department. The Department shall notify Contractor if its records are being requested under the Open Records Law.

However, non-individual identified data and information required to be reported to the Department either by this Contract or by CMS or by applicable laws or regulations, shall not be considered confidential.

38.3 Privacy, Confidentiality, and Ownership of Information

The Department is the designated owner of all data and shall approve all access to that data. The Contractor shall not have ownership of Commonwealth data at any time. The Contractor shall be

in compliance with privacy policies established by governmental agencies or by state or federal law. Privacy policy statements may be developed and amended from time to time by the Commonwealth and will be appropriately displayed on the Commonwealth portal (Ky.gov). The Contractor shall provide sufficient security to protect the Commonwealth and CHFS data in network transit, storage, and cache.

38.4 Identity Theft Prevention and Reporting Requirements

In the delivery and/or provision of Information Technology hardware, software, systems, and/or services through a contract/s established as a result of this solicitation, the Contractor shall prevent unauthorized access to "Identity Information" of Commonwealth citizens, clients, constituents and employees. "Identity Information" includes, but is not limited to, an individual's first name or initial and last name in combination with any of the following information:

- A. Social Security Number;
- B. Driver's License Number;
- C. System Access ID's and associated passwords; and
- D. Account Information such as account number(s), credit/debit/ProCard number(s), and/or passwords and/or security codes.

The Contractor shall also immediately notify the Department, FAC, the Office of Procurement Services, and the Commonwealth Office of Technology upon learning of any unauthorized breach/access, theft, or release of Commonwealth data containing "Identity Information."

For even a single knowing violation of these Identity Theft Prevention and Reporting Requirements, the Contractor agrees that the Commonwealth may terminate for default the Contract(s) and may withhold payment(s) owed to the Contractor in an amount sufficient to pay the cost of notifying Commonwealth customers of unauthorized access or security breaches.

38.5 Compliance

The Contractor shall agree to use and disclose Protected Health Information in compliance with the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996. The Contractor shall ensure that all Contractor actions are compliant with HIPAA rules for access, authentications, storage and auditing, and transmittal of electronic personal health information (e-PHI). Where applicable, The Contractor shall establish and maintain HIPAA compliant controls and procedures that protect, define, and limit circumstances for access, use, and disclosure of personal health information. An analysis shall be performed by the Contractor during the System Design phase to ensure implementation of appropriate controls for the relevant HIPAA requirements. The Contractor shall not be permitted to use or disclose health information for any reason other than what is mandated within this Contract. All CHFS Projects must adhere to the Commonwealth Office of Technology (COT) security and enterprise policies and procedures and the Cabinet for Health and Family Services (CHFS) security policies and procedures. Below is a listing of additional applicable policies, procedures, and laws for which the proposing Contractors must be prepared to comply:

- A. Computer Fraud and Abuse Act [PL 99-474, 18 USC 1030]
- B. Privacy Act of 1974 as amended [5 USC 552a]
- C. Protection of Sensitive Agency Information [OMB M-06-16]
- D. NIST 800-53 [Moderate]
- E. IRS Publication 1075
- F. Center for Medicare and Medicaid Services requirements
- G. Health Insurance Portability and Accountability (HIPAA)

H. Federal Information Processing Standards (FIPS) Publications

38.6 Application Vulnerability Assessment

Contractor shall perform a non-intrusive vulnerability assessment on web applications and web services; scan the web applications and web services without credentials to identify vulnerabilities related to the OWASP top ten (10) vulnerabilities and SANS top twenty-five (25) programming errors; scan the web applications and web services with credentials to identify vulnerabilities related to the OWASP top ten (10) vulnerabilities and SANS top twenty-five (25) programming errors.

The initial web applications and web services assessment should be a gray box approach with the chosen Contractor only having knowledge of the IP information, but having no other knowledge with the web application. The chosen Contractor should perform a non-intrusive vulnerability assessment to discover if access can be discovered, programming flaws, data leakage, and information that could allow an intruder to attack the web applications.

The second part of the web applications and web services assessment included a provide role(s) with access to the application(s). The vulnerability assessment of the chosen Contractor will be a non-intrusive security test. A walk through of the application will be very limited and will be at a high level to allow the chosen Contractor to review the application at first glance as a discovery. The high level walk through will include all IPs and URLs only. The application(s) vulnerability assessment should address at the very minimum:

- A. Injection;
- B. Broken Authentication and Session Management;
- C. Cross-Site Scripting (XSS);
- D. Insecure Direct Object References;
- E. Security Misconfiguration;
- F. Sensitive Data Exposure;
- G. Missing Function Level Access;
- H. Cross-Site Request Forgery (CSRF);
- I. Using Known Vulnerable Components; and
- J. Invalidated Redirects and Forwards.

The Cabinet shall have a copy of the application vulnerability assessment within fourteen (14) Business Days of its execution. The Contractor will provide a mediation plan which meets risk assignment and in agreement with the Commonwealth.

39.0 REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

39.1 Contract Violations, Breach, or Non-Performance

The Contractor shall comply with all terms, conditions, requirements, performance standards, and applicable Commonwealth and Federal laws as set forth in this Contract or any amendments thereto including any rules, policies, or procedures incorporated pursuant to this Contract.

The Department reserves the right to impose any and all remedies available under the terms of the Contract, at law or equity in the event that the Department determines, in its sole discretion, that the Contractor or a Subcontractor has violated any provision of the Contract, or if the Contractor or a Subcontractor does not comply with any other applicable Kentucky or federal law or regulation, compliance with which is mandated expressly or implicitly by this Contract.

39.2 Risk Categories

The Department may conduct performance reviews at its discretion at any time that relate to any Contractor responsibility for timely and responsive performance of Contract requirements. Based on such performance reviews or as determined through other means, upon the discovery of a Contractor's or Subcontractor's violation, breach, or non-performance of the terms, conditions, or requirements of this Contract, the Department shall assign the violation, breach, or non-performance into one of the following categories of risk:

- A. **Category 1:** Action(s) or inaction(s) that seriously jeopardize the health, safety, and welfare of Enrollee(s); reduces Enrollees' access to care; and/or jeopardize the integrity or viability of Kentucky's Medicaid Managed Care program;
- B. **Category 2:** Action(s) or inaction(s) that jeopardize the viability or integrity of Kentucky's Medicaid Managed Care program, but do(es) not necessarily jeopardize Enrollee(s)' health, safety, and welfare or reduce access to care; or
- C. **Category 3:** Action(s) or inaction(s) that diminish the efficient operation and effective oversight and administration of the Kentucky Medicaid Managed Care program.

39.3 Requirement of Corrective Action

A. Department Decisions to Impose Remedies

The Department will consider some or all of the following factors in determining need to impose remedial action(s), intermediate sanction(s), penalty(ies), and/or liquidated damages against the Contractor:

1. Risk category assignment based on the nature, severity, and duration of the violation, breach, or non-performance;
2. The type of harm suffered (e.g., impact to quality of care, access to care, Program Integrity);
3. Whether the violation (or one that is substantially similar) has previously occurred;
4. The timeliness in which the Contractor self-reports a violation;
5. The Contractor's history of compliance;
6. The good faith exercised by the Contractor in attempting to stay in compliance (including self-reporting by the Contractor); and
7. Any other factor the Department deems relevant based on the nature of the violation, breach, or non-performance.

The Department may impose additional remedial actions, intermediate sanctions, penalties or liquidated damages and/or elevate the violation to a higher Category of Risk if the non-compliance continues, or if the Contractor fails to comply with the originally imposed action.

B. Letter of Concern

Should the Department determine that the Contractor or any Subcontractor is in violation or is at risk of violation of any requirement of this Contract, the Department shall issue a "Letter of Concern." The Contractor shall contact the Department's representative designated by the

Department within two (2) Business Days of receipt of the Letter of Concern and shall indicate how such concern is unfounded or how it will be addressed. If the Contractor fails to timely contact the designated representative regarding a Letter of Concern, the Department shall proceed to the additional enforcement contained in this Contract.

C. Corrective Action Plan

Should FAC or the Department determine that the Contractor or any Subcontractor is not in substantial compliance with any material provision of this Contract, FAC or the Department shall issue a Written Deficiency Notice to the Contractor specifying the deficiency and requesting a corrective action plan be filed by the Contractor within ten (10) Business Days following the date of the notice. The Department reserves the right to require a more accelerated timeframe if the deficiency warrants a more immediate response.

A corrective action plan shall delineate the following information at a minimum:

1. The names of the individuals who are responsible for implementing the corrective action plan.
2. A description of the deficiency(ies) and the cause of the deficiency(ies) that resulted in need for corrective action.
3. A detailed approach for addressing the existing deficiency(ies) and prevention of the repeated and/or similar deficiency(ies) in the future.
4. The timeline for implementation, establishment of major milestones and correspondence dates to the Department, and notification of completion of corrective actions.

The corrective action plan shall be subject to approval by FAC or the Department, which may accept the plan as submitted, may accept the plan with specified modifications, or may reject the plan within ten (10) Business Days of receipt. FAC or the Department may reduce the time allowed for corrective action depending upon the nature of the deficiency. ‘

39.4 Penalties for Failure to Correct

Except for failure to substantially provide Medically Necessary items and services that are required under law and under this Contract following failure on the part of the Contractor to cure a default in accordance with a plan of correction under **Section 39.3 “Requirement of Corrective Action,”** or as otherwise required by the Department, Contractor will be subject to penalties as set forth in this Contract.

A penalty for Failure to substantially provide Medically Necessary items and services that are required under law and under this Contract may be assessed simultaneously with a request for corrective action plan.

If the Department elects not to exercise any of the penalty clauses as set forth in this Contract and in a particular instance, this decision shall not be construed as a waiver of the Department’s right to pursue the future assessment of that performance standard requirement and associated penalties.

A. Civil Money Penalties

FAC or the Department may impose civil money penalties in the circumstances and the amounts set forth below and as required in 42 C.F.R. 438.700.

| Circumstance | Penalty Amounts |
|---|--|
| Failure to substantially provide Medically Necessary items and services that are required under law and under this Contract. | Up to \$25,000.00 for each determination. |
| Imposes excess premiums and charges on Enrollees. | Up to \$25,000.00 or double the excess amount charged, whichever is greater. The Department shall deduct the amount of the overcharge from the penalty and return it to the affected Enrollee. |
| Acts to discriminate among Enrollees on the basis of their health status or need for health care services, including termination of enrollment or refusal to re-enroll an Enrollee, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment of an Enrollee whose medical condition or history indicates probable need for substantial future medical services. | Up to \$15,000.00 per Enrollee with an amount not to exceed \$100,000 per determination. |
| Misrepresents or falsifies information provided to CMS or to the Commonwealth. | Up to \$100,000 per determination. |
| Misrepresents or falsifies information furnished to an Enrollee, potential Enrollee, or a health care provider. | Up to \$25,000.00 per determination. |
| Failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§422.208 and 422.210, and as set forth in Section 11.5 “Physician Incentive Plans.” | Up to \$25,000.00 per determination. |
| Distributed directly, or indirectly, through any Agent or independent contractor, Marketing materials that have not been approved by the Department or that contain false or materially misleading information. | Up to \$25,000.00 per determination. |

B. Other Penalties

The Department also reserves the right to assess other penalties, as applicable, for violations that occur but that are not specifically listed in this Section. See **Appendix B “Remedies for Violation, Breach, or Non-Performance of Contract.”** for penalties.

Should the Contractor have repeated contractual violations for a similar deficiency, the Department may impose additional penalties as follows:

1. First (1st) Offense: \$5,000 per determination.
2. Second (2nd) Offense: \$10,000 per determination.
3. Third (3rd) through sixth (6th) Offense: \$20,000 per determination.
4. Seventh (7th) Offense and each subsequent offense: \$40,000 per determination.

Penalties for Failure to Submit Reports and Encounters

Violations specific to **Appendix D “Reporting Requirements and Reporting Deliverables”** shall not require a Letter of Concern or a Corrective Action Plan before fines are imposed as set forth in **Appendix B “Remedies for Violation, Breach, or Non-Performance of Contract.”**

The Department will work with the Contractor to resolve problems in obtaining data at all times. The Contractor acknowledges its responsibility to provide data on Enrollees upon request.

Kentucky HEALTH Performance Penalties

In addition to any other penalties provided for in this Contract, Contractor shall be penalized as set forth in **Appendix B “Remedies for Violation, Breach, or Non-Performance of Contract.”** for failures to perform its obligations under **Section 41.0 “Kentucky HEALTH Policies and Performance Requirements,”** of the Contract. See **Appendix B “Remedies for Violation, Breach, or Non-Performance of Contract.”** for penalties.

The parties understand that, DMS may grant a grace period for certain Kentucky HEALTH requirements prior to penalties being imposed.

1. Premium Collection Performance Penalties

The State, or its designee, shall have the right to audit the performance of the Contractor in collecting premiums as required by **Section 41.18.1 “Premium Collection”** and the payment files sent by the Contractor to IEES for accuracy and completeness on all required data elements, including, but not limited to: (i) coverage month; (ii) payment date; and (iii) payment status.

2. Medically Frail Identification Performance Penalties

The Contractor shall be subject to an audit of Kentucky HEALTH Medically Frail determinations made pursuant to **Section 41.12.3 “Contractor Medically Frail Determination.”** The Department may use a contracted entity to conduct the audit.

Prior to imposing sanctions, the Contractor, at its sole expense, shall have the right to dispute the audit findings. The Contractor may present to the Department documentation used to determine whether the Member met the Medically Frail criteria. Sanctions shall not be imposed if the Department determines, based upon this documentation, that a Member met the Medically Frail criteria at the time of the determination.

3. My Rewards Account Performance Penalties

The Contractor shall be responsible for transmitting data for the My Rewards Account in accordance with Kentucky HEALTH Business Requirements and **Section 41.15 “My Rewards Account,”** for activities completed by Kentucky HEALTH Members.

C. Sanction

If a Contractor, in the sole determination of the Cabinet, fails to complete a Corrective Action Plan or engages in a pattern of behavior requiring multiple Corrective Action Plans for similar deficiencies, the Department may issue a Sanction for one of the two types of deficiencies:

Type A deficiencies shall be a written deficiency in the requirements in the following

Contract sections: 22 through 36, inclusive.

Type B deficiencies shall be a written deficiency in the requirements in the following Contract sections: 3-15, 17-21, 37 and 40-42.

The Department shall withhold one quarter of one (0.25%) percent of the monthly Capitation Payment for Type B deficiencies until the corrective action has been completed to the Department's satisfaction. The Department shall impose a nonrefundable penalty of \$10,000 for each Type B infraction.

The Department shall withhold one-half of one (0.5%) percent of the monthly Capitation Payment for Type A deficiencies until the corrective action has been completed to the Department's satisfaction. The Department shall impose a nonrefundable penalty of \$50,000 for each Type A infraction.

If the deficiency is not remedied within three (3) months from acceptance of the corrective action plan, one-half of the funds withheld shall be forfeited in addition to the nonrefundable penalty referenced above. If the deficiency is not remedied within six (6) months from acceptance of the corrective action plan, all of the funds withheld shall be forfeited in addition to the nonrefundable penalty referenced above.

39.5 Notice of Contractor Breach

A Contractor shall be considered in breach if the Contractor is not in substantial compliance with any material provision of this Contract that cannot be cured, if the Contractor fails to cure a default in accordance with a plan of correction under **Section 39.3 "Requirement of Corrective Action" after issuance of a Sanction**, or comply with Sections 1932, 1903(m), and 1905(t) of the Social Security Act, or 42 C.F.R. 438. Upon determination of Contractor breach, FAC shall issue a timely written notice to the Contractor, explaining any Appeal rights provided to the Contractor, indicating the nature of the default, and advising the Contractor that failure to cure the default within a defined time period to the satisfaction of the Department, may lead to the imposition of any sanction or combination of sanctions provided by the terms of this Contract, or otherwise provided by law, including but not limited to all of the following:

- A. Suspension of receipt of further Enrollment for a defined time period after the date the Secretary or the Commonwealth notifies the Contractor of a determination of a violation of any requirement under Sections 1903(m) or 1932 of the Social Security Act;
- B. Suspension of Capitation Payments for Enrollees after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;
- C. Suspension or recoupment of the Capitation Rate paid for any month for any Enrollee who was denied the full extent of Covered Services meeting the standards set by this Contract, or who received or is receiving substandard services;
- D. A claim against Contractor's Performance Bond;
- E. Appoint temporary management;
- F. Grant Enrollees the right to disenroll without cause and notifying the affected Enrollees of their right to disenroll; and
- G. Termination of the contract.

The Department shall impose mandatory temporary management when a Contractor repeatedly fails to meet substantive requirements established in Sections 1903(m) or 1932 of the Social Security Act or 42 C.F.R. 438. The Department shall not delay the imposition of temporary management to provide a hearing and shall not terminate temporary management until it determines that the Contractor can ensure the sanctioned behavior will not reoccur. If the Department imposes temporary management, the Department shall notify affected Enrollees of

their right to terminate enrollment without cause, pursuant to 42 C.F.R. 438.706(b).

39.6 Violation of State or Federal Law

A finding by any authorized agency that the Contractor has violated any State or Federal Law as it relates to any obligations or requirements under this Contract shall subject the Contractor to immediate withholding, penalty and forfeiture as a Type A violation without the necessity for a Letter of Concern or a Corrective Action Plan.

39.7 Annual Contract Monitoring

FAC or the Department retains the right to withhold payment if the Contractor does not comply with programmatic and fiscal reporting and monitoring requirements following failure on the part of the Contractor to cure a default in accordance with a plan of correction under **Section 39.3 "Requirement of Corrective Action."**

39.8 Performance Bond

The Contractor shall maintain a \$30,000,000 performance bond payable to the Kentucky Department for Medicaid Services throughout the life of the contract. Contractor shall provide a copy of such bond to the Department annually.

FAC or the Department shall have the right to enforce the Contractor's Performance Bond pursuant to the terms thereof for any material breach of this Contract after prior written notice to Contractor and an opportunity to cure such material breach within thirty (30) Days of the date of the notice, and subject to Contractor's Appeal rights pursuant to **Section 40.12 "Disputes."**

39.9 Additional Sanctions Required by CMS

Payments provided for under this Contract will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. 438.730(e).

39.10 Appeal of Penalties

Prior to exercising the dispute provision of Section 40.12 "Disputes", the Contractor may request reconsideration of a penalty imposed in accordance with this Section 39.0 "Remedies for Violation, Breach, or Non-Performance" of the Contract and Appendix B "Remedies for Violation, Breach, or Non-Performance of Contract" that equals or exceeds fifty thousand dollars (\$50,000) by sending a letter to the Commissioner of the Department for Medicaid Services, or his/her designee, within thirty (30) Days of receipt of notification of the penalty.

39.11 Termination for Default

In addition to nonperformance of the particular terms and conditions of this Contract by the Contractor, each of the following shall constitute breach of the Contract by Contractor for which actual and consequential money damages and any of the other remedies set forth in the Contract are available to FAC, as well as a remedy of immediate termination of this Contract if the problem is not cured in the time frame specified by the Department:

- A. The conduct of the Contractor, any Subcontractor or supplier, or the standard of services provided by or on behalf of the Contractor, fails to meet the Department's minimum standards of care or threatens to place the health or safety of any group of Enrollees in jeopardy;
- B. The Contractor is either expelled or suspended from the federal health insurance programs under Title XVIII or Title XIX of the Social Security Act;
- C. Contractor's license to operate as an HMO is suspended or terminated by the DOI, or any

- adverse action is taken by the DOI which is deemed by the Department to affect the ability of the Contractor to provide health care services as set forth in this Contract to Enrollees;
- D. The Contractor fails to maintain protection against fiscal Insolvency as required under state or federal law, or as required by the terms of this Contract, or the Contractor fails to meet its financial obligations as they become due other than with respect to contested or challenged Claims filed by Enrollees or Providers;
 - E. The Contractor fails to or knowingly permits any Subcontractor, supplier, or any other person or entity who receives compensation pursuant to performance of this Contract, to fail to comply with the nondiscrimination and affirmative action requirements of **Section 5.3 "Nondiscrimination and Affirmative Action"** of this Contract;
 - F. The Contractor provides or knowingly permits any Subcontractor to provide fraudulent, or intentionally misleading or misrepresentative information to any Enrollee, or to any agent of the Commonwealth or the United States in connection with;
 - G. Gratuities other than de minimus or otherwise legal gratuities are offered to, or received by, any public official, employee or agent of the Commonwealth from the Contractor, its agent's employees, Subcontractors or suppliers, in violation of Offer of Gratuities and Affirmative Action of this Contract;
 - H. The Contractor violates any of the confidentiality provisions of this Contract; or
 - I. The Contractor fails to provide Covered Services to its Enrollees.

As part of FAC's option to terminate, if the Contractor is in uncured material breach of the Contract or is insolvent, the Department has the option to assume the rights and obligations of the Contractor and directly operate the Contractor's Network, using the existing Contractor's administrative organization, to ensure delivery of care to Enrollees through the Contractor's Network until cured by the Contractor of the breach or by demonstrated financial solvency, or until the successful transition of those Enrollees to other MCOs at the expense of the Contractor.

The certification by the Commissioner of the Department of the occurrence of any of the events stated above shall be conclusive. The Contractor, however, shall retain all rights to dispute resolution specified in **Disputes** of this Contract.

Before terminating the Contract under 42 C.F.R. 438.708, FAC must provide the Contractor with a pre-termination hearing. The State shall give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of hearing. FAC shall give the Contractor, after the hearing, written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of termination. For an affirming decision, the Department shall give Enrollees notice of the termination and information, consistent with 42 C.F.R. 438.10 on their options for receiving Medicaid services following the effective date of termination

39.12 Obligations upon Termination

Upon termination of this Contract before the end of its term regardless of cause except for the convenience of the Commonwealth, the Contractor shall be solely responsible for the provision and payment for all Covered Services for all Enrollees for the remainder of any month for which the Department has paid the monthly Capitation Rate. Contractor may be requested to continue in place for two additional months. Upon final notice of termination, on the date, and to the extent specified in the notice of termination, the Contractor shall:

- A. Provide a written Transition Plan for the Department's approval. In the event of Contract termination, the Transition Plan shall be due within ten (10) Days of receiving Notice of Termination from the Commonwealth. The Contractor will revise and resubmit the Transition Plan to the Department on a regular basis, the frequency of which will be determined by the Department;
- B. Appoint a liaison for post-transition concerns;

- C. Provide for sufficient staff in all operational areas across all Enrollee populations to ensure a smooth transition;
- D. Continue providing Covered Services to all Enrollees until midnight on the last day of the calendar month for which a Capitation Payment has been made by the Department;
- E. Continue providing all Covered Services to all infants of female Enrollees who have not been discharged from the hospital following birth, until each infant is discharged, or for the period specified in (a) above, whichever period is shorter;
- F. Continue providing inpatient hospital services to any Enrollees who are hospitalized on the termination date, until each Enrollee is discharged, or for the period specified in (a) above, whichever period is shorter;
- G. Arrange for the transfer of Enrollees and Medical Records to other appropriate Providers;
- H. Be responsible for resolving Enrollee grievances and Appeals with respect to Claims with dates of service prior to the date of contract termination or expiration, including those grievances and Appeals filed on or after the day of termination or expiration for those dates of service;
- I. Be financially responsible for Enrollee Appeals of adverse decisions rendered by the Contractor concerning treatment of services requested prior to termination or expiration of the Contract which are subsequently upheld on behalf of the Enrollee after an Appeal proceeding or after a State Fair Hearing;
- J. Be responsible for submitting Encounter data for all Claims incurred for dates of service prior to contract termination;
- K. Be responsible for submitting all reports necessary to facilitate the collection of pharmacy rebates and assisting in the resolution of all drug rebate disputes with the manufacturer for all Claims incurred prior to the contract termination date;
- L. Be responsible for submitting all performance data with a due date following the termination or expiration of the Contract, but covering a reporting period prior to termination or expiration of the Contract;
- M. Promptly supply to the Department such information as it may request respecting any unpaid Claims submitted by Out-of- Network Providers and arrange for the payment of such Claims within the time periods provided herein;
- N. Provide the Department with all information requested in the format and within the timeframe set forth by the Department, which shall be no later than thirty (30) Days of the request;
- O. Take such action as may be necessary, or as the Department may direct, for the protection of property related to this Contract, which is in the possession of the Contractor and in which the Department has or may acquire an interest; and
- P. Provide for the maintenance of all records for audit and inspection by the Department, CMS and other authorized government officials, in accordance with terms and conditions specified in this Contract including the transfer of all such data and records, or copies thereof, to the Department or its agents as may be requested by the Department; and the preparation and delivery of any reports, forms or other documents to the Department as may be required pursuant to this Contract or any applicable policies and procedures of the Department.

The covenants set forth in this Section shall survive the termination of this Contract and shall remain fully enforceable by FAC against the Contractor. In the event that the Contractor fails to fulfill each covenant set forth in this Section, the Department shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such covenants, all at the sole cost and expense of the Contractor and the Contractor shall refund to the Department all sums expended by the Department in so doing.

After FAC notifies the Contractor that it intends to terminate the Contract, the Department may provide the Enrollees written notice of FAC's intent to terminate the Contract and allow the Enrollees to disenroll immediately without cause.

39.13 Liquidated Damages

If the Contractor breaches the Contract and the actual and consequential damages caused by that breach cannot be demonstrated, the Contractor shall pay to the Department liquidated damages of ten percent (10%) of the Contractor's annual Capitation Payment. Such payment is to be made no later than thirty (30) Days following the date of termination. FAC and the Contractor agree that the sum set forth herein as liquidated damages is a reasonable pre-estimate of the probable loss which will be incurred by the Department in the event this Contract is terminated prior to the end of the Contract term and actual or consequential money damages cannot be demonstrated.

If this Contract is terminated by FAC for convenience as specified in **Section 39.15 "Termination for Convenience"** of this Contract, the Contractor may seek a remedy pursuant to 200 KAR 5:312.

39.14 Right of Set Off

The Contractor hereby grants to FAC a lien and right of set off for any refund and liquidated damages due the Department pursuant to this Contract, upon and against any deposits, credits, payments due or other property of the Contractor at any time in the possession or control of the Department or in transit to the Department.

39.15 Termination for Convenience

FAC upon thirty (30) Days prior written notice to the Contractor may terminate this Contract without cause. Termination shall be effective only at midnight of the last day of a calendar month, except for termination notices received in June, which termination shall be effective on June 30. In the event of such a termination, Contractor shall have a transition period of not less than three (3) nor more than six (6) months to transition services, during which time the terms and conditions of this Contract shall continue to apply, and Contractor shall provide Covered Services to, and shall be paid pursuant to the Capitation Rate set forth herein for, each Enrollee up to and including the date of transition of such Enrollee.

39.16 Funding Out Provision

The Contractor agrees that if funds are not appropriated to the Department or are not otherwise available for the purpose of making payments, the Commonwealth shall be authorized, upon sixty (60) Days written notice to the Contractor to terminate this Contract. The termination shall be without any other obligation or liability of any cancellation or termination charges, which may be fixed by this Contract.

40.0 MISCELLANEOUS

40.1 Documents Constituting Contract

This Contract shall include:

- A. This Medicaid Managed Care Contract and any subsequent amendments;
- B. The Appendices to this Contract;
- C. The Request for Proposal and all attachments and addendums thereto;
- D. General Conditions contained in 200 KAR 5:021 and Office of Procurement Services' FAP110-10-00; and
- E. The Contractor's proposal in response to the RFP. Provided however, by submitting materials in response to the RFP, the Contractor has not fulfilled any obligation under this Contract to submit plans, programs, policies, procedures, forms or documents, etc. to the Department for approval as required by this Contract.

In the event of any conflict between or among the provisions contained in the Contract, the order of precedence shall be as enumerated above. The documents listed above constitute the entire agreement between the parties.

40.2 Definitions and Construction

The terms used in this Contract shall have the definitions set forth in **Section 1.0 “Definitions,”** unless this Contract expressly provides otherwise. References to numbered sections refer to the designated sections contained in this Contract. Titles of sections used in this Contract are for reference only and shall not be deemed to be a part of this Contract.

40.3 Amendments

This Contract may be amended at any time by written mutual consent of the Contractor and FAC and the Department, and upon approval of CMS. In the event that changes in state or federal law require the Department to amend its Contract with the Contractor, notice shall be made to the Contractor in writing and any such amendment shall be subject to the applicable payment rate revision provisions as described in **Section 11.2 “Rate Adjustments.”** The Department may, from time to time provide clarification of the Providers’ and the Contractor’s responsibilities, provided, however, such clarification shall not expand or amend the duties and obligations under this Contract without an amendment.

40.4 Notice of Legal Action

The Contractor shall provide written notice to FAC of any legal action or notice listed below, within ten (10) Days following the date the Contractor receives written notice of:

- A. Any action, proposed action, lawsuit or counterclaim filed against the Contractor, or against any Subcontractor or supplier, related in any way to this Contract;
- B. Any administrative or regulatory action, or proposed action, respecting the business or operations of the Contractor, any Subcontractor or supplier, related in any way to this Contract;
- C. Any notice received from the DOI or the Cabinet for Health and Family Services;
- D. Any claim made against the Contractor by an Enrollee, Subcontractor or supplier having the potential to result in litigation related in any way to this Contract;
- E. The filing of a petition in bankruptcy by or against a Subcontractor or supplier, or the insolvency of a Subcontractor or supplier; and
- F. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in the Contractor, any Subcontractor or supplier, or who is an agent or managing employee of the Contractor, any Subcontractor or supplier, of a criminal offense related to that person’s involvement in an program under Medicare, Medicaid, or Title XX of the Act, or of Fraud, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as specified in 42 USC 1320a-7.

A complete copy of all documents, filings or notices received by the Contractor shall accompany the notice to FAC. A complete copy of all further filings and other documents generated in connection with any such legal action shall be provided to FAC within ten (10) Days following the date the Contractor receives such documents.

40.5 Conflict of Interest

By the signature of its authorized representative, the Contractor certifies that it is legally entitled to enter into this Contract with the Commonwealth, and in holding and performing this Contract, the Contractor does not and will not violate either applicable conflict of interest statutes

(KRS 45A.330-45A.340, 45A.990, 164.390), or KRS 11A.040 of the Executive Branch Code of Ethics, relating to the employment of former public servants.

40.6 Offer of Gratuities/Purchasing and Specifications

The Contractor certifies that no Enrollee or delegate of Congress, nor any elected or appointed official, employee or agent of the Commonwealth, the Kentucky Cabinet for Health and Family Services, CMS, or any other federal agency, has or will benefit financially or materially from this procurement. This Contract may be terminated by FAC pursuant to **Section 39.11 "Termination for Default,"** herein if it is determined that gratuities were offered to or received by any of the aforementioned officials or employees from the Contractor, its agents, employees, Subcontractors or suppliers.

The Contractor certifies by its signatories hereinafter that it will not attempt in any manner to influence any specifications to be restrictive in any way or respect nor will it attempt in any way to influence any purchasing of services, commodities or equipment by the Commonwealth. For the purpose of this paragraph, "it" is construed to mean any person with an interest therein, as required by applicable law.

40.7 Independent Capacity of the Contractor and Subcontractors

It is expressly agreed that the Contractor and any Subcontractors and agents, officers, and employees of the Contractor or any Subcontractors shall act in an independent capacity in the performance of this Contract and not as officers or employees of the Department or the Commonwealth. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any Subcontractor and the Department or the Commonwealth.

40.8 Assignment

Except as allowed through subcontracting, this Contract and any payments that may become due hereunder shall not be assignable by the Contractor, either in whole or in part, without prior written approval of FAC. The transfer of five percent (5%) or more of the direct ownership in the Contractor at any time during the term of this Contract shall be deemed an assignment of this Contract. FAC shall be entitled to assign this Contract to any other agency of the Commonwealth which may assume the duties or responsibilities of the Department relating to this Contract. FAC shall provide written notice of any such assignment to the Contractor, whereupon the Department shall be discharged from any further obligation or liability under this Contract arising on or after the date of such assignment.

40.9 No Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract may be waived except by written agreement of the parties. The forbearance or indulgence in any form or manner by either party shall not constitute a waiver of any covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity, notwithstanding any such forbearance or indulgence.

40.10 Severability

In the event that any provision of this Contract (including items incorporated by reference) is found to be unlawful, invalid or unenforceable, such provision shall be deemed severed from this Contract and FAC the Department and the Contractor shall be relieved of all obligations arising under such provision. If the remaining parts of this Contract are capable of performance, this Contract shall continue in full force and effect, and all remaining provisions shall be binding upon each party to this Contract as if no such unlawful, invalid or unenforceable provision had been part of this Contract. If the laws or regulations governing this Contract should be amended or judicially interpreted so as to render the fulfillment of this Contract impossible or economically not feasible, as determined jointly by FAC, the Department and the Contractor, FAC, the Department and the Contractor shall be discharged from any further obligations created under the terms of this Contract.

40.11 Force Majeure

The parties shall be excused from performance thereunder for any period that it is prevented from providing, arranging for, or paying for services as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

40.12 Disputes

Any disputes arising under this Contract which cannot be disposed of by agreement between the parties, shall be decided by the Secretary of the Cabinet for Health and Family Services or his/her duly authorized representative. Such decision shall be produced in writing and sent via first-class mail to the Contract Compliance Officer for the Contractor at the address specified in **Section 40.16 "Notices"** of this Contract. The decision of the Secretary or his representative shall be final and conclusive unless, within ten (10) Business Days following the date of notice to the Contractor of such decision, the Contractor mails or otherwise furnishes a written appeal to the Secretary of FAC.

Any appeal to the Secretary of FAC shall be in accordance with KRS Chapter 45A.230 and regulations promulgated thereunder. The Contractor shall proceed diligently with the performance of this Contract in accordance with the decision rendered by the Secretary of the Cabinet for Health and Family Services until the Secretary of the Finance and Administration Cabinet renders a final decision.

The Contractor acknowledges that, pursuant to KRS Chapter 45A.230 et seq., the Secretary of the Finance and Administration Cabinet is the final arbiter of any and all disputes concerning the Contract or the Department, subject to the right of the Contractor to appeal any such determination to the Circuit Court of Franklin County, Kentucky.

40.13 Modifications or Rescission of Section 1915 Waiver / State Plan Amendment

It is understood Contractor operates either pursuant to authority granted to the Department under a waiver granted by CMS. Notwithstanding any other provision contained herein, if at any time the waiver is rescinded or materially changed in scope, format, funding or is withdrawn or modified the Department reserves the right to immediately and without notice suspend or terminate this Contract pursuant to **Sections 39.1 through 39.13 "Remedies for Violation, Breach or Non-Performance of Contract"** herein.

40.14 Choice of Law

The Contract shall be governed by and construed in accordance with the laws of the Commonwealth and applicable federal law and regulations. The Contractor shall be required to

bring all legal proceedings against the Commonwealth in the Franklin County Circuit Court of the Commonwealth and the Contractor shall accept jurisdiction of the Kentucky courts over all matters arising out of this Contract.

40.15 Health Insurance Portability and Accountability Act

The Contractor agrees to abide by the rules and regulations regarding the confidentiality of Protected Health Information (PHI) as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 C.F.R. Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this Contract shall mandate that the Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of PHI as are the Contractor.

40.16 Notices

All notices required by, or pursuant to, this Contract shall be deemed duly given upon delivery, if delivered by hand (against receipt), or three (3) Business Days after posting, if sent by registered or certified mail, return receipt requested, to a party's representative or representatives, as designated in this Contract at the address or addresses designated in this Contract. Notices to FAC and the Department, except those specified to be given to the Department's Fiscal Agent, shall be given to both of the following:

Finance and Administration Cabinet
Office of Procurement Services
Attn: Executive Director
Room 96 Capitol Annex
Frankfort, Kentucky 40601

And

Department for Medicaid Services
Commissioner
275 East Main Street, 6W-A
Frankfort, Kentucky 40621

Notices to the Contractor shall be given to the designated point of contact.

40.17 Survival

The provisions of this Contract which relate to the obligations of the Contractor to maintain records and reports shall survive the expiration of earlier termination of this Contract for a period of five (5) years or such other period as may be required by record retention policies of the Commonwealth or CMS, or otherwise required by law. Each party's right to recoupment pursuant to **Section 10.4 "Contractor Recoupment from Enrollee for Fraud, Waste and Abuse"** of this Contract shall survive the expiration or earlier termination of this Contract until such time as all payments and/or recoupment have been finally settled.

FAC's, the Department's and the Contractor's rights pursuant to **Section 13.0 "Contractor's Financial Security Obligations"** of this Contract shall survive expiration, or earlier termination of this Contract, until such time as the Contractor has satisfactorily complied with the terms thereof.

40.18 Prohibition on Use of Funds for Lobbying Activities

The contractor agrees that no funding derived directly or indirectly from funds pursuant to this Contract shall be used to support lobbying activities or expenses of state or federal government agencies or state or federal lawmakers.

40.19 Adoption of Auditor of Public Account (APA) Standards for Public and Nonprofit Boards

The contractor agrees to adopt the APA Standards for Public and Nonprofit Boards, if applicable. The contractor agrees to provide documentation of this adoption within thirty (30) Days of execution of the Contract.

40.20 Review of Distributions

The Contractor agrees to seek approval from the Department prior to submitting a request for approval of the Kentucky Department of Insurance of any distributions of capital and surplus that are subject to the provisions of KRS Chapter 304. The parties agree that capital and surplus amounts in excess of the required minimum amount required to be maintained under the Kentucky Insurance Code or as may be determined by the Kentucky Insurance Commissioner at any time represents net worth assets for the purposes of benefitting the Commonwealth of Kentucky's Medicaid Program and its beneficiaries. The parties agree to make a good faith effort to cooperatively decide how much excess capital and surplus is needed by the contractor and possible uses of excess capital and surplus that should not be retained by the contractor. This Section shall not apply in the event the Contractor is not domiciled in the Commonwealth of Kentucky, provided, however that on a semi-annual basis Contractor shall provide the Department with Medical Loss Ratio calculations relating specifically to this Contract and risk-based capital calculations, and on a quarterly basis Contractor shall provide to the Department the most recent quarterly financial filing that the Contractor submitted to the Department of Insurance in its state of domicile.

40.21 Audits

The Contractor agrees that the Department, FAC, the Auditor of Public Accounts, and the Legislative Research Commission, or their duly authorized representatives, shall have access to any books, documents, papers, records, or other evidence, which are directly pertinent to this contract for the purpose of financial audit or program review. Records and other prequalification information confidentially disclosed as part of the bid process shall not be deemed as directly pertinent to the contract and shall be exempt from disclosure as provided in KRS 61.878(1)(c). The contractor also recognizes that any books, documents, papers, records, or other evidence, received during a financial audit or program review shall be subject to the Kentucky Open Records Act, KRS 61.870 to 61.884 subject to applicable exceptions.

40.22 Cost Effective Analyses

The Contractor will cooperate with any analyses conducted by the Department or its agent(s) of the cost effectiveness of the Contract for any period. Such analyses may review cost effectiveness from any number of comparisons. Such analyses will be used to assist the Department to meet federal requirements, program management and provide accountability and transparency to the public.

40.23 Open Meetings and Open Records

The Contractor agrees that only those portions of its Board of Directors meetings or parts of its meetings that are with the Department shall be open to the public.

The Contractor for the purpose of this Contract and any documents or records pertaining to this Contract provided to the Department or FAC shall be considered a “public record” under the Open Records Act, KRS 61.870 through KRS 61.884. If the Contractor wishes to claim any documents or records provided to the Department or FAC exempt from release under the Open Records Act, the Contractor shall be required to note the appropriate exemption when providing the documents or records and, if necessary, to take the appropriate legal actions to defend such exemption.

40.24 Disclosure of Certain Financial Information

The Contractor agrees to provide the Department upon request information regarding salaries, travel, other compensation, and other expenses listed in **Appendix D “Reporting Requirements and Reporting Deliverables.”** The contractor agrees to provide any information requested by the Department regarding expenditures related to this Contract. Including but not limited to any findings of the Medicaid Managed Care Operations Examination.

40.25 Disclosure of Certain Financial Information

The Contractor agrees to provide the Department, upon request, information regarding salaries, travel, other compensation, and other expenses listed in **Appendix D “Reporting Requirements and Reporting Deliverables.”** The contractor agrees to provide any information requested by the Department regarding expenditures related to this Contract. Including but not limited to any findings of the Medicaid Managed Care Operations Examination.

41.0 KENTUCKY HEALTH POLICIES AND PERFORMANCE REQUIREMENTS

Contingent upon timing or implementation of Kentucky HEALTH, the provisions of this section are intended to implement and support the Kentucky Health Waiver project. To the extent that any provisions in this section conflict with the preceding provisions of the Contract for the populations known as Kentucky HEALTH Enrollees, set forth in Section 41.1, the provisions of Section 41 shall control upon implementation of the Kentucky HEALTH waiver.

The Contractor shall apply Kentucky HEALTH policies as outlined in this Section to all Kentucky HEALTH Enrollees. The requirements of this Section shall not apply to Enrollees assigned to the Kentucky HEALTH Random Control Trial (RCT). The Contractor shall comply with all requirements of the Kentucky HEALTH Special Terms and Conditions (STCs).

41.1 Kentucky HEALTH Enrolled Populations

The following eligibility groups shall be enrolled in Kentucky HEALTH:

- A. ACA Expansion Enrollees;
- B. Parents and Caretaker Relatives;
- C. Transitional Medical Assistance (TMA);
- D. Pregnant Women;
- E. Former Foster Youth;
- F. Kentucky HEALTH Children; and
- G. KCHIP Enrollees.

41.2 Enrollment Effective Date

The Contractor shall provide coverage to Kentucky HEALTH Enrollees in accordance with the HIPAA 834 effective date information. Pregnant Women, Former Foster Youth and Kentucky HEALTH Children, with the exception of Deemed Newborns as described in 42 CFR §435.117, shall have retroactive eligibility effective up to three (3) months prior to Medicaid application, to the extent that the conditions of 42 CFR §435.915 are met. Deemed Newborns shall have eligibility from the date of birth if the conditions of 42 CFR §435.117 are met. The Contractor shall be responsible for coverage of benefits during periods of retroactivity as described in **Section 26.8 “Persons Eligible for Enrollment and Retroactivity.”**

ACA Expansion Enrollees, Parents and Caretaker Relatives, and TMA Enrollees shall not receive retroactive eligibility. Their eligibility effective date is contingent upon the date of initial premium payment; they shall be deemed Conditionally Eligible Enrollees prior to initial premium payment. Upon such payment, Conditionally Eligible Enrollees shall become eligible for Kentucky HEALTH, effective the first day of the month of initial premium payment. Conditionally Eligible Enrollees whose household income is at or below one hundred percent (100%) FPL who do not make an initial premium payment within sixty (60) Days of the Contractor's invoice date shall become eligible for Kentucky HEALTH under the Copayment Plan effective the first day of the month in which the sixty (60) Day premium payment period expired.

Kentucky HEALTH Enrollees who make a Fast Track Payment, as further described in **Section 41.3 “Fast Track Enrollment”** shall be enrolled in Kentucky HEALTH effective the first day of the month in which the Fast Track Payment was made.

Kentucky HEALTH Enrollees who are determined Medically Frail at the time of application, as described in **Section 41.12.1 “State Identification of Medically Frail”** shall be eligible for Enrollment on the first day of the month of application.

41.3 Fast Track Enrollment

Applicants shall be given the opportunity to expedite enrollment into the Premium Plan by making a Fast Track Payment, in accordance with the Kentucky HEALTH Business Requirements. If determined eligible for coverage, submission of a Fast Track Payment shall render a Kentucky HEALTH Enrollee eligible for Kentucky HEALTH coverage effective the first day of the month that the payment is made, which may be as early as the first day of the month of application. If the applicant's eligibility is pending upon electronic application for a reason other than income verification, the amount of the Fast Track Payment shall be a premium dollar amount defined by the Department. If eligibility is determined in real time and the individual is a Conditionally Eligible Enrollee, or has submitted an application which is pending but whose income has been verified, the Fast Track Payment shall be the calculated premium amount determined in accordance with **Section 41.5.2 “Premiums.”** The Department shall establish the dollar amount of the Fast Track Payment and may adjust the amount at any time. The Department shall provide the Contractor at least sixty (60) Days advance written notice of any change in the dollar amount of the Fast Track Payment.

The opportunity to make a Fast Track Payment shall not be available to applicants who are in a Presumptive Eligibility period. Notwithstanding the foregoing, if an Enrollee in a Presumptive Eligibility period submits a Medicaid application with other household Enrollees who are not in a Presumptive Eligibility period, the case will have a Fast Track option; however, the Enrollee in a Presumptive Eligibility period shall not be eligible to transfer to the Premium Plan until the next administratively feasible month, in order to avoid an overlap in coverage in the Copayment Plan.

Applicants who select the option to make a Fast Track Payment on the application shall also select whether to join the Contractor's Network. Once both selections are made, the Cabinet shall direct the applicant to the Contractor's electronic payment portal.

The Contractor shall establish and maintain an electronic portal for Fast Track Payments which integrates with the IEES electronic application portal, and by which Fast Track Payments may be accepted. The Contractor's electronic portal shall display language, which meets the readability requirements of **Section 22.6 "Enrollee Information Materials,"** indicating the implications for an applicant's Enrollment effective date in the event that a Fast Track Payment is not made. Such language shall be subject to Department review and approval.

The Contractor, via its electronic portal, shall accept and process Fast Track Payments made by credit card, debit card, pre-paid debit card, and electronic check. The Contractor's electronic portal shall provide the applicant a confirmation number upon the real-time processing of a payment. Additionally, the Contractor shall send a payment record in accordance with the Kentucky HEALTH Business Requirements, including, but not limited to inclusion of the payment date. Pursuant to the Kentucky HEALTH Business Requirements, the Contractor shall store the application identification number provided by IEES, the payment amount, and the payment date for the purpose of matching Fast Track Payments to HIPAA 834 records.

Upon receipt of the payment record for applicants who made a Fast Track Payment, IEES shall set the eligibility effective date as the first day of the month in which the Fast Track Payment was received by the Contractor. If no HIPAA 834 is received indicating the eligibility status of an applicant who has made a Fast Track Payment within sixty (60) Days of the Contractor's original receipt of the Fast Track Payment, the Contractor shall issue a refund of the full amount within the next ten (10) Business Days.

If the applicant is determined eligible for Kentucky HEALTH as Cost Sharing Required or Cost Sharing Optional Enrollee, the Contractor shall calculate the difference between the Fast Track Payment made by the applicant and the actual premium obligation owed by the Enrollee as indicated on the HIPAA 834. The Enrollee's subsequent invoice shall display the following:

- A. If the applicant's Fast Track Payment was made for a dollar amount more than the calculated premium amount as indicated on the HIPAA 834, the amount paid in excess of the premium shall be credited to the Enrollee's account, and the Enrollee's first invoice shall reflect the amount due as the calculated premium for the subsequent coverage month minus the amount of the excess Fast Track Payment.
- B. If the applicant's Fast Track Payment was made for an amount less than the calculated premium amount as indicated on the HIPAA 834, the additional amount owed to complete the Enrollee's premium obligation shall be reflected on the Enrollee's first invoice, and the invoice shall reflect the amount due as the calculated premium for the subsequent coverage month plus the difference between the amount of the Fast Track Payment made and the total premium amount owed.

If the Contractor receives a HIPAA 834 with a matching Fast Track Payment indicator prior to the run cycle for Batch Invoicing on the fifteenth (15th) Day of the month, the Contractor shall add the Enrollee to the batch scheduled on the fifteenth of the month during which the eligibility determination was made. If the Contractor receives a HIPAA 834 with a matching Fast Track Payment indicator after the Contractor's run cycle for Batch Invoicing on the fifteenth of the month, the Contractor shall send one (1) additional invoice to the Enrollee within three (3) Business Days of receiving the HIPAA 834. This Ad Hoc Invoice shall be due the first day of the following month. The Contractor shall then add the Enrollee to the Batch Invoicing for the following month.

If an applicant is determined Medicaid eligible but not as a Kentucky HEALTH Enrollee, or is enrolled as Cost Sharing Exempt, and no other Enrollee of the household is Cost Sharing Required or Cost Sharing Optional and enrolled with the Contractor, then the Contractor shall issue a refund of the full amount of the Fast Track Payment within ten (10) Business Days of receipt of the HIPAA 834 record indicating such eligibility. Additionally, if an applicant is determined eligible as a Former Foster Youth or Medically Frail Enrollee, the Contractor shall issue a refund of the Fast Track Payment if requested by the Enrollee. When a refund of a Fast Track Payment is made to a Cost Sharing Optional Enrollee, the Contractor shall transmit the refund information to the Department in accordance with the Kentucky HEALTH Business Requirements in order to facilitate Enrollee transition out of the Premium Plan without application of a Non-Payment Penalty. Refunds of Fast Track Payment shall be made to the original source of payment.

41.4 Kentucky HEALTH Presumptive Eligibility

Individuals determined presumptively eligible for Kentucky HEALTH shall be enrolled with an MCO for the Presumptive Eligibility period. Presumptive Eligibility applicants shall be given the opportunity to select an MCO at the point of application. The Department shall assign the applicant in the absence of a self-selection.

The Contractor shall provide covered benefits during the Presumptive Eligibility period in accordance with the table below.

| Category | Description | Presumptive Eligibility Benefits |
|----------------------|--|---|
| PEAD | Presumptively Eligible ACA Expansion Enrollee | ABP (refer to Section 41.10) |
| PEPC | Presumptively Eligible Parent and Caretaker Relative | State Plan Benefits (refer to Section 30.0) |
| PEC1 PEC2 PEC4 | Presumptively Eligible Child | State Plan Benefits (refer to Section 30.0) |
| PEPR | Presumptively Eligible Pregnant Woman | Ambulatory Prenatal Care (as required under 42 CFR §435.1103) |

The Contractor shall not send premium invoices during the Presumptive Eligibility period. Presumptively eligible ACA Expansion Enrollees and Parent and Caretaker Relatives shall be responsible for copayments for all services received during the Presumptive Eligibility period. The Contractor shall charge copayments to these Enrollees in accordance with **Section 41.5.3 “Copayments”** and deduct the applicable copayment amount from provider Claims reimbursement.

The Presumptive Eligibility period shall end either (i) the last day of the month following the start of the Presumptive Eligibility period for individuals who do not file a Medicaid application; (ii) the day of the Medicaid application denial; or (iii) for individuals found fully eligible for Kentucky HEALTH, the first day of the month of the eligibility determination.

The HIPAA 834 shall contain information on presumptively eligible Enrollees who have been determined fully eligible for Kentucky HEALTH. ACA Expansion Enrollees and Parent and Caretaker Relatives transitioning from Presumptive Eligibility to fully eligible Kentucky HEALTH Enrollees shall be enrolled in the Copayment Plan initially, regardless of FPL, to provide sufficient time for the Enrollee to make a premium payment and avoid a coverage gap. Kentucky HEALTH Children, Former Foster Youth, Pregnant Women and Medically Frail Enrollees transitioning from

Presumptive Eligibility to fully eligible Kentucky HEALTH Enrollees shall be enrolled in Kentucky HEALTH with no cost sharing requirement.

The Contractor shall send a prospective initial premium invoice within three (3) Business Days of receipt of a record on the HIPAA 834 indicating that the ACA Expansion Enrollee or Parent and Caretaker Relative Enrollee has transitioned from Presumptive Eligibility to the Copayment Plan. The invoice shall be due to be paid within sixty (60) Days. The Contractor shall report invoice details to IEES in accordance with the Kentucky HEALTH Business Requirements. Enrollees transitioning from a Presumptive Eligibility period who do not make an initial premium payment within sixty (60) Days of the invoice date shall be subject to a Non-Payment Penalty as outlined in **Section 41.8.12 “Non-Payment of Premiums and Non-Payment Penalties.”** If the Enrollee pays the invoice on or before its due date, the Contractor shall report the payment to IEES as part of its daily payment reporting, in accordance with the Kentucky HEALTH Business Requirements, which shall trigger conversion of the Enrollee to the Premium Plan effective the first day of the month following the month in which the payment was made. The Contractor shall then initiate ongoing Batch Invoicing as described in **Section 41.8.1 “Batch Invoicing Obligations.”**

41.5 Kentucky HEALTH Cost Sharing

41.5.1 Cost Sharing Obligations

All Kentucky HEALTH Enrollees shall be responsible for making financial contributions toward their health care coverage either through payment of premiums or copayments, except for the following groups:

- A. Pregnant Women;
- B. Kentucky HEALTH Children; and
- C. Former Foster Youth and Medically Frail Enrollees, who may optionally pay premiums to gain access to the My Rewards Account.

41.5.2 Premiums

The Contractor shall impose monthly premiums in accordance with the premium amount reflected on the HIPAA 834 for all Conditionally Eligible and Premium Plan Enrollees. Premiums shall be calculated by the Department based on an Enrollee’s MAGI household FPL. The Department shall have the right to adjust the premium amounts at any time and shall provide the Contractor at least sixty (60) Days advance written notice of such adjustments becoming effective, after the initial premium. Initial premium amounts shall be charged as outlined in the table below. Kentucky HEALTH premiums shall be applied to the entire MAGI household enrolled with the Contractor. For example, if a husband and wife are both enrolled with the Contractor, and their combined income is below twenty-five percent (25%) FPL, a total monthly premium of one dollar (\$1.00) shall be charged to the household by the Contractor. Kentucky HEALTH MAGI households with a premium obligation who are enrolled with multiple MCOs shall be charged a premium for each MCO with which they are enrolled. For example, if a husband and wife are enrolled in separate MCOs and their income is below twenty-five percent (25%) FPL, each MCO with which they are enrolled shall charge a one dollar (\$1.00) monthly premium.

| FPL | Monthly Premium Amount |
|------------|-------------------------------|
| ≤25% FPL | \$1.00 |

| | |
|---------------|---------|
| >25% - ≤50% | \$4.00 |
| >50% - ≤100% | \$8.00 |
| >100% - ≤138% | \$15.00 |

For Kentucky HEALTH Enrollees with an income above one hundred percent (100%) FPL, premiums shall increase based on length of enrollment in Kentucky HEALTH. The duration of enrollment shall be calculated based on the Kentucky HEALTH Enrollee within a MAGI household with the longest enrollment in Kentucky HEALTH. The Contractor shall charge escalating premiums in accordance with the table below.

| Duration of Kentucky HEALTH Enrollment | Monthly Premium |
|---|------------------------|
| 0-24 months | \$15.00 |
| 25-36 months | \$22.50 |
| 37-48 months | \$30.00 |
| 49+ months | \$37.50 |

The Contractor shall accommodate the premium schedule in accordance with any future modifications made by the Department. The Department shall provide sixty (60) Days advanced notice to the Contractor of any such modifications.

41.5.3 Copayments

The Contractor shall impose copayment requirements on all Copayment Plan Enrollees. The copayment schedule shall be the copayments approved by CMS in the Kentucky Medicaid State Plan. The Contractor shall update the copayment schedule in accordance with any future modifications made by the Department. The Department shall provide sixty (60) Days advanced notice to the Contractor of any such modifications.

The Contractor shall establish education efforts, policies, and procedures for contracted providers to collect copayments from Kentucky HEALTH Enrollees enrolled in the Copayment Plan at the time of service. In accordance with 42 CFR §447.52, providers shall not deny care or services to any Enrollee at or below one hundred percent (100%) FPL because of his or her inability to pay the copayment. The Contractor shall implement the following mechanisms to enforce this policy: (i) provider education; (ii) documentation in the provider manual; and (iii) assistance to Enrollees who report that they have been denied services due to inability to pay.

Additionally, the Contractor shall reduce the payment it makes to providers by the amount of the Enrollee's copayment obligation, regardless of whether the provider has collected the payment. The Contractor shall ensure that copayments are not imposed on the following exempt services:

- A. Emergency Services as defined at Section 1932(b)(2) of the Social Security Act and 42 CFR §438.114(a);
- B. Family planning services and supplies described in Section 1905(a)(4)(C) of the Social Security Act, including contraceptives and pharmaceuticals for which the State can claim enhanced federal match under Section 1903(a)(5) of the Social Security Act;
- C. Preventive Services, defined as (i) all the preventive services assigned a grade of A or B

- by the United States Preventive Services Task Force (USPSTF); or (ii) all approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices, as well as the influenza vaccine; or (iii) preventive care and screening recommended by the Health Resources and Services Administration Bright Future Program Project; or (iv) preventive services recommended by the Institute of Medicine;
- D. Pregnancy-related services, which in accordance with 42 C.F.R. 447.56 shall include all services provided to pregnant Kentucky HEALTH Enrollees; and
- E. Provider-preventable services as defined in 42 CFR §447.26(b).

In imposing a copayment for an emergency room visit for a non-emergent service, the Contractor shall ensure compliance with 42 CFR §447.54 and **Section 41.11 “Non-Emergency Use of the Emergency Room.”** The Contractor shall consider an emergency room visit emergent, for purposes of waiving the copayment, if the Enrollee had a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- A. Placing the health of the Enrollee (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- B. Serious impairment to bodily functions; or
- C. Serious dysfunction of any bodily organ or part.

The Contractor shall not limit what constitutes a non-emergent visit, for purposes of imposition of the copayment, on the basis of lists of diagnoses or symptoms. Conditional Eligibility, Initial Invoicing, and Payment Processing

41.6 Conditional Eligibility, Initial Invoicing, and Payment Processing

41.6.1 Conditional Eligibility Welcome Packet and Initial Invoicing

Within three (3) Business Days of receipt of a HIPAA 834 with a new Conditionally Eligible Enrollee, the Contractor shall send a Kentucky HEALTH welcome packet. The Kentucky HEALTH welcome packet shall include, at minimum, an initial premium invoice and a welcome letter. The Contractor’s welcome packet shall be subject to Department review and approval in accordance with **Section 4.4 “Approval of Department.”**

The initial premium invoice shall meet the requirements of **Section 41.8.1 “Batch Invoicing Obligations.”** Additionally, it shall include: (i) a clear indication that benefit coverage is conditioned upon premium payment, including a description of how the benefit effective date is impacted by premium payment; and (ii) that the individual may change MCOs until the first payment is made, including clarification that once initial payment is made, the Enrollee may only change MCOs for cause, except during the annual open enrollment period.

The welcome letter shall be tailored individually to address differences for households with income at or below one hundred percent (100%) FPL, and those with income above one hundred percent (100%) FPL. The welcome letter shall include the following:

- A. An explanation that payment is due sixty (60) Days from the date of first invoice;
- B. An explanation that eligibility shall be effective the first day of the month during which a timely payment is made;
- C. An explanation of the consequences of non-payment, which shall be as follows:
 1. For households with income at or below one hundred percent (100%) FPL, the letter shall explain that if an initial premium payment is not received within sixty (60) Days

of the invoice date, coverage in the Copayment Plan shall begin the first day of the month in which the sixty (60) Day payment period ends. Further, it may describe the benefits of enrollment in the Premium Plan versus Copayment Plan, including, but not limited to, predictability in healthcare costs and access to the My Rewards Account; and

2. For households with income above one hundred percent (100%) FPL, the letter shall indicate that failure to make an initial premium payment within sixty (60) Days of the invoice date shall result in denial of eligibility and the requirement to reapply for Kentucky HEALTH coverage;
- D. A description of the option to change the Enrollee's MCO before payment is made and how to do so;
- E. Information about requirements for reporting any changes that may impact eligibility;
- F. An explanation that once initial payment is made, an Enrollee may only change MCOs for cause, except during the annual open enrollment period.

The Contractor shall invoice Conditionally Eligible Enrollees experiencing transitions or changes in accordance with Kentucky HEALTH Business Requirements. Transitions which may occur during the conditional eligibility period which impact Contractor invoicing include, but are not limited to (i) case changes; (ii) Medically Frail determinations; (iii) pregnancy reports; and (iv) MCO changes.

41.6.2 Conditional Eligibility Initial Invoice Reporting

The Contractor shall send conditionally eligible invoice information to IEES daily and in accordance with the Kentucky HEALTH Business Requirements.

41.6.3 Conditional Eligibility Reporting of Payment and Non-Payment

The Contractor shall report payments received from Conditionally Eligible Enrollees on a daily basis to IEES. The Contractor shall report the payment date as the date of receipt; however, payment records shall only be sent after the payment has cleared. Notwithstanding the foregoing, the Contractor shall ensure the timely processing of payments and shall send payment records to IEES within one (1) Business Day of the payment clearing and no later than the sixth day of the month following receipt of payment. The Conditionally Eligible Enrollee shall become fully eligible for Kentucky HEALTH effective the first day of the month of the reported premium payment date. The Contractor shall transition Conditionally Eligible Enrollees who become fully eligible for Kentucky HEALTH to ongoing Batch Invoicing in accordance with Kentucky HEALTH Business Requirements.

Once the Contractor has confirmed from all payment sources that payment was not received by the due date (sixty (60) Days following the date of invoice), the Contractor shall send IEES a termination record indicating the Enrollee's late payment. When either a late payment is reported, or no record is sent by the Contractor within seventy-five (75) Days of the initial eligibility determination date, the Conditionally Eligible Enrollee shall be subject to non-payment penalties in accordance with **Section 41.6.5 "Non-Payment Penalty During Conditional Eligibility."**

If the Contractor receives a payment of an initial invoice following the close of the sixty (60) Day payment period, the payment shall not be reported to IEES as payment of the initial invoice. Rather, for individuals in households with income at or below one hundred percent (100%) FPL, the Contractor shall retain the payment and apply it to a future invoice. For individuals in households with income above one hundred percent (100%) FPL, the Contractor shall refund the payment within thirty (30) Days of receipt.

41.6.4 Conditional Eligibility Payment Reminders

The Contractor shall send a minimum of two (2) written payment reminder notices to Conditionally Eligible Enrollees between the date of initial invoice and the close of the sixty (60) day payment period. Payment reminders shall not be required once payment of the initial invoice is made. The intervals by which these payment reminders are sent shall be at the discretion of the Contractor. The Contractor's payment reminder notices shall be subject to Department review and approval in accordance with **Section 4.4 "Approval of Department."**

41.6.5 Non-Payment Penalty During Conditional Eligibility

Conditionally Eligible Enrollees shall make a premium payment within sixty (60) Days of the Contractor's invoice date. IEES shall determine Conditionally Eligible Enrollees' payment as untimely upon the first of (i) receipt of the Contractor's non-payment file; or (ii) passage of seventy-five (75) Days since the Enrollee was determined eligible for Kentucky HEALTH.

Conditionally Eligible Enrollees over one hundred percent (100%) FPL who fail to make a premium payment within sixty (60) Days of the invoice date shall be denied eligibility for Kentucky HEALTH. A Conditionally Eligible Enrollee over one hundred percent (100%) FPL who has previously been denied eligibility for Kentucky HEALTH shall submit a new application should they wish to participate in Kentucky HEALTH, and no non-payment penalty shall be applied. The Contractor shall have no ongoing responsibilities to a formerly Conditionally Eligible Enrollee who has been denied eligibility for Kentucky HEALTH. Notwithstanding the foregoing, if the Contractor has received a partial payment from the Conditionally Eligible Enrollee that does not satisfy the individual's full premium obligation, the Contractor shall issue a refund of the partial payment within thirty (30) Days.

Conditionally Eligible Enrollees at or below one hundred percent (100%) FPL who fail to make a premium payment within sixty (60) Days of the invoice date shall be enrolled in the Copayment Plan effective the first day of the month in which the sixty (60) Day payment period expires. The Enrollee shall then receive a six (6) month Non-Payment Penalty effective the first of the next administratively feasible month.

41.7 Kentucky HEALTH Enrollment Materials

Within five (5) Business Days of receipt of a HIPAA 834 record indicating Enrollment of a fully eligible Kentucky HEALTH Enrollee, the Contractor shall issue a Kentucky HEALTH Enrollee identification card.

The Enrollee identification card shall include, at minimum, the following components:

- A. The Kentucky HEALTH Enrollee's name and identification number;
- B. The Contractor's Enrollee services call center phone number;
- C. The Contractor's nurse hotline phone number, which shall be operable twenty-four (24) hours per day, seven (7) Days per week;
- D. The Contractor's provider call center phone number;
- E. The Contractor's website; and
- F. The Kentucky HEALTH logo.

To account for potential movement between the Premium Plan and Copayment Plan, the Enrollee identification card shall not include an indication of the cost sharing plan in which the Kentucky HEALTH Enrollee is enrolled.

Additionally, in accordance with **Section 22.2 “Enrollee Handbook,”** the Contractor shall deliver to Kentucky HEALTH Enrollees an Enrollee handbook within five (5) Business Days of receipt of a HIPAA 834 fully eligible add record. In addition to the general Enrollee handbook requirements described in **Section 22.2 “Enrollee Handbook,”** the Enrollee handbook shall include, at minimum, the following Kentucky HEALTH information:

- A. Cost sharing requirements, including consequences for non-payment;
- B. My Rewards Account overview, including information on how to accrue funds and policies pertaining to deductions;
- C. Instructions regarding how to request a Medically Frail determination;
- D. Community Engagement requirements;
- E. Requirements for early re-entry and curing penalties for premium non-payment, Community Engagement and recertification non-compliance, voluntary withdrawal, and penalties for failure to report a change;
- F. Description of vision and dental benefits available through the My Rewards Account versus directly through the Contractor; and
- G. An overview of the Deductible Account.

The Contractor’s Enrollee identification card and Enrollee handbook shall be subject to Department review and approval in accordance with **Section 4.4 “Approval of Department.”** Additionally, the Department shall have the right to establish guidelines regarding the use of the Kentucky HEALTH logo; with which the Contractor shall comply. The Contractor may establish a separate supplement for Kentucky HEALTH to be included with the Enrollee Handbook.

41.8 Billing and Collections

The Contractor shall operate billing and collection services for Kentucky HEALTH which include, at minimum, the following key components:

- A. Generating invoices available in the format requested by the Kentucky HEALTH Enrollee in accordance with **Section 41.8.1 “Batch Invoicing Obligations;”**
- B. Receiving and reporting premium payments;
- C. Monitoring and tracking missed premium payments;
- D. Processing returned checks;
- E. Generating delinquent payment notices;
- F. Providing documentation of premium payment activities and other related financial reports in the timeframe and format requested by the Department;
- G. Processing electronic Fast Track Payments in accordance with **Section 41.3 “Fast Track Enrollment;”**
- H. Providing documentation and reconciliation of premium payments received;
- I. Providing Enrollees the opportunity to review and seek correction of their payment history;
- J. Maintaining premium collection system that identifies, validates, and provides reasonable modifications related to the obligation to pay premiums to Enrollees with disabilities protected by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act; and
- K. Complying with the requirements of the Kentucky HEALTH STCs.

In operating billing and collection services, the Contractor shall not pass along to Enrollees any costs associated with the processing of payments or collecting past-due payments.

41.8.1 Batch Invoicing Obligations

The Contractor shall develop and send ongoing Batch Invoices for Kentucky HEALTH Enrollees enrolled in the Premium Plan.

The Contractor shall provide Enrollees the option to receive invoices electronically as an alternative to paper. The Contractor shall mail invoices with a detachable payment coupon and a return envelope without postage paid to all Enrollees that do not elect to receive invoices electronically.

The Contractor shall submit the invoice template to the Department for review and approval in accordance with **Section 4.4 “Approval of Department.”** The Contractor invoice shall be developed at a sixth (6th) grade reading level in a font no smaller than twelve (12) point. The Contractor shall send invoices in Spanish to households for whom the HIPAA 834 indicates Spanish as the primary household language. The Contractor shall also translate invoices to each Prevalent Non-English Language. The invoice shall include, at minimum, the following information:

- A. The Contractor’s name, even if the Contractor Subcontracts the invoicing function;
- B. First name, last name, and address of the Head of Household to whom the invoice is being sent;
- C. First and last name(s) of the Kentucky HEALTH Enrollee(s) enrolled with the Contractor to whom the premium applies with an indication that the family premium applies to each MCO with which the family is enrolled;
- D. First and last name of the Kentucky HEALTH Enrollee(s) enrolled with the Contractor within the household who currently have a Kentucky HEALTH penalty period or suspension status;
- E. The invoice amount, which clarifies the monthly premium contribution plus any amounts Past Due;
- F. Any applicable overpayments shown as a credit;
- G. Invoice due date;
- H. Non-payment consequences;
- I. Notification of all forms of payment accepted by the Contractor as outlined in **Section 41.8.4 “Payment Methods;”**
- J. Inclusion of a Department-developed insert or language provided by the Department which details instructions on how to report a change in household composition or monthly income, including the deadline for reporting changes and consequences for failure to report a change in a circumstance that may affect eligibility;
- K. Indication that once payment is made, a change in MCO is permitted only for cause or during the annual open enrollment period;
- L. Contractor contact information for questions or concerns regarding the premium payment or invoice, including the Contractor’s Enrollee call center and TTY-TDD telephone number;
- M. A tagline in compliance with 42 CFR §438.10 written in the Prevalent Non-English Languages spoken by at least five percent (5%) of the Contractor’s Kentucky HEALTH population and in font no smaller than eighteen (18) point that explains the availability of written translation or oral interpretation to understand the information provided;
- N. Clear indication on invoices for Medically Frail and Former Foster Youth Enrollees that the premium obligation is optional, including consequences for non-payment;
- O. Detachable portion, on paper invoices, identifying case number to which the invoice applies, which can be returned with payment; and
- P. Any additional information as directed by the Department.

Batch Invoices shall reflect the next full month of coverage. The Contractor shall send ongoing monthly premium invoices no later than the fifteenth of each month with a due date of the first day of the following month.

The Head of Household shall be indicated on the HIPAA 834; however, the Contractor shall permit a household to designate a different primary responsible payer to whom invoices shall be sent.

41.8.2 Invoice Reporting Obligations

The Contractor shall send invoice information to IEES monthly, and in accordance with the Kentucky HEALTH Business Requirements, for ongoing monthly premium invoices.

41.8.3 Invoicing Medically Frail and Former Foster Youth

Individuals known to be Medically Frail at the time of Medicaid application and Former Foster Youth shall be Cost Sharing Optional upon enrollment with the Contractor. These Enrollees shall be given the opportunity to opt into the Premium Plan to gain access to the My Rewards Account. The Contractor shall invoice Cost Sharing Optional Enrollees within three (3) Business Days of receipt of the HIPAA 834 reflecting initial enrollment with the Contractor. Unless there are Cost Sharing Required Enrollees in the household, the Contractor shall ensure the invoice clearly indicates that the premium payment is optional. For cases in which there are no Cost Sharing Required Enrollees in the household, the Contractor shall send a welcome letter with the invoice containing, at minimum, the following information: (i) that payment is optional; and (ii) that a premium payment shall give the Enrollee access to the My Rewards Account.

If the Cost Sharing Optional Enrollee opts not to pay the premium within sixty (60) Days of the initial invoice, the Enrollee shall be considered to have opted out of premium payments. No Non-Payment Penalty shall be applied to Medically Frail or Former Foster Youth who choose not to make premium payments. The Contractor shall not be required to continue invoicing Cost Sharing Optional Enrollees who have opted out of premium payments. However, the Contractor shall develop an outreach program, subject to Department approval, targeted to Cost Sharing Optional Enrollees to assist them in learning about the benefits of the Premium Plan. This outreach shall include, at minimum, requirements for accessing the Premium Plan and benefits of the Premium Plan, including but not limited to access to the My Rewards Account.

41.8.4 Payments Methods

The Contractor shall accept, at minimum, premium payments via the following methodologies:

- A. Check;
- B. Money order;
- C. Automatic payroll deduction;
- D. Cash;
- E. Online payment via web portal;
- F. Electronic check or debit card payment via telephone;
- G. Automatic draft withdrawal from a designated account;
- H. Credit and debit card;
- I. Automated Clearinghouse (ACH); and
- J. Electronic funds transfer.

The Department encourages the Contractor to establish arrangements for Kentucky HEALTH Enrollees to make no-cost premium payments at in-person locations, particularly via cash. To the extent such arrangements are utilized, the Contractor shall ensure that any in-person contributions are processed and communicated to IEES in accordance with the timelines and requirements established at **Section 41.8.5 “Payment Processing and Reporting.”**

41.8.5 Payment Processing and Reporting

The Contractor shall communicate all information regarding premium payments to IEES in accordance with the Kentucky HEALTH Business Requirements. This shall include, but shall not be limited to, transmission of the Contractor invoice date for each Kentucky HEALTH Enrollee with a premium obligation, premium payments received, and the date of payment receipt. The Contractor shall transmit records of all premium payments and non-payments for ongoing Batch Invoicing no later than the sixth day of each month.

For premium payments via direct deposit or payroll deduction, the Contractor shall provide confirmation to the Enrollee that the payment was debited. Additionally, for electronic and telephonic payments, the Contractor shall provide the Enrollee with a confirmation number upon real-time processing of the payment.

The Contractor shall make premium payment status available to its Enrollees (i.e., via an Enrollee web portal or helpline). Available information shall include, but not be limited to, the Enrollee's required monthly premium contribution amount, a record of premium payments received year-to-date, and Past Due premium payment amounts. The Contractor shall give Enrollees an opportunity to review and seek correction of their payment history.

Payment via a dishonored check due to insufficient funds shall be considered non-payment. If an Enrollee's check is returned for insufficient funds, the Contractor may charge a commercially reasonable fee for the returned check. However, any Enrollee non-payment of the returned check fee shall be considered Debt and under no circumstances shall the Contractor be permitted to treat such non-payment as Past Due. The Contractor shall develop, print, and mail notices to Enrollees if their payments are returned from the bank due to insufficient funds. These notices shall be subject to Department review and approval in accordance with **Section 4.4 "Approval of Department,"** and shall include, at minimum, notification that the premium payment could not be processed due to insufficient funds, the premium amount due, the due date, and consequences for non-payment.

The Contractor shall accept partial premium payments. However, the Kentucky HEALTH Enrollee shall pay the monthly premium payment in full, and all other amounts due, within sixty (60) Days of the invoice date or be subject to a Non-Payment Penalty described in **Section 41.8.12 "Non-Payment of Premiums and Non-Payment Penalties."**

As such, the Contractor shall track partial payments of premiums, but shall only send a payment record to IEES after the complete premium payment has cleared.

The Contractor shall also accept pre-payments of future premium contributions. The Contractor shall track such payments as a credit toward future premium payments. The Contractor shall continue to send monthly Batch Invoices when prepayments have been made; the invoice shall reflect the premium amount due with any prepayment listed as a credit applied to the premium.

41.8.6 Delinquent Payment Notices

If an Enrollee has not made the required premium payment for the current month of coverage, the Contractor shall send the Enrollee a delinquent payment notice. The first notice may be sent as early as the second day of the month of coverage for which payment has not been received and shall be sent no later than the seventh day of the month of coverage for which the premium payment was to be applied. If the Contractor does not receive a premium payment from an Enrollee for a second consecutive month, a second delinquent payment notice shall be sent. This notice may be sent as early as the second day of the second unpaid coverage month and shall be sent no later than the seventh day of the second coverage month of non-payment.

The Contractor shall develop three (3) separate delinquent payment notices targeted to: (i) individuals at or below one hundred percent (100%) FPL; (ii) individuals above one hundred percent (100%) FPL; and Cost Sharing Optional Enrollees who have opted into premium payments. The notice targeted by FPL shall include an explanation noting a change in income moving the Enrollee above or below one hundred percent (100%) FPL will impact the type of Non-Payment Penalty applied. These notices shall advise the Enrollee of (i) the delinquent payment; (ii) the date that the payment shall be made to prevent a Non-Payment Penalty; (iii) the option for Medically Frail screening; (iv) consequences of nonpayment of required premiums; and (v) information about reporting changes in circumstances, including household income. The notice targeted to households with only Cost Sharing Optional Enrollees shall indicate that the Enrollee shall no longer have access to the My Rewards Account if payment is not received.

The Contractor's delinquent payment notices are subject to Department review and approval in accordance with **Section 4.4 "Approval of Department."**

41.8.7 Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Periods

The Contractor shall not be required to invoice Enrollees who have been assessed a Non-Payment Penalty. However, the Contractor shall conduct outreach to these Enrollees, in accordance with a Contractor-developed and Department-approved outreach strategy. At a minimum, as part of its outreach strategy, the Contractor shall correspond to the Enrollee in writing during the month in which the penalty is effectuated, which shall include details necessary to facilitate Enrollee payment. This communication shall include, at a minimum: (i) how to remove the Non-Payment Penalty; (ii) amount of premium owed; (iii) forms of payment accepted; (iv) where payment can be made; and (v) the overall benefits of Kentucky HEALTH, including the benefits of participating in the Premium Plan for individuals on the Copayment Plan.

Notwithstanding the foregoing, the Contractor shall send a premium invoice on the fifteenth of the month prior to the end of an Enrollee's Non-Payment Penalty period. This invoice shall include a cover letter indicating that the Enrollee's penalty period is ending and the Enrollee need only make one (1) premium payment to enter the Premium Plan and regain access to the My Rewards Account. The invoice shall only require payment of the upcoming coverage month.

The Contractor shall not invoice Enrollees in a Community Engagement Suspension. However, the Contractor shall develop an outreach program approved by the Department to assist such Enrollees in regaining coverage. At a minimum, this outreach shall include requirements for ending the Community Engagement Suspension and the overall benefits of Kentucky HEALTH.

41.8.8 Invoicing During Kentucky HEALTH Transition Scenarios

The Contractor shall follow Kentucky HEALTH Business Requirements for invoicing Enrollees under any of the following transition scenarios: (i) from Cost Sharing Optional to Cost Sharing Required; (ii) from Cost Sharing Exempt to Cost Sharing Required; and (iii) from Cost Sharing Required to Cost Sharing Optional.

41.8.9 Third Party Payment of Premiums

Third parties are permitted to contribute toward a Kentucky HEALTH Enrollee's premium up to one hundred percent (100%) of the Enrollee's monthly premium obligation. The Contractor shall credit third party contributions to the Enrollee's balance upon receipt and may not use the contribution for any other purpose.

If a third party contributes more than one (1) month premium payment, the Contractor shall treat the excess funds as a prepayment, tracking the overpayment as a credit toward future premium payments. The Contractor shall continue to send the Enrollee an ongoing Batch Invoice on the fifteenth (15th) day of each month, with the prepayment listed as a credit.

Any third party contributions that exceed an Enrollee's total premium obligation for the remainder of the Benefit Year shall be returned by the Contractor to the contributing third party within thirty (30) Days of receipt.

The Contractor shall ensure healthcare providers or provider-related entities making premium payments on behalf of Kentucky HEALTH Enrollees have criteria for providing assistance that does not distinguish between Enrollees based on whether or not they will receive services from the contributing provider(s) or class of provider(s). Further, the Contractor shall ensure that contributing providers do not include the cost of Kentucky HEALTH premium contributions in the cost of care for purposes of Medicare and Medicaid cost reporting or as part of a Medicaid shortfall or uncompensated care.

The Contractor shall maintain a record of all contributions made by third parties on behalf of Enrollees and make reports available to the Department in the timeframe, frequency and format requested. The Contractor shall not make any premium contribution on behalf of a Kentucky HEALTH Enrollee. Further, the Contractor shall be prohibited from reducing the premium amount below the limits established by the Department as described in **Section 41.5.2 "Premiums."**

41.8.10 Premium Recalculations

Enrollees shall report to the Cabinet all changes which may affect eligibility and their required premium contribution, including changes in income and family size. The Department shall notify the Contractor, via the HIPAA 834, of changes to premium amounts as a result of reported changes. The Contractor shall begin invoicing Kentucky HEALTH Enrollees the updated premium amount in the billing cycle in which the change is effective. If the Contractor receives the change in premium amount after the monthly invoice has already been sent, the amount shall be adjusted on the next month's premium invoice. If the premium payment received after the adjusted premium amount is effective exceeds the new monthly premium obligation, the Contractor shall apply the surplus amount as a credit toward future months' premiums. If the premium payment received after the adjusted premium amount is effective is less than the new monthly premium obligation, the Contractor shall add the remaining balance to the Enrollee's next monthly invoice.

41.8.11 Premium Refunds

If an individual makes a premium payment following termination of enrollment or transfer to another MCO, the Contractor shall apply the payment to any Past Due amounts or Debt owed to the Contractor by the individual. If there are no Past Due amounts or Debt, the Contractor shall refund the payment to the individual. If the payment exceeds the Past Due or Debt amount, the Contractor shall apply the payment to the Past Due or Debt amount and refund to the individual any remaining credit. Such refunds shall be made to the individual within thirty (30) Days of the last date of the Enrollee's participation with the Contractor. The Contractor shall report payment of Past Due amounts and refunds to IEES. The Contractor shall not report the terminated individual's payment as a payment toward a future month of coverage.

If an Enrollee makes a payment while in a suspended status, the Contractor shall apply the payment in accordance with Kentucky HEALTH Business Requirements. However, if a

suspended individual requests a refund of an advanced payment, the Contractor shall refund the payment within thirty (30) Days of the request.

In accordance with 42 CFR §447.56, Pregnant Women shall be Cost Sharing Exempt. Enrollees are required to report changes, including pregnancy; therefore, the Contractor is not obligated to retroactively refund premiums paid for months prior to Contractor identification or Kentucky HEALTH Enrollee self-report of pregnancy. The Contractor shall implement strategies to educate Enrollees on the requirement to report pregnancy to the Cabinet. However, once the Contractor is aware of a Kentucky HEALTH Enrollee's pregnancy, the Contractor shall ensure that no premiums are imposed on the pregnant Enrollee. Therefore, in the event that the Contractor has received a prospective premium payment from a woman who is subsequently identified as pregnant, the Contractor shall refund the premium payment for the future month of coverage, within thirty (30) Days of the notification of pregnancy. Notwithstanding the foregoing, the Contractor shall apply the premium payment to the Enrollee's premium obligation at the end of her sixty (60) Day post-partum period, if that is the preference indicated by the Enrollee. Additionally, the Contractor shall not refund the payment if there are household Enrollees also enrolled in the Premium Plan with the Contractor as the Kentucky HEALTH premium payment is a family premium payment.

41.8.12 Non-Payment of Premiums and Non-Payment Penalties

If a Cost Sharing Required Enrollee fails to make a premium payment by the due date of an ongoing Batch Invoice, the Contractor shall send a non-payment file no later than the sixth day of the month. There shall be no immediate consequence to an Enrollee the first time they are sent in a non-payment status on the Contractor's monthly payment status file. If an Enrollee is included on a second consecutive non-payment file from the Contractor, a Non-Payment Penalty shall become effective the first day of the following month if the Enrollee does not ensure that all owed payments are up-to-date prior to the penalty effective date.

The Non-Payment Penalty for Enrollees whose household income is over one hundred percent (100%) FPL shall be suspension from Kentucky HEALTH enrollment. Kentucky HEALTH Enrollees with income at or below one hundred percent (100%) FPL shall be enrolled in the Copayment Plan. Under the Copayment Plan, Enrollees shall be subject to a copayment for every Kentucky HEALTH service received, as outlined in **Section 41.5.3 "Copayments."** Additionally, the Department shall deduct twenty-five dollars (\$25) from the Enrollee's My Rewards Account. The My Rewards Account shall also be suspended for the duration of the Enrollee's enrollment in the Copayment Plan, and the Enrollee shall be unable to either use funds from the account or accrue funds in the account for services or activities completed during the suspension.

The Contractor shall report any payments received by the Enrollee to cure the Non-Payment Penalty before it is effectuated, and in accordance with the Kentucky HEALTH Business Requirements. If the Enrollee makes payment prior to the end of the month before the Non-Payment Penalty effective date, but with insufficient time for the Contractor to send a payment record which voids the Non-Payment Penalty prior to it taking effect, the following shall occur:

- A. Enrollees with an income at or below one hundred percent (100%) FPL who were moved to the Copayment Plan shall be moved to the Premium Plan effective the first day of the following month to avoid retroactively overlaying coverage. The Contractor shall invoice these Enrollees during the Batch Invoicing cycle on the fifteenth day of the month to reflect the premium due for the following month of coverage in the Premium Plan.
- B. Enrollees with income over one hundred percent (100%) FPL whose enrollment was suspended shall be enrolled in the Premium Plan effective the first day of the month with no gap in coverage. The Contractor shall continue invoicing the Enrollee on the Batch Invoicing cycle.

The Contractor shall wait until receipt of a HIPAA 834 record to take any actions associated with the Non-Payment Penalty, including suspension or movement from the Premium Plan to the Copayment Plan.

Notwithstanding the foregoing, the following Kentucky HEALTH Enrollees shall not be subject to a Non-Payment Penalty: (i) Cost Sharing Optional Enrollees; and (ii) Enrollees determined to have good cause for non-payment as described in **Section 41.8.13 “Good Cause for Premium Non-Payment.”**

A Non-Payment Penalty shall remain effective for six (6) months unless the Kentucky HEALTH Enrollee (i) completes early re-entry requirements outlined in **Section 41.8.14 “Non-Payment Early Re-Entry;”** (ii) has a good cause for non-payment; or (iii) during the penalty period becomes pregnant, is determined to be Medically Frail, or otherwise becomes eligible for Medicaid under an eligibility group not subject to a Non-Payment Penalty.

In the absence of early re-entry, the Contractor shall send one (1) premium invoice the month before the expiration of the Enrollee’s Non-Payment Penalty. The invoice shall include a cover letter indicating that the Enrollee’s Non-Payment Penalty is ending and that the Enrollee shall make at least one (1) prospective premium payment to transition back to the Premium Plan and regain access to the My Rewards Account. The Contractor may still pursue collection of Debt in accordance with **Section 41.8.16 “Debt Collection.”** Upon expiration of the Non-Payment Penalty, the effective date of an Enrollee’s transition from the Copayment Plan to the Premium Plan shall be the first day of the month following premium payment. The effective date of an Enrollee’s transition from a suspended status to the Premium Plan shall be the first day of the month in which the premium payment is made.

Enrollees with income at or below one hundred percent (100%) FPL who opt not to make a premium payment at the close of the Non-Payment Penalty period shall remain enrolled with the Contractor in the Copayment Plan with no additional Non-Payment Penalty. Suspended Enrollees with income above one hundred percent (100%) FPL who opt not to make a premium payment at the close of the Non-Payment Penalty period shall remain suspended. The Contractor shall continue outreach to these Enrollees in accordance with **Section 41.8.7 “Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Periods.”**

41.8.13 Good Cause for Premium Non-Payment

An Enrollee who fails to make the required premium payment for any of the following reasons shall not be subject to a Non-Payment Penalty:

- A. The Enrollee is hospitalized or otherwise incapacitated, or has a disability as defined by the ADA, Section 504 of the Rehabilitation Act, or Section 1557 of the Affordable Care Act, and as a result is unable to pay premiums during the entire sixty (60) Day payment period; has a disability and was not provided with reasonable modifications needed to pay the premium; or has a disability, and there were no reasonable modifications which would have enabled the Enrollee to pay premiums during the entire sixty (60) Day payment period;
- B. An individual in the Enrollee’s immediate family who was living in the same home as the Enrollee was institutionalized or died during the sixty (60) Day payment period; an immediate family Enrollee living in the same home as the Enrollee has a disability as defined by the ADA, Section 504 of the Rehabilitation Act, or Section 1557 of the Affordable Care Act, and caretaking or other disability-related responsibilities resulted in the Enrollee’s inability to pay the premiums;
- C. The Enrollee was evicted from his or her home or experienced homelessness during the sixty (60) Day payment period;

- D. The Enrollee was the victim of a declared natural disaster, such as a flood, storm, earthquake, or serious fire, that occurred during the sixty (60) Day payment period; or
- E. The Enrollee was a victim of domestic violence during the sixty (60) Day payment period.

The Contractor shall be responsible for educating Enrollees on the good cause reasons for premium non-payment as outlined in paragraphs A through E (above) of this subsection, as well as the process for reviewing and processing premium non-payment good cause requests. Kentucky HEALTH Enrollees may report good cause for premium non-payment to the Cabinet or the Contractor. If the report is made to the Contractor, the Contractor shall complete the following:

- A. Gather the good cause reason reported by the Enrollee;
- B. Determine if the reported reason is in alignment with the non-payment good cause reasons outlined in paragraphs A through E (above) of this subsection;
- C. Determine how many months, and for which months, the good cause reason applies. If a good cause reason only applies to one (1) month, the Contractor shall log the good cause reason for the one (1) month;
- D. Inform the Enrollee of the obligation to provide verification to the Cabinet, the acceptable forms of verification, and the process for submission; and
- E. Send the file to IEES with premium non-payment good cause records in accordance with the Kentucky HEALTH Business Requirements.

The Contractor shall continue to invoice Enrollees with a pending good cause request during the ongoing Batch Invoicing schedule. Because only verified good cause reasons shall be accepted, and these must be reviewed and confirmed by the Cabinet, the Contractor shall continue to invoice the Enrollee and reflect non-payments as Past Due until receipt of verification from the Department that the good cause request has been approved. The Contractor may collect any Debt owed as a result of the good cause non-payment; however, the unpaid amounts shall be considered a Debt owed, rather than a Past Due amount that is required in order to avoid a penalty.

41.8.14 Non-Payment Penalty Early Re-Entry

Kentucky HEALTH Enrollees subject to a Non-Payment Penalty may re-enter the Premium Plan prior to the expiration of the six (6) month penalty period by completing early re-entry requirements. These early re-entry requirements shall include: (i) payment of any applicable Past Due premium amounts; (ii) payment of one (1) month's future premium payment; and (iii) completion of a Re-Entry Course. Enrollees may only exit the Non-Payment Penalty period once during any Benefit Year.

The Contractor shall not be responsible for providing Re-Entry Courses. Rather, the Contractor shall implement outreach and communication strategies to Enrollees in a Non-Payment Penalty period as described in **Section 41.8.7 "Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Periods."** Additionally, the Contractor shall ensure that its call center staff are prepared to answer inbound calls from Enrollees in a Non-Payment Penalty period with information regarding the requirements for early re-entry.

41.8.15 Five Percent (5%) Maximum Cost Sharing

In accordance with the Special Terms and Conditions and 42 CFR §447.56, a Kentucky HEALTH Enrollee's total cost sharing shall not exceed five percent (5%) of the Enrollee's MAGI household income applied on a quarterly basis. Upon receipt of a HIPAA 834 file indicating that a Kentucky HEALTH Enrollee has reached the five percent (5%) cost sharing limit, for Kentucky HEALTH Enrollees in the Copayment Plan, the Contractor shall ensure that copayments are

no longer collected from the Enrollee and are not deducted from provider Claims reimbursement through the end of the calendar quarter. For Kentucky HEALTH Enrollees enrolled in the Premium Plan, the Contractor shall send monthly premium invoices reflecting a premium obligation of one dollar (\$1.00) for the remainder of the calendar quarter. In the event that a Kentucky HEALTH Enrollee made a premium payment in excess of one dollar (\$1.00) after the five percent (5%) limit has been met, the Contractor shall apply the amount paid over one dollar (\$1.00) to a future coverage month and reflect the credit on the next invoice. The Contractor shall process updated HIPAA 834 files reflecting the reinstatement of cost sharing for the next calendar quarter and begin charging copayments and premiums in accordance with Kentucky HEALTH policies as outlined in this Contract.

41.8.16 Debt Collection

The Contractor may pursue unpaid premiums for months in which a Kentucky HEALTH Enrollee was fully enrolled but did not make a premium payment. Unpaid premiums during months of conditional eligibility shall not be collected by the Contractor. In pursuing the payment of Debt by an Enrollee, the Contractor shall not: (i) report the Debt to credit reporting agencies; (ii) place a lien on an Enrollee's home; (iii) refer the case to debt collectors; (iv) file a lawsuit; (v) seek a court order to seize a portion of the Enrollee's earnings; or (vi) sell the Debt for collection by a third party.

41.9 MCO Change Policies

Kentucky HEALTH Enrollees with a mandatory premium contribution and Medically Frail Enrollees may change MCOs without cause if the change is requested prior to (i) the date on which the Enrollee pays an initial premium; or (ii) the date on which the Enrollee has enrolled in Kentucky HEALTH after the sixty (60) Day initial payment period has expired. Pregnant Women, Former Foster Youth, Kentucky HEALTH Children and KCHIP Enrollees may change MCOs within the first ninety (90) Days of enrollment with an MCO.

All Kentucky HEALTH Enrollees may request Disenrollment for cause in accordance with **Section 26.13 "Enrollee Request for Disenrollment"** and for any reason during the annual open enrollment period. The Department shall not approve retroactive MCO changes for cause for Kentucky HEALTH Enrollees; therefore, the Contractor shall be required to work with the Department to resolve issues related to an Enrollee's Disenrollment request prior to a prospective MCO transfer. If an Enrollee is transferred from the Contractor to another MCO, the Contractor shall refund any applicable premium payment received for a future coverage month within thirty (30) Days of the Enrollee's last date of participation with the Contractor.

41.10 Kentucky HEALTH Alternative Benefit Plan

Beginning July 1, 2018, ACA Expansion Enrollees shall receive all services, including coverage criteria, limitations and procedures, identified in the Kentucky HEALTH ABP. In the event that the requirements of the ABP conflict with any of the terms of this Contract, the requirements of the ABP shall prevail.

The ABP shall cover the ten (10) essential health benefits: (i) ambulatory patient services; (ii) Emergency Services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance use disorder services, including behavioral health treatment; (vi) prescription drugs; (vii) rehabilitative and habilitative services and devices; (viii) laboratory services; (ix) preventive and wellness services and Chronic Disease Management; and (x) pediatric services. The ABP shall also specify and cover additional pregnancy-only benefits which the Contractor shall only make available for ACA Expansion Enrollees who are pregnant. Additionally, the Contractor shall ensure that all ACA Expansion Enrollees under age twenty-one (21) are covered for EPSDT benefits in

accordance with **Section 32.1 “Early and Periodic Screening, Diagnostic and Treatment.”** This shall include, but is not limited to, vision and dental coverage which are otherwise not covered under the ABP.

41.10.1 Populations Exempt from Kentucky HEALTH ABP

The following Kentucky HEALTH Enrollees shall not receive the ABP benefits described in Section 42.10 “Kentucky HEALTH ABP”:

- A. Parents and Caretaker Relatives;
- B. TMA;
- C. Former Foster Youth;
- D. Pregnant Women who are not ACA Expansion Enrollees;
- E. Kentucky HEALTH Children;
- F. KCHIP recipients; and
- G. Medically Frail Enrollees.

The Contractor shall ensure that the Enrollees described in this Section have access to Covered Services in accordance with **Section 30.0 “Covered Services.”**

41.11 Non-Emergency Use of the Emergency Room

To impose copayments and My Rewards Account deductions for non-emergency use of the emergency room, as described in **Sections 41.5.3 “Copayments”** and **41.15 “My Rewards Account,”** the Contractor shall ensure that any hospital in its network providing non-emergency care in its emergency room to a Kentucky HEALTH Enrollee shall first conduct an appropriate medical screening pursuant to 42 CFR §489.24 to determine that the Enrollee does not require Emergency Services. The Contractor shall instruct its provider network of the following emergency room services copayment and My Rewards Account deduction policies and procedures, as well as the circumstances under which the hospital shall waive or return the copayment:

- A. Inform Enrollees in the Copayment Plan of the amount of their cost sharing obligation for non-emergency services provided in the emergency room;
- B. Inform Enrollees with a My Rewards Account that non-emergency visits shall result in a deduction to the My Rewards Account, and the deduction amount shall escalate for each inappropriate visit during the Benefit Year;
- C. Provide the Enrollee with the name and location of an available and accessible alternative non-emergency services provider;
- D. Determine that the alternative provider can provide services to the Enrollee in a timely manner with the imposition of a lesser cost sharing amount; and
- E. Provide a referral to coordinate scheduling for treatment by the alternative provider.

41.12 Medically Frail

Enrollees who meet the definition of Medically Frail shall be enrolled in Kentucky HEALTH, but shall not be subject to: (i) Community Engagement requirements; (ii) mandatory cost sharing through premiums or copayments; or (iii) enrollment in the ABP. Medically Frail Enrollees may pay premiums in order to access a My Rewards Account. In accordance with 42 CFR §440.315(f), a person shall be determined Medically Frail if the Enrollee has a disabling mental disorder (including serious mental illness); chronic substance use disorder; serious and complex medical condition; or physical, intellectual or developmental disability which significantly impairs the Enrollee’s ability to perform one or more activities of daily living.

As described in the subsections below, Enrollees shall be identified as Medically Frail in one of the following ways: (i) State identification based on eligibility data; (ii) Enrollee self-attestation; and (iii) Contractor identification through either the Provider Attestation Scoring Tool or Medically Frail Identification Tool.

41.12.1 State Identification of Medically Frail

Individuals eligible for Kentucky HEALTH who are diagnosed with HIV/AIDS as identified by the Ryan White Program, or receiving Retirement, Survivors and Disability Insurance (RSDI) income based upon a disability, or Enrollees with refugee status following their first year of entrance into the United States, shall automatically be determined Medically Frail at the point of application. The Contractor shall not be responsible for initial confirmation or annual reconfirmation of the Medically Frail status of these Enrollees.

41.12.2 Self-Attestation of Medically Frail

Applicants and Enrollees who self-attest to chronic homelessness or inability to complete Activities of Daily Living (ADL) and who become otherwise eligible for Kentucky HEALTH will receive six (6) months of Medically Frail status. The Contractor shall verify the Enrollee's Medically Frail status prior to the expiration of the six (6) month period. The Contractor shall provide the results of the verification to the State and to the Enrollee in accordance with Kentucky HEALTH Business Requirements and **Section 41.12.3 "Contractor Medically Frail Determination."**

41.12.3 Contractor Medically Frail Determination

Applicants and Enrollees can also self-report a variety of health indicators through the Cabinet operated IEES self-service portal or with the assistance of a DCBS case worker in the IEES worker portal. Upon self-attestation of a physical or behavioral health disorder, the individual will be directed to contact the Contractor to begin the Medically Frail determination process.

Enrollees may also be identified as Potentially Medically Frail through Contractor completion of the HRA, as described in **Section 34.3.b "Health Risk Assessment."** Completion of the HRA and Enrollee self-reporting, with the exception of the self-attestation indicators specified in **Section 41.12.2 "Self-Attestation of Medically Frail,"** does not automatically result in designation of an Enrollee as Medically Frail.

Within thirty (30) Days of identification of an Enrollee as Potentially Medically Frail through the HRA, the Contractor shall determine if the Enrollee meets the Medically Frail criteria, utilizing the Medically Frail Identification Tool. If the Medically Frail Identification Tool determines the Enrollee as Possibly Medically Frail, the Contractor shall assist the Enrollee or Conditionally Eligible Enrollee in scheduling an appointment with a medical provider, who shall complete the Provider Attestation. The Contractor shall accept completed Provider Attestations, at a minimum, via fax, mail and electronically. Upon receipt of the Provider Attestation, the Contractor shall process the Provider Attestation through the Provider Attestation Scoring Tool.

The Contractor shall also identify Medically Frail Enrollees through ongoing use, on at least a monthly basis, of the Medically Frail Identification Tool. In utilizing the Medically Frail Identification Tool, the Contractor shall include all Claims data, including but not limited to, denied Claims, Medicare crossover Claims, and TPL Claims. An Enrollee shall be considered Medically Frail if the Medically Frail Identification Tool identifies the Enrollee as automatically Medically Frail. If the Medically Frail Identification Tool identifies the Enrollee as Possibly Medically Frail, the Contractor shall assist the Enrollee in scheduling an appointment with their medical provider for completion of the Provider Attestation within sixty (60) Days.

The Contractor shall notify the Department in accordance with the Kentucky HEALTH Business Requirements when an Enrollee is determined Medically Frail by the Contractor through either the Medically Frail Identification Tool or the Provider Attestation Scoring Tool. Upon receipt of the confirmation, the Department shall transfer the Enrollee to Medicaid State Plan benefits, in accordance with **Section 30.1 “Medicaid Covered Services,”** effective the first day of the month following the Medically Frail confirmation.

Following the Medically Frail determination, the Contractor shall be responsible for notifying the Enrollee, in writing, of the decision, using a Medically Frail notice template developed by the Department. The notice shall include, at minimum, the following information:

- A. The Medically Frail designation decision;
- B. For denials of Medically Frail status, the reasons for the determination and the Enrollee’s right to Appeal;
- C. A description of any changes to the Enrollee’s benefits; and
- D. A description of applicable changes to the Enrollee’s cost sharing obligations.

Enrollees with an active My Rewards Account who were enrolled in the Premium Plan prior to a Medically Frail determination shall continue enrollment in the Premium Plan. The Contractor shall ensure, in accordance with **Section 41.8.1 “Batch Invoicing,”** that premium invoices sent to the Enrollee following the Medically Frail determination clearly indicate that the premium obligation is optional, including consequences for non-payment. Enrollees determined Medically Frail who have a suspended My Rewards Account shall continue to have their My Rewards Account suspended, but shall no longer be responsible for copayments for services received.

41.12.4 Ongoing Review

Enrollees determined Medically Frail by the Contractor shall be deemed Medically Frail for twelve (12) months. The Contractor shall utilize the Medically Frail Identification Tool and Provider Attestation Scoring Tool to review the status of all Medically Frail Enrollees prior to the expiration of their twelve (12) month period. Enrollees who are reconfirmed Medically Frail shall receive an additional twelve (12) month Medically Frail determination.

The Contractor shall track when it identifies Enrollees whose Medically Frail status has ended prior to the end of the twelve (12) month period through the monthly run of the Medically Frail Identification Tool or via the Provider Attestation as described in **Section 41.12.3 “Contractor Medically Frail Determination.”** If the Contractor determines that the Enrollee’s Medically Frail status has ended, the Enrollee shall lose the Medically Frail designation effective the first day of the month following the determination. The Contractor shall notify the Enrollee of the denial in accordance with **Section 41.12.3 “Contractor Medically Frail Determination.”**

Additionally, the Contractor shall review all Kentucky HEALTH Children, KCHIP Enrollees and Former Foster Youth at least thirty (30) Days prior to aging out of their eligibility category and Pregnant Women prior to the end of their postpartum period to determine if they are Medically Frail.

41.12.5 Department Audit

The Department shall conduct regular audits of the Contractor’s Medically Frail assessment and confirmation process pursuant to **Section 41.12.3 “Contractor Medically Frail Determination”** to determine appropriate identification and placement of Medically Frail Enrollees. The Department may subcontract this audit function.

41.13 Community Engagement Initiative

The Contractor shall:

- A. Communicate Community Engagement requirements through the Enrollee handbook and other Enrollee education materials;
- B. Suspend premium invoicing if an Enrollee enters a Community Engagement Suspension status, as communicated on the HIPAA 834. However, the Contractor shall continue invoicing other Enrollees in the same case who have a premium obligation;
- C. Conduct outreach to Enrollees in a Community Engagement Suspension in accordance with the Department-approved outreach plan described in **Section 41.8.7 “Invoicing and Outreach During Kentucky HEALTH Penalty and Suspension Period;”**
- D. Reinstate Batch Invoicing upon notice of an Enrollee’s Community Engagement Suspension as defined in the Kentucky HEALTH Business Requirements;
- E. Ensure that the Enrollee call center can address basic Enrollee inquiries regarding Community Engagement, including, but not limited to:
 1. Community Engagement requirements;
 2. Applicable exemptions and how to report meeting an exemption requirement;
 3. How to report Community Engagement hours;
 4. How to avoid Community Engagement Suspension when an Enrollee falls short in a given month;
 5. How to Appeal a Community Engagement Suspension;
 6. Providing referrals to the appropriate State or vendor Community Engagement resources; and
 7. Requirements for early re-entry from a suspension status.

41.14 Deductible Account

The Contractor shall establish a Deductible Account for all Kentucky HEALTH Enrollees except for Kentucky HEALTH Children, KCHIP Enrollees, and Pregnant Women. The beginning balance of a Deductible Account shall be one thousand dollars (\$1,000), regardless of a Kentucky HEALTH Enrollee’s date of enrollment. The Contractor shall track the first one thousand dollars (\$1,000) of non-preventive services received by Enrollees with a Deductible Account and deduct such expenses from the Deductible Account balance. The Contractor shall ensure that the amount deducted for each non-preventive service received equals the actual dollar amount that the Contractor reimbursed to the provider and is not based on the Department’s fee-for-service schedule. The Contractor shall not deduct expenses for any preventive services received from the Deductible Account. For purposes of this requirement, the definition of preventive services shall be developed by the Department based on U.S. Preventive Services Task Force (USPSTF) and Centers for Disease Control (CDC) age and gender appropriate preventive services. The Contractor shall comply with the list of preventive services provided by the Department and any updates thereto.

Kentucky HEALTH Enrollees who become pregnant shall have their Deductible Account frozen during their pregnancy and through their sixty (60) Day post-partum period. The Contractor shall ensure that healthcare expenses are not deducted from the Deductible Account of a female Enrollee during her pregnancy. Kentucky HEALTH applicants who are pregnant at the time of application shall not have a Deductible Account established until the close of their sixty (60) Day post-partum period.

The Contractor shall send a monthly Deductible Account statement to all Kentucky HEALTH Enrollees by the tenth day of each month, utilizing the Department’s standardized template. The statement shall be sent in the preferred mode selected by the Enrollee, either via mail or electronically. The Deductible Account statement shall list, at minimum: (i) the previous statement balance; (ii) Claims applied to the account during the time period in which the statement applies,

including pharmacy Claims; (iii) the remaining Deductible Account balance; (iv) an explanation of benefits (EOB) summary for all services received by the Enrollee during the statement period; and (v) the Contractor's helpline number for Kentucky HEALTH Enrollees to contact with questions or concerns regarding the statement.

The Contractor shall continue to send the Deductible Account Statement in months where an Enrollee has Claims to display in the EOB summary, even after the full balance has been depleted. The Contractor shall not display a negative Deductible Account balance; rather, the balance shall be displayed as zero dollars (\$0) when funds have been depleted. Exhaustion of the Deductible Account before the end of the Enrollee's Benefit Year shall not change the Contractor's covered service requirements, and the Contractor shall continue to ensure that the Enrollee is able to access Covered Services.

The Contractor shall implement mechanisms to ensure that its call center staff are able to view an Enrollee's Deductible Account balance and relevant transactions in order to assist with Enrollee phone calls related to the Deductible Account.

To encourage the appropriate utilization of healthcare services, Kentucky HEALTH Enrollees are eligible to have up to one-half of their remaining Deductible Account balance transferred to their My Rewards Account following the close of the Benefit Year. Enrollees with a My Rewards Account that is suspended or inactive shall not be eligible for such a transfer. The percentage of the Deductible Account balance eligible for transfer to a My Rewards Account shall be based on the number of active months of the Enrollee's enrollment in Kentucky HEALTH within a Benefit Year. For purposes of this requirement, active months are months in which an Enrollee is not disenrolled or in a suspension status. Ninety (90) Days after the end of the calendar year, the Contractor shall transmit all Deductible Account balances maintained by its Kentucky HEALTH Enrollees to the Department's designee in accordance with the Kentucky HEALTH Business Requirements. The Contractor shall continue to process Claims received after this transmission, but shall not be responsible for continuing to track such expenditures against Deductible Accounts.

In the event that a Kentucky HEALTH Enrollee with a Deductible Account changes MCOs during a Benefit Year, the Enrollee's Deductible Account balance information shall transfer to the Enrollee's new MCO. To facilitate this transfer, the Contractor shall transmit the Enrollee's Deductible Account balance information in accordance with the Kentucky HEALTH Business Requirements. The Contractor shall not be required to track expenditures against the Enrollee's Deductible Account from the effective date of the Enrollee's transfer to another MCO, although the Contractor shall remain responsible for Claims incurred prior to the date of transfer.

41.15 My Rewards Account

All Premium Plan Enrollees shall have access to a My Rewards Account. Additionally, pregnant Enrollees aged nineteen (19) or older shall also have access to a My Rewards Account, even though they do not have a premium payment obligation. Pregnant Enrollees who are in a penalty status from their previous enrollment, however, shall not be eligible for a My Rewards Account, unless they complete a Re-Entry Course.

The My Rewards Account may be utilized by Enrollees to access the following services:

- A. Routine dental benefits;
- B. Routine vision benefits;
- C. Limited reimbursement for fitness activities; and
- D. Other services designated by the Department.

Only ACA Expansion Enrollees receiving ABP benefits shall be required to utilize the My Rewards Account to access routine dental and vision benefits. The Contractor shall be responsible for providing routine dental and vision services for all other Kentucky HEALTH Enrollees, as described in **Section 41.10.1 “Populations Exempt from Kentucky HEALTH ABP,”** and including ACA Expansion Enrollees who are pregnant or nineteen (19) or twenty (20) years of age. The Contractor shall ensure that if Claims are submitted to the Contractor, or any applicable subcontracted entities, for dental or vision services for ACA Expansion Enrollees, the Denial reason codes and explanations shall be clear that while benefits are not reimbursed by the Contractor, reimbursement may be available through the My Rewards Account.

Kentucky HEALTH Enrollees may accrue funds in their My Rewards Account by completing activities as outlined in the Kentucky HEALTH Business Requirements. The Contractor shall not be responsible for operating the My Rewards Account; however, the Contractor shall provide customer service and transmit data, in accordance with the Kentucky HEALTH Business Requirements, regarding Enrollee participation in My Rewards Account accrual activities.

The Contractor shall communicate an Enrollee’s completion of any of the following preventive health activities to the Department in accordance with the Kentucky HEALTH Business Requirements:

- A. Completion of a Health Risk Assessment with the Contractor;
- B. Enrollee follow-up visit to a physician within fifteen (15) Days of an emergency room visit;
- C. Completion of mammogram, pap smear, colonoscopy, flu shot, annual physical, preventive dental exam, preventive vision exam, or other preventive services as defined by the Department;
- D. Completion of a well-child preventive or comprehensive dental exam or comprehensive vision screening for a dependent child of a Kentucky HEALTH Enrollee;
- E. Participation in drug addiction counseling; and
- F. Participation in smoking cessation activity.

The Department may audit the Contractor’s performance regarding the submission of data upon Enrollee completion of My Rewards Account eligible activities, including, but not limited to, comparisons against submitted Encounter data.

Activities eligible for My Rewards Account accrual shall be subject to change by the Department, and the Department shall provide the Contractor sixty (60) Days advance notice of any such modification. The Contractor shall comply with all modifications to the activities eligible for accrual and shall begin communicating Enrollee completion of new activities for which the Contractor is responsible to the Department immediately upon the modification effective date.

Deductions shall be taken from an Enrollee’s My Rewards Account for improper use of hospital emergency room services. The Contractor shall educate its provider network regarding this My Rewards Account deduction policy and ensure compliance with the requirements of **Section 41.11 “Non-Emergency Use of the Emergency Room.”** The deduction shall be applied based on the number of improper visits as described in the table below.

| Inappropriate Emergency Room Visit | My Rewards Account Deduction |
|------------------------------------|------------------------------|
| 1st visit | \$20 |
| 2nd visit | \$50 |
| 3rd visit or more | \$75 |

The Contractor shall review paid emergency room Claims against the Department established list of ICD-10 diagnoses, which indicate non-emergent use of the emergency room. If the Contractor's review determines that the emergency room Claim included a primary diagnosis on the non-emergent diagnosis list, the Contractor shall verify whether the Enrollee contacted the twenty-four (24) nurse hotline described in **Section 22.1 "Required Functions"** within twenty-four (24) hours prior to the emergency room visit. If such a call was made, the visit shall be treated as a valid emergency room visit and the Enrollee shall not be subject to a My Rewards Account deduction. If no call was made to the nurse hotline, the emergency room visit shall be considered improper, and an Enrollee with an active My Rewards Account on the date of service shall be subject to a My Rewards Account deduction. Notwithstanding this policy, if a behavioral health diagnosis is included on the emergency room Claim, the visit shall be considered appropriate, and the Enrollee shall not be subject to a My Rewards Account deduction, regardless of whether the primary diagnosis on the Claim is included on the non-emergent diagnosis list. The Contractor shall communicate inappropriate use of the emergency room by an Enrollee to IEES in accordance with the Kentucky HEALTH Business Requirements.

The Contractor shall comply with any updates to the non-emergent diagnoses list in accordance with any future modifications made by the Department. The Department shall provide thirty (30) Days advance notice to the Contractor of any such modifications.

The Contractor shall provide Enrollee service support to Enrollees who have inquiries regarding their My Rewards Account. At a minimum, the Contractor shall provide the following information in Enrollee communication materials and via the Contractor's Enrollee helpline:

- A. How Enrollees may check their My Rewards Account balance;
- B. Which activities Enrollees may complete to earn funds in their My Rewards Account;
- C. Which benefits can be purchased with My Rewards Account funds;
- D. A link on the Contractor's website to the My Rewards Account website where Enrollees may locate all information regarding their My Rewards Account; and
- E. The Enrollee's My Rewards Account balance, with the ability to transfer an Enrollee to the My Rewards Account call center identified by the Department when more complex issues such as My Rewards Account Claims denials are raised.

41.16 Kentucky HEALTH Grievances and Appeals

The Contractor shall process grievances and Appeals related to Kentucky HEALTH in accordance with **Section 24.0 "Enrollee Grievances and Appeals"** and all applicable subsections. In addition, the Contractor shall comply with the following requirements applicable to Kentucky HEALTH:

- A. In the event that an Enrollee's ineligibility determination is overturned on appeal, the Contractor shall be responsible for reactivating an Enrollee's Deductible Account in accordance with the date of eligibility reinstatement. To the extent that the Enrollee's eligibility is reinstated effective in the same Benefit Year during which eligibility was initially lost, upon the reinstatement of the Enrollee's Deductible Account, the Contractor shall apply the balance that was in effect as of the date of loss of eligibility;
- B. Benefits currently held by Enrollees who timely appeal a Cabinet termination of eligibility shall be continued while the appeal is pending. During the appeal period, the Contractor shall continue to send monthly premium invoices and collect premium payments in accordance with **Section 41.8 "Billing and Collections;"**
- C. Benefits shall not be continued during an appeal period if the Enrollee's appeal concerns an eligibility suspension for premium non-payment;
- D. If an appeal is related to an increase in premium amount, the Contractor shall invoice the Enrollee at the new premium amount, as reflected on the HIPAA 834. If the premium increase is overturned on appeal, the Contractor shall apply any overpayments made toward future months' premiums;

- E. Enrollees shall continue to receive State Plan benefits in the event that they timely appeal a transition to the ABP. If a change in benefits is appealed but not within the timeframe required to continue benefits in the State Plan, the Contractor shall provide coverage to the Enrollee via the ABP. Further, in the event that the Enrollee's benefit change is overturned on appeal, the Contractor shall transfer the Enrollee to State Plan benefits in accordance with the effective date of the appeal determination;
- F. The Contractor shall manage grievances related to Deductible Accounts in accordance with 42 CFR 428, Subpart F and **Section 24.0 "Enrollee Grievances and Appeals"** of this Contract. Further, the Contractor shall adjust each Deductible Account balance in alignment with the applicable grievance resolution and communicate any such balance updates in accordance with the Kentucky HEALTH Business Requirements;
- G. Appeals regarding Medically Frail determinations shall be processed by the Contractor in accordance with the appeals requirements at 42 CFR 428, Subpart F and **Section 24.0 "Enrollee Grievances and Appeals"** of this Contract. In the event that an Enrollee subsequently appeals the Contractor's appeal decision to the Cabinet, the Contractor shall comply with requests for documentation from the Department, its designee, or State Fair Hearings. The Contractor shall comply with the final determination of the Enrollee's Medically Frail status, including the application of benefits and cost sharing in accordance with Kentucky HEALTH policy; and
- H. Appeals of eligibility suspension due to premium non-payment shall be processed by State Fair Hearings; however, the Contractor shall provide to the Cabinet either proof of payment receipt, or non-payment.

41.17 Recertification

Kentucky HEALTH Enrollees shall complete an eligibility recertification every twelve (12) months, in accordance with 42 CFR §435.916. If eligibility is maintained at recertification, the Kentucky HEALTH Enrollee shall maintain enrollment in their current cost sharing plan (i.e., Premium Plan or Copayment Plan).

ACA Expansion Enrollees, Parent and Caretaker Relatives, and TMA Enrollees who are not Medically Frail and who fail to submit required recertification documentation within ninety (90) Days of their benefit end date shall be subject to a six (6) month recertification penalty, during which they shall be prohibited from re-enrolling in Kentucky HEALTH. Kentucky HEALTH Enrollees shall be exempted from the six (6) month recertification penalty period if they meet a just cause exemption, as defined by the Department. Additionally, Kentucky HEALTH Enrollees may complete a Re-Entry Course to initiate early re-entry into Kentucky HEALTH prior to the expiration of the six (6) month recertification penalty period.

To facilitate the continuous enrollment of Kentucky HEALTH Enrollees, and to minimize the number of Enrollees subject to the recertification penalty, the Contractor is encouraged to assist Enrollees in the recertification process. Permitted assistance may include:

- A. Conducting outreach calls and sending letters to Enrollees reminding them to renew their eligibility. All recertification call center scripts and letters shall be subject to Department approval in accordance with **Section 4.4 "Approval of Department;"**
- B. Reviewing recertification requirements with Enrollees;
- C. Answering questions about the recertification process; and
- D. Helping the Enrollee to obtain required documentation and collateral verification needed to process the recertification.

In providing recertification assistance, the Contractor shall be prohibited from the following:

- A. Discriminating against Enrollees, particularly high-cost Enrollees or Enrollees that have

- indicated a desire to change MCOs;
- B. Talking to Enrollees about changing MCOs. If an Enrollee has questions or requests to change MCOs, the Contractor shall refer the Enrollee to the Department;
 - C. Providing any indication as to whether the Enrollee may be eligible;
 - D. Engaging in or supporting fraudulent activity in association with helping the Enrollee complete the recertification process;
 - E. Signing the Enrollee's recertification forms; and
 - F. Completing or sending recertification materials to DCBS on behalf of the Enrollee.

The Contractor shall provide recertification assistance equally across its membership and be able to demonstrate to the Department that its recertification-related procedures are applied consistently for each Enrollee.

41.18 Kentucky HEALTH Contract Compliance Requirements

The Contractor shall comply with the Kentucky HEALTH performance standards described in this Section. Failure to meet these standards shall subject the Contractor to the penalties described herein, and as applicable, the remedies in **Section 39.0 "Remedies for Violation, Breach, or Non-Performance of Contract."**

41.18.1 Premium Collection

The Contractor shall provide premium collection services in accordance with the standards described below.

- A. Premium invoices shall be sent to Conditionally Eligible Enrollees within three (3) Business Days of receipt of the HIPAA 834 indicating conditional eligibility.
- B. Ongoing premium invoices shall be sent to Kentucky HEALTH Enrollees enrolled in the Premium Plan by the fifteenth day of the month for the subsequent month's coverage.
- C. Contractor invoice information shall be sent to IEES for each Kentucky HEALTH Enrollee and Conditionally Eligible Enrollee with a premium obligation in accordance with the Kentucky HEALTH Business Requirements.
- D. Record of premium payment receipt or non-payment for Kentucky HEALTH Enrollees shall be sent to IEES in accordance with Kentucky HEALTH Business Requirements no later than the sixth of each month.
- E. Record of premium payment or non-payment for Conditionally Eligible Enrollees shall be sent to IEES in accordance with Kentucky HEALTH Business Requirements no later than seventy-five (75) Days after the Conditionally Eligible Enrollee's eligibility determination.

APPENDICES

APPENDIX A. CAPITATION PAYMENT RATES

Incorporated by reference, upon actuarial certification and notification to the Contractor.

APPENDIX B. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE

This Appendix includes deficiencies for which the Department may invoke penalties. The Department in its sole discretion reserves the right to assess penalties, as applicable, for any violation not listed in this Appendix and in compliance with Kentucky statutes.

| No. | Deficiencies | Penalty Amounts |
|--|---|--|
| Readiness Reviews and Initiating Operations | | |
| 1. | Failure to meet readiness review requirements as set forth in Section 8.0 “Readiness Review” within timelines as set by the Department, including non-submission of deliverables or submitting deliverables late, with inaccuracies or incomplete. | Up to \$5,000.00 per day for each day of non-compliance or \$5,000.00 per deliverable for non-submission, late, inaccurate, or incomplete deliverables. |
| 2. | Failure to be operational by the agreed upon operational start date, based on DMS determination as to when the Contractor is considered to be operational. | Up to \$10,000.00 per day for each day beyond the Operational Start Date that the Contractor is not operational until the day that the Contractor is fully operational. |
| 3. | Failure to test and ensure the Contractor’s Management Information System, as set forth in Section 15.0 “Management Information System” is fully operational and meets all Contract requirements prior to the Operational Start Date. | Up to \$10,000.00 per day. |
| Administration and Management | | |
| 4. | Failure to comply with licensure requirements, as set forth in Section 3.0 “Contractor Terms.” | \$5,000.00 per day that Contractor or Provider is not licensed or qualified as required by applicable state or local law plus the amount paid to the Provider during that period. |
| 5. | Violation of a subcontracting requirement as set forth in Section 6.0 “Subcontracts” and other sections of the Contract as applicable. | Up to \$25,000.00 per violation. |
| 6. | Failure to comply with the Contractor staffing requirements, as set forth in Section 9.0 “Organization and Collaboration.” | Up to \$5,000.00 per day for each separate failure to comply, for the first 30 days non-compliance. At its discretion, the Department may double this amount for each day after thirty (30) days for each specific instance that the Contractor remains non-compliant. |
| 7. | Failure to have appropriate staff member(s) attend meetings as requested and designated by the Department. | \$250.00 per appropriate staff person per meeting as requested by the Department. |

| No. | Deficiencies | Penalty Amounts |
|---|---|---|
| 8. | Failure of the Contractor to respond to a Letter of Concern (LOC) within two (2) business days of receipt of the Letter of Concern or to provide a sufficient response as set forth in Section 39.3 “Requirement of Corrective Action.” | \$500.00 per day for each day until the response is received and \$1,000.00 for failure to sufficiently respond sufficiently to an LOC request. |
| 9. | Failure of the Contractor to submit a Corrective Action Plan within ten (10) business days following the date of the Written Deficiency Notice or to provide an acceptable Corrective Action Plan as set forth in Section 39.3 “Requirement of Corrective Action.” | \$1000.00 per day for each day until the Corrective Action Plan is received. \$5,000.00 for failure to provide an acceptable initial Corrective Action Plan as determined by the Department and \$500.00 per day from the date of the Written Deficiency Notice for each day the Corrective Action Plan remains deficient. |
| 10. | Failure to timely implement and comply with an accepted Corrective Action Plan as set forth in Section 39.3 “Requirement of Corrective Action.” | \$500.00 per day for each day the Contractor fails to comply with an accepted Corrective Action Plan as determined by the Department. |
| 11. | For requests not otherwise specifically addressed in this Contract, failure to respond or to submit a complete or accurate written response to a Department’s written request within the designated timeframe. | \$500.00 per day penalty until the response is received, complete or accurate, whichever is applicable |
| 12. | Failure to disclose activities related to or to comply with Conflict of Interest, Lobbying, and/or Gratuities requirements, as set forth in Section 40.0 “Miscellaneous.” | 110% of the total amount of compensation paid by the Contractor to inappropriate individuals. \$1,000.00 per day that disclosure is late. |
| 13. | Failure to provide notice of any known or suspected conflicts of interest or criminal conviction disclosures, as set forth in Section 40.0 “Miscellaneous.” | \$1,000.00 per day that disclosure is late. |
| Financial Requirements and Reimbursement | | |
| 14. | Failure to submit accurate and complete information or respond to a Department request regarding Medical Loss Ratio Calculation within the requested timeframe and as defined in Section 11.4 “Medical Loss Ratio Adjustment.” | \$500.00 per day until the information or response is received |

| No. | Deficiencies | Penalty Amounts |
|----------------------------|--|--|
| 15. | Failure to seek, collect and/or report third party information, as set forth in Section 14.2 “Third Party Liability.” | Up to \$5,000.00 per day. |
| 16. | Failure to submit the required report of the total amount paid to each FQHC and RHC per month within the required timeframe and as set forth in Section 29.5 “Payment of Federally Qualified Health Centers (“FQHC”) and Rural Health Clinics (“RHC”).” | \$500.00 per day until the information is received. |
| 17. | Failure to remit an overpayment amount as identified through audit of claims paid by the Contractor within the timeframe and as set forth in Section 36.4 “Audit by Department or its Designee.” | \$500.00 per incident. |
| Information Systems | | |
| 18. | Failure of the Contractor’s MIS to meet all requirements in Section 15.0 “Management Information System” at any given time during operations. | Up to \$5,000.00 per day of non-compliance. |
| 19. | Failure of the Contractor to provide notice to the Department, as set forth in Section 15.0 “Management Information System” at least ten (10) days prior to implementation of any significant system changes that may impact data integrity, including such changes as new Claims processing software, new Claims processing vendors, and significant changes in personnel. | Up to \$5,000.00 per day of non-compliance. |
| Encounter Data | | |
| 20. | <i>Timeliness of Encounter Files.</i> Failure of the Contractor to submit the Encounter File within five (5) business days from the scheduled submission due date as set forth in Section 16.0, Encounter Data. | \$5,000.00 per day late fee. Penalties for encounter timeliness shall be capped at five percent (5%) of the Contractor’s monthly capitation rate. |

| No. | Deficiencies | Penalty Amounts |
|-----|---|--|
| 21. | <i>Timeliness of Encounters from Adjudication Date.</i> Failure of the Contractor to submit an Encounter File with all of the Encounters within thirty (30) days from the adjudication date as set forth in Section 16.0 “Encounter Data.” | Five dollars (\$5.00) per day per encounter late fee calculated as follows: the total number of days between adjudication and submission for the Encounter submitted in the Encounter File; 30 days are then subtracted from the days submitted for that Encounter. The late fee of \$5.00 per encounter is then assessed for each day over the 30 days. Penalties for encounter timeliness shall be capped at five percent (5%) of the Contractor’s monthly capitation rate. |
| 22. | <i>Timely Resubmission of Erred Encounters.</i> Failure to resubmit erred encounter records within thirty (30) days from receipt of the 277U Erred Record Report as set forth in Section 16.0 “Encounter Data.” | Five dollars (\$5.00) per day late fee per encounter over thirty (30) days. An additional penalty for FQHCs and RHCs encounters of \$11.00 per day shall be assessed for each day greater than thirty (30) days. Penalties for encounter timeliness shall be capped at five percent (5%) of the Contractor’s monthly capitation rate. |
| 23. | <i>Accuracy: Threshold Error.</i> Submission of an Encounter File that exceeds a five (5%) percent threshold error rate as set forth in Section 16.0 “Encounter Data.” | Per Encounter File error fee of 1,000.00. Penalties for encounter accuracy shall be capped at five percent (5%) of the Contractor’s monthly capitation rate. |
| 24. | <i>Accuracy: File Not in Required Format.</i> Failure of the Contractor to submit encounter data in the required form or format (as required by DMS, 837, ASC X12 EDI for Electronic Data Interchange and the KY Companion Guide or current industry standard with appropriate KY Companion Guide) for one calendar month as set forth in Section 16.0 “Encounter Data.” | \$50,000 per file. Penalties for encounter accuracy shall be capped at five percent (5%) of the Contractor’s monthly capitation rate. |
| 25. | <i>Accuracy: Duplicates.</i> Submission of duplicate encounter submissions as set forth in Section 16.0 “Encounter Data.” | Monthly \$5.00 per duplicate encounter fee or the amount of the encounter, whichever is greater. Penalties for encounter accuracy shall be capped at five percent (5.0%) of the Contractor’s monthly capitation rate. |

| No. | Deficiencies | Penalty Amounts |
|------------------------------------|---|---|
| 26. | <i>Completeness: Failure to Submit Required Attestation.</i> Failure of the Contractor to submit the required attestation showing all failed files were successfully resubmitted and accepted within thirty (30) days of notification as set forth in Section 16.0 “Encounter Data.” | \$10,000.00 per file and an additional penalty of \$1,000.00 per each late day beyond the thirty (30) days of notification. Penalties for encounter completeness shall be capped at five percent (5.0%) of the Contractor’s monthly capitation rate. |
| 27. | Encounter records are not resubmitted within thirty (30) days of the date the record is returned, as set forth in Section 16.0 “Encounter Data.” | Per Encounter File error fee of \$1,000.00. |
| Quality and Health Outcomes | | |
| 28. | Failure to submit quality measures including audited HEDIS and CAHPS results within required timeframes, as set forth in Section 19.0 “Quality Management and Health Outcomes” | \$1,000.00 per day for every day reports are late. |
| 29. | Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in Section 19.0 “Quality Management and Health Outcomes.” | \$100,000.00 per month for every month beyond the month NCQA accreditation must be obtained. |
| 30. | Failure to achieve performance targets for each quality performance measure as set forth in Section 19.0 “Quality Management and Health Outcomes.” | Up to \$100,000.00 per violation. |
| 31. | Failure to achieve annual targeted health outcomes measures as set forth in Section 19.0 “Quality Management and Health Outcomes.” | Up to \$100,000.00 per violation. |
| 32. | Failure to timely submit appropriate PIPs to the Department as set forth in Section 19.0 “Quality Management and Health Outcomes.” | Up to \$1,000.00 per day beyond the due date for which an appropriate PIP is received. |
| Utilization Management | | |
| 33. | Failure to provide a written discharge plan or provision of a defective discharge plan for short-term and long-term hospital stays and institutional stays as set forth in Section 20.1 “Utilization Management.” | \$1,000.00 per occurrence per case. |

| No. | Deficiencies | Penalty Amounts |
|-----|--|--|
| 34. | | |
| 35. | Imposing arbitrary utilization guidelines, prior authorization restrictions, or other quantitative coverage limits on an Enrollee as prohibited under the Contract or not in accordance with an approved policy. | \$5,000.00 per occurrence per Enrollee. |
| 36. | Failure to provide a timely and content-compliant Notice of Adverse Benefit Determination in accordance with Section 20.0 “Utilization Management.” | \$500.00 per day Contractor is in default. |
| | Enrollee Services | |
| 37. | Failure to obtain approval of Enrollee materials, as set forth in Section 22.0 “Enrollee Services.” | \$500.00 per day for each day that the Department determines the Contractor has provided Enrollee materials that have not been approved by the Department. |
| 38. | Failure to comply with timeframes for providing Enrollee materials to Enrollees as set forth Section 22.0 “Enrollee Services.” | \$250.00 per occurrence per Enrollee. |
| 39. | Engaging in prohibited marketing activities or discriminatory practices or failure to market statewide, as set forth in Section 25.0 “Marketing.” | Up to \$5,000.00 per occurrence. |
| 40. | Failure of Contractor to issue written notice to Enrollees upon Provider’s notice of termination in the Contractor’s plan, as set forth in Section 28.10 “Termination of Network Providers.” | \$1,000.00 per occurrence. |
| | Complaints, Grievances and Appeals | |
| 41. | Failure to resolve at least 99% of Enrollee and provider complaints within required timeframes from the date the complaint, grievance or appeal is received. | Up to \$250.00 per reporting period. |
| 42. | Identification of a systemic failure of Contractor’s Appeal System, as evidenced by Contractor’s failure to meet compliance requirements for any aspect of the Appeal system in over 20% of Appealed cases during a 60-day period. | \$500.00 per day Contractor is in default until an approved corrective action plan is fully implemented by the Contractor. |

| No. | Deficiencies | Penalty Amounts |
|--------------------------------------|--|---|
| 43. | Failure to maintain a Grievance or Appeal System as set forth in Section 24.0 “Enrollee Grievances and Appeals.” | \$500.00 per day Contractor is in default. |
| 44. | Failure to resolve Enrollee appeals and grievances within required timeframes as set forth in Section 24.0 “Enrollee Grievances and Appeals.” | Up to \$5,000.00 per violation. |
| 45. | Failure to comply with all orders and final decisions relating to claim disputes, grievances, appeals and/or State Fair Hearing as issued or as directed by the Department and as set forth in Section 24.0 “Enrollee Grievances and Appeals.” | \$5,000.00 per occurrence. |
| 46. | Failure to provide continuation or restoration of services where Member was receiving the service as required by Department rules or regulations, applicable Kentucky or federal law, and all appeal procedures as set forth in Section 24.0 “Enrollee Grievances and Appeals.” | The value of the reduced or terminated services as determined by the Department for the timeframe specified by the Department, and \$500.00 per day for each day the Contractor fails to provide continuation or restoration as required by the Department. |
| 47. | Failure to comply with Transition of Care requirements as set forth in Section 26.0 “Enrollee Eligibility, Enrollment, and Disenrollment.” | \$100.00 per day, per Enrollee and the value of the services the Contractor failed to cover during the applicable transition of care period, as determined by the Department. |
| Provider Services and Network | | |
| 48. | Failure to comply with requirements to work with any identified Credentialing Verification Organization (CVO) designated by the Department as set forth in Section 27.8 “Transition to a Credentialing Verification Organization (CVO).” | \$5,000.00 per incident. |
| 49. | Failure to comply with requirements and timeframes to process credentialing packets as set forth in Section 27.8 “Transition to a Credentialing Verification Organization (CVO).” | \$5,000.00 per incident. |
| 50. | Failure to maintain provider agreements as set forth in Section 28.0 “Provider Network.” | Up to \$5,000.00 per provider agreement found to be non-compliant. |
| 51. | Failure to provide an adequate provider network of physicians, pharmacies, hospitals and other specified health care providers for 95% of Enrollees as set forth in Section 28.0 “Provider Network.” | Up to \$10,000.00 per violation. |

| No. | Deficiencies | Penalty Amounts |
|--------------------------|---|--|
| 52. | Failure to provide covered services within the timely access, distance, and wait-time standards as described in Section 28.0 “Provider Network.” | \$2,500.00 per month for failure to meet any of the listed standards, either individually or in combination. |
| 53. | Failure to comply with Department-specified definitions of provider types for purposes of determining provider network adequacy as set forth in Section 28.0 “Provider Network.” | Up to \$5,000.00 per incident. |
| 54. | Failure to submit a Provider Enrollment File that meets the Department’s specifications, as set forth in Section 28.0 “Provider Network.” | \$1,000.00 per day after the due date that the Provider Enrollment File fails to meet the Department’s specifications. |
| 55. | Failure to maintain accurate provider directory information as set forth in Section 28.0 “Provider Network.” | \$500.00 per confirmed incident. |
| Claims Processing | | |
| 56. | Failure to comply with prompt pay requirements as set forth in Section 29.0 “Provider Payment Provisions” and as required in Kentucky regulations. | <p>As set forth in KRS 304.99-123, Contractor is subject to the following :</p> <p>A fine of \$1,000.00 per day or 10% of the unpaid claim amount, whichever is greater, for each day that a clean claim remains unpaid in violation of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123</p> <p>and</p> <p>When determined non-compliant with timely payment for the required percentages of clean claims, a fine of up to \$10,000.00 where the Commissioner determines the Contractor has willfully and knowingly violated KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 or has a pattern of repeated violations of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.</p> |
| Covered Services | | |

| No. | Deficiencies | Penalty Amounts |
|--------------------------------|---|---|
| 57. | Failure to timely provide a covered service as required under this Contract or when not specified therein, with reasonable promptness. | The cost of services not provided plus \$500 per day, per occurrence, for each day that covered service is not provided timely. |
| 58. | Failure to timely provide a covered service as required under this contract when determined by the Department that such failure results in actual harm to an Enrollee or places an Enrollee at risk of imminent harm. | Up to \$7,500.00 per day for each incidence of non-compliance. |
| 59. | Failure to timely authorize and arrange provision of a service under this Contract as directed by the Department and in accordance with 42 C.F.R. 438.210(d). | <p>\$500.00 per per standard service authorization request for each day the Contractor is in default, and at the Department's discretion, an additional amount for one of the following: (1) amounts sufficient to offset any savings Contractor garnered by failing to authorize provision of the service, or (2) actual cost to have the service covered.</p> <p>\$750.00 per expedited service authorization request for each day the Contractor is in default, and at the Department's discretion, an additional amount for plus one of the following: (1) amounts sufficient to offset any savings Contractor garnered by failing to authorize provision of the service, or (2) actual cost to have the service covered.</p> |
| 60. | Failure to comply with this Contract and federal rules/law regarding hysterectomies, sterilizations, or abortions. | \$500.00 per occurrence or the actual amount of the federal penalty created by the Contractor's failure to comply, whichever is greater. |
| 61. | Failure to provide coverage for prenatal care without a delay in care and in accordance with Section 32.5 "Maternity Care." | \$500.00 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Contract. |
| 62. | | |
| EPSDT | | |
| 63. | Failure to comply with obligations and timeframes in the delivery of EPSDT services as set forth in Section 32.1 "EPSDT, Early and Periodic Screening, Diagnosis and Treatment." | \$1,000.00 per violation. |
| Children in Foster Care | | |

| No. | Deficiencies | Penalty Amounts |
|--------------------------|---|---|
| 64. | Failure to respond to a request by DCBS or DMS to provide service(s) to a child at risk of entering DCBS custody. | The actual amount paid by DCBS and/or DMS for necessary services or \$1,000.00, whichever is greater. |
| 65. | Denial of a request for services to a child at risk of entering DCBS custody when the services have been reviewed and authorized by the Department's Chief Medical Officer. | The actual amount paid by DCBS and/or DMS for necessary services or \$1,000.00, whichever is greater. |
| Program Integrity | | |
| 66. | Failure to comply with fraud and abuse provisions not otherwise noted in this section. | \$1,000.00 per day for each day of non-compliance. |
| 67. | Failure to remit an amount or balance of a provider overpayment within the timeframes set forth in Section 36.4 "Audit by Department or its Designee." | \$500.00 per incident. Note: DPI discussed potentially changing such that whoever identifies the overpayment (MCO or DMS) keeps it. MCO would only keep it they acted on it within 180 days under current requirements – would like to see that changed to collecting it within 180 days. |
| 68. | Failure to identify a minimum of two percent (2%) in provider overpayments and prepayment cost avoidance related to Fraud and Abuse of the Monthly Benefit Payments total as reported. | \$5,000 on the first monthly occurrence, \$10,000 on the second occurrence and \$15,000 on the third and subsequent occurrence. |
| 69. | Failure of the Contractor's PIU to conduct a minimum of three (3) site visits per calendar quarter. | \$10,000 dollars per visit not conducted per calendar quarter. |
| 70. | Failure of the contractor to attend any required training or meeting related to program integrity, given by the Division of Program Integrity, Fiscal Agent, its designees, or other Contractor's organizations. | \$1,000 penalty per occurrence. |
| 71. | Failure to collect an outstanding debt owed to the Department from providers and releasing payments to the providers. | \$1,000 penalty if disclosed by the Contractor, a \$10,000 penalty per occurrence if discovered by the Department. |
| 72. | Failure to respond to informational or reporting requests whether recurring or a one-time request from the Department, the OIG, the OAG, or any other agent or contractor of the Department within the timeframe requested. | \$500 a day penalty until the information is received. The Contractor may request an extension prior to the deadline of the request(s). |

| No. | Deficiencies | Penalty Amounts |
|--|--|---|
| 73. | Failure to meet the provisions regarding two (2) full time investigators located in Kentucky with their caseload 100% dedicated to the Kentucky Medicaid Market. | \$5,000 on the first monthly occurrence, a penalty of \$10,000 on the second occurrence, \$15,000 on the third and subsequent occurrences. |
| 74. | Failure to request the Department's permission to administratively collect overpayments in excess of \$500 prior to collection. | A forfeiture of the amount collected from the provider by the Contractor and a \$10,000 penalty per occurrence. |
| 75. | Failure to submit or comply with the requirements of the Department-approved Program Integrity Plan and specific program integrity reporting. | Up to \$1,000.00 per day for each incident of non-compliance. |
| Data, Reporting Requirements and Deliverables | | |
| 76. | Failure to submit complete and accurate data except for encounter submission or if otherwise addressed in the Contract. | \$1,000.00 per determination. |
| 77. | Failure of the Contractor to provide a paid claims listing by the required date as set forth in Section 37.1 "General Reporting and Data Requirements." | \$50,000.00 per hospital and \$1,000.00 per day until provided. \$25,000.00 for any paid claims listing that is not in the required format, or is determined to contain errors or omissions. |
| 78. | Failure to provide a required report or deliverable set forth in Appendix D, Reporting Requirements and Reporting Deliverables in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting or deliverable errors within five (5) business days or other required timelines upon notification by the Department | \$250 per day until the violation is remedied, deducted from the next month's Capitation Payment. |
| Enrollee Confidentiality and Protected Health Information | | |
| 79. | Failure to ensure client confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of non-compliance will be assessed as per member and/or per HIPAA regulatory violation, as set forth in Section 38.0 "Records Maintenance and Audit Rights." | Up to \$5,000.00 for each breach. |
| 80. | Failure to ensure that all Kentucky Medicaid data containing protected health information (PHI), as defined by HIPAA, is secured as set forth in Section 38.0 "Records Maintenance and Audit Rights." (See also Business Associate Agreement). | \$500.00 per Enrollee per occurrence, and if the Commonwealth deems credit monitoring and/or identity theft safeguards are needed to protect those Enrollees whose PHI was placed at risk by Contractor's failure to comply with the terms of this Contract, the Contractor shall be liable for all costs associated with the provision of such monitoring and/or safeguard services. |

| No. | Deficiencies | Penalty Amounts |
|------------------------|---|---|
| 81. | Failure to seek express written approval from the Department prior to the use or disclosure of Enrollee data or Kentucky Medicaid confidential information as set forth in Section 38.0 “Records Maintenance and Audit Rights.” (See Business Associate Agreement). | \$1,000.00 per Enrollee or per occurrence. |
| 82. | Failure to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach (See also Business Associate Agreement). | \$500.00 per Enrollee per occurrence, not to exceed \$10,000,000.00. |
| Kentucky HEALTH | | |
| 83. | Failure to meet a requirement set forth in Section 41.18.1 “Premium Collection.” | \$1000.00 for each instance. If the results of an audit of payment files indicate that payment files are not ninety-five percent (95%) accurate and complete, the Contractor shall pay a penalty in an amount that corresponds the percentage of error to the percentage of capitation payment received by the Contractor during the audit period for the Kentucky HEALTH population. For example, If the audit indicates an error rate of 5%, then Contractor shall be penalized 5% of the total capitation payments received by it during the audit period for the Kentucky HEALTH population. |
| 84. | Results of an audit of Kentucky HEALTH Medically Frail determinations indicate that inappropriate determinations have been made in greater than ten percent (10%) of the audited cases as set forth in Section 41.0 “Kentucky HEALTH Policies and Performance Requirements.” | An amount that corresponds to the percentage of error above 10% of capitation payment received by the Contractor during the audit period for the Kentucky HEALTH population. |
| 85. | Failure to transmit completion of activities which qualify a Member for My Rewards Account accrual as set forth in Section 41.0 “Kentucky HEALTH Policies and Performance Requirements.” | \$1000.00 for each instance. |

APPENDIX C. REQUIRED STANDARD PROVISIONS FOR NETWORK PROVIDER CONTRACTS

The Contractor shall develop and implement provider contracts in accordance with this Contract and all applicable federal and State statutes, regulations, policies, procedures and rules, including but not limited to, 42 CFR 434, 42 CFR 438.214, 42 CFR 438.6 and 42 CFR 438.808. The Contractor shall include provisions to address the below items in its provider contracts, as applicable to the provider type. The parties agree and acknowledge that the Department may require amendment of provisions or additional provisions for the Contractor's provider contracts. All template provider contracts and amendments must be approved in writing in advance by the Department and the Contractor. These requirements also apply to Subcontractors that are developing provider networks.

A. General Provisions

1. Identify the parties to the provider contract and their legal basis of operation in the Commonwealth of Kentucky;
2. Require the provider to comply with all applicable Commonwealth and federal statutes, regulations, policies, procedures and rules;
3. Specify that during the term of the provider contract, the provider shall indemnify and hold CHFS harmless from all claims, losses, or suits relating to activities undertaken by the provider pursuant to this Contract;
4. Specify that the provider is not a third party beneficiary to this Contract and that the provider is performing services as agreed upon with the Contractor and outlined in this Contract;
5. Specify that if the Department determines that any provider contract provision conflicts with this Contract, such provision shall be null and void and all other provisions shall remain in full force and effect; and
6. Require that the provider maintain through the terms of this Contract and at its own expense professional and comprehensive general liability and medical malpractice insurance.

B. Marketing

Include Marketing restrictions as applicable and described in this Contract.

C. Provision of Services

1. Identify the Covered Services, tasks, and reporting to be performed by the provider, including provision(s) describing how Enrollees access Covered Services provided under the provider contract terms;
2. Provide that emergency services will be rendered without a requirement for prior authorization;
3. State that if the provider contract includes primary care services, PCP requirements set forth in this Agreement shall apply;
4. Require laboratory service providers to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988; and
5. Require providers to meet appointment waiting time standards set forth in this Contract.

D. Enrollee Services

1. Specify Medicaid populations to be served;

2. Require the provider to comply with Enrollee rights and responsibilities as outlined in this Contract;
3. Require Contract Providers to comply with applicable cultural competency requirements;
4. Require that Enrollee information be kept confidential, as defined by federal and State statutes or regulations;
5. Require that the provider display notices of the Enrollee's right to appeal adverse action affecting services in public areas of the provider's facility(ies) in accordance with Department rules and regulations, subsequent amendments; and
6. Specify the provider's responsibilities and prohibited activities regarding Enrollee cost sharing.

E. Quality and Utilization Management

1. Describe, as applicable, any physician incentive plan and/or value-based payment program to which the provider is subject to participation;
2. Provide for the provider's participation and cooperation in internal and external quality management or quality improvement activities, such as, monitoring, utilization review, peer review and/or appeal procedures established by the Contractor and/or the Department;
3. Include the definition and standards for Medical Necessity as required under this Contract;

F. Claims and Payment

1. Include the reimbursement rates and terms that the Contractor will pay the provider under the provider contract;
2. Provide for prompt submission of information needed to make payment;
3. Require provider submission of timely, complete, and accurate Encounter Claims;
4. Provide for timely payment to the provider for Covered Services upon approval of a clean claim properly submitted by the Provider within the required timeframes;
5. Specify acceptable billing and coding requirements;
6. Specify the provider's responsibilities for third party liability (TPL); and
7. State that the provider shall accept payment from the Contractor as payment for services performed, and cannot request payment from the Department or the Enrollee, unless the Member is required to pay a copayment for the service rendered.

G. Records Maintenance and Audit Requirements

1. Require providers to maintain all records relating to services provided to Enrollees for a ten (10) year period and to make all Enrollee medical records or other service records available for the purpose of quality review conducted by the Department, or their designated agents both during and after the term of the provider agreement; and
2. Include a provision that authorized representatives of the Department, or other Commonwealth and federal agencies shall have reasonable access to premises, physical facilities, equipment and records for financial and medical audit purposes both during and after the term of the Provider contract.

H. Oversight and Monitoring

1. Include a provision for the timely submission to the Contractor of any information, including reports and clinical information, necessary for the Contractor to perform its obligations under this Contract;
2. State that the Contractor will monitor the provider's performance on an ongoing basis and subject the provider to formal periodic review;
3. Provide for Contractor monitoring of the provider's performance and quality of services delivered under the provider contract; and
4. Require the provider to comply with corrective action plans required by the Contractor.

I. Program Integrity

1. Require, as a condition of receiving any amount of payment, that the provider comply with Program Integrity requirements of this Contract, as applicable.

J. Non-allowable Provisions

The Contractor shall not include in its provider contracts provisions that:

1. Prohibit a provider from entering into a contractual relationship with another MCO contracted to provide services for the Kentucky Medicaid managed care program;
2. Include incentives or disincentives that encourage a provider not to enter into a contractual relationship with another MCO contracted to provide services for the Kentucky Medicaid managed care program;
3. Contain any provisions that prohibit or otherwise restrict health professionals from advising patients about their health status or medical care or treatment as provided in section 1932(b)(3) of the Social Security Act or 42 CFR 438.102;
4. Prohibit a provider from acting within the provider's lawful scope of practice;
5. Prohibit a provider from discussing treatment or non-treatment options with Enrollees that may not reflect the Contractor's position or may not be covered by the Contractor;
6. Prohibit a provider from advocating on behalf of the Member in any Grievance System or Utilization Review process, or individual authorization process to obtain necessary Covered Services; and
7. Require a provider to participate or accept other plans or products offered by the Contractor unrelated to providing Covered Services to Enrollees.

K. Termination

1. Include criteria and procedures for terminating the provider contract including provisions for termination for any violation of applicable State or federal statutes, rules, and regulations and in accordance with this Contract;
2. Specify that the Department reserves the right to direct the Contractor to terminate or modify the provider contract when the Department has determined such termination or modification is in the best interest of the Commonwealth; and
3. Provide for continuity of care when a provider's participation terminates during the course of an Enrollee's treatment by the provider.

APPENDIX D. REPORTING REQUIREMENTS AND REPORTING DELIVERABLES

As described in Section 37. Reporting Requirements, the Department will collaborate with the MCOs to develop a finalized reporting package with the Department having final decision-making and approval of required reports. The below table provides a sample of reports the Department will require the Contractor to submit. However, the listing is subject to change based on the finalized reporting package as well as throughout the Contract Term when the Department identifies need for differing reports.

| No | Report Name | Description | Frequency |
|---|--|--|---|
| Administrative and Financial Reports | | | |
| 1 | Annual Managed Care Program Report | The Annual Managed Care Program Report should include financial performance, encounter data reporting, enrollment, benefits covered, grievances and appeals, availability and accessibility of covered services, evaluations of plan performance on quality measures and sanctions or corrective active plans. Narrative must be provided that details the Contractor's overall assessment of operations and impact to quality of care and healthcare outcomes for Enrollees. For identified challenges and where healthcare outcomes have not changed, include an assessment of the reasons and initiatives the Contractor will conduct to work to address. Trend analysis should be provided where appropriate. Information in this report will support the Department with requirements of 42 CFR 438.66 to submit annual reporting to CMS. | Annually |
| 2 | Operating Report | Report of each entity/Subcontractor of the Contractor, providing evidence of Contractor oversight activities and performance (e.g., performance metrics, corrective actions, sanctions). Include detailed description of entity/subcontractor role and reporting requirements. | Annually |
| 3 | NAIC Financial Statements | The Contractor shall comply with the Kentucky Department of Insurance (DOI) requirements for filing requirements for NAIC Financial Statements and Supplements. The Contractor shall submit a copy of the NAIC Financial Statement and Supplements, and any revisions to such, to the Department for Medicaid Services (Department) at the same time of submissions to the DOI. | Quarterly and Annually |
| 4 | Audit and Internal Control Reports | The Contractor shall comply with DOI requirements for Audit and Internal Control reporting as referenced in the DOI NAIC Checklist for Health. The Contractor shall submit a copy of the reports, and any revisions to such, to the Department at the same time of submissions to the DOI. | Annually |
| 5 | Statement on Standards for Attestation Engagements (SSAE) No. 16 | Provide the Statement on Standards for Attestation Engagements (SSAE) No. 16 Type II audit that addresses the engagements conducted by services providers on service organization for reporting design control and operational effectiveness. | Annually |
| 6 | Medical Loss Ratio (MLR) Report | Provides information on the components of the MLR, Department-defined MLR calculations, including but not limited to an accounting of expenditures on activities that improve health care quality and consistent with 42 C.F.R. 438.8(k) and 438.74. | Quarterly and Annually with Annual Audits |
| 7 | Total Cost of Care (TCOC) Per Member Per Month (PMPM) | Provides a summary of cost drivers and activities the Contractor will conduct to address the drivers and mitigate future cost growth, where possible. | Annually |

| No | Report Name | Description | Frequency |
|----------------------------------|--|--|-------------------|
| 8 | Expenditures Related to MCO's Operations | Provides the Executive Management's salary, bonus, other compensation, travel and other expenses based upon the reporting period. | |
| 9 | Pass-Through Payment Reporting | Provider pass-through payments are paid as a separate PMPM add-on to the capitation rates vary by region/rate cell. Payments are reconciled after a six (6) month runout period. It may be helpful to DMS to be able to track payment activity prior to reconciliation. | Quarterly |
| Enrollee Services Reports | | | |
| 10 | Enrollment Report | Provides summary of key enrollment data and activities. Examples of information that will be provided include: monthly enrollment and disenrollment by eligibility category, top 10 reasons for disenrollment, number of welcome packets, ID cards, and Enrollee Handbooks distributed to Enrollees (electronic and hard copy), and average time required for distribution of each. | Quarterly |
| 11 | Ineligible Assignment | Identify Enrollees for whom the Contractor identifies one of the following instances: <ul style="list-style-type: none"> • An Enrollee who the Contractor believes is not eligible for enrollment; • Conflicting Enrollee data elements; • A potential duplicate Enrollee assignment. When the potential ineligible Enrollee is identified through receipt of a HIPAA 834 transaction (daily or monthly), use the data received on the HIPAA 834 to complete the report. The MCO Comments field shall start with the date of the HIPAA 834 transaction. When the potential ineligible Enrollee conflicting data elements, or potential duplicate Enrollee assignments are identified through other means than the HIPAA 834 transaction, complete the report using the active data from the MCO Eligibility system. The Contractor may include in the MCO Comment field details as to why the Contractor thinks the Enrollee is a duplicate if the Enrollee deems the information critical for Department review. | Daily (as needed) |
| 12 | Newborn Enrollment Report | The 'Newborn' report indicates all newborns that are thirty (30) days or older for which the Contractor has not received a HIPAA 834 enrollment transaction. | Monthly |
| 13 | Changes in Primary Care Provider (PCP) Assignment Initiated by Enrollee, Provider, or MCO. | Provides changes in PCP assignment by eligibility category by source of initiation (Enrollee, Provider, or Contractor), and reasons for requested changes. Report includes analysis by Contractor of any trends over time (e.g., PCP panel changes greater than ten percent (10%) annually, multiple requests from same Enrollee, etc.) | Quarterly |
| 14 | Enrollee Outreach Report | Report that details progress of Enrollee outreach activities against Outreach Plan. Examples of information that will be provided include: <ul style="list-style-type: none"> • Summary of activities, including goal of activity, location or resource, activity, targeted Enrollee population(s) • Summary of Enrollee engagement by activity • Outcome of activity • Results that will be used by the Contractor to enhance operations, if applicable | Quarterly |
| 15 | Enrollee Services Annual Report | Report prepared by Enrollee Services staff for management to recommend changes, as applicable, to Enrollee services functions to improve either quality of care provided to Enrollees or method of delivery. Report should include a summary of changes the Contractor will implement. | Annually |

| No | Report Name | Description | Frequency |
|--|--|--|---|
| 16 | Enrollee Call Center Report | Provides Enrollee call center statistics on required metrics as measured by monthly averages and information about timeliness of resolution of requests. Includes reporting of average call volume statistics by monthly averages to assist in identifying spikes in calls against performance | Quarterly or more frequently as requested by Department |
| 17 | Marketing Activities Report | Report that details marketing activities. Examples of information that will be provided include: <ul style="list-style-type: none"> • Summary of activities, including goal of activity, location or resource, activity, targeted Enrollee population(s) • Listing of materials distributed (electronic and hard copy) • Estimated number of Enrollees reached • A total for all Splits/VDN and each individual Split/VDN is to be reported. | Quarterly |
| 18 | KY HEALTH Call Center Reports | KY HEALTH Report provides MCO reporting of call center performance in the areas of abandonment, blockage rate and average speed of answer. A total for all Splits/VDN and each individual Split/VDN is to be reported. | Monthly |
| 19 | EPSDT CMS – 416 Report | Specifications shall be in compliance with the most current CMS-416: Annual EPSDT Participation Report and shall be based on Federal Fiscal Year (FFY). | Annually |
| Provider Services and Network Reports | | | |
| 20 | Provider Credentialing and Contracting Status Report | Documents the following information at a minimum: - Credentialing status of providers requesting enrollment by Medicaid provider type and credentialing activity. - Number of providers by Medicaid provider type for which the Contractor provided assistance with Medicaid enrollment.- Number of providers by type - Number of newly contracted providers by Medicaid provider type.Providers who applied for credentialing and contracting under multiple provider types are to be reported under each type. Additionally, include location information for all requested information to identify, for example, potential shortage areas and network gaps. | Quarterly |
| 21 | Provider Network Status Report | Report documents information such as: - Additions to the Provider Network by provider type and Region. - Provider terminations from the Provider Network by provider type and region. Also stratified by reason type with summary detail of trends and how the Contractor is addressing areas of concern, where applicable. | Monthly |
| 22 | Provider Network File Layout | MCOs should provide MCO Provider Network File layouts as provided in Appendix L of the MCO Contract Appendices. | Monthly |
| 23 | Network Adequacy Exceptions Report | Report of active network adequacy exceptions approved by the Department, including date of approval, description of the network adequacy exception, description of how the Contractor is assuring Enrollees are receiving the necessary care, efforts the Contractor is making to address the deficiency, and progress. | Quarterly |

| No | Report Name | Description | Frequency |
|----|---|---|---|
| 24 | Primary Care Provider Assignment Report | Provides the following information at a minimum: - Provider Name, Provider Medicaid ID Number, NPI Number, number of Enrollees assigned by age category, total panel size (filled and open), percent change in Enrollee assignments. - Number of PCPs in network accepting new Enrollees and number of open panel slots. - Summary statistics by Region. Narrative description of identified areas of concern with access and Contractor activities to address. | Quarterly |
| 25 | GeoAccess Network Reports and Maps | Provide separate Geographical Access reports for each county addressing all Provider types specified by the Department, including separate analyses for the following: 1. Adult PCPs for ages twenty one (21) and over 2. Pediatric PCPs for children under the age of twenty one (21) 3. Adult Specialists 4. Pediatric Specialists 5. General Dentists 6. Telehealth Presentation Sites 7. Provider specialist shortages as identified by the Department or the Contractor including but not limited to Obstetrics (OB) Providers Prepare separate Geographical Access reports showing Providers with open panels only and showing all open and closed panel. | No less than quarterly, and more frequently as required by the Department |
| 26 | Timely Access Reports | Report demonstrating percentage of providers offering appointment wait times within specified timeframes by provider type as set forth in this Contract. Where percentages fall below a percentage set by the Department, include an explanation of how the Contractor is working to improve the percentages for the specified provider type. If corrective action plan required, report will include progress on actions taken. | No less than quarterly, and more frequently as required by the Department |
| 27 | Provider Compliance with Access Requirements Report | Summary of Contractor monitoring activities, findings, and opportunities for improvement of provider compliance with access standards, and a description of actions the Contractor will take to address the opportunities for improvement identified. | Annually |
| 28 | Denial of MCO Participation | Report documents any Provider or Subcontractor who is denied participation with the Contractor. Only those Providers or Subcontractors who are not currently participating with the Contractor are to be reported. | Monthly |
| 29 | Federally Qualified Health Centers and Rural Health Centers | Report provides the total amount paid to each Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) per month. All Providers with a specialty of FQHC or RHC are to be reported. | Quarterly |
| 30 | Provider Call Center Report | Provides Provider call center statistics on required metrics measured by monthly averages and information about timeliness of resolution of requests. Data should be reported by call center area (e.g., Provider Services, Utilization Management, Pharmacy Services). | Quarterly or more frequently as requested by Department |

| No | Report Name | Description | Frequency |
|------------------------|--|--|-----------|
| 31 | Telehealth Reporting | <p>Provide information and data on telehealth services to support the CHFS in providing an annual report to the Legislature as required under KAR 205.559. Information and data must be sufficient to enable the CHFS to analyze and report on the following:</p> <ol style="list-style-type: none"> 1. The economic impact of telehealth services on the Medicaid budget, including any costs or savings as a result of decreased transportation expenditures and office or emergency room visits; 2. The quality of care as a result of telehealth consultations; and 3. Any other issues deemed relevant by the CHFS. <p>In addition to the analysis required under KAR 205.557, report sufficient telehealth cost information to enable the CHFS report to compare telehealth reimbursement and delivery among all managed care partnerships or other entities under contract with the cabinet for the administration or provision of the Medicaid program.</p> | Annually |
| Quality Reports | | | |
| 32 | Report of Quality Improvement Activities; Monitoring Indicators, Benchmarks and Outcomes | Describe the quality assurance activities during the report period directed at improving the availability, continuity, and quality of services. Examples include problems identified from utilization review to be investigated, medical management committee recommendations based on findings, special research into suspected problems and research into practice guidelines or disease management. Include a narrative on the Contractor's progress in developing or obtaining baseline data and the required health outcomes, including proposed sampling methods and methods to validate data, to be used as a progress comparison for the Contractor's quality improvement plan. The report should include how the baseline data for comparison will be obtained or developed and what indicators of quality will be used to determine if the desired outcomes are achieved. | Annual |
| 33 | QAPI Status Reports | Report on status of QAPI activities. | Quarterly |
| 34 | QAPI Annual Report | <p>Report that provides an assessment of the effectiveness of the Contractor's QAPI program, included documentation for necessary changes. Examples of information the report will include are:</p> <ul style="list-style-type: none"> - Progress in implementing QAPI strategies and activities; - Effectiveness of QAPI program activities in impacting quality; - Findings of whether QAPI activities are completed timely and whether commitment of additional resources is necessary; - Findings that will drive change in program strategy, administration, or activities; and - Plan for implementing changes, including updated workplan. | Annually |
| 35 | Performance Improvement Projects Status Reports | Baseline, interim and final results reports that are to each be submitted in the format outlined in the Health Plan Performance Improvement Project document. Additional progress reports on the status of PIPs may be requested with report elements to be determined based on specific PIP. | Quarterly |

| No | Report Name | Description | Frequency |
|----|--|--|----------------------------|
| 36 | Audited HEDIS Reports | <p>Report audited HEDIS data annually as follows:</p> <ul style="list-style-type: none"> - Submit the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool. - For each measure reported, provide trending of results from previous years in chart and table format. Where applicable, indicate benchmark data and performance goals established for the reporting year. Include values for the denominator and numerator used to calculate the measures. - For all reportable Effectiveness of Care and Access/Availability of Care measures, stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age. | Annually |
| 37 | Other Quality and Performance Measurements Reports | Report of quality and performance measures other than HEDIS as specified by the Department, including stratification. | Quarterly and Annually |
| 38 | Member Satisfaction Survey Report | <p>Submit a copy of all survey results. Examples of information that will be included are as follows:</p> <ul style="list-style-type: none"> - A description of the survey conducted, and survey tool attached as an Exhibit; - A description of the survey methodology; - The number and percentage of Enrollees targeted to survey, by population grouping if specific Enrollee populations targeted; - Response rate by Enrollee population; - Comprehensive analysis of survey findings and action plan of interventions conducted or planned to address identified issues. <p>Include an evaluation describing the effectiveness of the previous' years interventions. After the first submission, submit updates on Contractor progress in implementing the action plan forty-five (45) days after the end of each quarter.</p> | Dependent on survey timing |
| 39 | Provider Satisfaction Survey Report | <p>Submit a copy of all survey results. Examples of information that will be included are as follows:</p> <ul style="list-style-type: none"> - A description of the survey conducted, and survey tool attached as an Exhibit; - A description of the survey methodology; - The number and percentage of providers targeted to survey, by population grouping if specific Enrollee populations targeted; - Response rate by provider type - Comprehensive analysis of survey findings and action plan of interventions conducted or planned to address identified issues. <p>Include an evaluation describing the effectiveness of the previous' years interventions. After the first submission, submit updates on Contractor progress in implementing the action plan forty-five (45) days after the end of each quarter.</p> | Dependent on survey timing |

| No | Report Name | Description | Frequency |
|-----------------------------------|--|--|-----------|
| 40 | Enrollee Appeals and Grievance Activity | <p>Document the number and types of informal and formal grievances and appeals received by or on behalf of Enrollees based on Category of Service. Examples of information that will be reported include:</p> <ul style="list-style-type: none"> - Number and types of grievances and appeals received, including identification of the top 10 types; - Disposition of all grievances and appeals (e.g., service denials or complaints, payment, quality of care) and status; - Number of grievances and appeals resolved by type of resolution (e.g., upheld, overturned); - The type of service and dollar amount for all overturned denials; and - Average turnaround times for resolution by type of grievance or appeal based on monthly totals. <p>In accordance with KRS 205.534, information shall be by provider category, as prescribed by the Department, and at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health services, and outpatient behavioral health services.</p> | Monthly |
| 41 | Provider Appeals and Grievance Activity | <p>Document the number and types of informal and formal grievances and appeals received by or on behalf of Enrollees based on Billing Provider Type/Category. Examples of information that will be reported include:</p> <ul style="list-style-type: none"> - Number and types of grievances and appeals received - Disposition of all grievances and appeals (e.g., service denials or complaints, payment, quality of care), status and final outcomes - Number of grievances and appeals resolved by type of resolution (e.g., upheld, overturned) - The type of service and dollar amount for all overturned denials - Average turnaround times for resolution by type of grievance or appeal based on monthly totals. <p>In accordance with KRS 205.534, information shall be by provider category, as prescribed by the Department, and at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health services, and outpatient behavioral health services.</p> | Monthly |
| 42 | KY HEALTH Grievance Activity - Members and Providers | <p>KY HEALTH Report provides summarized activity for both Member Grievances and Provider Grievances voiced to the MCO during the reporting period. Grievance means the definition established in 42 CFR 438.400. MCOs are to report:</p> <ul style="list-style-type: none"> - All Grievances received during the reporting period; - All Grievances received in prior periods that are resolved in the reporting period; All Grievances received in prior periods that have not been resolved. | |
| Pharmacy Reports | | | |
| 43 | Pharmacy Fraud, Waste and Abuse report | <p>Report by Prescriber, Pharmacies, and Enrollees. Include all cases acted upon during the reporting period. New cases, action taken on existing cases, and closed cases are to be identified and the outcome of the investigation documented. Report shall specify date of case, description of allegation/complaint, key findings, recoupment, and coordination activities with the Department and OIG.</p> | Quarterly |
| Capitation Payment Reports | | | |
| 44 | Capitation Payment Request | <p>Report of all Enrollees that the MCO identifies for which payment has not been received or an incorrect payment has been made. Only those months equal to or prior to the MMIS Managed Care Reconciliation Month (MMIS Recon Month) are to be reported.</p> | Monthly |
| 45 | Capitation Duplicate Payment | <p>Provides information for duplicate payments.</p> | Monthly |

| No | Report Name | Description | Frequency |
|-------------------------------|-------------------------------------|---|-----------|
| 46 | Capitation Adjustment Requests | Provides information for Enrollees who the Contractor thinks an inaccurate capitation payment was made. The capitation adjustment requests are limited to the capitation payments made for the MMIS Recon Month or capitation payments that were made as retroactive payments that will not be adjusted though the MMIS Recon processes because the capitation month is prior to the MMIS Recon Month. | Monthly |
| Claims Payment Reports | | | |
| 47 | Co-payments | Report on the Enrollees' co-payments, including recognition of the accumulation indicators for maximum out-of-pocket co-payments and cost sharing capitations per period that are shared through system files transmissions. | |
| 48 | Encounter Data Comparison Report | Compares what is reported in financials to what is submitted in encounter data with an accounting of discrepancies. | Quarterly |
| 49 | Prompt Payment | Copy of the quarterly Prompt Payment Report and any revisions submitted to the Department of Insurance (DOI) required as referenced in the DOI HIPMC-CP-3 Prompt Payment Reporting Manual. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time. | Quarterly |
| 50 | Original Claims Processed | <p>Provides the number of original clean claims processed during a reporting period reported by Billing Provider Type and claim status. There are four claim statuses to be included in the report:</p> <ol style="list-style-type: none"> 1. Received; 2. Pay; 3. Deny; and 4. Suspended <p>In accordance with KRS 205.534, information shall be by provider category, as prescribed by the Department, and at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health services, and outpatient behavioral health services.</p> | Monthly |
| 51 | Original Claims Inventory | Provides the number of original clean claims paid during a reporting period and length of time from receipt of a clean original claim to claim payment; the number of original clean claims denied during a reporting period and length of time from receipt of a clean original claim to claim denial; the number of original clean claims in a suspended status during a reporting period and length of time from receipt of an original claim. | |
| 52 | KY HEALTH Original Claims Processed | <p>Provides the number of original clean claims processed during a reporting period reported by Billing Provider Type and claim status. There are four claim statuses to be included in the report:</p> <ol style="list-style-type: none"> 1. Received; 2. Pay; 3. Deny; and 4. Suspended <p>Information shall be by provider category, as prescribed by the Department, and at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health services, and outpatient behavioral health services.</p> | Monthly |

| No | Report Name | Description | Frequency |
|----|---------------------------------|--|-----------|
| 53 | Post Payment Billing Recovery | Reports all recoveries for monies collected from commercial insurance carriers during the reporting period from claims that were paid prior to the commercial insurance carrier being identified. Report should include recoveries for pharmacy and non-pharmacy. If the Contractor has delegated recovery functions for any service to subcontractors, the amounts recovered by the subcontractors should also be broken out. | Quarterly |
| 54 | COB Savings | Reports the Medicare crossover claims denied during the reporting period because the claim was submitted without first having been submitted to Medicare for payment. | Monthly |
| 55 | Medicare Cost Avoidance | | Monthly |
| 56 | Non-Medicare Cost Avoidance | The report lists the claims that were denied during the reporting period because the claim was submitted without first having been submitted to another Insurer for payment. The report is not to include Medicare crossover claims. | Monthly |
| 57 | Potential Subrogation | Provides report for cases where an Enrollee has had an accident and there is potential for a liable third party or subrogation claim. | Monthly |
| 58 | Third Party Liability | Report all third party liability (TPL) claim types in monthly recoveries reports (dental, vision, pharmacy, inpatient, professional, behavioral health, and non-emergency transportation). Clearly define how the Contractor should report cost avoidance figures. An accurate indicator of actual cost avoidance would be the TPL amount applied on the claims for beneficiaries with other primary coverage. These amounts would more accurately reflect the claims amount that was "cost avoided" due to coverage by a third party. | |
| 59 | Out-of- Network Provider Report | Provides report of visits to out-of-network providers by provider type, including number of visits, number of visits prior authorized, reasons for out-of-network usage, and claims payment information. Assessment should be included for trends in use of out-of-network providers, including details about use to fill gaps in provider network and initiatives the Contractor is implementing to address gaps. | Quarterly |
| 60 | Payment of Abortion Procedures | Claim listing of abortion procedures paid by the Contractor within the reporting period. The report is required even if no procedures were paid during the reporting period. Attachments to be provided with the report include: 1. Claim Form 2. Pre-op and/or Post-op Notes 3. Physician Certificate 4. Remittance Advice The Department keeps all originals and provides CMS a copy of the Abortion Procedures Report, along with copies of all attachments stamped CONFIDENTIAL with confidential information redacted (except the last four numbers of the Social Security Number as required by CMS). | Quarterly |
| 61 | Monthly Benefit Payments | The Monthly Benefit Payments report provides MCO financial activity for the Medicaid expansion population, Kentucky Children's Health Insurance Program (KCHIP), and all other Medicaid populations by Month and State Category of Service. Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as defined by the Department. | Monthly |

| No | Report Name | Description | Frequency |
|----------------------------------|---|---|-----------|
| 62 | Quarterly Benefits Payment | Provides the Contractor's financial activity for the Medicaid and Kentucky Children's Health Insurance Program (KCHIP) by Region, month and State Category of Service. Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as defined by the Department. | Quarterly |
| 63 | Provider Outstanding Accounts Receivables | The Provider Outstanding Account Receivables report contains all accounts receivable that have reached one hundred eighty (180) days or older in age. If there are no accounts receivable one hundred eighty (180) days or older as of the last day of the reporting period then the report is to be submitted with the 'Total' values set to \$0.00 and the following comment located at the bottom of the report: 'NO ACCOUNTS RECEIVABLE 180 DAYS OR OLDER TO REPORT AS OF THE END OF THE REPORTING PERIOD' | Monthly |
| 64 | Provider-Preventable Conditions | Report of all identified provider preventable conditions in a form and frequency as specified by the Commonwealth and required in 42 CFR 438.3 (g). | Quarterly |
| Program Integrity Reports | | | |
| 65 | SUR Algorithms | The SUR Algorithm report identifies potential overpayments to providers determined to be erroneous, abusive or otherwise inconsistent with the Department's and/or Contractor policy. The report is to include only those providers for which a demand letter was sent. MCO algorithms that are routinely run are to be identified, documented and provided to the Department prior to the first submission of the SUR Algorithms Report. If the MCO modifies and/or creates specially designed algorithms that are used in reporting any subsequent SUR Algorithm report, the Contractor is to provide to the Department at the time of report submission documentation related to the algorithm including the algorithm name, algorithm description and algorithm logic. | Monthly |
| 66 | Provider Fraud Waste and Abuse | The Provider Fraud Waste and Abuse report should include all cases acted upon during the reporting period. New cases, action taken on existing cases, and closed cases are to be identified and the outcome of the investigation documented. Report shall specify date of case, description of allegation/complaint, key findings, recoupment, and coordination activities with the Department and OIG. | Quarterly |
| 67 | Member Fraud Waste and Abuse | The Enrollee Fraud Waste and Abuse report should include all cases acted upon during the reporting period. New cases, action taken on existing cases, and closed cases are to be identified and the outcome of the investigation documented. Report shall specify date of case, description of allegation/complaint, key findings, recoupment, and coordination activities with the Department and OIG. | Quarterly |

| No | Report Name | Description | Frequency |
|---|---|---|-----------|
| 68 | Medicaid Program Lock-In Report | The report includes the monthly savings for the total number of Enrollees admitted during the month and sub-categorized by the billing provider type codes, total savings created by the Lock-in Program reported on a quarterly basis, and the total number of Enrollees who have been admitted and discharged into the Lock-In Program for the month reported. The report also lists the total number of currently active Enrollees assigned to the Lock-In Program. Analysis of success of the program is required. | Monthly |
| 69 | Medicaid Program Violation Letters and Collections | The report lists the complaints received and actions taken regarding potential Medicaid program violations (MPV) by an Enrollee. The Contractor is to open a case for each complaint received and document the related activity for all active/open cases during the reporting period. A copy of each MPV letter with signature that is mailed during the reporting period is to be provided as an attachment when the Member Violation Letters and Collections report is submitted. | Monthly |
| 70 | Explanation of Member Benefits (EOMB) | The report identifies the Contractor's activity in verifying Enrollee benefits for which the Contractor received, processed, and paid a claim in accordance with 42 CFR 455.20. A minimum of five hundred (500) claims is to be sampled for purpose of complying with 42 CFR 455.20. An EOMB is to be mailed within forty-five (45) days of payment of claims. | Monthly |
| 71 | Overpayment Recoveries | Report on overpayment recoveries as required in 42 C.F.R. § 438.604(a)(7). | Annual |
| Utilization Management Program Reports | | | |
| 72 | Prior Authorizations | Lists the Prior Authorization (PA) activity during the reporting period, including the number of requests for service authorizations and the number approved or denied in accordance with KRS 205.534. Information shall be by provider category, as prescribed by the Department, and at a minimum include inpatient acute care hospital services, inpatient psychiatric hospital services, outpatient hospital services, residential behavioral health services, and outpatient behavioral health services. All PAs required by the Contractor are to be listed regardless of level of activity during the reporting period. Indicate any additions or deletion of a prior authorization requirement/policy from program requirements during the reporting period. Assess trends in requests made authorizations approved or denied, and effectiveness in managing care. | Monthly |
| 73 | Utilization Report | Provides a summary of Contractor findings of over- and under-utilized services for the reporting period and trended over timeframes as determined by Department. | Quarterly |
| 74 | Utilization of Subpopulations and Individuals with Special Healthcare Needs | <ul style="list-style-type: none"> - Utilization of Ambulatory Care by Age Breakdown - Utilization of Emergency and Ambulatory Care Resulting in Hospital Admission - Emergency Care by ICD-10 Diagnosis - Home Health Utilization - Utilization of Ambulatory Care by Provider Type and Category of Aid | Quarterly |

| No | Report Name | Description | Frequency |
|---|--|--|------------------------|
| 75 | Behavioral Health Services In/Out State Facility Utilization | Contractor should provide Special Services. Report will contain Behavioral Health services placement information for Enrollees. Identify in and out of state BH facility utilization for all Enrollees under age twenty-one (21), all Enrollees under age twenty-one (21) who are in a facility for ten (10) days or longer in and out of the state of Kentucky for a BH service no matter what service they are receiving. If the Enrollee is in a facility and receiving an EPSDT Special Service, it should be reported. | Monthly |
| 76 | Utilization Management Program Annual Evaluation | Provide findings from annual Utilization Management Program evaluation, including an assessment of effectiveness in improving clinical and service outcomes. Include a discussion of identified changes, if any, the Contractor plans to make to the program to address challenges or increase effectiveness. | Annual |
| Population Health Management Program Reports | | | |
| 77 | Population Health Management Program Report | <p>Provides summary statistics by month by eligibility category and total Enrollees such as:</p> <ul style="list-style-type: none"> - Number of Enrollees requested to complete Health Risk Assessment (HRA) and number/percent who completed. - Number/percent of Enrollees who completed HRA or were referred from other sources to complete Enrollee Needs Assessment and number/percent who completed. Information should be provided by source type. - Number/percent of Enrollees referred for management of chronic conditions and percent who are participating or opted out. - Number/percent of Enrollees referred for complex care management and percent who are participating or opted out. - Number/percent of Enrollees who were discharged or dropped out from a PHM Program by program and by reason. - Number/percent of Enrollees who refused participation. <p>Information provided must also include information about conditions being addressed, including statistics such as percent of Enrollees with specified conditions receiving PHM Program services by risk level.</p> <p>Provides a summary of key programmatic considerations, such as trends the Contractor has identified, short term and intermediate outcomes data, successes and ongoing challenges, efforts to decrease Enrollee opt out and also to increase Enrollee participation in their own care management, key challenges that have been encountered and how the Contractor has or is working to resolve. Information should also be provided for health promotion and wellness activities during the reporting period and the Contractor's findings for success of those activities.</p> | Quarterly and Annually |

| No | Report Name | Description | Frequency |
|----------------------------------|--|--|------------------------|
| 78 | PHM Program Oversight Report | <p>Report provides information to assure Contractor is providing oversight of the PHM Program to assure compliance with PHM Program requirements and processes and the quality and appropriateness of care provided to Enrollees. Examples of areas to be addressed are as follows, but are not comprehensive:</p> <ul style="list-style-type: none"> - Enrollee identification and assessment occurs according to Contractor's processes and stratification methodologies. - Referrals for varying levels of PHM Programs are processed in accordance with identified procedures and timelines. - Care managers are assigned and care plans are developed for Enrollees identified as in need of this level of care. - Multi-disciplinary teams are formed and meeting as identified in care plans, as applicable to specific Enrollees. - Face-to-face engagement with Enrollee occurs as deemed necessary in care plans. <p>Report will include Contractor findings, opportunities for improvement, and activities the Contractor will conduct to address opportunities.</p> | Quarterly and Annually |
| 79 | PHM Staffing Report | <p>Report provides information to assure that the Contractor has and maintains staffing levels needed by type and specialty to provide adequate services to the enrollees participating in PHM programs. The report should detail number of staff by type, titles, professional specification (RN, SW, CSW etc.) and average monthly caseloads by risk level.</p> | Quarterly |
| Behavioral Health Reports | | | |
| 80 | Behavioral Health Adults and Children Population | <p>The report identifies the behavioral health populations as defined by the Contract to whom services have been provided during the reporting period. The populations in this report should be consistent with the populations across all reports. Count an individual as an adult if at any time during the reporting period the individual was 18 years old or older. Specific sections of this report require a look back of 24 months from the quarter end date of the reporting period. Both paid and denied claims should be counted when determining if a service has been rendered.</p> | Quarterly |

| No | Report Name | Description | Frequency |
|----|---|---|-----------|
| 81 | Mental Health Statistics Improvement Project Adult Survey Findings Report | <p>The Contractor shall annually implement the Mental Health Statistics Improvement Program (MHSIP) Adult Survey. The Contractor shall administer the 28-Item Mental Health Statistics Improvement Program (MHSIP) Adult Survey plus eight (8) additional items for the Social Connectedness and Functioning National Outcome Measures (for adult behavioral health members).</p> <p>The Contractor may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. The Contractor shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration. DBHDID shall review and approve any behavioral health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Members who report positively about the following domains:</p> <ul style="list-style-type: none"> • Access • Quality and Appropriateness • Outcomes • Treatment Planning • General Satisfaction with Services | Annual |
| 82 | Youth Services Satisfaction Caregiver Survey | <p>The Contractor shall annually implement the Youth Services Satisfaction Caregiver Survey (YSSF). The Contractor shall administer the 21-item Youth Services Survey Family Version (YSS-F) plus additional 4 items for the Social Connectedness National Outcome Measure (for parents /caregiver of child members). The Contractor may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. The Contractor shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration. DBHDID shall review and approve any Behavioral Health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Youth Members who report positively about the following domains:</p> <ul style="list-style-type: none"> • Access • Outcomes • Treatment Planning • Family Members Reporting high Cultural Sensitivity of Staff • General Satisfaction with Services | Annual |
| 83 | IMD Report Institution for Mental Diseases | Report of the status of all of the Contractor's Enrollee who have been admitted to IMD that Exceeds 15 Days and all Enrollees who have been admitted to IMD 15 Days or Under. | Monthly |
| 84 | Evidence-based Practices Report | Report of EBPs for behavioral health care employed by the Contractor and network providers. | Quarterly |

| No | Report Name | Description | Frequency |
|--------------|--|--|-----------|
| Other | | | |
| 85 | Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death | Provide an overview of activities related to EPSDT, Pregnant Women, Maternal and Infant Death programs and trends noted in prenatal visit appropriateness, birth outcomes, including death, and program interventions. Describe activities of the EPSDT staff, including outreach, education, and care management. Provide data on levels of compliance during the report period (including screening rates) with EPSDT regulations. | Quarterly |
| 86 | Absent Parent Canceled Court Order Information | | |

APPENDIX E. MEDICAL LOSS RATIO CALCULATION

Unless specifically addressed below, the Medical Loss Ratio (MLR) calculation shall follow guidelines described in the Affordable Care Act. The formula to be used for the MLR Calculation is as follows:

$$\text{Adjusted MLR} = [(i + q - s + n - r) / \{(p + s - n + r) - t - f - (s - n + r)\}] + c$$

Where,

i = incurred claims

q = expenditures on quality improving activities

s = issuer's transitional reinsurance receipts

p = earned premiums (excluding MCO tax)

t = Federal and State taxes (excluding MCO tax)

f = licensing and regulatory fees

n = issuer's risk corridors and risk adjustment related payments

r = issuer's risk corridors, and risk adjustment related receipts

c = credibility adjustment, if any.

Additional guidance regarding financial items to be excluded or included in the Numerator or Denominator of the Medical Loss Ratio calculation is as follows:

➤ Numerator

• Incurred Claims

- Direct claims that the MCO pays to providers (including under capitation contracts with health care professionals) for services or supplies covered under the managed care contract with DMS, provided to enrollees;
- Direct claims that the MCO pays to providers (including under capitation contracts with health care professionals) for services or supplies defined under §438.3(e) that are in addition to services defined in the managed care contract with DMS, provided to enrollees
- Incurred but not reported and unpaid claims reserves for the MLR Reporting year, including claims reported in the process of adjustment;
- Percentage withholds from payments made to contracted providers;
- Claims that are recoverable for anticipated coordination of benefits;
- Claims payments recoveries received as a result of subrogation;
- Changes in other claims-related reserves;
- Claims payments recoveries as a result of fraud reduction efforts, not to exceed the amount of fraud reduction expenses;
- Reserves for contingent benefits and the medical claim portion of lawsuits; and
- The amount of incentive and bonus payments made to providers.
- Value added benefits provided by the MCO and approved by DMS

• Deductions from Claims

- Overpayment recoveries received from providers;
- Prescription drug rebates received by the MCO or PIHP; and
- State subsidies based on a stop-loss payment methodology.

- Solvency Funds

- Payments made by an MCO to mandated solvency funds.

- Health Care Quality Activities May be included in numerator

- Any MCO expenditure that is related to Health Information Technology and meaningful use, and is not considered incurred claims.

- Excluded from Claims

- Amounts paid to third party vendors for secondary network savings;
- Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; and
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services, or services meeting the definition in §438.3(e) and provided to an enrollee, **except for Value Added Benefits as defined in the Incurred Claims subheader above.**
- Amounts paid to the State as remittance
- Pass-through Payments made under 42 CFR 438.6(d)

➤ **Denominator**

- Revenue

- State capitation payments to the MCO for all enrollees under a risk contract less any unreturned withholds
- State-developed one time payments, for specific life events;
- Payments to the MCO for incentive arrangements or payments for the amount of a withhold the MCO earns in accordance with conditions in the contract
- Unpaid cost sharing amounts that the MCO could have collected from enrollees under the contract
- All changes to unearned premium reserves.

- Exclusions

- Federal and State taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees
 - e.g. Health Insurer Fee
- Statutory assessments to defray the operating expenses of any State or Federal department.
- State taxes and assessments
- Pass-through Payments made under 42 CFR 438.6(d)

APPENDIX F. THIRD PARTY PAYMENTS/COORDINATION OF BENEFITS

I. To meet the requirements of 42 CFR 433.138 through 433.139, the MCO shall be responsible for:

A. Maintaining an MIS that includes:

1. Third Party Liability Resource File

- a) Cost Avoidance - Use automated daily and monthly TPL files to update the MCO's MIS TPL files as appropriate. This information is to cost avoid claims for members who have other insurance.

The MCO shall obtain subscriber data and perform data matches directly with a specified list of insurance companies, as defined by DMS.

- b) Department for Community Based Services (DCBS) - Apply Third Party Liability (TPL) information provided electronically on a daily basis by DMS through its contract with DCBS to have eligibility caseworkers collect third party liability information during the Recipient application process and reinvestigation process.
- c) Workers' Compensation - The fiscal agent performs this function. The data is provided electronically on a quarterly basis. This data should be applied to TPL files referenced in I.A.1.a (Commercial Data Matching) in this Attachment.

2. Third Party Liability Billing File

- a) Commercial Insurance/Medicare Part B Billing - The MCO's MIS should automatically search paid claim history and recover from providers, insurance companies or Medicare Part B in a nationally accepted billing format for all claim types whenever other commercial insurance or Medicare Part B coverage is discovered and added to the MCO's MIS that was unknown to the MCO at the time of payment of a claim or when a claim could not be cost avoided due to federal regulations (pay and chase) which should have been paid by the health plan. Within sixty (60) Days from the date of identification of the other third party resource billings must be generated and sent to liable parties.
- b) Medicare Part A - The MCO's MIS should automatically search paid claim history and generate reports by Provider of the billings applicable to Medicare Part A coverage whenever Medicare Part A coverage is discovered and added to the MCO's MIS that was unknown to the MCO at the time of payment of a claim. Providers who do not dispute the Medicare coverage should be instructed to bill Medicare immediately. The MCO's MIS should recoup the previous payment from the Provider within sixty (60) days from the date the reports are sent to the Providers, if they do not dispute that Medicare coverage exists.
- c) Manual Research/System Billing - System should include capability for the manual setup for billings applicable to workers' compensation, casualty, absent parents and other liability coverages that require manual research to determine payable claims.

3. Questionnaire File

- MAID
- Where it was sent
- Type of Questionnaire Sent
- Date Sent
- Date Followed Up
- Actions Taken

All questionnaires should be tracked in a Questionnaire history file on the MIS.

B. Coordination of Third Party Information (COB)

1. Division of Child Support Enforcement (DCSE)

Provide county attorneys and the Division of Child Support Enforcement (DCSE) upon request with amounts paid by the MCO in order to seek restitution for the payment of past medical bills and to obtain insurance coverage to cost avoid payment of future medical bills.

2. Casualty Recoveries

Provide the necessary information regarding paid claims in order to seek recovery from liable parties in legal actions involving Members.

In cases where an attorney has been retained, a lawsuit filed or a lump sum settlement offer is made, the MCO shall notify Medicaid within five days of identifying such information so that recovery efforts can be coordinated when the Department has a claim for the same accident.

C. Claims

1. Processing

a) MCO MIS edits:

- Edit and cost avoid Claims when Member has Medicare coverage;
- Edit and cost avoid Claims when Provider indicates other insurance on claim but does not identify payment or denial from third party;
- Edit and cost avoid Claims when Provider indicates services provided were work related and does not indicate denial from workers' compensation carrier;
- Edit and cost avoid or pay and chase as required by federal regulations when Member has other insurance coverage. When cost avoiding, the MCO's MIS should supply the Provider with information on the remittance advice that would be needed to bill the other insurance, such as carrier name, address, policy #, etc.;
- Edit Claims as required by federal regulations for accident/trauma diagnosis codes. Claims with the accident/trauma diagnosis codes should be flagged and accumulated for ninety (90) Days and if the amount accumulated exceeds \$250, a questionnaire should be sent to the Member in an effort to identify whether other third party resources may be liable to pay for these medical bills;
- The MCO is prohibited from cost avoiding Claims when the source of the insurance coverage was due to a court order. All Claims with the exception of hospital Claims must be paid and chased. Hospital claims may be cost avoided; and
- A questionnaire should be generated and mailed to Members and/or Providers for claims processed with other insurance coverage indicated on the claim and where no insurance coverage is indicated on the MCO's MIS Third Party Files.

2. Encounter Record

- a) TPL Indicator
- b) TPL Payment

II. DMS shall be responsible for the following:

1. Provide the MCO with an initial third party information tape;
2. Provide electronic computerized files of third party information transmitted from DCBS;
3. Provide the MCO with a copy of the information received from the Labor Cabinet on a quarterly basis;

4. Provide the MCO with a list of the Division of Child Support Contracting Officials.
5. Refer calls from attorneys to the MCO in order for their Claims to be included in casualty settlements; and
6. Monitoring Encounter Claims and reports submitted by the MCO to ensure that the MCO performs all required activities.

APPENDIX G. MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

The Contractor's MIS must enable the Contractor to provide format and file specifications for all data elements as specified below for all of the required seven subsystems.

Member Subsystem

The primary purpose of the member subsystem is to accept and maintain an accurate, current, and historical source of demographic information on Members to be enrolled by the Contractor.

The maintenance of enrollment/member data is required to support Claims and encounter processing, third party liability (TPL) processing and reporting functions. The major source of enrollment/member data will be electronically transmitted by the Department to the Contractor on a daily basis in a HIPAA 834 file format. The daily transaction file will include new, changed and terminated member information. The Contractor shall be required to process and utilize the daily transaction files prior to the start of the next business day. A monthly HIPAA 834 file of members will be electronically transmitted to the Contractor. The Contractor must reconcile Member and Capitation Payment information with the Department for Medicaid Services.

Specific data item requirements for the Contractor's Member subsystem shall contain such items as maintenance of demographic data, matching Primary Care Providers with Members, maintenance information on Enrollments/Disenrollments, identification of TPL information, tracking EPSDT preventive services and referrals.

A. Inputs

The Recipient Data Maintenance function will accept input from various sources to add, change, or close records on the file(s). Inputs to the Recipient Data Maintenance function include:

1. Daily and monthly electronic member eligibility updates (HIPAA ASC X12 834)
2. Claim/encounter history – sequential file; file description to be determined
3. Social demographic information
4. Initial Implementation of the Contract, the following inputs shall be provide to the contractor:
 - Initial Member assignment file (sequential file; format to be supplemented at contract execution); a file will be sent approximately sixty (60) calendar days prior to the Contractor effective date of operations
 - Member claim history file – twelve (12) months of member claim history (sequential file; format to be supplemented at Contract execution)
 - Member Prior Authorizations in force file (medical and pharmacy; sequential file; format will be supplemented at Contract execution)

B. Processing Requirements

The Recipient Data Maintenance function must include the following capabilities:

1. Accept a daily/monthly member eligibility file from the Department in a specified format.
2. Transmit a file of health status information to the Department in a specified format.
3. Transmit a file of social demographic data to the Department in a specified format.
4. Transmit a primary care provider (PCP) enrollment file to the Department in a specified format.
5. Edit data transmitted from the Department for completeness and consistency, editing all data in the transaction.
6. Identify potential duplicate Member records during update processing.
7. Maintain on-line access to all current and historical Member information, with inquiry capability by case number, Medicaid Recipient ID number, social security number (SSN), HIC number, full name or partial name, and the ability to use other factors such as date of birth and/or county code to limit the search by name.
8. Maintain identification of Member eligibility in special eligibility programs, such as

hospice, etc., with effective date ranges/spans and other data required by the Department.

9. Maintain current and historical date-specific managed care eligibility data for basic program eligibility, special program eligibility, and all other Member data required to support Claims processing, Prior Authorization processing, managed care processing, etc.
10. Maintain and display the same values as the Department for eligibility codes and other related data.
11. Produce, issue, and mail a managed care ID card pursuant to the Department's approval within Department determined time requirements.
12. Identify Member changes in the primary care provider (PCP) and the reason(s) for those changes to include effective dates.
13. Monitor PCP capacity and limitations prior to Enrollment of a Member to the PCP.
14. Generate and track PCP referrals if applicable.
15. Assign applicable Member to PCP if one is not selected within thirty (30) Days, except Members with SSI without Medicare, who are allowed ninety (90) Days.

C. Reports

Reports for Member function are described in Appendix D.

D. On-line Inquiry Screens

On-line inquiry screens that meet the user interface requirements of this section and provide access to the following data:

1. Member basic demographic data
2. Member liability data
3. Member characteristics and service utilization data
4. Member current and historical managed care eligibility data
5. Member special program data
6. Member social/demographic data
7. Health status data
8. PCP data

E. Interfaces

The Member Data Maintenance function must accommodate an external electronic interface (HIPAA ASC X12 834, both 4010A1 and 5010 after January 1, 2012) with the Department.

Third Party Liability (TPL) Subsystem

In order to ensure that federal third party liability requirements are met and to maximize savings from available Third Party Resources, identification and recovery of Third Party Resources must be a joint effort between the Department and the Contractor. The Department will provide Contractor with the Medicare effective dates.

The Third Party Liability (TPL) processing function permits the Contractor to utilize the private health, Medicare, and other third-party resources of its Members and ensures that the Contractor is the payer of last resort. This function works through a combination of cost avoidance (non-payment of billed amounts for which a third party may be liable) and post-payment recovery (post-payment collection of Contractor paid amounts for which a third party is liable).

Cost avoidance is the preferred method for processing claims with TPL. This method is implemented automatically by the MIS through application of edits and audits which check claim information against various data fields on recipient, TPL, reference, or other MIS files. Post-payment recovery is primarily a back-up process to cost avoidance, and is also used in certain situations where cost avoidance is impractical or unallowable.

The TPL information maintained by the MIS must include Member TPL resource data, insurance

carrier data, health plan coverage data, threshold information, and post payment recovery tracking data. The TPL processing function will assure the presence of this information for use by the Edit/Audit Processing, Financial Processing, and Claim Pricing functions, and will also use it to perform the functions described in this subsection for TPL Processing.

A. Inputs

The following are required inputs to the TPL function of the MIS:

1. Member eligibility, Medicare, and TPL, information from the Department via proprietary file formats.
2. Enrollment and coverage information from private insurers/health plans, state plans, and government plans.
3. TPL-related data from claims, claim attachments, or claims history files, including but not limited to:
 - diagnosis codes, procedure codes, or other indicators suggesting trauma or accident;
 - indication that a TPL payment has been made for the claim (including Medicare);
 - indication that the Member has reported the existence of TPL to the Provider submitting the claim;
 - Indication that TPL is not available for the service claimed.
4. Correspondence and phone calls from Members, carriers, and Providers and DMS.

B. Processing Requirements

The TPL processing function must include the following capabilities:

1. Maintain accurate third-party resource information by Member including but not limited to:
 - Name, ID number, date of birth, SSN of eligible Member;
 - Policy number or Medicare HIC number and group number;
 - Name and address of policyholder, relationship to Member,
 - SSN of policyholder;
 - Court-ordered support indicator;
 - Employer name and tax identification number and address of policyholder;
 - Type of policy, type of coverage, and inclusive dates of coverage;
 - Date and source of TPL resource verification; and
 - Insurance carrier name and tax identification and ID.
2. Provide for multiple, date-specific TPL resources (including Medicare) for each Member.
3. Maintain current and historical information on third-party resources for each Member.
4. Maintain third-party carrier information that includes but is not limited to:
 - Carrier name and ID
 - Corporate correspondence address and phone number
 - Claims submission address(s) and phone number
5. Identify all payment costs avoided due to established TPL, as defined by the Department.
6. Maintain a process to identify previously paid claims for recovery when TPL resources are identified or verified retroactively, and to initiate recovery within sixty (60) Days of the date the TPL resource is known to the Contractor.
7. Maintain an automated tracking and follow-up capability for all TPL questionnaires.
8. Maintain an automated tracking and follow-up capability for post payment recovery actions which applies to health insurance, casualty insurance, and all other types of recoveries, and which can track individual or group claims from the initiation of recovery efforts to closure.
9. Provide for the initiation of recovery action at any point in the claim processing

- cycle.
10. Maintain a process to adjust paid claims history for a claim when a recovery is received.
 11. Provide for unique identification of recovery records.
 12. Provide for on-line display, inquiry, and updating of recovery case records with access by claim, Member, carrier, Provider or a combination of these data elements.
 13. Accept, edit and update with all TPL and Medicare information received from the Department through the Member eligibility update or other TPL updates specified by the Department.
 14. Implement processing procedures that correctly identify and cost avoid claims having potential TPL, and flag claims for future recovery to the appropriate level of detail.
 15. Provide verified Member TPL resource information generated from data matches and claims, to the Department for Medicaid Services, in an agreed upon format and media, on a monthly basis.

C. Reports

The following types of reports must be available from the TPL Processing function by the last day of the month for the previous month:

1. Cost-avoidance summary savings reports, including Medicare but identifying it separately;
2. Listings and totals of cost-avoided claims;
3. Listings and totals of third-party resources utilized;
4. Reports of amounts billed and collected, current and historical, from the TPL recovery tracking system, by carrier and Member;
5. Detailed aging report for attempted recoveries by carrier and Member;
6. Report on the number and amount of recoveries by type; for example, fraud collections, private insurance, and the like;
7. Report on the unrecoverable amounts by type and reason, carrier, and other relevant data, on an aged basis and in potential dollar ranges;
8. Report on the potential trauma and/or accident claims for claims that meet specified dollar threshold amounts;
9. Report on services subject to potential recovery when date of death is reported;
10. Unduplicated cost-avoidance reporting by program category and by type of service, with accurate totals and subtotals;
11. Listings of TPL carrier coverage data;
12. Audit trails of changes to TPL data.

D. On-line Inquiry Screens

On-line inquiry screens that meet the user interface requirements of this section and provide the following data:

1. Member current and historical TPL data
2. TPL carrier data
3. Absent parent data
4. Recovery cases

Automatically generate letters/questionnaires to carriers, employers, Members, and Providers when recoveries are initiated, when TPL resource data is needed, or when accident information is required and was not supplied with the incoming claim.

Automatically generate claim facsimiles, which can be sent to carriers, attorneys, or other parties.

Provide absent parent canceled court order information generated from data matches with the Division of Child Support Enforcement, to the Department, in an agreed upon format

and media, on an annual basis.

Provider Subsystem

The provider subsystem accepts and maintains comprehensive, current and historical information about Providers eligible to participate in the Contractor's Network. The maintenance of provider data is required to support Claims and encounter processing, utilization/quality processing, financial processing and report functions. The Contractor shall electronically transmit provider enrollment information to the Department on a monthly basis, by the first Friday of the month following the month reported.

The Contractor's provider subsystem shall contain such items as demographic data, identification of provider type, specialty codes, maintenance of payment information, identification of licensing, credentialing/re-credentialing information, and monitoring of Primary Care Provider capacity for enrollment purposes.

The Contractor shall demonstrate compliance with standards of provider network capacity and member access to services by producing reports illustrating that services, service locations, and service sites are available and accessible in terms of timeliness, amount, duration and personnel sufficient to provide all Covered Services on an emergency or urgent care basis, 24 hours a day, seven days a week.

The Department shall monitor the Contractor's Network capacity and member access by use of a Decision Support System. The Encounter Record submitted will be used to display Primary Care Provider location, Service Location, Member distribution, patterns of referral, quality measures, and other analytical data.

A. Inputs

The inputs to the provider Data Maintenance function include:

1. Provider update transactions
2. Licensure information, including electronic input from other governmental agencies
3. Financial payment, adjustment, and accounts receivable data from the Financial Processing function.

B. Processing Requirements

The Provider Data Maintenance function must have the capabilities to:

1. Transmit a provider enrollment file to the Department in a specified format;
2. Maintain current and historical provider enrollment applications from receipt to final disposition (approval only);
3. Maintain on-line access to all current and historical provider information, including Provider rates and effective dates, Provider program and status codes, and summary payment data;
4. Maintain on-line access to Provider information with inquiry by Provider name, partial name characters, provider number, NPI, SSN, FEIN, CLIA number, Provider type and specialty, County, Zip Code, and electronic billing status;
5. Edit all update data for presence, format, and consistency with other data in the update transaction;
6. Edits to prevent duplicate Provider enrollment during an update transaction;
7. Accept and maintain the National Provider Identification (NPI);
8. Provide a Geographic Information System (GIS) to identify Member populations, service utilization, and corresponding Provider coverage to support the Provider recruitment, enrollment, and participation;
9. Maintain on-line audit trail of Provider names, Provider numbers (including old and new numbers, NPI), locations, and status changes by program;
10. Identify by Provider any applicable type code, NPI/TAXONOMY code, location

code, practice type code, category of service code, and medical specialty and sub-specialty code which is used in the Kentucky Medicaid program, and which affects Provider billing, claim pricing, or other processing activities;

11. Maintain effective dates for Provider membership, Enrollment status, restriction and on-review data, certification(s), specialty, sub-specialty, claim types, and other user-specified Provider status codes and indicators;
12. Accept group provider numbers, and relate individual Providers to their groups, as well as a group to its individual member Providers, with effective date ranges/spans. A single group provider record must be able to identify an unlimited number of individuals who are associated with the group;
13. Maintain multiple, provider-specific reimbursement rates, including, but not necessarily limited to, per diems, case mix, rates based on licensed levels of care, specific provider agreements, volume purchase contracts, and capitation, with beginning and ending effective dates for a minimum of sixty (60) months.
14. Maintain provider-specific rates by program, type of capitation, Member program category, specific demographic classes, Covered Services, and service area for any prepaid health plan or managed care providers;
15. Provide the capability to identify a Provider as a PCP and maintain an inventory of available enrollment slots;
16. Identify multiple practice locations for a single provider and associate all relevant data items with the location, such as address and CLIA certification;
17. Maintain multiple addresses for a Provider, including but not limited to:
 - Pay to;
 - Mailing, and
 - Service location(s).
18. Create, maintain and define provider enrollment status codes with associated date spans. For example, the enrollment codes must include but not be limited to:
 - Application pending
 - Limited time-span enrollment
 - Enrollment suspended
 - Terminated-voluntary/involuntary
19. Maintain a National Provider Identifier (NPI) and taxonomies;
20. Maintain specific codes for restricting the services for which Providers may bill to those for which they have the proper certifications (for example, CLIA certification codes);
21. Maintain summary-level accounts receivable and payable data in the provider file that is automatically updated after each payment cycle;
22. Provide the capability to calculate and maintain separate 1099 and associated payment data by FEIN number for Providers with changes of ownership, based upon effective dates entered by the Contractor;
23. Generate a file of specified providers, selected based on the Department identified parameters, in an agreed upon Department approved format and media, to be provided to the Department on an agreed upon periodic basis; and
24. Generate a file of provider 1099 information.
25. Reports – Reports for Provider functions are as described in Appendix D.

C. On-line Inquiry Screens

On-line inquiry screens that meet the user interface requirements of this contract and provide access to the following data:

1. Provider eligibility history
2. Basic information about a Provider (for example, name, location, number, program, provider type, specialty, sub-specialty, certification dates, effective dates)
3. Provider group inquiry, by individual provider number displaying groups and by group number displaying individuals in group (with effective and end dates for those individuals within the group)

4. Provider rate data
5. Provider accounts receivable and payable data, including claims adjusted but not yet paid
6. Provider Medicare number(s) by Medicare number, Medicaid number, and SSN/FEIN
7. Demographic reports and maps from the GIS, for performing, billing, and/or enrolled provider, listing provider name, address, and telephone number to assist in the provider recruitment process and provider relations

D. Interfaces

The Provider Data Maintenance function must accommodate an external interface with:

1. The Department; and
2. Other governmental agencies to receive licensure information.

Reference Subsystem

The reference subsystem maintains pricing files for procedures and drugs, and maintains other general reference information such as diagnoses, edit/audit criteria, edit dispositions and reimbursement parameters/modifiers. The reference subsystem provides a consolidated source of reference information which is accessed by the MIS during the performance of other functions, including Claims and encounter processing, TPL processing and utilization/quality reporting functions.

The Contractor's reference subsystem shall contain such items as maintenance of procedure codes/NDC codes and diagnosis codes, identification of pricing files, maintenance of edit and audit criteria.

The contractor must maintain sufficient reference data (NDC codes, HCPCS, CPT4, Revenue codes, etc.) to accurately process fee for service claims and develop encounter data for transmission to the Department as well as support Department required reporting.

A. Inputs

The inputs to the Reference Data Maintenance function are:

1. NDC codes
2. CMS - HCPCS updates
3. ICD-9-CM or 10 and DSM III diagnosis and procedure updates
4. ADA (dental) codes

B. Processing Requirements

The Reference Processing function must include the following capabilities:

1. Maintain current and historical reference data, assuring that updates do not overlay or otherwise make historical information inaccessible.
2. Maintain a Procedure data set which is keyed to the five-character HCPCS code for medical-surgical and other professional services, ADA dental codes; a two-character field for HCPCS pricing modifiers; and the Department's specific codes for other medical services; in addition, the procedure data set will contain, at a minimum, the following elements for each procedure:
 - Thirty-six (36) months of date-specific pricing segments, including a pricing action code, effective beginning and end dates, and allowed amounts for each segment.
 - Thirty-six (36) months of status code segments with effective beginning and end dates for each segment.
 - Multiple modifiers and the percentage of the allowed price applicable to each modifier.
 - Indication of TPL actions, such as Cost Avoidance, Benefit Recovery or Pay, by procedure code.

- Other information such as accident-related indicators for possible TPL, federal cost-sharing indicators, Medicare coverage and allowed amounts.
3. Maintain a diagnosis data set utilizing the three (3), four (4), and five (5) character for ICD-9-CM and 7 digits for ICD-10 and DSM III coding system, which supports relationship editing between diagnosis code and claim information including but not limited to:
 - Valid age
 - Valid sex
 - Family planning indicator
 - Prior authorization requirements
 - EPSDT indicator
 - Trauma diagnosis and accident cause codes
 - Description of the diagnosis
 - Permitted primary and secondary diagnosis code usage
 4. Maintain descriptions of diagnoses.
 5. Maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the implementation of ICD-10 by October 1, 2013.
 6. Maintain a drug data set of the eleven (11) digit National Drug Code (NDC), including package size, which can accommodate updates from a drug pricing service and the CMS Drug Rebate file updates; the Drug data set must contain, at a minimum:
 - Unlimited date-specific pricing segments that include all prices and pricing action codes needed to adjudicate drug claims.
 - Indicator for multiple dispensing fees
 - Indicator for drug rebate including name of manufacturer and labeler codes.
 - Description and purpose of the drug code.
 - Identification of the therapeutic class.
 - Identification of discontinued NDCs and the termination date.
 - Identification of CMS Rebate program status.
 - Identification of strength, units, and quantity on which price is based.
 - Indication of DESI status (designated as less than effective), and IRS status (identical, related or similar to DESI drugs).
 7. Maintain a Revenue Center Code data set for use in processing claims for hospital inpatient/outpatient services, home health, hospice, and such.
 8. Maintain flexibility to accommodate multiple reimbursement methodologies, including but not limited to fee-for-service, capitation and carve-outs from Capitated or other “all inclusive” rate systems, and DRG reimbursement for inpatient hospital care, etc.
 9. Maintain pricing files based on:
 - Fee schedule
 - Per DIEM rates
 - Capitated rates
 - Federal maximum allowable cost (FMAC), estimated acquisition (EAC) for drugs
 - Percentage of charge allowance
 - Contracted amounts for certain services
 - Fee schedule that would pay at variable percentages.
 - (MAC) Maximum allowable cost pricing structure

C. On-line Inquiry Screens

Maintain on-line access to all Reference files with inquiry by the appropriate service code, depending on the file or table being accessed.

Maintain on-line inquiry to procedure and diagnosis files by name or description including support for phonetic and partial name search.

Provide inquiry screens that display:

- All relevant pricing data and restrictive limitations for claims processing including historical information, and
- All pertinent data for claims processing and report generation.

D. Interfaces

The Reference Data Maintenance function must interface with:

1. ADA (dental) codes
2. CMS-HCPCS updates;
3. ICD-9, ICD-10, DSM, or other diagnosis/surgery code updating service; and
4. NDC Codes.

Financial Subsystem

The financial function encompasses claim payment processing, adjustment processing, accounts receivable processing, and all other financial transaction processing. This function ensures that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied accurately. The financial processing function is the last step in claims processing and produces remittance advice statements/explanation of benefits and financial reports.

The Contractor's financial subsystem shall contain such items as: update of provider payment data, tracking of financial transactions, including TPL recoveries and maintenance of adjustment and recoupment processes.

A. Inputs

The Financial Processing function must accept the following inputs:

1. On-line entered, non-claim-specific financial transactions, such as recoupments, mass adjustments, cash transactions, etc.;
2. Retroactive changes to Member financial liability and TPL retroactive changes from the Member data maintenance function;
3. Provider, Member, and reference data from the MIS.

B. Processing Requirements

The MIS must perform three types of financial processing: 1) payment processing; 2) adjustment processing; 3) other financial processing. Required system capabilities are classified under one of these headings in this subsection.

C. Payment Processing

Claims that have passed all edit, audit, and pricing processing, or which have been denied, must be processed for payment by the Contractor if the contractor has fee for service arrangements. Payment processing must include the capability to:

1. Maintain a consolidated accounts receivable function and deduct/add appropriate amounts and/or percentages from processed payments.
2. Update individual provider payment data and 1099 data on the Provider database.

D. Adjustment Processing

The MIS adjustment processing function must have the capabilities to:

1. Maintain complete audit trails of adjustment processing activities on the claims history files.
2. Update provider payment history and recipient claims history with all appropriate financial information and reflect adjustments in subsequent reporting, including claim-specific and non-claim-specific recoveries.
3. Maintain the original claim and the results of all adjustment transactions in claims history; link all claims and subsequent adjustments by control number, providing for identification of previous adjustment and original claim number.
4. Reverse the amount previously paid/recovered and then processes the adjustment so that the adjustment can be easily identified.

5. Re-edit, re-price, and re-audit each adjustment including checking for duplication against other regular and adjustment claims, in history and in process.
 6. Maintain adjustment information which indicates who initiated the adjustment, the reason for the adjustment, and the disposition of the claim (additional payment, recovery, history only, etc.) for use in reporting the adjustment.
 7. Maintain an adjustment function to re-price claims, within the same adjudication cycle, for retroactive pricing changes, Member liability changes, Member or provider eligibility changes, and other changes necessitating reprocessing of multiple claims.
 8. Maintain a retroactive rate adjustment capability which will automatically identify all Claims affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted Claim.
- E. Other Financial Processing
- Financial transactions such as stop payments, voids, reissues, manual checks, cash receipts, repayments, cost settlements, overpayment adjustments, recoupments, and financial transactions processed outside the MIS are to be processed as part of the Financial Processing function. To process these transactions, the MIS must have the capability to:
1. Maintain the following information:
 - Program identification (for example, TPL recovery, rate adjustment);
 - Transaction source (for example, system generated, refund, Department generated);
 - Provider number/entity name and identification number;
 - Payment/recoupment detail (for example, dates, amounts, cash or recoupment);
 - Account balance;
 - Reason indicator for the transaction (for example, returned dollars from provider for TPL, unidentified returned dollars, patient financial liability adjustment);
 - Comment section;
 - Type of collection (for example, recoupment, cash receipt);
 - Program to be affected;
 - Adjustment indicator; and
 - Internal control number (ICN) (if applicable).
 2. Accept manual or automated updates including payments, changes, deletions, suspensions, and write-offs, of financial transactions and incorporate them as MIS financial transactions for purposes of updating claims history, Provider/Member history, current month financial reporting, accounts receivable, and other appropriate files and reports.
 3. Maintain sufficient controls to track each financial transaction, balance each batch, and maintain appropriate audit trails on the claims history and consolidated accounts receivable system, including a mechanism for adding user narrative.
 4. Maintain on-line inquiry to current and historical financial information with access by Provider ID or entity identification, at a minimum to include:
 - Current amount payable/due
 - Total amount of claims adjudication for the period
 - Aging of receivable information, according to user defined aging parameters
 - Receivable account balance and established date
 - Percentages and/or dollar amounts to be deducted from future payments
 - Type and amounts of collections made and dates
 - Both non-claim-specific, and
 - Data to meet the Department's reporting.
 5. Maintain a recoupment process that sets up Provider accounts receivable that can be either automatically recouped from claims payments or satisfied by repayments

- from the provider or both.
6. Maintain a methodology to apply monies received toward the established recoupment to the accounts receivable file, including the remittance advice date, number, and amount, program, and transfer that data to an on-line provider paid claims summary.
 7. Identify a type, reason, and disposition on recoupments, payouts, and other financial transactions.
 8. Provide a method to link full or partial refunds to the specific Claim affected, according to guidelines established by the Department.
 9. Generate provider 1099 information annually, which indicate the total paid claims plus or minus any appropriate adjustments and financial transactions.
 10. Maintain a process to adjust providers' 1099 earnings with payout or recoupment or transaction amounts through the accounts receivable transactions.
 11. Maintain a process to accommodate the issuance and tracking of non-provider-related payments through the MIS (for example, a refund or an insurance company overpayment) and adjust expenditure reporting appropriately.
 12. Track all financial transactions, by program and source, to include TPL recoveries, Fraud, Waste and Abuse recoveries, provider payments, drug rebates, and so forth.
 13. Determine the correct federal fiscal year within claim adjustments and other financial transactions are to be reported.
 14. Provide a method to direct payments resulting from an escrow or lien request to facilitate any court order or legal directive received.

F. Reports

Reports from the financial processing function are described in Appendix D and Contractor Reporting Requirements Section of Contract.

Utilization/Quality Improvement

The Contractor shall capture and maintain a patient-level record of each service provided to Members using CMS 1500, UBO4, NCPDP, HIPAA code sets or other Claim or Claim formats that shall meet the reporting requirements in this Contract. The computerized database must contain and hold a complete and accurate representation of all services covered by the Contractor, and by all providers and Subcontractors rendering services for the contract period. The Contractor shall be responsible for monitoring the integrity of the database and facilitating its appropriate use for such required reports as encounter data, and targeted performance improvement studies.

Contractor shall comply with the requirements of 42 CFR 455.20 (a) by employing a selected sample method approved by CMS and the Department of verifying with Members whether the services billed by provider were received.

The utilization/quality improvement subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis which focus on the review and assessment of access, availability and continuity of services, quality of care given, detection of over and underutilization of services, and the development of user-defined reporting criteria and standards. This system profiles utilization of Providers and Members and compares them against experience and norms for comparable individuals.

The subsystem shall support tracking utilization control function(s) and monitoring activities, including Geo Network for all Encounters in all settings particularly in-patient and outpatient care, emergency room use, outpatient drug therapy, EPSDT and out-of-area services. It shall complete provider profiles; occurrence reporting, including adverse incidents and complications, monitoring and evaluation studies; Members and Providers aggregate Grievances and Appeals; effects of educational programs; and Member/Provider satisfaction survey compilations. The subsystem may integrate the Contractor's manual and automated processes or incorporate other software reporting and/or analysis programs.

The Contractor's utilization/quality improvement subsystem shall contain such items as: monitoring of primary care and specialty provider referral patterns processes to monitor and identify deviations in patterns of treatment from established standards or norms, performance and health outcome measures using standardized indicators. The quality improvement subsystem will be based upon nationally recognized standards and guidelines, including but not limited to, a measurement system based upon the most current version of HEDIS published by the National Committee for Quality Assurance.

Surveillance Utilization Review Subsystem (SURS)

In accordance with 42 CFR 455, the Contractor shall establish a SURS function which provides the capability to identify potential fraud and/or abuse of providers or Members. The SURS component supports profiling, random sampling, groupers (for example Episode Treatment Grouper), ad hoc and targeted queries.

The utilization/quality improvement function combines data from other external systems, such as Geo Network to produce reports for analysis which focus on the review and assessment of access and availability of services and quality of care given, detection of over and underutilization, and the development of user-defined reporting criteria and standards. This system profiles utilization of Providers and Members and compares them against experience and norms for comparable individuals.

This system supports tracking utilization control function(s) and monitoring activities for inpatient admissions, emergency room use, and out-of-area services. It completes Provider profiles, occurrence reporting, monitoring and evaluation studies, and Member/Provider satisfaction survey compilations. The subsystem may integrate the Contractor's manual and automated processes or incorporate other software reporting and/or analysis programs.

This system also supports and maintains information from Member surveys, Provider and Member Grievances, Appeal processes.

A. Inputs

The Utilization/Quality Improvement system must accept the following inputs:

1. Adjudicated Claims/encounters from the claims processing subsystem;
2. Provider data from the provider subsystem;
3. Member data from the Member subsystem.

B. Processing Requirements

The Utilization/Quality Improvement function must include the following capabilities:

1. Maintain Provider credentialing and recredentialing activities.
2. Maintain Contractor's processes to monitor and identify deviations in patterns of treatment from established standards or norms. Provide feedback information for monitoring progress toward goals, identifying optimal practices, and promoting continuous improvement.
3. Maintain development of cost and utilization data by Provider and services.
4. Provide aggregate performance and outcome measures using standardized quality indicators similar to Medicaid HEDIS as specified by the Department.
5. Support focused quality of care studies.
6. Support the management of referral/utilization control processes and procedures.
7. Monitor PCP referral patterns.
8. Support functions of reviewing access, use and coordination of services (i.e. actions of peer review and alert/flag for review and/or follow-up; laboratory, x-ray and other ancillary service utilization per visit).
9. Store and report Member satisfaction data through use of Member surveys, Grievance/Appeals processes, etc.
10. Provide Fraud, Waste and Abuse detection, monitoring and reporting.

- C. Reports
Utilization/quality improvement reports are listed in Appendices K and L.

Claims Control and Entry

The Claims Control function ensures that all claims are captured at the earliest possible time and in an accurate manner. Claims must be adjudicated within the parameters of Prompt Pay standards set by CMS and the American Recovery and Reinvestment Act (ARRA).

Edit/Audit Processing

The Claims processing subsystem collects, processes, and stores data on all health services delivered. The functions of this subsystem are Claims payment processing and capturing medical service utilization data. Claims are screened against the provider and Member subsystems. The Claims processing subsystem captures all medically related services, including medical supplies, using standard codes (e.g. HCPCS, ICD9-CM/ICD-10 CM/PCS diagnosis and procedure code, Revenue Codes, ADA Dental Codes and NDCs) rendered by medical providers to a Member regardless of remuneration arrangement (e.g. capitation/fee-for-service). The Contractor shall be required to electronically transmit Encounter Record to the Department on a weekly basis, or on a department approved schedule that is determined by the Contractor's financial schedule.

The Contractor's Claims processing/encounter subsystem shall contain such items as: apply edit and audit criteria to verify timely, accurate and complete Encounter Record; edit for prior-authorized Claims; identify error codes for Claims.

The Edit/Audit Processing function ensures that Claims are processed in accordance with Department and Contractor policy and the development of accurate encounters to be transmitted to the department. This processing includes application of non-history-related edits and history-related audits to the Claim. Claims are screened against Member and Provider eligibility information; pended and paid/denied claims history; and procedure, drug, diagnosis, and edit/audit information. Those Claims that exceed Program limitations or do not satisfy Program or processing requirements, suspend or deny with system assigned error messages related to the Claim.

Claims also need to be edited utilizing all components of the CMS mandated National Correct Coding Initiative (NCCI)

A. Inputs

The inputs to the Edit/Audit Processing function are:

1. The Claims that have been entered into the claims processing system from the claims entry function;
2. Member, Provider, reference data required to perform the edits and audits.

B. Processing Requirements

Basic editing necessary to pass the Claims onto subsequent processing requires that the MIS have the capabilities to:

1. Edit each data element on the Claim record for required presence, format, consistency, reasonableness, and/or allowable values.
2. Edit to assure that the services for which payment is requested are covered.
3. Edit to assure that all required attachments are present.
4. Maintain a function to process all Claims against an edit/audit criteria table and an error disposition file (maintained in the Reference Data Maintenance function) to provide flexibility in edit and audit processing.
5. Edit for prior authorization requirements and to assure that a prior authorization number is present on the Claim and matches to an active Prior Authorization on the MIS.
6. Edit Prior-Authorized claims and cut back billed units or dollars, as appropriate, to remaining authorized units or dollars, including Claims and adjustments processed within the same cycle.

7. Maintain edit disposition to deny Claims for services that require Prior Authorization if no Prior Authorization is identified or active.
8. Update the Prior Authorization record to reflect the services paid on the Claim and the number of services still remaining to be used.
9. Perform relationship and consistency edits on data within a single Claim for all Claims.
10. Perform automated audit processing (e.g., duplicate, conflict, etc.) using history Claims, suspended Claims, and same cycle Claims.
11. Edit for potential duplicate claims by taking into account group and rendering Provider, multiple Provider locations, and across Provider and Claim types.
12. Identify exact duplicate claims.
13. Perform automated audits using duplicate and suspect-duplicate criteria to validate against history and same cycle claims.
14. Perform all components of National Correct Coding Initiative (NCCI) edits
15. Maintain audit trail of all error code occurrences linked to a specific Claim line or service, if appropriate.
16. Edit and suspend each line on a multi-line Claim independently.
17. Edit each Claim record completely during an edit or audit cycle, when appropriate, rather than ceasing the edit process when an edit failure is encountered.
18. Identify and track all edits and audits posted to the claim from suspense through adjudication.
19. Update Claim history files with both paid and denied Claims from the previous audit run.
20. Maintain a record of services needed for audit processing where the audit criterion covers a period longer than thirty-six (36) months (such as once-in-a-lifetime procedures).
21. Edit fields in Appendices D and E for validity (numerical field, appropriate dates, values, etc.).

Claims Pricing

The Claims Pricing function calculates the payment amount for each service according to the rules and limitations applicable to each Claim type, category of service, type of provider, and provider reimbursement code. This process takes into consideration the Contractor allowed amount, TPL payments, Medicare payments, Member age, prior authorized amounts, and any co-payment requirements. Prices are maintained on the Reference files (e.g., by service, procedure, supply, drug, etc.) or provider-specific rate files and are date-specific.

The Contractor MIS must process and pay Medicare Crossover Claims and adjustments.

A. Inputs

The inputs into the Claims Pricing function are the Claims that have been passed from the edit/audit process.

The Reference and Provider files containing pricing information are also inputs to this function.

B. Processing Requirements

The Claims Pricing function for the Fee for Service contracts the vendor has with providers of the MIS must have the capabilities to:

1. Calculate payment amounts according to the fee schedules, per diems, rates, formulas, and rules established by the Contractor.
2. Maintain access to pricing and reimbursement methodologies to appropriately price claims at the Contractor's allowable amount.
3. Maintain flexibility to accommodate future changes and expanded implementation of co pays.

4. Deduct Member liability amounts from payment amounts as defined by the Department.
5. Deduct TPL amounts from payments amounts.
6. Provide adjustment processing capabilities.

Claims Operations Management

The Claims Operations Management function provides the overall support and reporting for all of the Claims processing functions.

A. Inputs

The inputs to the Claims Operations Management function must include all the claim records from each processing cycle and other inputs described for the Claims Control and Entry function.

B. Processing Requirements

The primary processes of Claims Operations Management are to maintain sufficient on-line claims information, provide on-line access to this information, and produce claims processing reports. The claims operations management function of the MIS must:

1. Maintain Claim history at the level of service line detail.
2. Maintain all adjudicated (paid and denied) claims history. Claims history must include at a minimum:
 - All submitted diagnosis codes (including service line detail, if applicable);
 - Line item procedure codes, including modifiers;
 - Member ID and medical coverage group identifier;
 - Billing, performing, referring, and attending provider Ids and corresponding provider types;
 - All error codes associated with service line detail, if applicable;
 - Billed, allowed, and paid amounts;
 - TPL and Member liability amounts, if any;
 - Prior Authorization number;
 - Procedure, drug, or other service codes;
 - Place of service;
 - Date of service, date of entry, date of adjudication, date of payment, date of adjustment, if applicable.
3. Maintain non-claim-specific financial transactions as a logical component of Claims history.
4. Provide access to the adjudicated and Claims in process, showing service line detail and the edit/audits applied to the Claim.
5. Maintain accurate inventory control status on all Claims.

C. Reports

The following reports must be available from the Claims processing function fifteen days after the end of each month:

1. Number of Claims received, paid, denied, and suspended for the previous month by provider type with a reason for the denied or suspended claim.
2. Number and type of services that are prior-authorized (PA) for the previous month (approved and denied).
3. Amount paid to providers for the previous month by provider type.
4. Number of Claims by provider type for the previous month, which exceed processing timelines standards defined by the Department.
Claim Prompt Pay reports as defined by ARRA

Analysis and Reporting Function

The analysis capacity function supports reporting requirements for the Contractor and the Department with regard to the QAPI program and managed care operations. The Contractor shall show sufficient capacity to support special requests and studies that may be part of the financial and quality systems. The reporting subsystem allows the Contractor to develop various reports to enable Contractor management and the Department to make informed decisions regarding managed care activity, costs and quality.

The Contractor's reporting subsystem shall contain such items as: specifications for a decision support system; capacity to collect, analyze and report performance data sets such as may be required under this Contract; HEDIS performance measures; report on Provider rates, federally required services, reports such as family planning services, abortions, sterilizations and EPSDT services.

APPENDIX H. COVERED SERVICES

I. Contractor Covered Services

- A. Alternative Birthing Center Services
- B. Ambulatory Surgical Center Services
- C. Behavioral Health Services – Mental Health and Substance Abuse Disorders
- D. Chiropractic Services
- E. Community Mental Health Center Services
- F. Dental Services, including Oral Surgery, Orthodontics and Prosthodontics
- G. Durable Medical Equipment, including Prosthetic and Orthotic Devices, and Disposable Medical Supplies
- H. Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening and special services
- I. End Stage Renal Dialysis Services
- J. Family Planning Services in accordance with federal and state law and judicial opinion
- K. Hearing Services, including Hearing Aids for Members Under age 21
- L. Home Health Services
- M. Hospice Services (non-institutional only)
- N. Independent Laboratory Services
- O. Inpatient Hospital Services
- P. Inpatient Mental Health Services
- Q. Meals and Lodging for Appropriate Escort of Members
- R. Medical Detoxification, meaning management of symptoms during the acute withdrawal phase from a substance to which the individual has been addicted.
- S. Medical Services, including but not limited to, those provided by Physicians, Advanced Practice Registered Nurses, Physicians Assistants and FQHCs, Primary Care Centers and Rural Health Clinics
- T. Organ Transplant Services not Considered Investigational by FDA
- U. Other Laboratory and X-ray Services
- V. Outpatient Hospital Services
- W. Outpatient Mental Health Services
- X. Pharmacy and Limited Over-the-Counter Drugs including Mental/Behavioral Health Drugs
- Y. Podiatry Services
- Z. Preventive Health Services, including those currently provided in Public Health Departments, FQHCs/Primary Care Centers, and Rural Health Clinics
- AA. Psychiatric Residential Treatment Facilities (Level I and Level II)
- BB. Specialized Case Management Services for Members with Complex Chronic Illnesses (Includes adult and child targeted case management)
- CC. Specialized Children's Services Clinics
- DD. Targeted Case Management
- EE. Therapeutic Evaluation and Treatment, including Physical Therapy, Speech Therapy, Occupational Therapy
- FF. Transportation to Covered Services, including Emergency and Ambulance Stretcher Services
- GG. Urgent and Emergency Care Services
- HH. Vision Care, including Vision Examinations, Services of Opticians, Optometrists and Ophthalmologists, including eyeglasses for Members Under age 21

II. Member Covered Services and Summary of Benefits Plan

- A. General Requirements and Limitations

The Contractor shall provide, or arrange for the provision of, health services, including Emergency Medical Services, to the extent services are covered for Members under the

then current Kentucky State Medicaid Plan, as designated by the department in administrative regulations adopted in accordance with KRS Chapter 13A and as required by federal and state regulations, guidelines, transmittals, and procedures.

This Appendix was developed to provide, for illustration purposes only, the Contractor with a summary of currently covered Kentucky Medicaid services and to communicate guidelines for the submission of specified Medicaid reports. The summary is not meant to act, nor serve as a substitute for the then current administrative regulations and the more detailed information relating to services which is contained in administrative regulations governing provision of Medicaid services (907 KAR Chapters 1, 3 4, 8, 9, 10, 11, 13, 15 and 17) and in individual Medicaid program services benefits summaries incorporated by reference in the administrative regulations. If the Contractor questions whether a service is a Covered Service or Non-Covered Service, the Department reserves the right to make the final determination, based on the then current administrative regulations in effect at the time of the contract.

Administrative regulations and incorporated by reference Medicaid program services benefits summaries may be accessed by contacting:

Kentucky Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6th Floor
Frankfort, Kentucky 40621

Kentucky's Medicaid State Plan, administrative regulations, and incorporated by reference materials are also accessible via the Internet at <http://www.chfs.ky.gov/dms/Regs.htm>.

Kentucky Medicaid covers only Medically Necessary services. These services are considered by the Department to be those which are reasonable and necessary to establish a diagnosis and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with the standards of health care generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 USC 1396d(r). Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The amount, duration, or scope of coverage must not be arbitrarily denied or reduced solely because of the diagnosis, scope of illness, or condition.

The Contractor shall provide any Covered Services ordered to be provided to a Member by a Court, to the extent not in conflict with federal laws. The Department shall provide written notification to the Contractor of any court-ordered service. The Contractor shall additionally cover forensic pediatric and adult sexual abuse examinations performed by health care professional(s) credentialed to perform such examinations and any physical and sexual abuse examination(s) for any Member when the Department for Community Based Services is conducting an investigation and determines that the examination(s) is necessary.

III. EMERGENCY CARE SERVICES (42 CFR 431.52)

The Contractor must provide, or arrange for the provision of, all covered emergency care immediately using health care providers most suitable for the type of injury or illness in accordance with Medicaid policies and procedures, even when services are provided outside the Contractor's region or are not available using Contractor enrolled providers. Conditions related to provision of emergency care are shown in 42 CFR 438.144.

IV. MEDICAID SERVICES COVERED AND NOT COVERED BY THE CONTRACTOR

The Contractor must provide Covered Services under current administrative regulations. The scope of services may be expanded with approval of the Department and as necessary to comply with federal mandates and state laws. Certain Medicaid services are currently excluded from the Contractor benefits package, but continue to be covered through the traditional fee-for-service Medicaid Program. The Contractor will be expected to be familiar with these Contractor excluded services, designated Medicaid “wrap-around” services and to coordinate with the Department’s providers in the delivery of these services to Members.

Information relating to these excluded services’ programs may be accessed by the Contractor from the Department to aid in the coordination of the services.

- A. Health Services Not Covered Under Kentucky Medicaid
Under federal law, Medicaid does not receive federal matching funds for certain services. Some of these excluded services are optional services that the Department may or may not elect to cover. The Contractor is not required to cover services that Kentucky Medicaid has elected not to cover for Members.

Following are services currently not covered by the Kentucky Medicaid Program:

- Any laboratory service performed by a provider without current certification in accordance with the Clinical Laboratory Improvement Amendment (CLIA). This requirement applies to all facilities and individual providers of any laboratory service;
- Cosmetic procedures or services performed solely to improve appearance;
- Hysterectomy procedures, if performed for hygienic reasons or for sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization, etc.);
- Induced abortion and miscarriage performed out-of-compliance with federal and Kentucky laws and judicial opinions;
- Paternity testing;
- Personal service or comfort items;
- Post mortem services;
- Services, including but not limited to drugs, that are investigational, mainly for research purposes or experimental in nature;
- Sex transformation services;
- Sterilization of a mentally incompetent or institutionalized member;
- Services provided in countries other than the United States, unless approved by the Secretary of the Kentucky Cabinet for Health and Family Services;
- Services or supplies in excess of limitations or maximums set forth in federal or state laws, judicial opinions and Kentucky Medicaid program regulations referenced herein; and
- Services for which the Member has no obligation to pay and for which no other person has a legal obligation to pay are excluded from coverage.;

V. Health Services Limited by Prior Authorization

The following services are currently limited by Prior Authorization of the Department for Members. Other than the Prior Authorization of organ transplants, the Contractor may establish its own policies and procedures relating to Prior Authorization.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Special Services

The Contractor is responsible for providing and coordinating Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), and EPSDT Special Services, through the

primary care provider (PCP), for any Member under the age of twenty-one (21) years.

EPSDT Special Services must be covered by the Contractor and include any Medically Necessary health care, diagnostic, preventive, rehabilitative or therapeutic service that is Medically Necessary for a Member under the age of twenty-one (21) years to correct or ameliorate defects, physical and mental illness, or other conditions whether the needed service is covered by the Kentucky Medicaid State Plan in accordance with Section 1905 (a) of the Social Security Act.

- Transplantation of Organs and Tissue (Must be in compliance with State Plan and 907 KAR 1:350.)
- Other Prior Authorized Medicaid Services

Other Medicaid services limited by Prior Authorization are identified in the individual program coverage areas in Section VI.

VI. Current Medicaid Programs' Services and Extent of Coverage

The Contractor shall cover all services for its Members at the appropriate level, in the appropriate setting and as necessary to meet Members' needs to the extent services are currently covered. The Contractor may expand coverage to include other services not routinely covered by Kentucky Medicaid, if the expansion is approved by the Department, if the services are deemed cost effective and Medically Necessary, and as long as the costs of the additional services do not affect the Capitation Rate.

The Contractor shall provide covered services as required by statutes or administrative regulations. The current location of Covered Services can be found in the following regulations:

- Alternative Birthing Center Services (907 KAR 1:180)
- Ambulatory Surgical Center (907 KAR 1:008)
- Behavioral Health Service Organization Services (907 KAR 15:020)
- Behavioral Health Services Provided by Independent Providers (907 KAR 15:010)
- Chemical Dependency Treatment Center Services (907 KAR 15:080)
- Chiropractic Services (907 KAR 3:125)
- Commission for Children with Special Health Care Needs (911 KAR Chapter 1)
Coverage includes physician, EPSDT, dental, occupational therapy, physical therapy, speech therapy, durable medical equipment, genetic screening and counseling, audiological, vision, case management, laboratory and x-ray, psychological and hemophilia treatment and related services.
- Community Mental Health Center Primary Care Services (907 KAR 1:046)
- Community Mental Health Center Behavioral Health Services (907 KAR 1:044)
- Dental Health Services (907 KAR 1:026)
- Dialysis Center Services (907 KAR 1:400)
- Durable Medical Equipment, Medical Supplies, Orthotic and Prosthetic Devices (907 KAR 1:479)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (907 KAR 11:034)
- Family Planning Clinic Services (907 KAR 1:048 & 1:434)
- Federally Qualified Health Clinics, Primary Care Clinics and Rural Health Center Services (907 KAR 1:054, 1:082,)
- Hearing Program Services (907 KAR 1:038)
- Home Health Services (907 KAR 1:030)
- Hospice Services – non-institutional (907 KAR 1:330 & 1: 436)
- Hospital Inpatient Services (907 KAR 10:012)
- Hospital Outpatient Services (907 KAR 10:014)

- Independent Occupational Therapy Services (907 KAR 8:005 and 907 KAR 8:101)
- Independent Physical Therapy Services (907 KAR 8:005 and 907 KAR 8:020)
- Independent Speech Language Pathology Services (907 KAR 8:005 and 907 KAR 8:030)
- Inpatient Psychiatric Hospital Services (907 KAR 10:016)
- Laboratory Services (907 KAR 1:028)
- Medical Necessity and Clinical Appropriate Determination Basis (907 KAR 3:130)
- Medicare Non-Covered Services (907 KAR 1:006)
- Mental Health Inpatient Services (907 KAR 10:012 & 10:016)
- Mental Health Outpatient Services (see physician, community mental health center, FQHC and RHC, 907 KAR Chapter 15)
- Psychiatric Hospital Inpatient Services (907 KAR 10:016)
- Psychiatric Hospital Outpatient Services (907 KAR 10:020)
- Nursing Facility Services (907 KAR 1:022 & 1:037)
- Organ Transplants (907 KAR 1:350)
- Other Laboratory and X-ray Provider Services (907 KAR 1:028)
- Outpatient Pharmacy Prescriptions and Over-the-Counter Drugs including Behavioral Health Drugs (907 KAR 1:019, KRS 205.5631, 205,5632, 205.560)
- Outpatient Psychiatric Hospital Behavioral Health Services (907 KAR 10:020)
- Physicians and Nurses in Advanced Practice Medical Services (907 KAR 3:005 and 907 KAR 1:102)
- Podiatry Services (907 KAR 1:270)
- Preventive and Remedial Public Health Services (907 KAR 1:360)
- Private Duty Nursing (907 KAR Chapter 13)
- Psychiatric Residential Treatment Facility Services – (907 KAR 9:005)
- Residential Crisis Stabilization Unit Services (907 KAR 15:075)
- Specialized Children’s Services Clinics (907 KAR 3:160)
- Sterilization, Hysterectomy and Induced Termination of Pregnancy Procedures (Sterilizations of both male and female Members are covered only when performed in compliance with 42 CFR 441.250, KRS 205.560 and *Glenda Hope, et al. v. Masten Childers, et al.*)
- Substance Use Disorder Services (907 KAR 15:005, 907 KAR 15:010 – 15:025)
- Targeted Case Management Services (907 KAR 15:005, 907 KAR 15:040 - 15:065)
- Tobacco Cessation Services (907 KAR 3:215)
- Transportation, including Emergency and Non-emergency Ambulance (907 KAR 1:060)
- Vaccines for Children (VFC) Program (907 KAR 1:680)
- Vision Services (907 KAR 1:632)

APPENDIX I. TRANSITION/COORDINATION OF CARE PLANS

Upon receipt of a HIPAA 834 indicating that a Member is transferring from one Medicaid Managed Care Organization (Former MCO) to another MCO (New MCO), the Former MCO shall be responsible to contact the New MCO, the recipient and the recipient's providers in order to transition existing care. A Prior Authorization (PA) shall be honored by the New MCO for 90 days or until the recipient or provider is contacted by the New MCO regarding the PA. If the recipient and provider are not contacted by the New MCO, the existing Medicaid PA shall be honored until expired.

Hospital Admission Prior to the Member's Transition.

If the Member is an in-patient in any facility at the time of transition, the entity responsible for the Member's care at the time of admission shall continue to provide coverage for the Member at that facility, including all Professional Services, until the recipient is discharged from the facility for the current admission. An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five digits of a diagnosis code.

Outpatient Facility Services and Non-Facility Services

Effective on the Member's Transition date, the New MCO will be responsible for outpatient services both facility and non-facility. Outpatient reimbursement includes outpatient hospital, ambulatory surgery centers, and renal dialysis centers.

Nursing Homes

Eligibility for Long Term Care in a Nursing Facility (NF) includes some financial requirements not needed for basic Medicaid eligibility. When an eligible member enters an NF the facility must receive a Level of Care (LOC) determination to ensure the member meets medical criteria for Nursing Facility. That LOC is passed electronically to the DCBS eligibility worker, triggering the eligibility determination for this additional benefit. That determination can generally be completed within thirty days. *Once LTC eligible, worker entries exempt the member from managed care effective with the next feasible month.* If the worker action is completed prior to cut off (eight business days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for ancillary, physician and pharmaceuticals charges and the Department will reimburse for those services billed by Nursing Facility. Once exempt from Managed Care, the Department will be responsible for all eligible services associated with this recipient.

Waiver Participation

1915(c) Home and Community Based Services Wavier programs are simply added benefits for eligible members; however, the action that exempts those members from being subject to Managed Care resides with the DCBS eligibility worker. These services require a Level of Care (LOC). The LOC is passed electronically to the DCBS eligibility worker; receipt of the LCO triggers the eligibility worker to complete entries within the eligibility system. Those entries exempt the member from managed care effective the next feasible month. If the worker action is completed prior to cut off (eight business days before the end of the month), managed care ends at the last day of current month. If the action is after cut off, managed care ends the last day of the following month. During this transition, the MCO will be responsible for all services except the additional Waiver benefits. The Waiver Services will be paid by the Department as fee for service. Coding in our billing system allows the Wavier Service to be processed during the transition period, once the eligibility worker has completed the necessary entries. Once exempt from Managed Care the Department will be responsible for all services associated with this recipient.

Transplants

Follow up care provided on or after the Member's Transition that is billed outside the Global Charges, will be the responsibility of the New MCO.

Eligibility Issues

For a Member who loses eligibility during an inpatient stay, an MCO is responsible for the care through discharge if the hospital is compensated under a DRG methodology or through the day of ineligibility if the hospital is compensated under a per diem methodology.

APPENDIX J. CREDENTIALING PROCESS

Provider Enrollment Coversheet

1. Provider Name
2. Address-Physical & telephone number
3. Address-Pay-to-address
4. Address-Correspondence
5. E-mail address
6. Address-1099 & telephone number
7. Fax Number
8. Electronic Billing
9. Specialty
10. SSN/FEIN#
11. License#/Certificate
12. Begin and End date of Eligibility
13. CLIA
14. NPI
15. Taxonomy
16. Ownership (5%or more)
17. Previous Provider Number (if applicable) this also includes Change in Ownership
18. Existing provider number if EPSDT
19. Tax Structure
20. Provider Type
21. DOB
22. Supervising Physician (for Physician Assist)
23. Map 347 (need group# and effective date)
24. EFT (Account # and ABA #)
25. Bed Data
26. DEA (Effective and Expiration dates)
27. Fiscal Year End Date
28. Document Control Number
29. Contractor Credentialing Date
30. Credentialing Required

Credentialing and Recredentialing Requirements

This documentation shall include, but not be limited to, defining the scope of providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements. The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers. Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant and other licensed or certified practitioners. Providers required to be recredentialled by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department. The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:

- A. The Contractor shall verify that its enrolled network Providers to whom Members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations and have in effect such current policies of malpractice insurance as may be required by the Contractor.
- B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the

Department.

- C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.
- D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 205.560(12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.

The process for verification of Provider credentials and insurance shall include the following:

- A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;
- B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;
- C. A review of the credentialing policies and procedures by the formal body;
- D. A credentialing committee which makes recommendations regarding credentialing;
- E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;
- F. Written procedures for the termination or suspension of Providers; and
- G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.

The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of Provider's credentials shall include the following:

- A. A current valid license or certificate to practice in the Commonwealth of Kentucky;
- B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;
- C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program as applicable; if provider is not board certified.
- D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;
- E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;
- F. Previous five (5) years' work history;
- G. Professional liability claims history;
- H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;
- I. Current, adequate malpractice insurance, as verified through attestation;
- J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;
- K. Documentation of curtailment or suspension of medical staff privileges;
- L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;
- M. Documentation of censure by the State or County professional association; and
- N. Most recent information available from the National Practitioner Data Bank.
- O. Health and Human Services Office of Inspector General (HHS OIG)
- P. System for Award Management (SAM)

The provider shall complete a credentialing application that includes a statement by the applicant regarding:

- A. The ability to perform the essential functions of the positions, with or without accommodation;
- B. Lack of present illegal drug use;
- C. History of loss of license and felony convictions;
- D. History of loss or limitation of privileges or disciplinary activity;
- E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and
- F. Applicants attest to the correctness and completeness of the application.

Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:

- A. National practitioner data bank, if applicable;
- B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and
- C. Other recognized monitoring organizations appropriate to the practitioner's discipline.

At the time of credentialing, the Contractor shall perform an initial visit to providers as it deems necessary and as required by law. (See 42 CFR Part 455 Subpart E.). The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract. The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractor's organizational standards and this contract.

The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:

- A. A current license to practice;
- B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;
- C. A valid DEA number, if applicable;
- D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialled;
- E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and
- F. A current signed attestation statement by the applicant regarding:
 - (1) The ability to perform the essential functions of the position, with or without accommodation;
 - (2) The lack of current illegal drug use;
 - (3) A history of loss, limitation of privileges or any disciplinary action; and
 - (4) Current malpractice insurance.
 - (5) Health and Human Services Office of Inspector General (HHS OIG)
 - (6) System for Award Management (SAM)

There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:

- A. The national practitioner data bank;
- B. Medicare and Medicaid;
- C. State boards of practice, as applicable; and

- D. Other recognized monitoring organizations appropriate to the practitioner's specialty.

The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers, and clinics. At least every three (3) years, the Contractor shall confirm that the provider is in good standing with state and federal regulatory bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.

The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services. The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.

If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.

The contractor shall use the provider type summaries listed at <https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/prov-summaries.aspx>

APPENDIX K. MCO PROVIDER NETWORK FILE LAYOUT (EFFECTIVE 11-07-12)

Submit one delimited text file per network.

Submit one record for each provider to include the values indicated in the layout.

| Field | Data Type | Length | Description | Valid Values |
|------------------------------------|-----------|--------|---|---|
| Provider Type | Character | 2 | Medicaid Provider Type | Utilize valid values from sheet titled Medicaid Provider Types |
| Provider Contracted | Character | 1 | Valid values are C or L. C=provider has a signed contract to be a participating provider in the network or L=provider has signed a letter of intent stating they will be a participating provider in the network. | Valid values are C or L. C=provider has a signed contract to be a participating provider in the network or L=provider has signed a letter of intent stating they will be a participating provider in the network. |
| Provider License | Character | 10 | Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky. | Must be submitted for physicians and leave blank if physician is licensed in a state other than Kentucky. |
| National Provider Identifier (NPI) | Character | 10 | Must be submitted for providers required to have an NPI. | Must be submitted for providers required to have an NPI. |
| Medicaid Provider ID | Character | 10 | Provider ID assigned by Kentucky Medicaid. Must be submitted - if known. | Provider ID assigned by Kentucky Medicaid. Must be submitted - if known. |
| Primary Specialty Code | Character | 3 | Medicaid Provider Specialty | Utilize valid values from sheet titled Medicaid Provider Specialties. |
| Secondary Specialty Code | Character | 3 | Medicaid Provider Specialty | Utilize valid values from sheet titled Medicaid Provider Specialties |
| Name | Character | 50 | If a physician name, enter as last name, first name, MI | If a physician name, enter as last name, first name, MI. |
| Address Line 1 | Character | 50 | Location street address line 1 | DO NOT SUBMIT PO BOX OR MAILING ADDRESS. THIS MUST BE LOCATION ADDRESS! |
| Address Line 2 | Character | 50 | Location street address line 2 | DO NOT SUBMIT PO BOX OR MAILING ADDRESS. THIS MUST BE LOCATION ADDRESS! |
| City | Character | 50 | Location city | |

| Field | Data Type | Length | Description | Valid Values |
|--------------------------|-----------|-----------------|--|--|
| State | Character | 2 | Location state | |
| Zip Code | Character | 5 | Location zip code | |
| County Code | Character | 3 | Location county | County Code of the Provider's location address. See the following list for Kentucky County Codes. |
| Phone Number | Character | 15 | Phone number excluding dashes | Do not include dashes, etc. |
| Latitude | Character | 11 | Latitude of the Provider's location address. Precision to the 6th digit. Must be in format 99.999999 | Latitude of the Provider's location address. Precision to the 6th digit. Must be in format 99.999999 |
| Longitude | Character | 11 | Longitude of the Provider's location address. Precision to the 6th digit. Must be in format -99.999999 | Longitude of the Provider's location address. Precision to the 6th digit. Must be in format -99.999999 |
| PCP Specialist or Both | Character | 1 | Valid entries are P, S or B. P=PCP, S=Specialty, B=Both. Leave blank for all other providers. | Valid entries are P, S or B. P=PCP, S=Specialty, B=Both. Leave blank for all other providers. |
| PCP Open or Closed Panel | Character | 1 | Mandatory for PCP. Valid entries are O or C. O=Open, C=Closed. Leave blank for all other providers. | Mandatory for PCP. Valid entries are O or C. O=Open, C=Closed. Leave blank for all other providers. |
| PCP Panel Size | Character | 9 | PCP Provider's maximum panel size | PCP Provider's maximum panel size |
| PCP Panel Enrollment | Character | 9 | PCP Provider's current panel enrollment count | PCP Provider's current panel enrollment count |
| Spanish | Character | 1 | Y = yes | Y - yes |
| Language 1 | Character | 3 | Language code | See the following codes |
| Language 2 | Character | 3 | Language code | See the following codes |
| Language 3 | Character | 3 | Language code | See the following codes |
| Language 4 | Character | 3 | Language code | See the following codes |
| MCO Medicaid Provider ID | Character | 10 | Provider ID assigned to the MCO by Kentucky Medicaid | Provider ID assigned to the MCO by Kentucky Medicaid. |
| Effective Date | Character | 8 (CCYYMMDD) | Effective date that the provider joined the MCO and can provide services | Effective date that the provider joined the MCO and can provide services. |

| Field | Data Type | Length | Description | Valid Values |
|--------------------------|-----------|-----------------|--|--|
| End Date | Character | 8 (CCYYMMDD) | Last date the provider is contracted with the MCO. (If provider contract is open ended send 22991231.) | Last date the provider is contract with the MCO. (If provider contract is open ended send 22991231.) |
| Is Included in directory | Character | 1 | Y - yes, provider will be included in the state as well as MCO network directories. N - No, provider is still part of the network, but will not be included in the state as well as MCO network directories. | Y - yes, provider will be included in the state as well as MCO network directories. N - No, provider is still part of the network, but will not be included in the state as well as MCO network directories. |
| Reserved1 | | 20 | Reserved | Reserved |
| Reserved2 | | 20 | Reserved | Reserved |
| Reserved3 | | 20 | Reserved | Reserved |
| Reserved4 | | 20 | Reserved | Reserved |
| Reserved5 | | 20 | Reserved | Reserved |

Provider Types:

| Provider Type Code | Provider Type Description |
|--------------------|--|
| 01 | General hospital |
| 02 | Mental Hospital |
| 04 | Psychiatric Residential Treatment Facility |
| 10 | ICF/MR Clinic |
| 11 | ICF/MR |
| 12 | Nursing Facility |
| 13 | Specialized Children Service Clinics |
| 14 | MFP Pre-Transition Services |
| 15 | Health Access Nurturing Development Svcs |
| 17 | Acquired Brain Injury |
| 20 | Preventive & Remedial Public Health |
| 21 | School Based Health Services |
| 22 | Commission for Handicapped Children |
| 23 | Title V/DSS |
| 24 | First Steps/Early Int. |
| 25 | Targeted Case Management |
| 27 | Adult Targeted Case Management |
| 28 | Children Targeted Case Management |
| 29 | Impact Plus |
| 30 | Community Mental Health |
| 31 | Primary Care |
| 32 | Family Planning Service |
| 33 | Support for Community Living (SCL) |
| 34 | Home Health |
| 35 | Rural Health Clinic |
| 36 | Ambulatory Surgical Centers |
| 37 | Independent Laboratory |
| 38 | Lab & X-Ray Technician |
| 39 | Dialysis Clinic |
| 40 | EPSDT Preventive Services |
| 41 | Model Waiver |

| | |
|----|---|
| 42 | Home and Community Based Waiver |
| 43 | Adult Day Care |
| 44 | Hospice |
| 45 | EPSDT Special Services |
| 46 | Home Care Waiver |
| 47 | Personal Care Waiver |
| 50 | Hearing Aid Dealer |
| 52 | Optician (528 - Optical clinic) |
| 54 | Pharmacy |
| 55 | Emergency Transportation |
| 56 | Non-Emergency Transportation |
| 57 | Net (Capitation) |
| 58 | Net Clinic (Capitation) |
| 60 | Dentist - Individual |
| 61 | Dental - Group |
| 64 | Physician Individual |
| 65 | Physician - Group |
| 70 | Audiologist |
| 72 | Nurse Midwife |
| 73 | Birthing Centers |
| 74 | Nurse Anesthetist |
| 77 | Optometrist - Individual |
| 78 | Certified Nurse practitioner |
| 80 | Podiatrist |
| 82 | Clinical Social Worker |
| 85 | Chiropractor |
| 86 | X-Ray / Misc. Supplier |
| 87 | Physical Therapist |
| 88 | Occupational Therapist |
| 89 | Psychologist |
| 90 | DME Supplier |
| 91 | CORF (Comprehensive Out-patient Rehab Facility) |
| 92 | Psychiatric Distinct Part Unit |
| 93 | Rehabilitation Distinct Part Unit |
| 95 | Physician Assistant |
| 96 | HMO/PHP |
| 98 | MCO (Managed Care Organization) |
| 99 | Not on File |

Medicaid Provider Specialties:

| Provider Specialty Code | Provider Specialty Description |
|-------------------------|--|
| 010 | Acute Care |
| 012 | Rehabilitation |
| 014 | Critical Access |
| 015 | Children's Specialty |
| 016 | Emergency |
| 017 | Ventilator Hospital |
| 011 | Psychiatric |
| 013 | Residential Treatment Center |
| 038 | ICF/MR Clinic |
| 030 | Nursing Facility |
| 031 | ICF/MR > 6 Beds |
| 032 | Pediatric Nursing Facility |
| 033 | Residential Care Facility |
| 034 | ICF/MR < 6 Beds |
| 035 | Skilled Nursing Facility |
| 036 | Respite Care - Facility Based |
| 037 | Assisted Living |
| 179 | Brain Injury |
| 131 | Specialized Children's Service Clinics |
| 141 | MFP \$15,000 Bucket |
| 142 | MFP \$2000 Visa Pro-card Expenditures |
| 143 | MFP \$2000 Check Expenditures |
| 159 | Health Access Nurturing Development Svcs Group |
| 151 | Health Access Nurturing Development Svcs |
| 201 | General Preventive Care |
| 209 | General Preventive Care Group |
| 120 | School Board |
| 228 | Commission For Handicapped Children Group |
| 229 | Commission For Handicapped Children |
| 239 | Title V/DSS |
| 238 | Title V/DSS Group |

| | |
|-----|--|
| 249 | First Steps Early Int. |
| 248 | First Steps Early Int. Group |
| 211 | HIV Case Manager |
| 214 | High Risk Pregnant Women |
| 215 | TB Case Mgmt |
| 216 | OJA Targeted Case Management |
| 221 | MH Case Mgmt All Ages |
| 222 | MH Case Mgmt, Over 21, Public |
| 223 | MH Case Mgmt, Over 21, Contracted |
| 224 | MH Case Mgmt, Over 21, Private |
| 226 | MH Case Mgmt, Under 21, Contracted |
| 227 | MH Case Mgmt, Under 21, Private |
| 225 | MH Case Mgmt, Under 21, Public |
| 291 | Impact Plus DMH |
| 292 | Impact Plus DCBS |
| 299 | Impact Plus Other |
| 110 | Outpatient Mental Health Clinic |
| 111 | Community Mental Health Center (CMHC) |
| 114 | Health Service Provider in Psychology (HSPP) |
| 118 | Mental Health - DMHSAS |
| 080 | Federally Qualified Health Clinic (FQHC) |
| 082 | Medical Clinic |
| 308 | Family Planning Clinic Group |
| 083 | Family Planning Clinic |
| 039 | Supports for Community Living |
| 050 | Home Health Agency |
| 051 | Specialized Home Nursing Services |
| 210 | Care Coordinator for Pregnant Women |
| 081 | Rural Health Clinic (RHC) |
| 020 | Ambulatory Surgical Center (ASC) |

| | |
|-----|--|
| 280 | Independent Lab |
| 281 | Mobile Lab |
| 861 | Other Laboratory And X-Ray |
| 300 | Free-standing Renal Dialysis Clinic |
| 183 | EPSDT Preventive Services |
| 411 | Model Waiver 1 |
| 412 | Model Waiver 2 |
| 561 | Home and Community Based Waiver |
| 410 | Adult Day Care |
| 060 | Hospice |
| 150 | Chiropractor |
| 455 | Prescribed Pediatric Extended Care Facility (PPEC) |
| 550 | EPSDT Services - OBSOLETE |
| 551 | General hospital |
| 552 | Psychiatric Hospital |
| 553 | Psychiatric Residential Treatment Facility |
| 554 | Commission for Handicapped Children |
| 555 | Children Targeted Case Management |
| 556 | Community Mental Health |
| 557 | Physician |
| 558 | Home Health |
| 559 | Rural Health Clinic |
| 560 | Independent Laboratory |
| 563 | Hearing Aid Dealer |
| 564 | Optician |
| 565 | Pharmacy |
| 567 | Dentist - Individual |
| 568 | Dental - Group |
| 569 | Physician Individual |
| 570 | Physician - Group |
| 571 | Audiologist |
| 573 | Optometrist |
| 574 | Certified Nurse practitioner |
| 575 | Podiatrist |
| 579 | DME Supplier |
| 580 | CORF |
| 999 | None on File |

| | |
|-----|---|
| 463 | Provider of Case Management Services Only |
| 464 | Provider of Homemaker and Personal Care Services Only |
| 465 | Provider of Home Adaptations Only |
| 466 | Homemaker Personal Care & Home Adaptation Services |
| 470 | Provider of Case Management Services Only |
| 471 | Provider of Personal Care Coordination Services Only |
| 472 | Provider of Personal Care Assistance Services Only |
| 473 | Both Personal Care Coordinator and Care Assist Services |
| 220 | Hearing Aid Dealer |
| 509 | Hearing Aid Dealer Group |
| 180 | Optometrist |
| 190 | Optician |
| 528 | Multi-Specialty Group - Optician |
| 240 | Pharmacy |
| 260 | Ambulance |
| 261 | Air Ambulance |
| 262 | Bus |
| 263 | Taxi |
| 264 | Common Carrier (Ambulatory) |
| 265 | Common Carrier (Non-ambulatory) |
| 266 | Family Member / Private Auto |
| 661 | AMBULANCE Non-Emergency |
| 073 | NET (Non-Emergency Transportation) |
| 671 | Net Cap |
| 672 | NET - DOT |
| 270 | Endodontist |
| 271 | General Dentistry Practitioner |
| 272 | Oral Surgeon |
| 273 | Orthodontist |
| 274 | Pediatric Dentist |
| 275 | Periodontist |
| 276 | Oral Pathologist |
| 277 | Prosthesis |
| 610 | Multi-Specialty Group - Dental |

| | |
|-----|--|
| 543 | Teleradiology |
| 112 | Psychologist |
| 310 | Allergist |
| 311 | Anesthesiologist |
| 312 | Cardiologist |
| 313 | Cardiovascular Surgeon |
| 314 | Dermatologist |
| 315 | Emergency Medicine Practitioner |
| 316 | Family Practitioner |
| 317 | Gastroenterologist |
| 318 | General Practitioner |
| 319 | General Surgeon |
| 320 | Geriatric Practitioner |
| 321 | Hand Surgeon |
| 322 | Internist |
| 323 | Neonatologist |
| 324 | Nephrologist |
| 325 | Neurological Surgeon |
| 326 | Neurologist |
| 327 | Nuclear Medicine Practitioner |
| 328 | Obstetrician/Gynecologist |
| 329 | Oncologist |
| 330 | Ophthalmologist |
| 331 | Orthopedic Surgeon |
| 332 | Otologist, Laryngologist, Rhinologist |
| 333 | Pathologist |
| 334 | Pediatric Surgeon |
| 335 | Maternal Fetal Medicine |
| 336 | Physical Medicine and Rehabilitation Practitioner |
| 337 | Plastic Surgeon |
| 338 | Proctologist |
| 339 | Psychiatrist |
| 340 | Pulmonary Disease Specialist |
| 341 | Radiologist |
| 342 | Thoracic Surgeon |
| 343 | Urologist |
| 344 | General Internist |
| 345 | General Pediatrician |
| 346 | Dispensing Physician |
| 347 | Radiation Therapist |

| | |
|-----|--|
| 348 | Osteopathy |
| 544 | Immunology |
| 545 | Colon and Rectal Surgery |
| 546 | Medical Genetics |
| 547 | Preventive Medicine |
| 293 | Medicare Clinic |
| 650 | Multi-Specialty Group - Physician |
| 200 | Audiologist |
| 709 | Audiologist Group |
| 095 | Certified Nurse Midwife |
| 729 | Nurse Midwife Group |
| 913 | Birth Centers |
| 094 | Certified Registered Nurse Anesthetist (CRNA) |
| 749 | Multi-Specialty Group - Nurse Anesthetist |
| 779 | Multi-Specialty Group - Optometrist |
| 090 | Pediatric Nurse Practitioner |
| 091 | Obstetric Nurse Practitioner |
| 092 | Family Nurse Practitioner |
| 093 | Nurse Practitioner (Other) |
| 789 | Multi-Specialty Group - Nurse Practitioner |
| 140 | Podiatrist |
| 809 | Podiatrist Group |
| 115 | Certified Clinical Social Worker |
| 116 | Certified Social Worker |
| 829 | Clinic Social Worker Group |
| 859 | Chiropractor Group |
| 251 | Assistive Technology |
| 542 | Other Lab Toxicology |
| 170 | Physical Therapist |
| 879 | Physical Therapist Group |
| 171 | Occupational Therapist |
| 889 | Occupational Therapist Group |
| 899 | Psychologist Group |
| 250 | DME/Medical Supply Dealer |
| 911 | CORF |
| 912 | Other CORF Group |
| 040 | Rehabilitation Facility |
| 100 | Physician Assistant |

| | |
|-----|---------------------------|
| 101 | Anesthesiology Assistant |
| 959 | Physician Assistant Group |
| 071 | Managed Care Organization |

| | |
|-----|------------------|
| | (MCO) |
| 072 | IHS Case Manager |
| | |

Kentucky County Codes:

| County Code | County Description |
|--------------------|---------------------------|
| 001 | Adair |
| 002 | Allen |
| 003 | Anderson |
| 004 | Ballard |
| 005 | Barren |
| 006 | Bath |
| 007 | Bell |
| 008 | Boone |
| 009 | Bourbon |
| 010 | Boyd |
| 011 | Boyle |
| 012 | Bracken |
| 013 | Breathitt |
| 014 | Breckinridge |
| 015 | Bullitt |
| 016 | Butler |
| 017 | Caldwell |
| 018 | Calloway |
| 019 | Campbell |
| 020 | Carlisle |
| 021 | Carroll |
| 022 | Carter |
| 023 | Casey |
| 024 | Christian |
| 025 | Clark |
| 026 | Clay |
| 027 | Clinton |
| 028 | Crittenden |
| 029 | Cumberland |
| 030 | Daviess |
| 031 | Edmonson |
| 032 | Elliott |
| 033 | Estill |
| 034 | Fayette |
| 035 | Fleming |
| 036 | Floyd |
| 037 | Franklin |
| 038 | Fulton |
| 039 | Gallatin |
| 040 | Garrard |

| | |
|-----|------------|
| 041 | Grant |
| 042 | Graves |
| 043 | Grayson |
| 044 | Green |
| 045 | Greenup |
| 046 | Hancock |
| 047 | Hardin |
| 048 | Harlan |
| 049 | Harrison |
| 050 | Hart |
| 051 | Henderson |
| 052 | Henry |
| 053 | Hickman |
| 054 | Hopkins |
| 055 | Jackson |
| 056 | Jefferson |
| 057 | Jessamine |
| 058 | Johnson |
| 059 | Kenton |
| 060 | Knott |
| 061 | Knox |
| 062 | Larue |
| 063 | Laurel |
| 064 | Lawrence |
| 065 | Lee |
| 066 | Leslie |
| 067 | Letcher |
| 068 | Lewis |
| 069 | Lincoln |
| 070 | Livingston |
| 071 | Logan |
| 072 | Lyon |
| 073 | McCracken |
| 074 | McCreary |
| 075 | McLean |
| 076 | Madison |
| 077 | Magoffin |
| 078 | Marion |
| 079 | Marshall |
| 080 | Martin |
| 081 | Mason |

| | |
|-----|--------------|
| 082 | Meade |
| 083 | Menifee |
| 084 | Mercer |
| 085 | Metcalfe |
| 086 | Monroe |
| 087 | Montgomery |
| 088 | Morgan |
| 089 | Muhlenberg |
| 090 | Nelson |
| 091 | Nicholas |
| 092 | Ohio |
| 093 | Oldham |
| 094 | Owen |
| 095 | Owsley |
| 096 | Pendleton |
| 097 | Perry |
| 098 | Pike |
| 099 | Powell |
| 100 | Pulaski |
| 101 | Robertson |
| 102 | Rockcastle |
| 103 | Rowan |
| 104 | Russell |
| 105 | Scott |
| 106 | Shelby |
| 107 | Simpson |
| 108 | Spencer |
| 109 | Taylor |
| 110 | Todd |
| 111 | Trigg |
| 112 | Trimble |
| 113 | Union |
| 114 | Warren |
| 115 | Washington |
| 116 | Wayne |
| 117 | Webster |
| 118 | Whitley |
| 119 | Wolfe |
| 120 | Woodford |
| 121 | Guardianship |
| 200 | Out of State |

| | |
|-----|----------------|
| 220 | Alabama |
| 221 | Alaska |
| 222 | Arizona |
| 223 | Arkansas |
| 224 | California |
| 225 | Colorado |
| 226 | Connecticut |
| 227 | Delaware |
| 228 | District Col |
| 229 | Florida |
| 230 | Georgia |
| 231 | Hawaii |
| 232 | Idaho |
| 233 | Illinois |
| 234 | Indiana |
| 235 | Iowa |
| 236 | Kansas |
| 237 | Louisiana |
| 238 | Maine |
| 239 | Maryland |
| 240 | Massachusetts |
| 241 | Michigan |
| 242 | Minnesota |
| 243 | Mississippi |
| 244 | Missouri |
| 245 | Montana |
| 246 | Nebraska |
| 247 | Nevada |
| 248 | New Hampshire |
| 249 | New Jersey |
| 250 | New Mexico |
| 251 | New York |
| 252 | North Carolina |
| 253 | North Dakota |
| 254 | Ohio |
| 255 | Oklahoma |
| 256 | Oregon |
| 257 | Pennsylvania |
| 258 | Puerto Rico |
| 259 | Rhode Island |
| 260 | South Carolina |

| | |
|-----|----------------|
| 261 | South Dakota |
| 262 | Tennessee |
| 263 | Texas |
| 264 | Utah |
| 265 | Vermont |
| 266 | Virginia |
| 267 | Virgin Islands |

| | |
|-----|---------------|
| 268 | Washington |
| 269 | West Virginia |
| 270 | Wisconsin |
| 271 | Wyoming |
| 296 | Canada |

Language Codes:

| Language Code | Language Description |
|----------------------|-----------------------------|
| 001 | Abkhazian |
| 002 | Afan (Oromo) |
| 003 | Afar |
| 004 | Afrikaans |
| 005 | Albanian |
| 006 | Amharic |
| 007 | Arabic |
| 008 | Armenian |
| 009 | Assamese |
| 010 | Zerbaijani |
| 011 | Bashkir |
| 012 | Basque |
| 013 | Bengali; Bangla |
| 014 | Bhutani |
| 015 | Bihari |
| 016 | Bislama |
| 017 | Breton |
| 018 | Bulgarian |
| 019 | Burmese |
| 020 | Byelorussian |
| 021 | Cambodian |
| 022 | Catalan |
| 023 | Chinese |
| 024 | Corsican |
| 025 | Croatian |
| 026 | Czech |
| 027 | Danish |
| 028 | Dutch |
| 029 | english |
| 030 | Esperonto |
| 031 | Estonian |
| 032 | Faroese |
| 033 | Fiji |
| 034 | Finnish |
| 035 | French |
| 036 | Frisian |
| 037 | Galican |
| 038 | Georgian |

| | |
|-----|------------------|
| 039 | German |
| 040 | Greek |
| 041 | Greenlandic |
| 042 | Guarani |
| 043 | Gujarati |
| 044 | Hausa |
| 045 | Hebrew |
| 046 | Hindi |
| 047 | Hungarian |
| 048 | Icelandic |
| 049 | Indonesian |
| 050 | Interlingua |
| 051 | Ingerlingue |
| 052 | Inuktitut |
| 053 | Inupiak |
| 054 | Irish |
| 055 | Italian |
| 056 | Japanese |
| 057 | Javanese |
| 058 | Kannada |
| 059 | Kashmiri |
| 060 | Kazakh |
| 061 | Kinyarwanda |
| 062 | Kirghiz |
| 063 | Kurundi |
| 064 | Korean |
| 065 | Kurdish |
| 066 | Laothian |
| 067 | Latin |
| 068 | Latvian; Lettish |
| 069 | Lingala |
| 070 | Lithuanian |
| 071 | Macedonian |
| 072 | Malagasy |
| 073 | Malay |
| 074 | Malayalam |
| 075 | Maltese |
| 076 | Maori |
| 077 | Marathi |
| 078 | Moldavian |

| | |
|-----|-----------------|
| 079 | Mongolian |
| 080 | Nauru |
| 081 | Nepali |
| 082 | Norwegian |
| 083 | Occitan |
| 084 | Oriya |
| 085 | Pashto; Pushto |
| 086 | Persian (Farsi) |
| 087 | Polish |
| 088 | Portuguese |
| 089 | Punjabi |
| 090 | Quechua |
| 091 | Rhaeto-Romance |
| 092 | Romanian |
| 093 | Russian |
| 094 | Samoan |
| 095 | Sangho |
| 096 | Sanskrit |
| 097 | Scot Gaelic |
| 098 | Serbian |
| 099 | Serbo-Croatian |

| | |
|-----|------------|
| 100 | Seotho |
| 101 | Setswana |
| 102 | Shona |
| 103 | Sindhi |
| 104 | Singhalese |
| 105 | Siswati |
| 106 | Slovak |
| 107 | Slovenian |
| 108 | Somali |
| 110 | Sundanese |
| 111 | Swahili |
| 112 | Swedish |
| 113 | Tagalog |
| 114 | Tajik |
| 115 | Tamil |
| 116 | Tatar |
| 117 | Telugu |
| 118 | Thai |
| 119 | Tibetan |
| 120 | Tigrinya |

PROVIDER MASTER EXTRACT FILE LAYOUT FOR MCOS

Description:

Full extract of Medicaid providers active in the last 6 months

Destination(s):

Each MCO

Interface Id:

524

Frequency

Daily

Criteria:

All providers that have been active within the last six months

Header Record

| Field | Data Type | Start | End | Length | Description |
|-----------------------|-----------|-------|-----|--------|---|
| RECORD ID | Char | 1 | 2 | 2 | Value 'HH' to denote header record |
| CREATE DATE | Char | 3 | 12 | 10 | Date file is created in MM/DD/CCYY format |
| FILE SENDER | Char | 13 | 52 | 40 | 'KENTUCKY DEPARTMENT OF MEDICAID SERVICES' |
| FILE DESCRIPTION | Char | 53 | 92 | 40 | 'INTERCHANGE PROVIDER FILE' |
| TIME PERIOD – MONTH | Char | 93 | 94 | 2 | Month this file is to be processed in MM format. |
| TIME PERIOD - YEAR | Char | 95 | 98 | 4 | Year this file is to be processed in CCYY format. |
| FILE DESTINATION | Char | 99 | 138 | 40 | 'MCO NAME' |
| DESTINATION FILE NAME | Char | 139 | 168 | 30 | prd962xx.dat (where xx stands for 01 for Coventry Health and Life Insurance Company 02 for WellCare Of Kentucky Inc. 03 for Kentucky Spirit Health Plan 04 for Humana Caresource 05 for Passport Health Plan |
| FILE ORIGIN | Char | 169 | 208 | 40 | 'KYMMIS CORPORATION, FRANKFORT, KENTUCKY' |
| PROD OR TEST | Char | 209 | 209 | 1 | Indicates a production or test file - 'P' or 'T' |
| RECORD LENGTH | Number | 210 | 214 | 5 | Length of detail record (600 bytes) |
| CREATE PROGRAM | Char | 215 | 222 | 8 | 'PRVP962D' |
| NEWLINE | Char | 223 | 223 | 1 | Newline character = 0x0a |

Detail Record

| Field | Data Type | Start | End | Length | Description |
|---------------------------|-----------|-------|-----|--------|---|
| RECORD ID | Char | 1 | 2 | 2 | Value 'DD' to denote detail record |
| PROVIDER TYPE | Char | 3 | 4 | 2 | Two character code designating the Provider type (not changing from Legacy) |
| PROVIDER NUMBER | Char | 5 | 14 | 10 | Legacy (converted) providers will continue to have an 8 byte ID with spaces padded on the end, newly enrolled providers will have a 10 byte id. |
| MEDICAID BEGIN DATE | Char | 15 | 22 | 8 | CCYYMMDD format |
| MEDICAID END DATE | Char | 23 | 30 | 8 | CCYYMMDD format |
| STATUS CODE (END REASN) | Char | 31 | 31 | 1 | Code describing the reason for termination. |
| NAME TYPE | Char | 32 | 32 | 1 | 'P' for Personal, 'B' for Business. If 'B' the name will be strung together in the Last, First, and MI fields. |
| LAST NAME | Char | 33 | 58 | 26 | Last Name |
| FIRST NAME | Char | 59 | 70 | 12 | First Name |
| MIDDLE INITIAL | Char | 71 | 71 | 1 | Middle Initial |
| TAX ID TYPE | Char | 72 | 72 | 1 | 'F' for FEIN, 'S' for SSN |
| TAX ID NUMBER | Char | 73 | 81 | 9 | IRS Tax ID Number |
| SSN | Char | 82 | 90 | 9 | Provider's Social Security Number |
| LICENSE NUMBER | Char | 91 | 100 | 10 | Provider's License Number. |
| LICENSE END DATE | Char | 101 | 108 | 8 | License's expiration date in CCYYMMDD format. |
| BOARD CERTIFIED SPECIALTY | Char | 109 | 111 | 3 | Do not currently have this data. Field is filled with spaces. |
| LANGUAGE 1 | Char | 112 | 114 | 3 | HIPAA defined language code. If not on file, field will be filled with spaces. (English will be assumed and not sent) |
| LANGUAGE 2 | Char | 115 | 117 | 3 | HIPAA defined language code. If not on file, field will be filled with spaces. (English will be assumed and not sent) |
| LANGUAGE 3 | Char | 118 | 120 | 3 | HIPAA defined language code. If not on file, field will be filled with spaces. (English will be assumed and not sent) |
| HOSPITAL AFFILIATION 1 | Char | 121 | 130 | 10 | Medicaid number of hospital. (Do not currently have this data). Field will be filled with spaces. |

| Field | Data Type | Start | End | Length | Description |
|------------------------|-----------|-------|-----|--------|---|
| HOSPITAL AFFILIATION 2 | Char | 131 | 140 | 10 | Medicaid number of hospital. (Do not currently have this data). Field will be filled with spaces. |
| HOSPITAL AFFILIATION 3 | Char | 141 | 150 | 10 | Medicaid number of hospital. (Do not currently have this data). Field will be filled with spaces. |
| NPI | Char | 151 | 160 | 10 | National Provider Identifier |
| NPI EFFECTIVE DATE | Char | 161 | 168 | 8 | Date NPI becomes effective. |
| NPI END DATE | Char | 169 | 176 | 8 | Date NPI is terminated. |
| NP2 (if Any) | Char | 177 | 186 | 10 | National Provider Identifier 2 |
| NPI2 EFFECTIVE DATE | Char | 187 | 194 | 8 | Date NPI2 becomes effective. |
| NPI2 END DATE | Char | 195 | 202 | 8 | Date NPI2 is terminated. |
| NP3 (if Any) | Char | 203 | 212 | 10 | National Provider Identifier 3 |
| NPI3 EFFECTIVE DATE | Char | 213 | 220 | 8 | Date NPI3 becomes effective. |
| NPI3 END DATE | Char | 221 | 228 | 8 | Date NPI3 is terminated. |
| NUMBER OF BEDS | Char | 229 | 234 | 6 | Number of beds |
| PRACTICE TYPE | Char | 235 | 235 | 1 | Practice Type values 'A' thru 'H'. |
| PROVIDER SPECIALTY | Char | 236 | 238 | 3 | Provider primary specialty code. |
| TITLE | Char | 239 | 253 | 15 | Example 'MD', 'DDS', etc... |
| PRIMARY ADDRESS 1 | Char | 254 | 283 | 30 | Primary (physical) address line 1. |
| PRIMARY ADDRESS 2 | Char | 284 | 313 | 30 | Primary (physical) address line 2. |
| PRIMARY CITY | Char | 314 | 343 | 30 | Primary (physical) address city. |
| PRIMARY STATE | Char | 344 | 345 | 2 | Primary (physical) address state. |
| PRIMARY ZIP | Char | 346 | 350 | 5 | Primary (physical) address zip code. |
| PRIMARY ZIP+4 | Char | 351 | 354 | 4 | Primary (physical) address zip code extension. |
| MAILING ADDRESS 1 | Char | 355 | 384 | 30 | Mailing address line 1. |
| MAILING ADDRESS 2 | Char | 385 | 414 | 30 | Mailing address line 2. |
| MAILING CITY | Char | 415 | 444 | 30 | Mailing address city. |
| MAILING STATE | Char | 445 | 446 | 2 | Mailing address state. |
| MAILING ZIP | Char | 447 | 451 | 5 | Mailing address zip code. |
| MAILING ZIP+4 | Char | 452 | 455 | 4 | Mailing address zip code extension. |
| REMIT ADDRESS 1 | Char | 456 | 485 | 30 | Remittance (pay-to) address line 1. |
| REMIT ADDRESS 2 | Char | 486 | 515 | 30 | Remittance (pay-to) address line 2. |
| REMIT CITY | Char | 516 | 545 | 30 | Remittance (pay-to) address city. |

| Field | Data Type | Start | End | Length | Description |
|---------------------------|-----------|-------|-----|--------|--|
| REMIT STATE | Char | 546 | 547 | 2 | Remittance (pay-to) address state. |
| REMIT ZIP | Char | 548 | 552 | 5 | Remittance (pay-to) address zip code. |
| REMIT ZIP+4 | Char | 553 | 556 | 4 | Remittance (pay-to) address zip code extension. |
| GROUP AFFILIATION | Char | 557 | 566 | 10 | Medicaid provider number of group this individual provider is associated with. |
| PHONE NUMBER | Char | 567 | 576 | 10 | Provider's telephone number. In '9999999999' format. |
| DEA NUMBER | Char | 577 | 585 | 9 | Provider's DEA number. |
| UPIN | Char | 586 | 591 | 6 | Provider's UPIN Number. |
| TAXONOMY | Char | 592 | 601 | 10 | Provider's primary taxonomy code. |
| PROVIDER ATTESTATION | Char | 602 | 602 | 1 | Provider Attestation indicator – 'Y' or blank |
| PROVIDER ATTEST. EFF DATE | Char | 603 | 610 | 8 | Provider Attestation effective date |
| PROVIDER ATTEST. END DATE | Char | 611 | 618 | 8 | Provider Attestation end date |
| VACC FOR CHILDREN PROV | Char | 619 | 619 | 1 | Vaccine-for-Children Provider indicator – 'Y' or blank |
| VFC PROV CURRENT EFF DATE | Char | 620 | 627 | 8 | Vaccine for Children Provider current effective date |
| VFC PROV CURRENT END DATE | Char | 628 | 635 | 8 | Vaccine for Children Provider current end date |
| VFC PROV PREV. EFF DATE | Char | 636 | 643 | 8 | Vaccine for Children Provider previous effective date |
| VFC PROV PREV END DATE | Char | 644 | 651 | 8 | Vaccine for Children Provider previous end date |
| GROUP MEMBER INDICATOR | Char | 652 | 652 | 1 | Indicates whether the Provider is a member of a group – 'Y' = group 'N' = individual |
| NPI4 | Char | 653 | 662 | 10 | National Provider Identifier 4 |
| NPI4 EFFECTIVE DATE | Char | 663 | 168 | 8 | Date NPI4 becomes effective. |
| NPI4 END DATE | Char | 671 | 176 | 8 | Date NPI4 is terminated. |
| NPI5 | Char | 679 | 160 | 10 | National Provider Identifier 5 |
| NPI5 EFFECTIVE DATE | Char | 689 | 170 | 8 | Date NPI5 becomes effective. |
| NPI5 END DATE | Char | 697 | 178 | 8 | Date NPI5 is terminated. |
| NPI6 | Char | 705 | 714 | 10 | National Provider Identifier 6 |

| Field | Data Type | Start | End | Length | Description |
|----------------------|-----------|-------|-----|--------|---------------------------------|
| NPI6 EFFECTIVE DATE | Char | 715 | 724 | 8 | Date NPI6 becomes effective. |
| NPI6 END DATE | Char | 723 | 730 | 8 | Date NPI6 is terminated. |
| NPI7 | Char | 731 | 740 | 10 | National Provider Identifier 7 |
| NPI7 EFFECTIVE DATE | Char | 741 | 748 | 8 | Date NPI7 becomes effective. |
| NPI7 END DATE | Char | 749 | 756 | 8 | Date NPI7 is terminated. |
| NPI8 | Char | 757 | 766 | 10 | National Provider Identifier 8 |
| NPI8 EFFECTIVE DATE | Char | 767 | 774 | 8 | Date NPI8 becomes effective. |
| NPI8 END DATE | Char | 775 | 782 | 8 | Date NPI8 is terminated. |
| NPI9 | Char | 783 | 792 | 10 | National Provider Identifier 9 |
| NPI9 EFFECTIVE DATE | Char | 793 | 800 | 8 | Date NPI9 becomes effective. |
| NPI9 END DATE | Char | 801 | 808 | 8 | Date NPI9 is terminated. |
| NPI10 | Char | 809 | 818 | 10 | National Provider Identifier 10 |
| NPI10 EFFECTIVE DATE | Char | 819 | 826 | 8 | Date NPI10 becomes effective. |
| NPI10 END DATE | Char | 827 | 834 | 8 | Date NPI10 is terminated. |
| NPI11 | Char | 835 | 844 | 10 | National Provider Identifier 11 |
| NPI11 EFFECTIVE DATE | Char | 845 | 852 | 8 | Date NPI11 becomes effective. |
| NPI11 END DATE | Char | 853 | 860 | 8 | Date NPI11 is terminated. |
| NPI12 | Char | 861 | 870 | 10 | National Provider Identifier 12 |
| NPI12 EFFECTIVE DATE | Char | 871 | 878 | 8 | Date NPI12 becomes effective. |
| NPI12 END DATE | Char | 879 | 886 | 8 | Date NPI12 is terminated. |
| NPI13 | Char | 887 | 896 | 10 | National Provider Identifier 13 |
| NPI13 EFFECTIVE DATE | Char | 897 | 904 | 8 | Date NPI13 becomes effective. |
| NPI13 END DATE | Char | 905 | 912 | 8 | Date NPI13 is terminated. |
| NPI14 | Char | 913 | 922 | 10 | National Provider Identifier 14 |
| NPI14 EFFECTIVE DATE | Char | 923 | 930 | 8 | Date NPI14 becomes effective. |
| NPI14 END DATE | Char | 931 | 938 | 8 | Date NPI14 is terminated. |
| NPI15 | Char | 939 | 948 | 10 | National Provider Identifier 15 |
| NPI15 EFFECTIVE DATE | Char | 949 | 956 | 8 | Date NPI15 becomes effective. |
| NPI15 END DATE | Char | 957 | 964 | 8 | Date NPI15 is terminated. |
| NPI16 | Char | 965 | 974 | 10 | National Provider Identifier 16 |
| NPI16 EFFECTIVE DATE | Char | 975 | 982 | 8 | Date NPI16 becomes effective. |
| NPI16 END DATE | Char | 983 | 990 | 8 | Date NPI16 is terminated. |

| Field | Data Type | Start | End | Length | Description |
|----------------------|-----------|-------|------|--------|---------------------------------|
| NPI17 | Char | 991 | 1000 | 10 | National Provider Identifier 17 |
| NPI17 EFFECTIVE DATE | Char | 1001 | 1008 | 8 | Date NPI17 becomes effective. |
| NPI17 END DATE | Char | 1009 | 1016 | 8 | Date NPI17 is terminated. |
| NPI18 | Char | 1017 | 1026 | 10 | National Provider Identifier 18 |
| NPI18 EFFECTIVE DATE | Char | 1027 | 1034 | 8 | Date NPI18 becomes effective. |
| NPI18 END DATE | Char | 1035 | 1042 | 8 | Date NPI18 is terminated. |
| NPI19 | Char | 1043 | 1052 | 10 | National Provider Identifier 19 |
| NPI19 EFFECTIVE DATE | Char | 1053 | 1060 | 8 | Date NPI19 becomes effective. |
| NPI19 END DATE | Char | 1061 | 1068 | 8 | Date NPI19 is terminated. |
| NPI20 | Char | 1069 | 1078 | 10 | National Provider Identifier 20 |
| NPI20 EFFECTIVE DATE | Char | 1079 | 1086 | 8 | Date NPI20 becomes effective. |
| NPI20 END DATE | Char | 1087 | 1094 | 8 | Date NPI20 is terminated. |
| NPI21 | Char | 1095 | 1104 | 10 | National Provider Identifier 21 |
| NPI21 EFFECTIVE DATE | Char | 1105 | 1112 | 8 | Date NPI21 becomes effective. |
| NPI21 END DATE | Char | 1113 | 1120 | 8 | Date NPI21 is terminated. |
| NPI22 | Char | 1121 | 1130 | 10 | National Provider Identifier 22 |
| NPI22 EFFECTIVE DATE | Char | 1131 | 1138 | 8 | Date NPI22 becomes effective. |
| NPI22 END DATE | Char | 1139 | 1146 | 8 | Date NPI22 is terminated. |
| NPI23 | Char | 1147 | 1156 | 10 | National Provider Identifier 23 |
| NPI23 EFFECTIVE DATE | Char | 1157 | 1164 | 8 | Date NPI23 becomes effective. |
| NPI23 END DATE | Char | 1165 | 1172 | 8 | Date NPI23 is terminated. |
| NPI24 | Char | 1173 | 1182 | 10 | National Provider Identifier 24 |
| NPI24 EFFECTIVE DATE | Char | 1183 | 1190 | 8 | Date NPI24 becomes effective. |
| NPI24 END DATE | Char | 1191 | 1198 | 8 | Date NPI24 is terminated. |
| NPI25 | Char | 1199 | 1208 | 10 | National Provider Identifier 25 |
| NPI25 EFFECTIVE DATE | Char | 1209 | 1216 | 8 | Date NPI25 becomes effective. |
| NPI25 END DATE | Char | 1217 | 1224 | 8 | Date NPI25 is terminated. |
| NPI26 | Char | 1225 | 1234 | 10 | National Provider Identifier 26 |
| NPI26 EFFECTIVE DATE | Char | 1235 | 1242 | 8 | Date NPI26 becomes effective. |
| NPI26 END DATE | Char | 1243 | 1250 | 8 | Date NPI26 is terminated. |
| NPI27 | Char | 1251 | 1260 | 10 | National Provider Identifier 27 |
| NPI27 EFFECTIVE DATE | Char | 1261 | 1268 | 8 | Date NPI27 becomes effective. |

| Field | Data Type | Start | End | Length | Description |
|----------------------|-----------|-------|------|--------|---|
| NPI27 END DATE | Char | 1269 | 1276 | 8 | Date NPI27 is terminated. |
| NPI28 | Char | 1277 | 1286 | 10 | National Provider Identifier 28 |
| NPI28 EFFECTIVE DATE | Char | 1287 | 1294 | 8 | Date NPI28 becomes effective. |
| NPI28 END DATE | Char | 1295 | 1303 | 8 | Date NPI28 is terminated. |
| NPI29 | Char | 1303 | 1312 | 10 | National Provider Identifier 29 |
| NPI29 EFFECTIVE DATE | Char | 1313 | 1320 | 8 | Date NPI29 becomes effective. |
| NPI29 END DATE | Char | 1321 | 1328 | 8 | Date NPI29 is terminated. |
| NPI30 | Char | 1329 | 1338 | 10 | National Provider Identifier 30 |
| NPI30 EFFECTIVE DATE | Char | 1339 | 1346 | 8 | Date NPI30 becomes effective. |
| NPI30 END DATE | Char | 1347 | 1354 | 8 | Date NPI30 is terminated. |
| FILLER | Char | 1355 | 1454 | 100 | For future expansion. Field filled with all spaces. |
| NEWLINE | Char | 1455 | 1455 | 1 | Newline character = 0x0a |

Trailer Record

| Field | Data Type | Start | End | Length | Description |
|----------------|-----------|-------|-----|--------|---|
| RECORD ID | Char | 1 | 2 | 2 | Value 'TT' to denote trailer record |
| DETAIL RECORDS | Number | 3 | 11 | 9 | Total number of detail records in the file. |
| TOTAL RECORDS | Number | 12 | 20 | 9 | Total number of records (including header and trailer) in the file. |
| NEWLINE | Char | 21 | 21 | 1 | Newline character = 0x0a |

APPENDIX L. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (EPSDT)

Periodicity Schedule

Infancy

- < 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months

Early Childhood

- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years

Middle Childhood

- 5 years
- 6 years
- 8 years
- 10 years

Adolescence

- 11 years
- 12 years
- 13 years
- 14 years
- 15 years
- 16 years
- 17 years
- 18 years
- 19 years
- 20 years

Required Components - Initial and Periodic Health Assessments

Initial and periodic health assessments shall follow the American Academy of Pediatrics (AAP) standards unless otherwise directed by the Department.”

Special Services

EPSDT provides any Medically Necessary diagnosis and treatment for Members under the age of 21 indicated as the result of an EPSDT health assessment or any other encounter with a licensed or certified health care professional, even if the service is not otherwise covered by the Kentucky Medicaid Program. These services which are not otherwise covered by the Kentucky Medicaid Program are called EPSDT Special Services.

The Contractor shall provide EPSDT Special Services as required by 42 USC Section 1396 and by 907 KAR 1:034, Section 7 and Section 8.

The Contractor shall provide the following medically necessary health care, diagnostic services, preventive services, rehabilitative services, treatment and other measures, described in 42 USC Section 1396d(a), to all members under the age of 21:

- (a) Inpatient Hospital Services;
- (b) Outpatient Services; Rural Health Clinics; Federally Qualified Health Center Services;
- (c) Other Laboratory and X-Ray Services;
- (d) Early and Periodic Screening, Diagnosis, and Treatment Services; Family Planning Services and Supplies;
- (e) Physicians Services; Medical and Surgical Services furnished by a Dentist;
- (f) Medical Care by Other Licensed Practitioners;
- (g) Home Health Care Services;
- (h) Private Duty Nursing Services;
- (i) Clinic Services;
- (j) Dental Services;
- (k) Physical Therapy and Related Services;
- (l) Prescribed Drugs including Mental/Behavioral Health Drugs, Dentures, and Prosthetic Devices; and Eyeglasses;
- (m) Other Diagnostic, Screening, Preventive and Rehabilitative Services;
- (n) Nurse-Midwife Services;
- (o) Hospice Care;
- (p) Case Management Services;
- (q) Respiratory Care Services;
- (r) Services provided by a certified pediatric nurse practitioner or certified family Nurse practitioner (to the extent permitted under state law);
- (s) Other Medical and Remedial Care Specified by the Secretary; and
- (t) Other Medical or Remedial Care Recognized by the Secretary but which are not covered in the Plan Including Services of Christian Science Nurses, Care and Services Provided in Christian Science Sanitariums, and Personal Care Services in a Recipient's Home.

Those EPSDT diagnosis and treatment services and EPSDT Special Services which are not otherwise covered by the Kentucky Medicaid Program shall be covered subject to Prior Authorization by the Contractor, as specified in 907 KAR 1:034, Section 9. Approval of requests for EPSDT Special Services shall be based on the standard of Medical Necessity specified in 907 KAR 1:034, Section 9.

The Contractor shall be responsible for identifying Providers who can deliver the EPSDT special services needed by Members under the age of 21, and for enrolling these Providers into the Contractor's Network, consistent with requirements specified in this Contract.

APPENDIX M. PROGRAM INTEGRITY REQUIREMENTS

I. ORGANIZATION

The Contractor shall establish a Program Integrity Unit (PIU) to identify Fraud, Waste and Abuse and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Program Integrity Unit (PIU) shall be organized so that:

- (a) Required Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and on-going basis;
- (b) Written policies, procedures, and standards of conduct demonstrate the organization's commitment to comply with all applicable contract requirements and standards and federal and state laws, regulations and standards;
- (c) The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with all applicable contract requirements and standards and Federal and State laws, regulations and requirements;
- (d) The staff consists of a compliance officer in addition to auditing and clinical staff;
- (e) The unit prioritizes work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:
 - (1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries,
 - (2) High dollar amount of potential overpayment, or
 - (3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern;
- (f) Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;
- (g) Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees, or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training; and
- (h) There are a minimum of two (2) full-time investigators:
 - (1) With a minimum of three (3) years of Medicaid fraud, waste and abuse investigatory experience
 - (2) Located in Kentucky; and
 - (3) Dedicated 100% to the Kentucky Medicaid Program.

II. FUNCTION

Contractor and/or Contractor's PIU, shall:

- (a) Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following:
 - (1) Recovery of overpayments,
 - (2) Changes to policy,
 - (3) Dispute resolution meetings, and
 - (4) Appeals;
- (b) Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;
- (c) Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;

- (d) Initiate appropriate administrative actions to collect overpayments adhering to state requirements;
- (e) At the closure of an initial investigation:
 - (1) Upon finding a factual basis for potential Fraud, Waste, or Abuse, refer to the Department for possible civil and/or criminal prosecution, and administrative sanctions; or
 - (2) Upon finding no factual basis for the potential of Fraud, Waste or Abuse, request and receive the Department's written permission to administratively collect overpayments in excess of \$500; or
 - (3) Upon finding no factual basis for potential Fraud, Waste, or Abuse, or overpayment, request and receive the Department's written permission to close the investigation without further action of the Contractor and/or Contractor's PIU.
- (f) Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;
- (g) Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;
- (h) Provide for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;
- (i) Provide for internal monitoring and auditing of Contractor and its subcontractors; and supply the Department with reports on a quarterly or as-requested basis on its activity or ad hoc as necessary;
- (j) Be subject to on-site reviews; and fully comply with requests from the Department to supply documentation and records;
- (k) Collect outstanding debt owed to the Department from members or providers; and provide monthly reports of activity and collections to the Department;
- (l) Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after one hundred and eighty (180) days;
- (m) The Contractor shall, as requested by the Department, remit the amount of provider overpayments not identified by the contractor within ninety (90) calendar days of notification by the Department unless otherwise notified in writing by the Department or its contracted entity;
- (n) Conduct continuous and on-going reviews of all MIS data including, Member and Provider Grievances and appeals, for the purpose of identifying potentially fraudulent acts;
- (o) Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;
- (p) Conduct on-site and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;
- (q) Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;
- (r) Designate a contact person to work with staff, investigators and attorneys from the Department, OIG and any other agent or contractor of the Department;
- (s) Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;
- (t) Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;
- (u) Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the

Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;

- (v) Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);
- (w) Comply with the program integrity requirements set forth in the Patient Protection and Affordable Care Act, specifically 42 CFR 438.608, and all applicable requirements and standards under this contract and any federal and state laws and regulations, and provide policies and procedures to the Department for review and approval;
- (x) Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;
- (y) Recover overpayments from Providers;
- (z) Identify Providers for pre-payment review as a result of the Provider's activities in accordance with the contract;

- (aa) Conduct a minimum of three (3) on-site visits per quarter related to investigations of suspected fraud and abuse. The site visit shall be approved within a minimum of ten (10) calendar days by the Department;
- (bb) Notify the Department if there is an absence or vacancy in an investigator position that is longer than thirty (30) days, and include a contingency plan to remain compliant with the contract requirements in the interim; and
- (cc) Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of thirty (30) calendar days or the timeframes established by Federal and state laws and regulations.

III. PATIENT ABUSE/MEMBER SAFETY

Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law with copy to the Department and OIG. Potential Member safety issues related to investigations shall be reported in accordance with state law with a copy to the Department's Program Integrity Division Director and Program Quality & Outcomes Division Director.

IV. COMPLAINT SYSTEM

The Contractor's PIU shall have an operational system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:

- (a) Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct an initial investigation to determine the validity of the complaint;
- (b) The PIU should review background information and MIS data; however, the initial investigation shall not include interviews with the subject concerning the alleged instance of Fraud or Abuse;
- (c) If the initial investigation results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to the Department; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments of \$500 or less;
- (d) If the initial investigation results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the Department;

- (e) The Department will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;
- (f) If, in the process of conducting an initial investigation, the PIU suspects a violation of either criminal Medicaid Fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department of their findings and proceed only in accordance with instructions received from the Department;
- (g) If the Department determines that it will refer a case referred by the PIU to the OIG, the OIG will conduct a preliminary investigation, review the PIU's report and evidence, gather additional evidence if needed, and forward information, if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate action;
- (h) If the OIG opens an investigation based on a complaint received from a source other than the Contractor, the OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;
- (i) If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;
- (j) Upon approval of the Department, Contractor shall suspend and escrow Provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;
- (k) Upon completion of the PIU's initial investigation, the PIU shall provide the Department a copy of their investigative report, which shall contain the following elements:
 - (1) Name and address of subject;
 - (2) Medicaid identification number;
 - (3) Source of complaint;
 - (4) State the complaint/allegation;
 - (5) Date assigned to the investigator;
 - (6) Name of investigator;
 - (7) Date of completion;
 - (8) Detail as to what timeframe was reviewed;
 - (9) How many member records were reviewed for that timeframe and the total of number of claims;
 - (10) The issues identified;
 - (11) Methodology used during investigation;
 - (12) Facts discovered by the investigation as well as the initial case report and supporting documentation;
 - (13) Attach all exhibits or supporting documentation;
 - (14) Include recommendations as considered necessary, for administrative action or policy revision;
 - (15) Identify overpayment, if any, and include recommendation concerning collection;
 - (16) Reason for closure of the report, if applicable;
 - (17) Request to send as a referral for a preliminary investigation for a credible allegation of fraud, if applicable; and
 - (13) Any other elements identified by CMS for fraud referral;
- (l) The Contractor's PIU shall provide the Department a quarterly Member and Provider status report of all cases including actions taken in adherence with state requirements, or case information shall be made available to the Department upon request;
- (m) The Contractor's PIU shall maintain access to a formal case tracking and case management system, which can report the status of a particular complaint or grievance process or the status of a specific identified overpayment or recoupment; and

- (n) The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.

V. CASE TRACKING AND CASE MANAGEMENT

- (a) The Contactor shall have a case tracking and case management system to track member and provider cases;
- (b) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for provider cases:
 - (1) PIU Case number,
 - (2) Provider name,
 - (3) Provider number,
 - (4) NPI (if applicable),
 - (6) Source of Complaint,
 - (7) OIG Referral Number (if applicable),
 - (8) MAT Case Y/N (if applicable to report),
 - (9) Date complaint received by Contractor,
 - (10) Date opened,
 - (11) Name of PIU investigator assigned,
 - (12) Summary of Complaint,
 - (13) Justification that a referral for a preliminary investigation was not warranted based upon the evidence in the case file,
 - (14) PIU action(s) taken and date(s),
 - (15) Amount of overpayment if any (please note potential overpayments of \$500 or more should be referred for preliminary investigation),
 - (16) Administrative actions (if any) or referral with description, and
 - (17) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file.
- (c) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for member cases:
 - (1) PIU Case number,
 - (2) Member name,
 - (3) Member number,
 - (4) Date of Birth (if known),
 - (5) Social Security Number (if known),
 - (6) Source of Complaint,
 - (7) OIG Referral Number (if applicable),
 - (8) Date complaint received by Contractor,
 - (9) Date opened,
 - (10) Name of PIU investigator assigned,
 - (11) Summary of Complaint,
 - (12) Justification that a preliminary investigation was not warranted based upon the evidence in the case file,
 - (13) PIU action(s) taken and date(s) within the ten (10) day review period,
 - (14) Amount of overpayment if any,
 - (15) Administrative actions (if any) or referral with description,
 - (16) Closure Date* (if applicable) of initial investigation with approval from supervisor.

Supervisor approval should demonstrate/attest verification of each component in the case file.

VI. REPORTING

- (a) The Contractor's PIU shall report on a monthly basis provider internal referrals (tips) and the disposition of the prior month's internal referrals, and on a quarterly basis, as required by the Department, all activities and processes for each investigative case for that quarter to the Department. The Contractor shall have the ability to report all aspects of a member or provider file from opening to closure upon request, including overpayments identified, overpayment adjusted and recoupments of overpayments;
- (b) If any employee or subcontractor employee of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator;
- (c) The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members, Providers or employees to the Department in adherence to state requirements;
- (d) The Contractor shall adhere to all ad hoc reporting requests whether one time or recurring in accordance with Section 37.0 "Contractor Reporting Requirements" of this contract;
- (e) The Contractor shall report all overpayments identified as prescribed by the Department;
- (f) The Contractor shall report the collection of provider overpayments and prepayment cost avoidance in relation to the quarterly total of Monthly Benefit Payments;
- (g) The Contractor shall report the escrow of provider payments in adherence to state requirements;
- (h) The Contractor shall report site visits conducted in adherence to state requirements; and
- (d) The Contractor is required to report the following data elements to the Department on a quarterly basis, in an excel format:
 - (1) PIU Case number;
 - (2) Provider /Member name;
 - (3) Provider Medicaid ID/Member Medicaid number;
 - (5) Date complaint received by Contractor;
 - (6) Provider NPI (if nonmember case);
 - (7) Source of complaint,
 - (8) OIG Case Number;
 - (9) Date complaint or referral received;
 - (10) Date case opened;
 - (11) MAT related (Y or N);
 - (12) Summary of Complaint with timeframe reviewed;
 - (13) Initial investigation (Y or N);
 - (14) Actions taken with date(s);
 - (15) Referred to DMS (with appropriate code);
 - (16) Date referred to DMS (if applicable);
 - (17) Provider on prepayment (Y or N);
 - (18) Overpayment identified, and
 - (19) Date case closed (if applicable).

VII. AVAILABILITY AND ACCESS TO DATA

The Contractor shall:

- (a) Gather, produce, and maintain records including, but not limited to, ownership disclosure, for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member

information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;

- (b) Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department, the OIG and any other agent or contractor of the Department;
- (c) Backup, store and be able to recreate reported data upon demand for the Department, the OIG and any other agent or contractor of the Department;
- (d) Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department, the OIG, any other agent or contractor of the Department or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;
- (e) Produce records in electronic format for review and manipulation by the Department, the OIG and any other agent or contractor of the Department;
- (f) Allow designated Department staff, the OIG, and any other agent or contractor of the Department read access to ALL data in the Contractor's MIS systems;
- (g) Provide Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;
- (h) Fully cooperate with the Department, the OIG, any other agent or contractor of the Department, the United States Attorney's Office and other law enforcement agencies in the investigation of Fraud or Abuse cases; and
- (i) Provide identity and cover documents and information for law enforcement investigators under cover.

APPENDIX N. PAID CLAIMS LISTING REQUIREMENTS

Hospitals:

1. The Contractor shall supply a paid claims listing to each contracted Hospital and to the Department for Medicaid Services (the Department) for each contracted hospital within sixty (60) days of the last day of the Hospital's fiscal year end date and a second set of data fourteen (14) months after the Hospital's fiscal year end date. The paid claims listing shall be in a format as required by the Department. The paid claims listing shall include all claims with discharge dates within the Hospital's fiscal year that are paid from the first day of the Hospital's fiscal year to ninety (90) days after the end of the Hospital's fiscal year. For all hospitals, the MCO shall provide separate reports for adjudicated claims associated with both inpatient services and outpatient services provided to eligible Members.
2. The Contractor shall supply a summary of payments outside claims payments. The summary should illustrate the amount of the payment, its purpose and its application to Inpatient or Outpatient services, reported for the hospital fiscal year end.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Upon request the Contractor shall supply a paid claims listing to each contracted FQHC or RHC to the Department for Medicaid Services (the Department) within ninety (90) days of the last day of the state fiscal year. The paid claims listing shall include all claims with dates for service falling within the state fiscal year that are paid within the same fiscal year.

NOTE: The vendor shall provide paid claims listing reports for other program areas as needed.

APPENDIX O. MCO CAPITATION RECONCILIATION INBOUND/OUTBOUND FILE LAYOUTS

There are two (2) capitation reconciliation file types with an inbound and outbound file for each.

'Report 230': Contains all Members and capitation months that the MCO identifies for which a capitation payment has not been received.

'Report 250': Contains all Members and capitation months for which the MCO believes an inaccurate capitation payment was made. This file is to also include potential duplicate capitation payments.

Format: Inbound and outbound files to use semi-colon delimited text.

Naming Convention:

Where XX is the MCO two character designation

Inbound (MCO to CHFS):
XX_Reports_YYMMDD_Report230

XX_Reports_YYMMDD_Report250

Outbound (CHFS to MCO):
CHFS_XX_YYMMDD_Report230

CHFS_XX_YYMMDD_Report250

File Transmission: Move-IT

Frequency:

MCO to submit the Inbound files once per month.

CHFS to provide the Outbound files, under normal circumstances, on the Monday following the MCO Inbound submission.

Inbound File Layout for 'Report 230'

| Field | Data Type | Format | Comments |
|--------------|--------------|--------|---|
| MCO_ID | Char(10) | | MCO Medicaid ID |
| MEDICAID_ID | Char(12) | | Member Medicaid ID that the MCO is requesting payment for |
| CAP_MONTH | int (6) | YYYYMM | Month that the MCO is requesting payment for |
| AMT_EXPECTED | Decimal(8,2) | | Cap payment amount the MCO is expecting |

Inbound File Layout for 'Report 250'

| Field | Data Type | Format | Comments |
|-------------|-----------|--------|--|
| MCO_ID | Char(10) | | MCO Medicaid ID |
| ADJUST_CDE | Char(2) | | Type of adjustment for the record |
| CAP_MONTH | int (6) | YYYYMM | Month that the MCO received an incorrect payment |
| MEDICAID_ID | Char(12) | | Member Medicaid ID that the MCO received a payment for |

| | | | |
|--------------|---------------|--|---|
| PD_AMT | Decimal (8,2) | | Cap payment amount the MCO received |
| AMT_EXPECTED | Decimal (8,2) | | Cap payment amount the MCO is expecting |

Outbound File Layout for 'Report 230'

| Field | Data Type | Format | Comments |
|-------------------|--------------|----------|---|
| MEDICAID_ID | Char(12) | | Data from MCO Inbound file to be returned |
| CAP_MONTH | int (6) | YYYYMM | Data from MCO Inbound file to be returned |
| RECON_DTE | Int (8) | YYYYMMDD | Date MCO transaction was processed for reconciliation |
| SAK_CAPITATION_PD | Int (9) | | Cap Payment Unique Identifier: provided when cap already paid |
| FIN_DTE_PD | Int (8) | YYYYMMDD | MMIS Financial Paid Date: provided when cap already paid |
| AMT_PD | Decimal(8,2) | | Cap Amount Paid: provided when cap already paid |
| MEDICAID_ID_PD | Char(12) | | Medicaid ID that the Cap Was Paid Under: provided when cap already paid |
| MESSAGE_CDE | Char(4) | | Code value for the message being returned |
| MESSAGE | Varchar(255) | | Findings based on current active MMIS data |

Outbound File Layout for 'Report 250'

| Field | Data Type | Format | Comments |
|-------------|--------------|----------|---|
| CAP_MONTH | int (6) | YYYYMM | Data from MCO Inbound file to be returned |
| MEDICAID_ID | Char(12) | | Data from MCO Inbound file to be returned |
| RECON_DTE | Int (8) | YYYYMMDD | Date MCO transaction was processed for reconciliation |
| MESSAGE_CDE | Char(4) | | Code value for the message being returned |
| MESSAGE | Varchar(255) | | Findings based on current active MMIS data |

Valid values for the ADJUST_CDE in the Inbound 'Report 250'

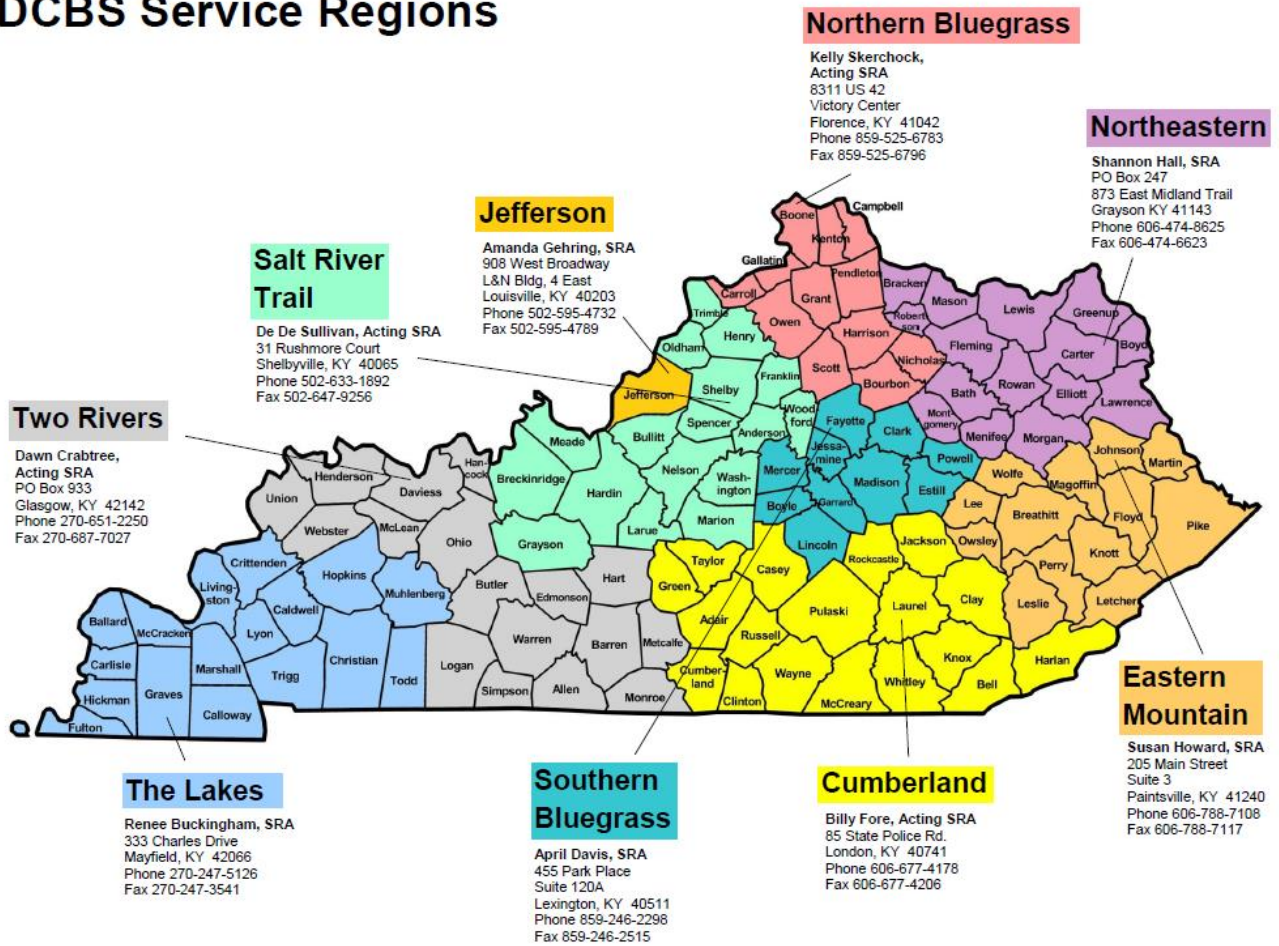
| ADJUST_CDE | COMMENT |
|------------|---|
| OP | Overpayment: MCO believes the capitation payment received was too high because the member qualifies under a different Category of Aid and/or resides in a different region. |
| UP | Underpayment: MCO believes the capitation payment received was too low because the member qualifies under a different Category of Aid and/or resides in a different region. |
| PR | Prorate: MCO believes the capitation payment received was incorrectly prorated based on the Member's Effective date and/or Category of Aid |

Valid Values for MESSAGE_CDE and MESSAGE in the Outbound 'Report 230' and Outbound 'Report 250'

| MESSAGE_CDE | MESSAGE | Report |
|-------------|---|--------|
| M_01 | MEMBER NOT MEDICAID ELIGIBLE DURING CAP MONTH | All |
| M_02 | MEMBER NOT ASSIGNED TO MCO DURING CAP MONTH | All |
| M_03 | RECORD REPORTED TO DMS MEMBER SERVICES FOR ADDITIONAL RESEARCH | All |
| M_04 | CAPITATION PAYMENT WAS PAID FOR CAP MONTH | 230 |
| M_05 | CURRENT DATA SHOWS CAP PAYMENT FOR CAP MONTH WILL BE PAID DURING NEXT RECON | 230 |
| M_06 | CURRENT DATA SHOWS PAID AMOUNT WAS CORRECT | 250 |
| M_07 | CURRENT DATA SHOWS PAID AMOUNT WAS AN OVERPAYMENT | 250 |
| M_08 | CURRENT DATA SHOWS PAID AMOUNT WAS AN UNDERPAYMENT | 250 |
| M_09 | CURRENT DATA SHOWS PAID AMOUNT WAS NOT PRORATED CORRECTLY | 250 |
| M_10 | MMIS DATA DOES NOT INDICATE THE PAYMENTS ARE DUPLICATE | 250 |
| M_11 | MMIS DATA INDICATES THE PAYMENTS ARE DUPLICATE - RESEARCH ITEM OPENED | 250 |
| M_12 | MEMBER MEDICAID ID IS INVALID | All |

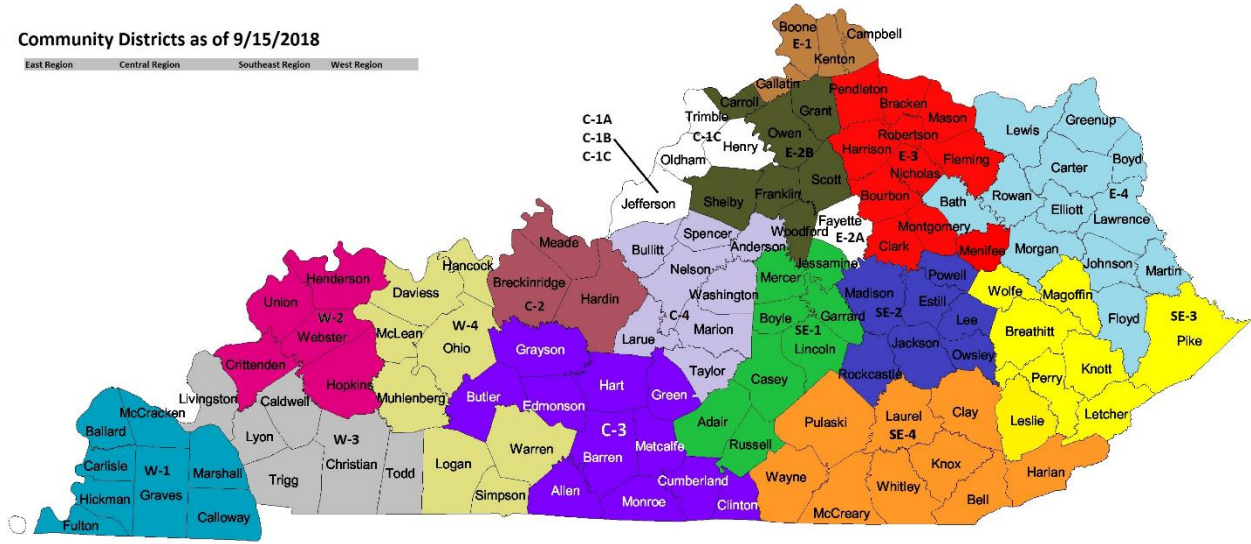
APPENDIX P. DEPARTMENT FOR COMMUNITY BASED SERVICES AND DEPARTMENT OF JUVENILE JUSTICE MAPS

DCBS Service Regions

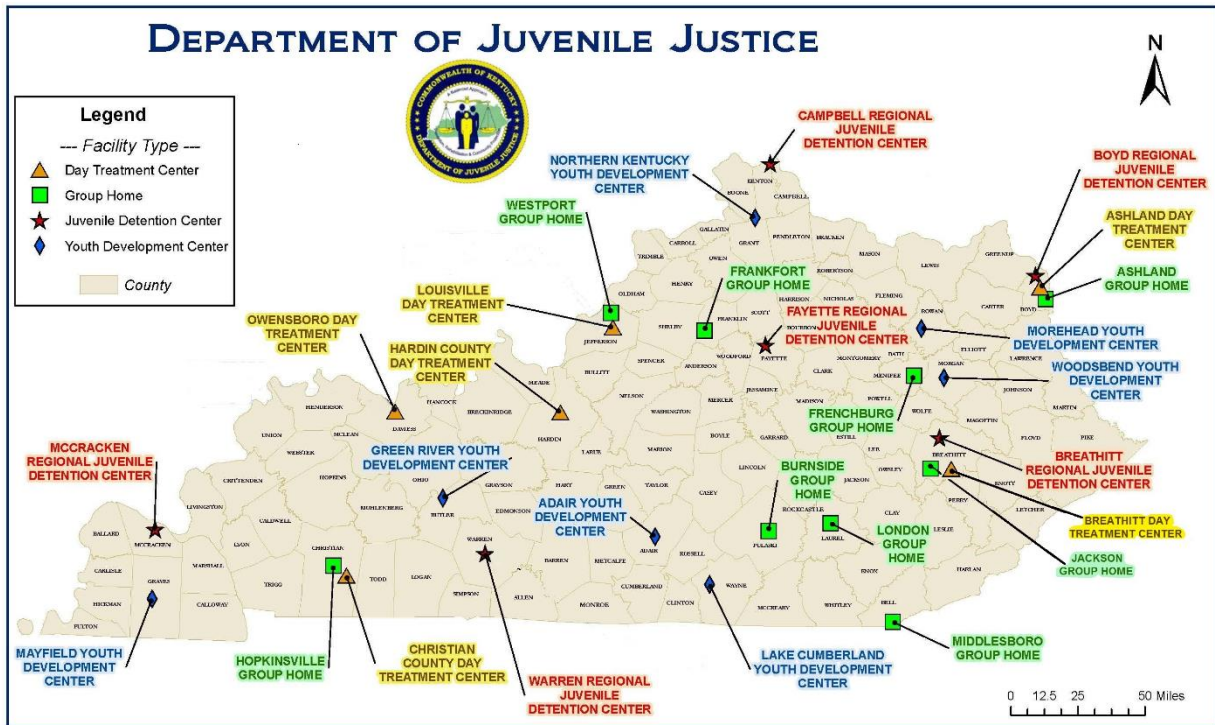


Department of Juvenile Justice Community Districts

Community Districts as of 9/15/2018



Department of Juvenile Justice Facilities Map



APPENDIX Q. CABINET FOR HEALTH AND FAMILY SERVICES CONTRACTOR SECURITY REQUIREMENTS

The Contractor is required to constantly assess their security program, adhere to most recent standards, practices, rules, regulations, laws, best practices and adapt as these may change or present new requirements. This includes, but not limited to, technology, reporting, standards, approach, strategy, and practices.

CHFS and The Commonwealth maintain the right to audit at any time without any notice.

Compliance with Commonwealth IT Enterprise Policy and Standards

The Contractor solution shall adhere to the most recent federal and Commonwealth standards as outlined below:

A. The Commonwealth Office of Technology (COT) IT Enterprise Policy and Standards provide guidelines, policies, directional statements and sets of standards so that technology choices can be made based on business objectives and service delivery. These documents are located here:

- COT Standards: <https://technology.ky.gov/Governance/Pages/KITS.aspx>
- COT Policies: <https://technology.ky.gov/policy/Pages/policies.aspx>

B. CHFS Policy and Standards reflect a set of principles for information, technology, applications, and organization which shall be followed for any solution that will be hosted and maintained by Contractor. CHFS OATS also has standards to which any solution that will be hosted and maintained by Contractor shall also adhere. These documents are located here:

- CHFS Standards: <https://chfs.ky.gov/agencies/os/oats/Pages/itstandards.aspx>
- CHFS Policies: <https://chfs.ky.gov/agencies/os/oats/Pages/ITpolicies.aspx>

C. In the event that the Contractor solution components hosted and maintained by Contractor deviate from the Policies and Standards referenced above, Contractor shall outline the reasons and benefits to the Commonwealth for that deviation. Any exceptions to these Policies and Standards must follow the CHFS OATS Policy 070-203.

Compliance with Federal Regulations and Standards

Contractor shall be responsible for ensuring that its work performed under this Contract, including all deliverables, will meet the requirements of all applicable federal and state laws, regulations, policies and guidance, including any amendments or updates thereto during the life of the Contract. Adherence to these laws, policies, regulations and guidance shall be a requirement of the Contractor solution.

The relevant laws, regulations, policies and guidance include, but are not limited to:

- Title XIX of the Social Security Act, the Medicaid statute
- The Office of the National Health Coordinator for Health Information Technology
- Health Insurance Portability and Accountability Act (HIPAA) and any related regulations and guidance

- Medicaid Information Technology Architecture (MITA) CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E) v2.0
- Kentucky Revised Statute KRS 61.931 to 61.934
- NIST Special Publication SP800-53 R4 Security and Privacy Controls for Federal Information Systems and Organizations
- IRS 1075 rule

Attestation Report

Contractor shall provide a copy of the SOC2 type 2 (or by its superseded standard) report to CHFS Office of Administrative and Technology Services (OATS) Security at least on annual basis.

Privacy, Confidentiality, and Ownership of Information

CHFS is the designated owner of all data and shall approve all access to that data. Contractor shall not have ownership of Commonwealth data at any time. Contractor shall be in compliance with privacy policies established by governmental agencies or by state or federal law. Such privacy policy statements may be developed and amended periodically by the Commonwealth.

Information Security Requirements

CHFS requires security assurance for functional, technical, and infrastructure components to ensure the systems meet all information security requirements throughout the project lifecycle. This includes physical, technical, and administrative controls.

Security assessment scenarios and strategies shall be approved by the CHFS Security Team prior to execution and all evidentiary artifacts shall be provided to CHFS and the CHFS Security Team as required.

A security assessment shall be performed by Contractor key applicable milestones throughout the project lifecycle with subsequent evidentiary artifacts provided to CHFS and the CHFS Security Team.

Contractor shall provide artifacts for Control Assessments, HIPAA Risk Assessments, Vulnerability assessments, or other security-related artifacts as required by CHFS.

As required to develop a secure solution, Contractor shall provide artifacts detailing secure code review processes used throughout the Software Development Lifecycle (SDLC) process. Artifacts shall be provided throughout the secure code review processes as requested by CHFS.

Plan of Action & Milestones (POAM) – Vulnerability Management

Weaknesses or findings (as identified by audit or other assessment methods) shall be documented in a CHFS-prescribed POAM template. Contractor shall maintain and remediate the gaps detailed within each POAM and provide bi-weekly status updates to designated CHFS personnel. Any necessary

exception (due to business, functional, or technical) that impacts the resolution of a POAM shall follow the CHFS OATS Policy 070.203.

POAM remediation timelines (from the date of Weakness, Vulnerability, or Gap Identified):

- High Risk POAM Items 30 Days
- Moderate Risk POAM Items 6 Months
- Low Risk POAM Items 1 Year

HIPPA Risk Assessment

The Cabinet for Health and Family Services (CHFS) Office of Administrative and Technology Services (OATS) must establish an acceptable level of security controls to be implemented through a risk assessment procedure. Following the guidance on risk assessment requirements under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule 45CFR164.308(a)(1)(ii)(A), states that all Electronic Personal Health Information (ePHI) that is created, received, maintained or transmitted by CHFS, is subject to the Security Rule. The Security Rule requires agencies to evaluate risks and vulnerabilities in their environments and to implement reasonable and appropriate security measures to protect against reasonably anticipated threats or hazards to the security or integrity of ePHI. This rule serves as the foundational element in the process of achieving compliance, and establishes several objectives that any methodology adopted must achieve. Risk assessments are conducted to identify risks in a particular system, assessing the risk and taking steps to reduce the risk to an acceptable level.

Critical systems that store HIPAA, Internal Revenue Services (IRS), Social Security Administration (SSA), and/or ePHI data require risk assessments on an annual basis. A risk assessment will also be conducted at the onset of any new development as part of the System Development Life Cycle (SDLC) and systems that have major system change/modifications. These ongoing risks assessments are the responsibility of an appointed designee (Data Owner) within each program area to ensure compliance with applicable security controls. This process helps CHFS implement security best practices with regard to conducting, reviewing, documenting and tracking internal inspections.

Upon completion of a risk assessment the Contractor will document and follow a mitigation plan for the identified risks.

Disaster Recovery (DR) drill suggestions

CHFS Information Security representatives will be invited to all meetings and provided key information that pertains to the actual performance of the drill. (e.g. In the most recent drill there was information pertinent to the exercise that was discussed earlier in the week, but not communicated to CHFS.)

Test processing in the DR environment with a realistic number of users. Testing must mirror the workload as closely to what would be needed in a true outage.

Identify metrics for DR success. By having specific goals and measuring if those goals were met will give a clearer overall view into if the drill was a success.

Contractor must conduct create a Business Continuity Plan (BCP) and a Disaster Recovery (DR) plan. These plans must be tested and updated annually.

Provide a DR after action report (AAR). The report should detail what was a success, what did not succeed, what can be improved and a plan to address those items and improve the exercise.

Incident Response (IR) suggestions

Contractor must create an Incident Response Plan (IRP) and it must align with the CHFS OATS IRP. The Contractor IRP must be updated and tested at least once a year.

Contractor shall report any Incident to CHFS along with a description of the Incident, the severity of the Incident (determined by a set of criteria, see Exhibit 1) and supporting information outlining the processes Contractor was following when the Incident occurred and/or was detected.

Any pertinent documentation showing results or evidence of the Incident (the foregoing information and documentation collectively referred to as an "Incident Report"). This incident report should be provided to CHFS as soon as possible after an incident is determined but no longer than one hour after determination. This notification window to CHFS is to be as timely as possible to adhere to federal and state data breach reporting requirements (see Exhibit 2). An Incident Report shall include at a minimum the following information:

- What was the incident
- Investigation results
- Impact of the incident
- Remediation
- Prevention
- Steps to reproduce the Incident (if known by Contractor)
- Screen shots related to the Incident (if any)
- Information relating to the Contractor process affected by the Incident including any logs

The more comprehensive Contractor Incident Report, the better CHFS will be able to properly assess the severity of the Incident.

Exhibit 1:

| Level | Definition |
|--------------------------------------|---|
| Level 1: Emergency Severity Incident | Defined as Incidents that have an Enterprise wide impact or pose a high risk to business operations resulting in financial impacts or failure to meet commitments to Customer patients or address significant security vulnerability. |
| Level 2: Urgent Severity Incident | Defined as Incidents that have an Enterprise wide impact or pose a high risk to business operations resulting in financial impacts or failure to meet commitments to Customer or address significant security vulnerability. |
| Level 3: Standard Severity Incidents | Defined as medium risk. Customer's business operations may be interrupted or delayed, but all Customer commitments can be met. |
| Level 4: Low Severity Incident | Incident poses no risk. Customer's business operations will not be affected. |

Exhibit 2:

| Governing entity | Breach reporting timeframe |
|--------------------------------|----------------------------|
| Social Security Administration | Within 1 hour |
| Internal Revenue Service | Within 24 hours |
| Commonwealth of Kentucky | Within 72 hours |
| HIPAA | Within 60 Days |

Cabinet for Health and Family Services (CHFS), Office of Administrative & Technology Services (OATS) reserves the right to update these policies at any time throughout the life of the contract. Written communication of any changes will be made to the MCO detailing the effective date of such change. Any requests for exemption or changes to the policies outline herein, would follow the contract modifications procedures.