Commonwealth of Kentucky

CONTRACT MODIFICATION

CONTRACT INFORMATION

DOC ID Number: **PON3 758 2000000678**

Effective Date:	01/01/2021	Record Date:	12/22/2025
Expiration Date:	12/31/2026	Procurement Folder:	667945
Document Description:	Medicaid Managed Care Organization (MCO) (UnitedHealthcare)	Procurement Type:	Personal Service Contract
Cited Authority:	Personal Services Contracts-Standard	Version Number:	6

CONTACT INFORMATION

ISSUER:
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REASON FOR MODIFICATION

Amendment to update Attachment C incorporated herein for mutual agreement between all parties as indicated by the track changes. No funds have been added; the total contract amount is unchanged. Documentation is on file with OPS.

VENDOR INFORMATION

Name /Address:

KS0004505: UnitedHealthcare of Kentucky, Ltd.
DBA: UnitedHealthcare Community Plan of Kentucky
9100 Shelbyville Road

Louisville KY 40222

Contact:

Krista Hensel
502-318-1864
krista_hensel@uhc.com

COMMODITY / SERVICE INFORMATION

Line	Quantity	UOM	Unit Price	Service Amount	Service From	Service To	Line Total
1	0.00000		$0.000000	$6,851,400,000.00	01/01/2021	12/31/2026	$6,851,400,000.00

Medicaid Managed Care Organization (MCO) - All Regions

Extended Description:
Provided managed care services for Kentucky Medicaid recipients.

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.

MASTER AGREEMENT
FOR
MEDICAID MANAGED CARE ORGANIZATION (MCO) - ALL REGIONS
BETWEEN
THE COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES (CHFS)
AND
UNITEDHEALTHCARE OF KENTUCKY, LTD.
9100 SHELBYVILLE ROAD
LOUISVILLE, KENTUCKY 40222
502-318-0120
Amy Johnston Little (amy_johnston-little@uhc.com)

*** ***

This Master Agreement ("Contract", "Award", or "Agreement") is entered into, by and between the Commonwealth of Kentucky ("Commonwealth") and UnitedHealthcare of Kentucky, Ltd. ("Contractor", "Vendor", or "UnitedHealthcare"), to provide managed care services for Kentucky Medicaid recipients.

The Commonwealth and the Contractor agree to the following:

I. SCOPE OF CONTRACT

UnitedHealthcare of Kentucky, Ltd. 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 January 01, 2021 through December 31, 2024 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 2000000202.

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 2000000202. 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 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 an 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, thorough 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.

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 **v*endor 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 **January 01, 2021** and expire **December 31, 2024.**

This contract may be renewed at the completion of the initial contract period for **six (6) 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 October 01, 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

Transition of membership upon award is outlined in Section 26.2 of the Draft Contract.

50.7 Scope of Work/Technical Requirements

See RFP Attachment C - **"Draft Medicaid Managed Care Contract and Appendices."**

Personal Service Contract Standard Terms and Conditions
Revised May 2025

Whereas, the first party, the state agency, has concluded that either state personnel are not available to perform said function, or it would not be feasible to utilize state personnel to perform said function; and

Whereas, the second party, the Contractor, is available and qualified to perform such function; and

Whereas, for the abovementioned reasons, the state agency desires to avail itself of the services of the second party;

NOW THEREFORE, the following terms and conditions are applicable to this contract:

1.00 Effective Date
This contract is not effective until the Secretary of the Finance and Administration Cabinet or his authorized designee has approved the contract and until the contract has been submitted to the Legislative Research Commission, Government Contract Review Committee ("LRC"). However, in accordance with KRS 45A.700, contracts in aggregate amounts of $10,000 or less are exempt from review by the committee and need only be filed with the committee within 30 days of their effective date for informational purposes.

KRS 45A.695(7) provides that payments on personal service contracts and memoranda of agreement shall not be authorized for services rendered after government contract review committee disapproval, unless the decision of the committee is overridden by the Secretary of the Finance and Administration Cabinet or agency head if the agency has been granted delegation authority by the Secretary.

The vendor shall be paid, upon the submission of proper invoices to the receiving agency at the prices stipulated for the supplies delivered and accepted, or services rendered. Unless otherwise specified, payment will not be made for partial deliveries accepted. Payments will be made within thirty (30) working days after receipt of goods or a vendor's invoice in accordance with KRS 45.453 and KRS 45.454.

2.00 Renewals
Upon expiration of the initial term, the contract may be renewed in accordance with the terms and conditions in the original solicitation. Renewal shall be subject to prior approval from the Secretary of the Finance and Administration Cabinet or his authorized designee and the LRC Government Contract Review Committee in accordance with KRS 45A.695 and KRS 45A.705, and contingent upon available funding.

3.00 LRC Policies
Pursuant to KRS 45A.725, LRC has established policies which govern rates payable for certain professional services. These are located on the LRC webpage https://apps.legislature.ky.gov/moreinfo/Contracts/homepage.html and would impact any contract established under KRS 45A.690 et seq., where applicable.

4.00 Choice of Law and Forum
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.

5.00 Cancellation
The Commonwealth shall have the right to terminate and cancel this contract at any time not to exceed thirty (30) days' written notice served on the Contractor by registered or certified mail.

6.00 Funding Out Provision
The state agency may terminate this contract if funds are not appropriated to the contracting agency or are not otherwise available for the purpose of making payments without incurring any obligation for payment after the date of termination, regardless of the terms of the contract. The state agency shall provide the Contractor thirty (30) calendar days' written notice of termination of the contract due to lack of available funding.

7.00 Reduction in Contract Worker Hours
The Kentucky General Assembly may allow for a reduction in contract worker hours in conjunction with a budget balancing measure for some professional and non-professional service contracts. If under such authority the agency is required by Executive Order or otherwise to reduce contract hours, the agreement will be reduced by the amount specified in that document. If the contract funding is reduced, then the scope of work related to the contract may also be reduced commensurate with the reduction in funding. This reduction of the scope shall be agreeable to both parties and shall not be considered a breach of contract.

8.00 Authorized to do Business in Kentucky
The Contractor affirms that it is properly authorized under the laws of the Commonwealth of Kentucky to conduct business in this state and will remain in good standing to do business in the Commonwealth of Kentucky for the duration of any contract awarded.

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.

Registration with the Secretary of State by a Foreign Entity
Pursuant to KRS 45A.480(1)(b), an agency, department, office, or political subdivision of the Commonwealth of Kentucky shall not award a state contract to a person that is a foreign entity required by KRS 14A.9-010: to obtain a certificate of authority to transact business in the Commonwealth ("certificate") from the Secretary of State under KRS 14A.9-030:

https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=40424 **therefore, foreign entities should submit a copy of their certificate with their solicitation response.**

If the foreign entity is not required to obtain a certificate as provided in KRS 14A.9-010: https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=44318 , the foreign entity should identify the applicable exception in its solicitation response. Foreign entity is defined within KRS 14A.1-070: https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=50474

Businesses can register with the Secretary of State at:.
https://www.sos.ky.gov/bus/business-filings/Pages/default.aspx

9.00 Invoices for fees
The Contractor shall maintain supporting documents to substantiate invoices and shall furnish same if required by state government. The invoice must conform to the method described in Section V of this contract.

Pursuant to KRS 45A.695, no payment shall be made on any personal service contract unless the individual, firm, partnership, or corporation awarded the personal service contract submits its invoice for payment on a form established by the committee.

*Invoice form is available on the Legislative Research Commission, Government Contract Review Committee website: https://apps.legislature.ky.gov/moreinfo/Contracts/homepage.html

10.00 Travel expenses, if authorized
The Contractor shall be paid for no travel expenses unless and except as specifically authorized by the specifications of this contract or authorized in advance and in writing by the Commonwealth. The Contractor shall maintain supporting documents that substantiate every claim for expenses and shall furnish same if requested by the Commonwealth.

11.00 Other expenses, if authorized herein
The Contractor shall be reimbursed for no other expenses of any kind, unless and except as specifically authorized within the specifications of this contract or authorized in advance and in writing by the Commonwealth.

If the reimbursement of such expenses is authorized, the reimbursement shall be only on an out-of-pocket basis. Request for payment of same shall be processed upon receipt from the Contractor of valid, itemized statements submitted periodically for payment at the time any fees are due. The Contractor shall maintain supporting documents that substantiate every claim for expenses and shall furnish same if requested by the Commonwealth.

12.00 Purchasing and specifications
The Contractor certifies that he/she will not attempt in any manner to influence any specifications to be restrictive in any way or respect nor will he/she attempt in any way to influence any purchasing of services, commodities or equipment by the Commonwealth of Kentucky. For the purpose of this paragraph and the following paragraph that pertains to conflict-of interest laws and principles, "he/she" is construed to mean "they" if more than one person is involved and if a firm, partnership, corporation, or other organization is involved, then "he/she" is construed to mean any person with an interest therein.

13.00 Conflict-of-interest laws and principles
The Contractor certifies that he/she is legally entitled to enter into this contract with the Commonwealth of Kentucky, and by holding and performing this contract, he/she will not be violating either any conflict of interest statute (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.

14.00 Campaign finance
The Contractor certifies that neither he/she nor any member of his/her immediate family having an interest of 10% or more in any business entity involved in the performance of this contract, has contributed more than the amount specified in KRS 121.056(2), to the campaign of the gubernatorial candidate elected at the election last preceding the date of this contract. The Contractor further swears under the penalty of perjury, as provided by KRS 523.020, that neither he/she nor the company which he/she represents, has knowingly violated any provisions of the campaign finance laws of the Commonwealth, and that the award of a contract to him/her or the company which he/she represents will not violate any provisions of the campaign finance laws of the Commonwealth.

15.00 Access to Records

The state agency certifies that it is in compliance with the provisions of KRS 45A.150, "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).

16.00 Protest
Pursuant to KRS 45A.285, the Secretary of the Finance and Administration Cabinet, or his designee, shall have authority to determine protests and other controversies of actual or prospective vendors in connection with the solicitation or selection for award of a contract.

Any actual or prospective vendor, who is aggrieved in connection with the solicitation or selection for award of a contract, may file protest with the Secretary of the Finance and Administration Cabinet. A protest or notice of other controversy must be filed promptly and, in any event, within two (2) calendar weeks after such aggrieved person knows or should have known of the facts giving rise thereto. All protests or notices of other controversies must be in writing and shall be addressed to:

Holly M. Johnson, Secretary
Commonwealth of Kentucky
Finance and Administration Cabinet
Office of the Secretary
200 Mero Street, 5th Floor
Frankfort, KY 40622
The Secretary of Finance and Administration Cabinet shall promptly issue a decision in writing. A copy of that decision shall be mailed or otherwise furnished to the aggrieved party and shall state the reasons for the action taken.

The decision by the Secretary of the Finance and Administration Cabinet shall be final and conclusive.

17.00 Social Security
The parties are cognizant that the state is not liable for social security contributions, pursuant to 42
U.S. Code, section 418, relative to the compensation of the second party for this contract.

Any exceptions to this stipulation require an attachment or exhibit that explicitly addresses, and provides a basis for, payment of second party’s social security contributions by the state, pursuant to 42 U.S. Code, section 418.

18.00 Violation of tax and employment laws
KRS 45A.485 requires the Contractor and all subcontractors performing work under the contract to reveal to the Commonwealth any final determination of a violation by the Contractor within the previous five (5) year period of the provisions of KRS chapters 136, 139, 141, 337, 338, 341, and 342. These statutes relate to corporate and utility tax, sales and use tax, income tax, wages and hours laws, occupational safety and health laws, unemployment insurance laws, and workers

compensation insurance laws, respectively. Disclosure of any violations is required prior to the award of any state contract and throughout the duration the contract.

Failure to disclose violations, shall be grounds for the Commonwealth's disqualification of a contractor or subcontractor from eligibility for future state contracts for a period of two (2) years.

To comply with KRS 45A.485, the Contractor and all subcontractors performing work under this contract shall report any such final determination(s) of any violation(s) within the previous five (5) years to the Commonwealth by providing a list of the following information regarding any violation(s): (1) specific KRS violated, (2) date of any final determination of a violation, and (3) state agency which issued the final determination.

A list of any disclosures made prior to award of a contract shall be attached to the contract. The Contractor affirms that it has not violated any of the provisions of the above statutes within the previous five (5) year period, aside from violations explicitly disclosed and attached to this contract. Contractor further affirms that it will (1) communicate the above KRS 45A.485 disclosure requirements to any subcontractors and (2) disclose any subcontractor violations it becomes aware of to the Commonwealth.

.

19.00 Nondiscrimination

The Equal Employment Opportunity Act of 1978 (the “Act”), KRS 45.560 to 45.640, applies to all State government contracts or subcontracts in an amount exceeding $500,000. The contractor shall comply with all terms and conditions of the Act.

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, color, religion, sex, age forty (40) and over, disability, veteran status, or national origin or.

(b) The Contractor shall take affirmative action in regard to employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination rates of pay or other forms of compensation, and selection for training, so as to ensure that applicants are employed and that employees are treated during employment without regard to their race, color, religion, sex, age forty (40) and over, disability, veteran status, and national origin. Such action shall include, but not be limited to the following:

(c) The Contractor shall state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, age forty (40) and over, disability, veteran status, or national origin.

(d) The Contractor shall post notices in conspicuous places, available to employees and applicants for employment, setting forth the provisions of this non-discrimination clause.

The Contractor shall send a notice to each labor union or representative of workers with which he/she has a collective bargaining agreement or other contract or understanding advising the said labor union or workers' representative of the Contractor's commitments under this nondiscrimination clause.

The Contractor's noncompliance with the nondiscrimination clauses of this contract shall constitute a material breach of the contract.

Each Contractor shall, for the length of the contract or at the point at which the contract is covered by this Act and until its conclusion, furnish such information as required by the Act and any rules,

regulations and orders issued pursuant thereto and permit access to all books and records pertaining to his employment practices and work sites by the contracting agency and the Cabinet to ascertain compliance with the Act.

This section applies to agreements disbursing federal funds, in whole or part, only when the terms for receiving those funds mandate its inclusion.

20.00 Bidder, Offeror, or Contractor Mandatory Representations Compliance with Commonwealth Law
The contractor represents that, pursuant to KRS 45A.485, they and any subcontractor performing work under the contract will be in continuous compliance with the KRS chapters listed below and have revealed to the Commonwealth any violation determinations within the previous five (5) years:

KRS Chapter 136 (CORPORATION AND UTILITY TAXES)
KRS Chapter 139 (SALES AND USE TAXES)
KRS Chapter 141 (INCOME TAXES)
KRS Chapter 337 (WAGES AND HOURS)
KRS Chapter 338 (OCCUPATIONAL SAFETY AND HEALTH OF EMPLOYEES)
KRS Chapter 341 (UNEMPLOYMENT COMPENSATION)
KRS Chapter 342 (WORKERS' COMPENSATION)

Boycott Provisions
The contractor represents that, pursuant to KRS 45A.607, they are not currently engaged in, and will not for the duration of the contract engage in, the boycott of a person or an entity based in or doing business with a jurisdiction with which Kentucky can enjoy open trade. **Note:** The term Boycott does not include actions taken for bona fide business or economic reasons, or actions specifically required by federal or state law.

Lobbying Prohibitions
The contractor represents that they, and any subcontractor performing work under the contract, have not violated the agency restrictions contained in KRS 11A.236 during the previous ten (10) years, and pledges to abide by the restrictions set forth in such statute for the duration of the contract awarded.

The contractor further represents that, pursuant to KRS 45A.328, they have not procured an original, subsequent, or similar contract while employing an executive agency lobbyist who was convicted of a crime related to the original, subsequent, or similar contract within five (5) years of the conviction of the lobbyist.

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ATTACHMENT C - Medicaid Managed Care Contract and Appendices

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

MASTER 2026 CONTRACT AMENDMENTS

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ATTACHMENT C - Medicaid Managed Care Contract and Appendices

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ATTACHMENT C - Medicaid Managed Care Contract and Appendices

Preamble

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

WHEREAS, the Kentucky Department for Medicaid Services ("Department") within the Cabinet for Health and Family Services ("CHFS") 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 related to the Kentucky Medicaid program 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 healthcare 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, that the Contractor can and shall provide quality services efficiently, effectively and economically during the term of this Contract, and 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 upon in entering into this Contract; and

WHEREAS, the parties agree that the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services ("CMS") must approve this Contract as it relates to 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 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 sixty-five (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 the Department;

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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 (ACA), and the Healthcare and Education Reconciliation Act of 2010 (HCERA).

Allowed Medical Expenses equals incurred medical Claims plus expenses for activities that improve healthcare 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.

Authorized Representative means an individual authorized under state or other applicable law to act on behalf of an Enrollee.

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 this Contract.

Behavioral Health Conditional Dismissal Program (BHCDP) means a program that is an alternative to incarceration. BHCDP allows eligible adults with qualifying charges, determined by a judge, and behavioral health needs, to receive treatment for a substance use disorder (SUD) and/or mental health disorder. Upon completion of the treatment plan, criminal charges are dismissed.

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 under 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 (CHFS).

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

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the Enrollee receives Covered Services during the period covered by the payment. Payments are contingent upon the availability of appropriated funds.

Capitation Payment Rate(s) and Capitation Rate(s) mean 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.

Carceral Setting means a State Prison, County or Local Jail, Juvenile Detention Center, or Juvenile Development Center.

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, preferences, 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 & Medicaid Services (CMS) is the federal agency within the U.S. Department of Health and Human Services that, administers the Medicare Program and works in partnership with state governments to administer Medicaid.

Certified Community Behavioral Health Clinic (CCBHC) as defined in Section of PAMA and Section 3814 of the CARES Act.

Children with Special Healthcare 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 Healthcare 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 defined in KRS 205.532, 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 and is consistent with the requirements of the National Committee for Quality Assurance (NCQA).

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Clinical Laboratories Improvement Amendments of 1988 (CLIA) is federal legislation at 42 U.S.C. §§ 201, 263a, and regulations promulgated thereunder.

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 Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has a uniquely close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

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 or modifications thereto as described in **Section 40.1 "Documents Constituting Contract"** of this Contract.

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

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

Coordination of Benefits (COB): Method of integrating benefits payable under more than one (1) form of health insurance coverage so that the Enrollee's benefits from all sources do not exceed one hundred percent (100%) of allowable medical expenses. COB rules also recognize that Medicaid is the payor of last resort and establish which insurer is the primary insurer.

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

Covered Services means services that the Contractor is required to provide under this Contract.

Credentialing Application Date, as defined in KRS 205.532, means the date that a CVO receives a Clean Application from a provider.

Credentialing Verification Organization (CVO), as defined in KRS 205.532, 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 NCQA.

Critical Access Hospital means a CMS-designated healthcare facility that provides cost-based reimbursement for inpatient services.

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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.

Delegate means the act of the Contractor transferring any obligation under this Contract to a Subcontractor by a Subcontract.

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; 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 that 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 that 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 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, residential placement, or, 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.

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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 healthcare services for children who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Special Services means necessary healthcare, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects, 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 needs 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 U.S.C. 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 would result in:
    1. Placing the health of the individual (or for 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.
B. For 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 is 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. Medical Supplies, Equipment, and Appliances (MSEA);
F. Transportation;
G. Institutional stays;
H. EPSDT screening; or

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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 the 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 C.F.R. § 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, or 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 is 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 submission requirements.

Ethnicity means a group or population of people whose shared attributes distinguish them from other groups and can include a common nation of origin, sets of ancestry, traditions, language, history, society, or religion.

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 posted 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. See KRS 304.17A-607 and **Section 18.6 "Service Review and Authorization Timeframes"** for time requirements.

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.

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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 the Social Security Act at 1905(l)(2).

Fee-For-Service (FFS) is a traditional indemnity healthcare delivery system in which payment is made to a healthcare 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 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**.**

Fraud means any act that constitutes Fraud under applicable federal or state law, including but not limited to KRS 205.8451-KRS 205.8483 or any applicable provider agreement.

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

Grievance means the same as the definition 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.

Healthcare 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 Disparity means a health difference between a disadvantaged population and a a reference population, based on one or more health outcomes, due to inequitable distribution of social, political, economic, or environmental resources.

Health Equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.

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 in 45 C.F.R. 160.103.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 means federal legislation and the implementing regulations (45 C.F.R. Sections 142, 160, 162, and 164) that established standards for privacy of health information.

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

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Health Related Social Needs-Recuperative Care (HRSN-RC) means a short-term residential service that provides medical oversight and supportive care to individuals experiencing homelessness or housing instability who are recovering from illness, injury, or hospitalization.

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. 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 the need for health, behavioral health, or community services, and to determine when to conduct a more comprehensive Enrollee Needs Assessment to identify Enrollees who need care management.

HHS Transaction Standard Regulation means the same as in 45 C.F.R. Parts 160 and 162.

High-Risk means members with complex needs, multiple comorbidities, or a history of frequent emergency department visits or inpatient admissions during the previous 12 months.

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

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

In Lieu of Services (ILOS) means a service or setting that is provided to an Enrollee as a substitute for a covered service or setting under the State Plan in accordance with 42 C.F.R 438.3(e)(2). An ILOS can be used as an immediate or longer-term substitute for a covered service or setting under the State plan, or when the ILOS can be expected to reduce or prevent the future need to utilize the covered service or setting under the State Plan.

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 conditions 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.

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

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

Kynector means a Certified Application Counselor (CAC) or navigator.

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 the Commonwealth has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

Marketing means, as defined by 42 C.F.R. 438.104, 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.

Maximum Allowable Cost (MAC) means the upper limits that a plan will pay for generic drugs and brand name drugs that have generic versions 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 that are medically necessary as defined under 907 KAR 3:130, meet national standards (if applicable), and are provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Medicare Advantage Plan also called Medicare Part C or MA plans are offered by Medicare approved private companies that must follow rules set by Medicare to provide Medicare Part A and Medicare Part B coverage. Medicare Advantage plans may cover services not covered by original Medicare.

Member means an individual eligible to enroll in, and who has enrolled in, a Managed Care Organization.

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

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

National Correct Coding Initiative (NCCI) means the 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 healthcare 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. This definition excludes Pharmacy Network Providers.

Non-covered Services means healthcare services that the Contractor is not required to provide under the terms of this Contract or any applicable provider agreement.

Non-Emergency Medical Transportation (NEMT) means a transportation delivery program for non-emergency services such as transportation to a provider's office.

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 healthcare 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 that provides specialty medical services for children with specific diagnoses and healthcare service needs that make them eligible to participate in Commission sponsored programs, including the 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. This definition excludes Pharmacy Network Providers.

Overpayment means any payment made to a provider by the Contractor to which the provider is not entitled under any applicable federal or state law or provider agreement.

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.

Pharmacy Network Provider includes any pharmacy enrolled in the Kentucky Medicaid program for the purposes of the Single MCO PBM delivery model.

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.

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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 SDoH.

Post Stabilization Services means Covered Services, related to an Emergency Medical Condition that are provided after an Enrollee is stabilized 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 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 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 healthcare 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, or 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 healthcare services to individuals, and for an Enrollee who has a gynecological or obstetrical healthcare 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 except for pharmacy services that are prior authorized by the Single MCO PBM.

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

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) of the Act and 42 C.F.R. Subpart K.

Protected Health Information (PHI) means individual patient demographic information, Claims data, insurance information, diagnosis information, and any other care or payment for healthcare 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

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highly structured environment than can be provided in a Qualified Residential Treatment Program, Residential Placement, and in the home and serve as a community-based alternative to hospitalization. The facilities also serve children and youth who are transitioning from hospitals, but who are not ready to live at home or in a foster home. (42 C.F.R. Parts 441 and 483, 902 KAR 20:320, and 902 KAR 20:330)

Quality Improvement (QI) means the process of ensuring that Covered Services provided to Enrollees are appropriate, timely, accessible, available, appropriately documented, 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.

Race means a group of people sharing a common cultural, geographical, linguistic, or religious origin or background.

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 larger but similarly characterized groups included but not limited to 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 "member" and "Enrollee."

Recovery Residence Support Services (RRSS) means community-based, peer supported housing services that provide a safe, substance free living environment to support individuals in maintaining recovery from substance use disorders.

Reentry means an adjudicated individual who is serving time in a Carceral Setting and enters a period of sixty (60) Days pre-release from the Carceral Setting and thirty (30) Days post-release from a Carceral Setting.

Residential Crisis Stabilization Services (RCSS) means services used when individuals in a behavioral health crisis cannot be safely accommodated within the community and do not need hospitalization but need overnight care.

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) of the Act 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.

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

Secret Shopper means a research technique used to evaluate the quality of service or compliance with standards. It involves having an individual pose as a customer or client and interact with a provider to assess the quality of service.

Serious Emotional Disorder/Disturbance/Disability (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.

Single MCO Pharmacy Benefit Manager (PBM) means the PBM contracted directly with and by the Commonwealth of Kentucky to provide pharmacy benefit management services for the Medicaid Managed Care program, as required by KRS 205.5512, and for which the Contractor must sign a Service Agreement for the administration of pharmacy services to its Enrollees.

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

Social Determinants of Health (SDoH) means 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, and access to healthcare are all determinants of health.

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 907 KAR 17:010.

Subcontract means a written contractual agreement between the Contractor and a Subcontractor to provide any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under this Contract. All Subcontracts shall include a description and role of the Subcontractor and a detailed listing of services provided.

Subcontractor means any individual, firm, corporation, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, delegated vendor, or any other entity with which

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Contractor has entered into a written agreement to provide any function or service for the Contractor specifically related to securing or fulfilling Contractor's obligations under this Contract. A network provider and the Single MCO PBM are not considered a Subcontractor.

Supplemental Nutrition Assistance Program (SNAP) means a program that helps low-income people buy food for healthy meals at participating stores. Kentucky SNAP benefits increase household food buying power when added to the household's income.

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.

Supporting Kentucky Youth (SKY) is the Commonwealth's Medicaid risk-based managed care delivery program for Foster Care, DJJ Youth, and Dually Committed Youth (DCBS and DJJ) Enrollees. Former Foster Care Youth and Adoption Assistance Enrollees may opt to participate in SKY.

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.

Targeted Case Management as defined at 907 KAR 15:040 - 15:065.

Taxonomy codes are reference codes designed to categorize the type, classification, and/or specialization of healthcare providers. Healthcare 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 parties to carry out financial or administrative activities related to healthcare as defined by 45 C.F.R. 160.103.

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Unhoused Person, when used in **Section 20.7 "Outreach to Unhoused Persons,"** means one who lacks a fixed, regular, or nighttime residence; is at risk of becoming unhoused 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.

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 that 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 healthcare services, procedures or settings, and ambulatory review, pre-certification, prospective review, concurrent review, second opinions, care management, Discharge Planning, or retrospective review.

Value Added Benefit is an additional service or good offered to members that is outside of the Medicaid benefit package but seeks to improve quality and health outcomes and/or reduce costs.

Value Based Payment (VBP) is a payment model that ranges from rewarding performance in FFS to capitation, including alternative payment models and comprehensive population-based payments.

Waste means generally, but is not limited to, the overutilization or inappropriate utilization of services or misuse of resources. The act does not have to be intentional and the actor does not have to specifically intend for waste to occur.

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

2.0 ABBREVIATIONS AND ACRONYMS

AA - Adoption Assistance

ABP - Alternative Benefit Plan

ACA - Affordable Care Act

ADA - American Dental Association

AHRQ - Agency for Healthcare Research and Quality

AIDS - Acquired Immune Deficiency Syndrome

APRN - Advanced Practice Registered Nurse

A/R - Accounts Receivable

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AT - Assessment Team

BBA - Balanced Budget Act

BH - Behavioral Health

BHCDP - Behavioral Health Conditional Dismissal Program

BIN - NCPDP Processor ID Number

CAA - Consolidated Appropriations Act

CAHPS - Consumer Assessment of Healthcare Providers and Systems

CANS - Child and Adolescent Needs and Strengths

CAP - Corrective Action Plan

CASA - Court Appointed Special Advocate

CCBHC - Certified Community Behavioral Health Clinic

CCD - Continuity of Care Document

CCT - Care Coordination Team

C.F.R. - Code of Federal Regulations

CHFS - Cabinet for Health and Family Services

CHW – Community Health Worker

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

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DJJ - Department of Juvenile Justice

DOC - Department of Corrections

DSH - Disproportionate Share Hospital

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

DUR – Drug Utilization Review

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

EVV – Electronic Visit Verification

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 - Health Access Nurturing Development Services

HCPCS - Healthcare Common Procedure Coding System

HEDIS™ - Healthcare Effectiveness Data and Information Set

HHS - The United States Department of Health and Human Services

HIPAA - Health Insurance Portability and Accountability Act

HIV - Human Immunodeficiency Virus

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HRA - Health Risk Assessment

HRSN-RC - Health Related Social Needs-Recuperative Care

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

ILOS – In Lieu of Services

JJ - Juvenile Justice

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

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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

PCRP - 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

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RFP - Request for Proposal

RHC - Rural Health Clinic

RN - Registered Nurse

RCSS – Residential Crisis Stabilization Services

RRSS - Recovery Residence Support Services

SDoH - Social Determinants of Health

SDP - State Directed Payments

SKY – Supporting Kentucky Youth

SNAP - Supplemental Nutrition Assistance Program

SOBRA - Sixth Omnibus Budget Reconciliation Act

SOP - Standards of Practice Manual

SPT - Separate Payment Term

SRCA - Service Region Clinical Associate

SSI - Supplemental Security Income

SSW - Social Service Worker

STC - Special Terms and Conditions

TCM -Targeted Case Management

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

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URAC - Utilization Review Accreditation Commission

U.S.C. - United States Code

VBP – Value Based Payment

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, in good standing under the laws of the Commonwealth, 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 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 the 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 in accordance with **Section 11.1 "Calculation of 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) Days to remit payment in full to the Department. In the event the assessment is increased, the increase shall be

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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, the 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 licensed 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 healthcare 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 shall have 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 healthcare program.

Contractor shall require by contract that neither any Provider of healthcare 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 healthcare program.

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The Contractor shall certify its compliance with 42 C.F.R. 438.610 and have processes and/or procedures in place to ensure ongoing compliance throughout the Contract.

3.7 Compliance with Federal Law

1.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 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. For any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
   5. For 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 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.

1.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 healthcare, Utilization Review, medical social work, or administrative services, with one of the following:
      a. Any individual or entity excluded from participation in federal healthcare programs.
      b. Any entity that would provide those services through an excluded individual or entity.

1.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

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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 for renewing or extending the agreement.

1.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.

1.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.

1.F. 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); (The address in the case of an individual must include date of birth and Social Security Number; 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.

1.G. The Contractor shall remain in compliance with all CMS Interoperability final rules at 45 C.F.R. § 170.213, including Payer-to-Payer and any other requirements pertaining to Medicaid Managed Care Plans. The Contractor shall submit progress reports to the Department for tracking purposes and notify the Department should the Contractor identify any risks to meeting CMS requirements within required timeframes in federal law.

1.H. Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., vacated by a court or CMS has withdrawn federal authority, or is legislatively repealed), the Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for

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that work even if the payment was made after the date the program or activity lost legal authority.

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 of 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 37.1 through 37.16 "Remedies for Violation, Breach, or Non-Performance of Contract."** The Contractor shall meet the applicable terms and conditions imposed upon Medicaid MCOs in 42 U.S.C. 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 under 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 the applicable provisions of 42 C.F.R. 438.230(b) and 42 C.F.R. 434.6. The Contractor shall ensure that the Subcontractor complies 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 the selection of providers to another entity, the Contractor must retain the right to approve, suspend, or terminate any provider selected by that Subcontractor.

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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 via SharePoint (or in a manner as directed by 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) within five (5) Business Days for expedited submissions. The Contractor shall not use or distribute such materials until the Department's 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 CHFS 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 comply 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 in **Appendix A** "**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 applicable Department policies and procedures, 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 for Covered Services be more stringent than those specified in the applicable Department's policies and procedures without the Department's approval. The Department shall provide reasonable prior written notice to the Contractor of any material changes to its policies and procedures, or any changes to its policies and procedures that materially alter this Contract.

5.2 Commonwealth and Federal Law

At all times during this Contract and in the performance of every aspect of this Contract, the Contractor shall adhere to all applicable federal and Commonwealth law (statutory and case law), regulations, and standards, except where waivers of said laws, regulations, or standards are granted by the applicable federal or Commonwealth authority. Any change mandated by law related to MCOs and/or Medicaid Services shall be implemented by the Contractor without amendment to this Contract. In the event of any conflict between the terms of this Contract and any applicable federal

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or Commonwealth law, regulation, or standard, such law, regulation, or standard shall control. In addition to the other laws specifically identified, the Contractor shall comply, as applicable, with the Davis-Bacon Act, the Clean Air Act, the Federal Water Pollution Control Act, and 45 C.F.R. 93 Appendix A.

5.3 Nondiscrimination

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

1.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 political belief, disability, veteran's status, age, or any other protected class identified in federal, state or local laws. The Contractor further shall comply with the provisions of the Americans with Disabilities Act of 1990, 42 U.S.C. 12101, and any applicable federal regulations 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, sexual orientation, gender identity, political belief, disability, or age. 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 including if applicable, the USDA And Justice for All Poster.

1.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.

1.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 for any Subcontract or purchase order as FAC may direct as a means of enforcing such provisions, including sanctions for noncompliance.

1.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 to ascertain compliance with such rules, regulations and orders.

1.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 Executive Order No. 11246 of September 24, 1965, as amended, and such other sanctions as may be imposed and remedies invoked by law.

1.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 nondiscrimination provisions of this Contract 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

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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:

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

5.5 Governance

The Contractor shall have a governing body. The governing body shall ensure the 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 CHFS, 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 Commonwealth, 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 of an audit, inspection, investigation, or other on-site visit. The Contractor shall provide log-in credentials to access the 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.

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In addition, upon reasonable notice, the Contractor shall allow duly authorized agents or representatives of the Commonwealth or federal government or the independent 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 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 that 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 or approval, in any federal waivers, grant initiatives, 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 healthcare 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 the planning and development of initiatives and models, and implementation of programmatic changes and innovations to support the implementation of the initiatives and models. The Contractor shall provide reporting and data as determined or requested by the Department. In the event a new waiver, model, or initiative results in a material change to benefits or administration, the Department will amend this Contract, the Capitation Payment Rates, or both, if necessary.

6.0 SUBCONTRACTS

6.1 Requirements

The Contractor has the right to Subcontract to provide services specified under this Contract subject to Department approval. The Contractor maintains ultimate responsibility for adherence and full compliance with all terms and conditions of its Contract with the Department. Any Subcontract the Contractor enters for performance under this Contract shall in no way relieve the Contractor of the legal responsibility to carry out its obligations under this Contract. The Department will consider the Contractor the sole point of contact concerning contractual matters, including payment of any and all charges resulting from the Contractor. Nothing contained in any Subcontract shall be construed as creating any contractual responsibility between the Subcontractor and the Department. The Contractor is solely responsible for fulfillment of the Contract terms with the Department and for the performance of any Subcontractor. The Department will make Contract payments only to the Contractor. The Contractor shall not enter into any Subcontract with Subcontractors outside of or that would be providing any services outside the United States or its territories.

The Contractor shall ensure all Subcontractors have and maintain Kentucky-specific expertise in each content area they are providing services and are eligible for participation in the Medicaid program, pursuant to federal and state law. The Contractor shall evaluate each prospective Subcontractor's ability to perform the proposed delegated activities. The Contractor shall obtain

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Department approval for the template agreement and any material amendments via submission on SharePoint. Furthermore, the Contractor shall submit any material change in terms or scope of a Subcontract or any notice of suspension or termination of a Subcontract to the Department for approval via SharePoint. The Department may approve, approve with modification, or reject Subcontracts 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. Likewise, any Department Subcontract approval does not in any way relieve the Contractor of any responsibility or liability for the performance of its duties pursuant to this Contract.

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

1.A. Identify the population covered by the Subcontract;
1.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;
1.C. Require participation in meetings with the Department by staff as requested by the Department;
1.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;
1.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 the provision of data or other information, participation in the drafting of materials or reports, or attendance in required meetings or other forums;
1.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;
1.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;
1.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 in **Appendix B. "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);
1.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;
1.J. Provide full disclosure of the method of compensation or other consideration to be received from the Contractor;
1.K. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Enrollees of Medically Necessary Covered Services;
1.L. Contain a prohibition on assignment, or any further subcontracting, without the prior written

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consent of the Department;

1.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;

1.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;

1.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;

1.P. Require participation in readiness reviews as requested by the Department, including submission of requested materials, participation in meetings, and onsite reviews;

1.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 of this Contract, 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 the results of the review to the Department;

1.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 the frequency of required updates on implementing the corrective actions;

1.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 Commonwealth, or for reasonable possibility of Fraud or similar risk;

1.T. Specify the Subcontractor will make its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to Medicaid Enrollees available;

1.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;

1.V. Requirement that Subcontractors notify the Contractor throughout the Contract Term of any new or existing litigation;

1.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 in **Appendix A** "**Remedies for Violation, Breach, or Non-Performance of Contract**":

1.X. Contain provisions that suspected Fraud and Abuse shall be reported to the Contractor.

1.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;

1.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;

1.AA. Specify procedures and criteria for extension, renegotiation, and termination.

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1.BB. 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; and

1.CC. Each such Subcontractor shall 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 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.

Redacted contracts will not be reviewed or accepted except that the Contractor may redact language that is solely applicable to another state/market. All approvals required by this section are subject to **Section 4.4 "Approval of Department."**

6.2 Subcontractor Notification Requirements

The Contractor shall notify the Department of the status of all Subcontractors every quarter via the Regulatory Report package. The Contractor shall notify the Department via SharePoint of any suspension or termination of any Department-approved Subcontract within ten (10) Days following the Contractor's notification to the Subcontractor of their suspension or termination.

6.3 Disclosure of Delegations by Contractor's 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 this Contract. This does not apply to Subcontractor's vendors performing administrative functions such as mail order or print services. As in **Section 6.1 "Requirements,"** such arrangements require submission via SharePoint and approval of the Department.

6.4 Remedies

The FAC and the Department each have the right to invoke against any Subcontractor any remedy in this Contract, including the right to require the termination of any Subcontract, for any 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 with Subcontractors that includes the assumption of risk by the Subcontractor. The notification shall include the scope of the risk, the contracting amount, and how the entity in turn pays its Subcontractors for providing Covered Services. The Contractor shall submit monthly reports of Capitation Payments made to Subcontractors, such as, but not limited to Subcontractors that administer vision or dental services, via the Regulatory Report Package. 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.

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7.0 CONTRACT TERM

7.1 Term

The term of the Contract shall be for the period **January 1, 2026** through **December 31, 2026**. 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 38.3 "Amendments."** The Contractor shall give at least sixty (60) Days' notice to the Commonwealth 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.

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 October 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.C 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.

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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 also reserves the right to conduct onsite reviews in Subcontractor facilities. Specifically, the Department will assess the Contractor's ability and readiness to, at a minimum, meet the requirements of the Contract, the Commonwealth, and 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 the Contractor with the timeline for 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 37.11 "Termination for Default**."

The Department reserves the right to conduct readiness reviews at any point during the Contract based on the 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:

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

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1.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 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 in **Section 6.0 "Subcontracts."** The Contractor shall set clear expectations that the Subcontractor is a representative of the Contractor in the 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 unless otherwise specified 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:

1.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.
1.B. A Chief Financial Officer who shall oversee the budget and accounting systems implemented by the Contractor.
1.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 the Contractor's implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.
1.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 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.
1.E. A Pharmacy Director licensed in Kentucky who shall coordinate, manage, and oversee the required contractual pharmacy services. The Contractor's Pharmacy Director shall be

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dedicated part-time, at a minimum, to this Contract. The Department has the right to request additional support should the level of involvement or responsiveness not be sufficient to meet Contract needs.

1.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.

1.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.

1.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.

1.I. A Quality Improvement Director who shall be responsible for the operation of the Contractor's Quality Improvement Program.

1.J. A Population Health Management Director who shall be responsible for coordination and oversight of the 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.

2.A. A Management Information System Director who shall oversee, manage, and maintain the Contractor Management Information System (MIS).

2.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.

2.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 timely respond to Providers seeking prompt resolution of problems or inquiries.

2.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.

2.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.

2.F. An EPSDT Coordinator who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for Enrollees.

2.G. A Guardianship Liaison who shall serve as the Contractor's primary liaison for meeting the needs of Enrollees who are adult guardianship clients.

2.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 responses to Department requests for information.

2.I. CHWs to assist in outreach and engaging members in appropriate health services and providing health education and disease self-management, with emphasis placed on preventive care within the population health program. The Contractor shall not consider CHW services provided by their staff as a duplication of services provided by an employee of a Medicaid

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provider, if such service is a Covered Service, or as a reason to deny the service or reimbursement as a duplication.

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 the Department a list of licensed staff and current licensure status.

The Contractor shall comply with all staffing/personnel obligations, including but not limited 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, prior to material revisions, and upon request by the Department:

3.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 conducting activities and filling all staff positions.

3.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.

3.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 submit current staff directories as required by the Department.

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. The Contractor shall include a transition plan (e.g., activities to be taken, estimated timeframes to find a new hire) with the notice, and provide the Department and FAC with updates at an agreed upon frequency until the position is filled.

9.3 Department Meetings

The Contractor's Pharmacy Director, Medical Director, Quality Improvement Director, PHM Director, Utilization Management Director, Dental Director, Behavioral Health Director, their designees, or other Contractor staff shall meet in separate or joint meetings with the Department as requested by the Department, other contracted MCOs, and 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 SDoH, 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.

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9.4 Kentucky Health Information Exchange

The Contractor shall encourage its contracted Kentucky Providers to sign a Participation Agreement with the Kentucky Health Information Exchange (KHIE). Providers will engage with KHIE to connect 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 the Contractor should be encouraged to also submit ADTs (Admission, Discharge, Transfer messages) to KHIE.

If the provider does not have an electronic health record, they must 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 Department regarding Network Providers' KHIE participation.

9.5 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 but is not limited to KHBE staff, Navigators, kynectors, 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.

10.0 CAPITATION PAYMENT INFORMATION

10.1 Monthly Payment

On or before the eighth (8th) day of each month during this Contract, the Department shall remit to the Contractor the Capitation Payment specified in **Section 11.1 "Calculation of 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.145. 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"** from the Department as payment in full for all services to be provided under 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

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Capitation Payment shall be borne in full by the Contractor. Interest generated through the investment of funds paid to the Contractor under 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) Days when it has identified Capitation Payments or other payments above 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. 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.

If 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 the DMS Medicaid Managed Care (MMC) Program Reporting Package for automated reporting requirements.

If 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 the DMS MMC Program Reporting Package for automated reporting requirements.

If 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.

If 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, or 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 for retroactive Disenrollment of Enrollees shall not exceed twelve (12) months from the effective date of Disenrollment.

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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 if 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 the Enrollee seeking voluntary repayment of all Claims paid by the Contractor on behalf of the Enrollee during the 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, every month, 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 collection by the Commonwealth and, if collected, 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 Capitation Payment Rates

The Capitation Payment Rates are established in accordance with 42 C.F.R. 438. The Capitation Payment Rates are developed and certified by the Department's actuaries and submitted to CMS for 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. In the event of a new rate, the Department will provide a Capitation Payment Rate Acknowledgement to be signed by the Contractor, which shall be deemed incorporated into this Contract and shall be binding to the Contractor and the Department.

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 by execution of a Capitation Payment Rate Acknowledgement, which shall be deemed incorporated into this Contract and shall be binding to the Contractor and the Department.

The Contractor is free to negotiate provider rates and methodologies that are tied to Medicaid FFS reimbursement, but such ties shall not be considered to have any direct impact on rates. Changes to FFS provider reimbursement rates or methodologies 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.

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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 unless otherwise modified. If the Contractor is or will be subject to the HIF 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 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

Beginning with calendar year 2021 and continuing annually on a calendar year basis thereafter, the Contractor shall calculate/report a MLR consistent with 42 C.F.R. 438.8 for the Medicaid populations covered under the managed care contract.

The MLR reporting process will begin ten (10) months after the end of each calendar 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.

The MLR information shall be conveyed from the Contractor to the Commonwealth through an MLR Reporting Template developed by the Commonwealth. An actuary and an office of the company shall attest to the accuracy of the MLR calculation and the information reported in the MLR Reporting Template. The MLR Reporting Template, and any other information the Contractor wants to submit for consideration, shall be due to the Commonwealth no later than twelve (12) months after the end of the reporting period.

The Commonwealth shall then determine, within ninety (90) Days of receipt of all information from all Contractors, if any remittance 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. The Commonwealth may extend the timeframe for completing the MLR calculation up to twenty-four (24) months after the end of the reporting period if there is additional information available that may result in a material change.

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 the MLR calculation within the requested timeframe, it shall be subject to a penalty of $500.00 per day until the information or response is received.

The MLR calculation to be submitted to CMS for each Contractor shall be the ratio of the numerator (42 C.F.R. 438.8(e)) to the denominator (42 C.F.R. 438(f)). A separate MLR calculation (referred to as minimum MLR calculation) will be performed for calculating a potential MLR remittance based on the exclusion of separate payment term (SPT) state directed payments (SDPs) from both the numerator and denominator. An SPT is an SDP where the Contractor does not incur any insurance risk. The remittance from the Contractor to the Commonwealth shall occur if the minimum MLR calculation, excluding the SPT SDPs, is less than ninety (90) percent. The remittance amount shall be calculated as follows:

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1.A. For a minimum MLR calculation of less than ninety percent (90%) but greater than or equal to eighty-six percent (86%), the Contractor shall submit a remittance to the Commonwealth for eighty-five percent (85%) of the difference between the dollar amount corresponding to actual minimum MLR calculation and the dollar amount corresponding to a ninety percent (90%) Medical Loss Ratio, excluding SPT SDPs.

1.B. For a minimum MLR calculation less than eighty-six percent (86%), the Contractor shall submit a remittance to the Commonwealth for the sum of: (1) eighty-five (85%) of the difference between the dollar amount corresponding to an eighty-six percent (86%) minimum MLR calculation and the dollar amount corresponding to a ninety percent (90%) minimum MLR calculation, excluding SPT SDPs; and (2) one hundred percent (100%) of the difference between the dollar amount corresponding to the actual minimum MLR calculation and the dollar amount corresponding to an eighty-six percent (86%) Medical Loss Ratio, excluding SPT SDPs.

The inclusion of Contractor provider incentive payments, as in **Section 11.5 "Physician Incentive Plans,"** in the numerator of the MLR calculation requires that Provider incentive payments must meet the requirements of 42 C.F.R. 438.3(i)(3):

2.A. Have defined performance periods that can be tied to the applicable MLR reporting period;

2.B. Have signed and dated incentive contracts that must be executed before the start of the performance period;

2.C. Include well-defined quality improvement or performance metrics that the Provider must meet to receive the incentive payment; and

2.D. Specify the dollar amount that is linked to the Provider's successful completion of the metrics and include a corresponding date of payment.

In accordance with 42 C.F.R. 438.3(i)(4)(i), the Contractor shall retain the following documentation for each Provider incentive arrangement:

3.A. A signed copy of the contract between the Contractor and the network Provider that is executed prior to the start of the performance period;

3.B. Documentation supporting the results of the Provider's quality improvement or performance metrics and the determination if each metric has been met; and

3.C. Documentation supporting the payment to the Provider (such as a check or remittance) for meeting the required quality improvement or performance metrics and proof that the payment was made in accordance with contract terms.

Additionally, the Department specifically prohibits management attestation as the sole supporting documentation of a Provider incentive payment. The Contractor shall make the documentation required above available to the Department upon request at any time during the contract year.

Within thirty (30) Days of the beginning of the contract year, for each incentive arrangement, the Contractor shall complete a Department-provided template to provide the necessary documentation required under 42 C.F.R. 438.3(i)(4). Concurrently with the completion of the MLR Reporting Templates for the MLR reporting period, the Contractor shall submit the payment amount associated with each previously documented incentive arrangement. To the extent the documentation for an incentive payment was not previously provided, the expenses associated with the payment will be disallowed from the MLR calculation.

The Department or its contractor will review the documentation submitted by the Contractor. The

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Department retains the right to request additional information to support its review. The Department reserves the right to audit the documentation of the Provider incentive arrangements to ensure compliance with 42 C.F.R. 438.3(i)(3). If the Department determines that an incentive arrangement does not meet these requirements, it may disallow the incentive payment from inclusion in the numerator of the minimum MLR calculation.

Expenses must be allocated in accordance with 42 C.F.R. 438.8(g), including the following provisions:

4.A. Each Contractor expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses.

4.B. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

4.C. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

4.D. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

4.E. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

In accordance with 42 C.F.R. 438.8(k)(1)(vii), the methodology for allocation of expenditures must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 C.F.R. 158.170(b).

A credibility adjustment will be added to the MLR in accordance with 42 C.F.R. 438.8(h) should the calculated MLR not meet the credibility thresholds in 42 C.F.R. 438.8(h)(4).

The Contractor shall meet all the reporting requirements in 42 C.F.R. 438.8, including but not limited to 42 C.F.R. 438.8(k).

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with the required MLR reporting (42 C.F.R. 438.8(k)) to the Contractor within one hundred and eighty (180) Days of the end of the MLR reporting year or within thirty (30) Days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of the MLR reporting.

The Department may, at its discretion and subject to CMS approval, implement MLR incentive programs by which the Contractor 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 in 42 C.F.R. 417.479(c); 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

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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 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:

1.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.
1.B. The type of incentive arrangement, (e.g., withhold, bonus, Capitation).
1.C. Percent of withhold or bonus (if applicable).
1.D. Panel size, and if patients are pooled, the approved method used.
1.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 FFS 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 in 42 C.F.R. 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 healthcare 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.
1.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.
1.B. Not all Enrollees will be risk scored. Exclusions, such as dual eligible Enrollees may exist.
1.C. Each MCO's proposed base Capitation rates will be risk adjusted based on its Enrollees' risk scores relative to the risk scores of other MCOs.
1.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.

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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 of DOI has the authority to require additional capital and surplus if it appears that an Insurer is in a financially hazardous condition.

The Contractor shall cover the 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:

1.A. For the Contractor's debts;
1.B. For the Covered Services provided to the Enrollee, for which the Department does not pay the Contractor;
1.C. For the Covered Services provided to the Enrollee for which the Department or the Contractor does not pay the individual or healthcare provider that furnishes the services under a contractual, referral, or other arrangement; and
1.D. For Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are more than 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 an 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. 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, suppliers, subcontractors, or providers, including without limitation any claim attributable to:

1.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;
1.B. The erroneous or negligent acts or omissions, including without limitation, noncompliance with 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 erroneous or negligent acts;
1.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

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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, the Contractor shall have no obligation to indemnify the Indemnified Parties for any losses due to the negligent acts, 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 under 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 the 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 the 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 the Contractor determines that 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

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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 but is not limited to subrogation collections from auto, homeowners, or malpractice insurance.

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 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 under this Contract. The Contractor shall maintain a current TPL Resource File that 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 via a daily 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. 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 in 907 KAR 1:604. Co-payments, co-insurance, or deductible amounts may be increased only with Department approval.

42 C.F.R. 435.610 requires that, as a condition of Medicaid eligibility each Enrollee will be required to:

1.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
1.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 to 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 covered only by the Medicaid program, as identified by the Department.

42 C.F.R. 433.139 requires the Contractor to be responsible for ensuring 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

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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 for seeking recovery from the Third Party Resource on a post-payment basis. See **Appendix C "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:

2.A. For dire needs/urgent requests, within one (1) Business Day; or
2.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, including 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 in **Appendix D "Management Information Systems Requirements"**.

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) with the Department, pursuant to Sections 261 through 264 of HIPAA ("the Administrative Simplification provisions"). The execution of the BAA is required prior to data exchanges being implemented and shall be incorporated by reference.

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. If the Department's technical requirements require amendment during the Contract term, the Department will work with the Contractor in establishing the new technical requirements. The Contractor shall be capable of adapting to any new technical requirements established by the Department. Any Contractor-initiated changes to the requirements, including delays, shall require Department approval. The Contractor shall develop processes for development, testing, and promotion of system changes and maintenance. The Contractor shall submit to the Department an annual systems maintenance schedule by January 31st of each calendar year.

The Contractor shall notify the Department at least ninety (90) Days prior to the installation or implementation of major software or hardware changes, upgrades, modifications, or replacements. "Major" changes, upgrades, modifications, or replacements are those that impact mission critical business processes, such as claims processing, eligibility and enrollment processing, service authorization management, Provider enrollment and data management, encounter data management,

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and any other processing impacting the Contractor's capability to interface with the Department or the Department's contractors. The Contractor shall have a work plan for such system changes or system upgrades that includes a timeline, milestones, and adequate testing to be completed prior to implementation. The Contractor shall provide such plans to the Department upon request in the timeframe and manner specified by the Department after receiving notice from the Contractor of the planned change or upgrade. The Department may require status reports at a frequency determined by the Department.

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:

1.A. Enrollee Subsystem;
1.B. Third Party Liability (TPL);
1.C. Provider Subsystem;
1.D. Reference Subsystem;
1.E. Claims Processing Subsystem (to include Encounter Data);
1.F. Financial Subsystem;
1.G. Utilization/Quality Improvement Subsystem; and
1.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:

2.A. Verifying, through edits and audits, the accuracy and timeliness of reported data;
2.B. Screening the data for completeness, logic, and consistency;
2.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;
2.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;
2.E. At a minimum, ensuring edits and audits comply with NCCI;
2.F. Resolving all reporting errors in transaction submission and reconciliation; and
2.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.

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15.4 Access to Contractor's MIS

The Contractor shall provide the Department with log-in credentials to access the 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.

15.5 Health Information Security and Privacy Policy

To ensure the confidentiality, integrity, and availability of ePHI in line with the sunsetting of the Health Information Technology for Economic and Clinical Health Act (HITECH), Contractor shall have a Health Information Security and Privacy policy that leverages National Institute of Standards and Technology (NIST) 800-53 Rev. 5 control families. This applies to all systems, networks, and data that store, process, or transmit ePHI. The policy should be reviewed at least annually or upon significant changes to regulations, technology, or organizational processes.

1.A. Access Control (AC)
   1. Implement controls to limit and control access to ePHI; and
   2. Employ the principle of least privilege, ensuring that users have the minimum access necessary to perform their job functions.

1.B. Audit and Accountability (AU)
   1. Generate, review, and retain audit records to ensure that actions affecting ePHI can be traced to responsible individuals.

1.C. Security Assessment and Authorization (CA)
   1. Regularly access the security controls in place, document deviations, and authorize system operations based on the risk to ePHI.

1.D. System and Communications Protection (SC)
   1. Implement safeguards to protect ePHI from interception during electronic transmission; and
   2. Utilize encryption techniques for data-in-transit.

1.E. Security Planning (PL)
   1. Develop, document, and update a security plan that describes the safeguards implemented to protect ePHI.

1.F. Incident Response (IR)
   1. Establish an operational incident response capability to handle potential breaches or exposures of ePHI; and
   2. Notify affected individuals, the Secretary of HHS, and potentially the media, in the event of a breach, as per HITECH requirements.

1.G. Risk Assessment (RA)
   1. Periodically evaluate the risks to ePHI, including potential vulnerabilities and threats.

1.H. System and Services Acquisition (SA)
   1. Ensure that ePHI considerations are part of the system development life cycle, and that they are part of the requirements for all new systems or services.

1.I. Training (AT)
   1. Ensure that all personnel with access to ePHI receive training on the proper handling of such information and the security controls in place.

1.J. Contingency Planning (CP)
   1. Develop and implement plans for responding to outages or emergencies that may threaten ePHI, such as data backup plans, disaster recovery plans, and emergency mode operation plans.

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16.0 ENCOUNTER DATA

16.1 Encounter Data Submission

In accordance with 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 before implementation, whenever possible. Other edits and processing requirements shall be provided to the Contractor in writing no less than thirty (30) Business Days before 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.

Each Encounter data file submitted to the Department by the Contractor shall adhere to the Department's standards for data timeliness, completeness, and accuracy. Pharmacy encounters for which the Single MCO PBM is responsible will be submitted to the Department by the Single MCO PBM. The Contractor will not be penalized for encounter submissions made by the Single MCO PBM.

Timeliness: The Contractor shall submit encounter data for all Claims within thirty (30) Days of adjudication.

Completeness: The Contractor shall submit Encounters for all services received by Enrollees and for which the Contractor has incurred a claim or any financial liability, whether directly or through subcontracts or other payment arrangements. The Contractor's weekly electronic Encounter data submission shall include all adjudicated (paid and denied) Claims, corrected Claims, and adjusted Claims processed by the Contractor and meet or exceed a submitted and accepted rate of ninety-eight percent (98%), as evaluated quarterly. The completeness penalties in **Appendix A "Remedies for Violation, Breach, or Non-Performance of Contract"** will not be assessed for the first two (2) quarters following the implementation of the Encounter Data Monitoring template used to determine compliance.

Accuracy: The Contractor shall submit Encounter data accurately in the required file formats with all data elements completed. Encounter File transmissions that exceed a five percent (5%) threshold error rate (total Claims/documents in error equal to or exceeding five percent (5%) of Claims/documents records submitted) will be subject to penalties as in **Appendix A** "**Remedies for**

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Violation, Breach, or Non-Performance of 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:

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.A. 837I – Instructional Transactions
1.B. 837P – Professional Transactions
1.C. 837D – Dental Transactions
1.D. 278 – Prior Authorization Transactions
1.E. 835 – Remittance Advice
1.F. 834 – Enrollment/Disenrollment
1.G. 820 – Capitation
1.H. 276/277 Claims Status Transactions
1.I. 270/271 Eligibility Transactions
1.J. 999 – Functional Acknowledgement
1.K. NCPDP 2.2
1.L. 2320 – Coordination of Benefits (COB) Payer Paid Amount

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 the 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 that is not resubmitted within one hundred twenty (120) 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.

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The Contractor shall specify to the Department the name of the primary contact person responsible 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 monthly.

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, at a minimum annually, a 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 ensuring that the Encounter was transmitted to the Department the month after adjudication.

The Department shall require the Contractor to submit a CAP and will require non-compliance penalties in **Appendix A** "**Remedies for Violation, Breach, or Non-Performance of Contract"** for the Contractor's failure to comply with Encounter data timeliness, completeness, and accuracy reporting standards.

The Department will randomly select an adequate sample that 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 shall 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:

2.A. A copy of the Claim, either paper or a generated hard copy for electronic Claims;
2.B. Data from the paid Claim's file;
2.C. Enrollee eligibility/enrollment data;
2.D. Provider eligibility data;
2.E. Reference data (e.g., diagnosis code, procedure rates) pertaining to the Claim;
2.F. Edit and audit procedures for the Claim;
2.G. A copy of the remittance advice statement/explanation of benefits;
2.H. A copy of the Encounter Record transmitted to the Department; and
2.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. Results of the review will be provided to the Contractor. The Contractor will be required to provide a CAP 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.

16.3 Electronic Visit Verification

Section 12006(a) of the 21st Century Cures Act mandates that states implement electronic visit verification (EVV) for all Medicaid personal care services (PCS) and home health services (HHCS) that require an in-home visit by a provider. The Contractor shall send visit information to the Department's EVV aggregator in accordance with the Department's program. The Contractor shall

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provide reporting, as required on the Kentucky Medicaid Managed Care (MMC) Program Package to the Department in accordance with Section 35.0 Reporting Requirements.

17.0 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, engage in their healthcare, drastically improve quality of care and healthcare outcomes, and 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 Contractor to develop focused and achievable approaches. The Contractor shall work to improve outcomes and performance metrics as determined by the Department under the Department's quality strategy and 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, the requirements of this Contract, and the Department's Medicaid Managed Care Quality Strategy. The Contractor shall implement a comprehensive QAPI Program in compliance with 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 Quality and Population Health.

17.1 National Committee for Quality Assurance (NCQA) Accreditation

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

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 as requested.

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

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

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

The Contractor shall obtain NCQA Health Equity Accreditation within two (2) years from January 1, 2025.

The Contractor shall provide its plan and timeline for obtaining this Accreditation to the Department and provide updates if any delays occur. The Contractor shall provide a copy of its accreditation certificate when received and maintain Accreditation throughout this Contract.

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The Contractor shall publish all accreditations on its website.

17.2 Quality Committees and Meetings

1.A. The Contractor shall have an organizational Quality Improvement Committee (QIC) 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 healthcare 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 Division of Quality and Population Health may request the agenda and meeting minutes of the Contractor's QIC.

1.B The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Enrollees, individuals from consumer advocacy groups, or a community who represents 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:

1. Providing review and comment on the following:

    a. Quality and access standards;
    b. Grievance and Appeals process and policy modifications based on review of aggregate Grievance and Appeals data;
    c. Enrollee Handbooks;
    d. Enrollee educational materials prepared by the Contractor; and
    e. Contractor and Department policies that affect Enrollees.

2. Recommending community outreach activities.

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The Department's Division of Quality and Population Health may request notice of all regularly scheduled meetings of the QMAC with an agenda and related meeting materials, as available. The Contractor shall submit meeting minutes to the Department if requested.

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

1.C. The Contractor shall participate in quality meetings with the Department, its designees, 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 the achievement of Department goals to improve outcomes. The Contractor shall be prepared to discuss opportunities and challenges in addressing quality, outcomes, and population health.

17.3 Quality Assurance and Performance Improvement (QAPI) Program

The Contractor shall implement and operate a comprehensive QAPI Program in compliance with 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), shall be incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding the 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 the 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:

1.A. Requirements in the Department's Quality Strategy and 42 C.F.R. 438.330, including:

1. Conducting and assessing PIPs further described in **Section 17.6 "Performance Improvement Projects"**;
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 healthcare needs, as defined by the State.

1.B. A QIC to provide oversight of QAPI functions;

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1.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;

1.D. Methods for addressing Department-mandated performance measures;

1.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;

1.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;

1.G. Methods to identify and act upon SDoH and health equity.

1.H. Use of a health information system to support collection, integration, tracking, analysis and reporting of data analytics specific to healthcare outcomes and performance metrics, including stratification of findings (e.g., by Region, provider type, Enrollee populations); and

1.I. 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 following information, at a minimum. The Department reserves the right to designate the required format and design for the QAPI Program Plan.

2.A. Detailed QAPI program description that addresses goals and objectives, all program elements, and scope of activities;

2.B. Discussion of innovative approaches the Contractor will implement to support the Department in achieving improved outcomes;

2.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;

2.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;

2.E. Workplan that provides the scope of activities and timelines, including reporting cycles and annual evaluation;

2.F. Clearly defined approaches to Quality Improvement efforts, including PIPs, that the Contractor will implement; and

2.G. A process to continually evaluate the impact and effectiveness of the QAPI program, and an approach to address deficiencies of the program that are identified through evaluation or other forums.

The Contractor shall establish new goals and objectives at least annually based on findings from Quality Improvement activities and studies, survey results, Grievances and Appeals, performance

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measures, and EQRO findings, among other information as identified by the Department or Contractor.

17.4 Kentucky Healthcare Outcomes

The Contractor's Quality Management and performance improvement approach shall incorporate rigorous outcomes measurement against relevant targets and benchmarks and the Medicaid Managed Care Quality Strategy. All health goals, outcomes, and indicators shall comply with 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 outcome measures that the Contractor shall address, including Healthcare Effectiveness Data and Information Set (HEDIS™) measures and Kentucky-specific measures. The Department may modify performance measures, benchmarks, and/or specifications throughout 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 requirement.

1.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.

1.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 the Contractor. The Contractor shall incorporate consideration of SDoH into the process for analyzing data to support population health management. Reported information may be used to determine disparities in healthcare. The Contractor shall submit a plan to the Department for initiatives and activities the Contractor will implement to address identified disparities.

1.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.

1.D. Where achievement is not showing progress towards meeting performance measure targets, as determined by the Department, 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 CAP 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) Days of receipt of notification of required corrective action.
3. Implementation of penalties, as deemed appropriate by the Department, due to the Contractor's failure to make improvements. See **Appendix A "Remedies for Violation, Breach, or Non-Performance of Contract"** for information about penalties.

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17.5 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 may select a subset of targeted performance measures 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 Contractor's submitted Encounter data. The Contractor shall have sixty (60) Days to review and respond to findings reported as a result of these activities.

17.6 Performance Improvement Projects (PIPs)

The purpose of healthcare quality 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 that focus on both clinical and non-clinical areas. PIPs focused on clinical areas, as designated by the Department, may address preventive and chronic healthcare needs of the whole Enrollee population and subpopulations, including, but not limited to Medicaid eligibility category, type of disability or special healthcare 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:

1.A. The Contractor shall design and implement PIPs that are focused on areas of concern to conduct on an ongoing basis.

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1.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 Contractor 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 the 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; and
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.

1.C. As required by the Department, the Contractor shall implement an additional PIP if findings from an EQR review or audit indicate a need or if directed by CMS. The Contractor shall assist the Department by supplying readily available data, soliciting input, and supporting clinicians.

1.D. Implement PIPs as identified and requested by CMS.

The Contractor's PIPs shall include the following elements:

2.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 the commencement of each PIP. In determining indicators and measures, the Department and Contractor shall confirm that they are not misaligned with those being used in other projects and that they are measurable and can be tracked. The Department shall have the final decision and approval of the required indicators and data definitions of each;

2.B. Implementation of interventions to achieve improvement in the access to and quality of care;

2.C. Evaluation of the effectiveness of the interventions based on the performance measures; and

2.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 the 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 healthcare delivery systems to achieve improvements in priority areas. Linkages with local public health agencies is essential for the 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 the quality of care each year. Each PIP will use a study period approved by the Department.

The Contractor shall continuously monitor its performance on a variety of dimensions of care and

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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.

17.7 Department for Public Health Initiatives

The Contractor is encouraged to work with DPH to support efforts to improve public health outcomes and to support DPH'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 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, the Tobacco Prevention and Cessation Program, and the DPH Quitline program.

17.8 Quality Management and Performance Improvement Monitoring and Evaluation

The Contractor, through the QAPI program, shall monitor and evaluate progress in improving the quality of healthcare 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. Healthcare needs such as preventive care, acute or chronic physical or behavioral conditions, SDoH, and high volume, high risk, and special healthcare 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 maximize outcomes.

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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, behavioral healthcare, and health equity, provided to Enrollees. The Contractor shall submit this report as specified by the Department. The Department shall give the Contractor advance notice of the annual QAPI report due date. The Department may require interim reports more frequently than annually to demonstrate Contractor progress.

17.9 Value-Based Payment Program

The Contractor shall collaborate with the Department and other MCOs to implement and execute a Value-Based Payment (VBP) model that aligns incentives for Enrollees, Providers, 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.

In support of these goals, the Department has established a VBP Program supported by payment incentives that the Contractor may earn if certain conditions are met. The compensation under the VBP Program is subject to the Contractor's achievement of performance measures and related targets in alignment with Kentucky's Medicaid Managed Care Quality Strategy to support improved healthcare outcomes and financial savings.

The VBP Program is designed as a two percent (2%) withhold from the Contractor's capitation amount that can be earned back in full or in part by the Contractor through the achievement of the designated performance measures. The program is designed with a set of Core Measure incentives that all Contractors are eligible to earn, as well as Bonus Pool incentives available to earn by those Contractors who attain the required performance on the Core Measures. Each measure is assigned a weight to earn a percentage of the total Core Measure withhold or Bonus Pool, respectively.

Contractors that maintain performance on all Core Measures in a measurement year compared to the baseline measurement period for that year and meet five (5) out of six (6) Core Measures, will be eligible to participate in the Bonus Pool for the current measurement year. To maintain performance, a Contractor must not demonstrate a decline in a VBP core measure from year to year. A one percent (1%) threshold will be applied to account for normal variation. For some measures, an increase in the measure score may represent a decline in performance. In such cases, the term "decline" refers to any change in the score that indicates worse performance, whether the score increases or decreases. The Bonus Pool is funded with the unearned Core Measure withhold dollars from all Contractors that were not earned through performance on Core Measures, meaning that an MCO potentially may earn withhold dollars originally available but unearned by a different MCO, if it qualifies for Bonus Pool participation.
The total Bonus Pool shall be allocated across the Bonus Measures based on measure weight. The total dollar amounts available for each measure (the "Bonus Measure Pool") is calculated by

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multiplying the total Bonus Pool by the Bonus Measure's assigned weight. For each Bonus Measure, the applicable Bonus Measure Pool will be divided equally among all Contractors qualified to participate in the Bonus Pool for the current measurement year. The resulting amount represents the maximum payment available to each eligible Contractor for that Bonus Measure. A Contractor that meets or exceeds the performance target for a given Bonus Measure shall earn its full share of the Bonus Measure Pool for that Bonus Measure. If a Contractor does not meet the performance target, that Contractor will not earn payment for that Bonus Measure and those unearned funds shall revert to the Department and shall not be redistributed to other Contractors.

The performance targets for both the Core Measures and the Bonus Pool Measures are set as pass or fail. No withhold is earned for a measure if the Contractor fails to achieve the required improvement for that measure. Performance on each Core Measure and Bonus Pool Measure will be evaluated based upon the Contractor's performance as reported through the External Quality Review (EQR) process. The Contractor will have no appeal rights or ability to submit additional performance documentation outside of this process.

The specific measures, weights, and targets for the VBP Program are detailed in **Appendix N "Value-Based Payment Measures."** Withhold payments will be calculated as in **Appendix N "Value-Based Payment Measures."**

The Department reserves the right to modify the VBP Program, its performance measures, weights, or targets, at its sole discretion and in consultation with the Contractor, on a year-to-year basis during the Contract Term as program priorities shift and as necessary to support continuous quality improvement. For any performance measures selected, the Department shall consult with the Contractor regarding the methodology for qualifying the Contractor's success in achieving targets and related incentives. If a performance measure is retired during the performance period, the Department, at its sole discretion and in consultation with the Contractor, may replace the performance measure for that performance period. The performance measures, weights, and targets will be established annually by the Department and reflected in an amendment to the Contract. Should the Department remove or replace a performance measure, the Department shall notify the Contractor in writing of such a change at least sixty (60) Days prior to the start of the measurement year.

In accordance with 42 C.F.R. 438.6(b)(2)(i)-(v) and 42 C.F.R. 438.6(b)(3)(i)-(v), withhold and incentive arrangements are for a fixed period and are measured during the rating period under the Contract in which the arrangements are applied. Withhold and incentive arrangements are not renewed automatically, are available to both public and private contractors under the same terms of performance, and do not condition Contractor participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements. All withhold and incentive arrangements are necessary for the specified activities, targets, performance measures, or quality based outcomes that support program initiatives as specified in the State's quality strategy in accordance with 42 C.F.R. 438.340.

The Department will assess Contractor performance under the VBP Program as identified in the EQR reporting (as documented in **Section 19.2 "External Quality Review"**) within ninety (90) Days after it becomes available and will make best efforts to calculate and distribute payments for the VBP program within the quarter that the EQR reporting is made available. For example, if EQR results for the measurement year 2026 are made available in October 2027, the Department will strive to make earnings for VBP before the end of December 2027. Delays in EQR reporting may impact the timing of VBP payments.

The Contractor shall develop and implement initiatives 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 Contractor may also implement its own strategies and incentives to encourage Enrollees'

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participation in addressing their own health needs, which may in turn support the achievement of identified performance measures. Enrollee incentives must be approved by the Department prior to use.

When the VBP model is implemented, the Contractor shall develop and implement initiatives to achieve the required targets and shall track progress and outcomes on a monthly and quarterly basis. The Contractor shall submit reports to the Department annually based on agreed upon reporting requirements. The Contractor shall highlight the 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 any need for modification of priorities, measures, and targets.

17.10 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' perspectives 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.

17.11 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.

18.0 UTILIZATION MANAGEMENT

The Contractor shall establish processes that are designed to maintain the quality of services, control costs, and be consistent with its responsibilities to Enrollees. The Contractor shall develop methods and procedures to safeguard against unnecessary utilization of care and services. Appropriate limits may be placed on a service based on criteria applied under the Medicaid State Plan, and applicable regulations (e.g., Medical Necessity) and for utilization control provided the services furnished can reasonably be expected to achieve their purpose. Services supporting individuals with ongoing chronic conditions, or identified SDoHs, 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. Family Planning Services are provided in a manner that protects and enables the Enrollee's freedom

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to choose the method of family planning.

18.1 Utilization Management Program

The Contractor shall implement a Utilization Management (UM) Program that meets the requirements in this section and that is documented in a Utilization review 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, and 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. The Contractor's Medical Director and Behavioral Health Director shall supervise the UM Program and shall be accessible and available for consultation as needed. The Contractor shall be registered with DOI to perform utilization review services in accordance with KRS 304.17A-607.

The Contractor shall implement innovative and effective UM 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 considers the individual Enrollee's circumstances when determining the Medical Necessity of healthcare 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 the Contractor delegates UM activities. The UM Program and Review Plan shall comply with KRS 304.17A-600 and KRS 304.17A-607 and include the following information, at a minimum:

1.A. Scope of the program;
1.B. The processes and information sources used to determine service coverage;
1.C. A list of which services require PCP Referral; which services require Prior Authorization, and how requests for initial and continuing services are processed;
1.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;
1.E. Policies and procedures to evaluate discharge criteria, site of services, levels of care, triage decisions, and cultural competence of care delivery;
1.F. Written policies and procedures for monitoring to ensure clinically appropriate overall continuity of care;
1.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.
1.H. Written policies and procedures that explain how Prior Authorization data shall be incorporated into the Contractor's overall Quality Improvement Plan;
1.I. Education plan for UM Program staff in the application of related policies and use of designated criteria in making UM decisions;
1.J. Written policies and procedures for complying with the Mental Health Parity and Addiction Equity Act (MHPAEA);
1.K. Mechanisms to identify or detect under-utilization and over-utilization of services; and
1.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.

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

Network Providers may participate in UM activities if there is no 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. 438.6(h) and 42 C.F.R. 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 annually (no later than June 30 each year) and at any time when making material revisions.

The Contractor shall evaluate the UM Program annually, including an assessment of its effectiveness in improving clinical and service outcomes. The evaluation shall include an 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.

18.2 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 and report findings to the Quality Improvement Committee. The UM Committee shall review, at a minimum:

1.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.
1.B. Grievances and Appeals (including expedited Appeals and State Fair Hearings) related to UM activities to determine any needed policy changes.

18.3 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 the consensus of health professionals; consider the needs of Enrollees; developed or adopted in consultation with contracting health professionals, and reviewed and updated periodically.

18.4 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

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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:

1.A. For adults: Level of Care Utilization System (LOCUS)
1.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 documentation requirements as required by the Department, DOI, CMS, or other relevant regulatory agencies. Criteria shall be readily available for review by the Department or the public by request and be available on the Contractor's website.

The Contractor and Subcontractors responsible for service authorization decisions shall have 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 mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other healthcare provider as appropriate.

The Contractor shall have a review body that includes representation by Kentucky licensed healthcare professionals who review internally developed 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 submit changes to previously approved criteria to the Department's Medical Director for review and approval to ensure compliance with the requirements of this Contract. Changes shall be submitted in a "track changes" or other revision format so that they are easily identifiable for review. The Contractor shall submit a final version after Department approval.

The Contractor shall notify the Provider at least thirty (30) Days prior to the implementation of changes in the Medical Necessity criteria.

18.5 Service Authorization

The Contractor may place limits on a service in accordance with federal regulations and requirements of this Contract as in this section and **Section 28.1 "Medicaid Covered Services."** Such limitations and authorization requirements shall be included in the UM Program description as in **Section 18.0 "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.

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In accordance with KRS 205.5591, the Contractor shall not require the following:

1.A. Require Prior Authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;
1.B. Demonstration that it is necessary to provide services to an Enrollee through telehealth; and
1.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 the 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).

18.6 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 based on 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 conducting Medical Necessity and service authorization reviews:

1.A. Complete the review process for a standard Prior Authorization request as expeditiously as the Enrollee's condition requires and no later than five (5) Days after receiving the necessary information for the request. Necessary information is limited to the information defined in KRS 304.17A-607. The timeframe for a standard authorization request may be extended up to fourteen (14) Days if the Provider or Enrollee requests an extension;
1.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 after obtaining all necessary information, . The Contractor shall provide notice as expeditiously as the Enrollee's health condition requires. Necessary information is defined in KRS 304-17A-607;
1.C. A request for authorization or preauthorization for treatment of an Enrollee's substance use disorder shall be considered an Expedited Authorization Request by the provider and the Contractor;
1.D. Complete post-service (retrospective) review requests within five (5) Days or within fourteen (14) Days if the Enrollee or the Provider requests an extension;
1.E. In accordance with KRS 304.17A-607(1)(h) and (j), provide written confirmation to the Enrollee, Authorized Representative, and/or Provider of the Contractor's decision within three (3) Business Days. The written confirmation shall be provided in accordance with Enrollee Rights and Responsibilities. The written notice may be provided electronically, including e-mail or facsimile, if the Enrollee, Authorized Representative, or Provider has agreed in advance in writing to receive the notices electronically.

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

The Contractor shall provide the Enrollee with 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:

1.A. The Adverse Benefit Determination the Contractor has made or intends to make;
1.B. The reason(s) for the Adverse Benefit Determination in clear, non-technical language that is understandable by a layperson;
1.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;
1.D. The federal or state regulation supporting the action, if applicable;
1.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;
1.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);
1.G. Procedures for exercising Enrollee's rights to Appeal or file a Grievance;
1.H. Circumstances under which the Appeal process can be expedited and how to request it;
1.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;
1.J. The Enrollee's right to request a State Fair Hearing after receiving notice that the Adverse Benefit Determination has been upheld.

Notices to Enrollees shall:

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

The Contractor shall give notice as follows at a minimum:

3.A. Within the timeframes outlined in **Section 18.6 "Service Review and Authorization Timeframes"** for Prior Authorization decisions.
3.B. 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 five (5) Days if Enrollee Fraud or Abuse has been determined.
3.C. 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 has been on 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

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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 the Enrollee has not resided in a nursing facility for thirty (30) Days.

3.D. On the date of the Adverse Benefit Determination, when the Adverse Benefit Determination is a Denial of payment.

3.E. 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; 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.

3.F. 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.

3.G. 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 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) 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.

18.8 Court-Ordered Evaluations and Services

If 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 E "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.

19.0 MONITORING AND OVERSIGHT

19.1 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.A. Tracking, 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;

1.B. Reviewing management systems and procedures;

1.C. 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;

1.D. Reviewing Contractor reports for progress, successes, trends, and challenges or problems;

1.E. Conducting random inspections of Contractor and Subcontractor facilities; and

1.F. Providing feedback to the Contractor about findings, and requiring corrective actions, as

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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 CAPs, provide reports on the timeline required by the Department, and any other activities 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 to fulfil the Contractor's obligation under this Contract.

The Contractor shall report healthcare-acquired conditions, as defined by 907 KAR 14:005. The Contractor shall comply with 42 C.F.R. 447.26.

19.2 External Quality Review

Section 1932(c)(2) of Title XIX of the Social Security Act requires the Commonwealth to acquire an independent external review body to perform 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 described in 42 C.F.R. 438, Subpart E. The results of EQR are made available, upon request, to specified groups and 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.

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.

19.3 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 the 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.

19.4 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 promptly in accordance with guidelines established by the Department and EQRO. The Contractor shall:

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1.A. Assign a staff person(s) to conduct follow-up concerning review findings;
1.B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation, and monitoring of the CAP;
1.C. Submit a CAP in writing to the Department within ten (10) Business Days that addresses the measures the Contractor intends to take to resolve the finding. See **Section 37.3 "Requirement of Corrective Action."** The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification;
1.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
1.E. If the Contractor disagrees with the EQRO's findings, submit its position to the Commissioner of the Department whose decision is final.

20.0 ENROLLEE SERVICES

20.1 Required Functions

The Contractor shall have an Enrollee Services function that includes a call center staffed and available by telephone Monday through Friday from 7:00 am to 7:00 pm Eastern Time (ET). The call center shall meet the following standards as measured by monthly averages for the Enrollee Services call center:

1.A. Abandonment Rate Less than or equal to five percent (5%);
1.B. Average Speed to Answer less than or equal to thirty (30) seconds;
1.C. Ninety percent (90%) or higher accurate responses to call center phone inquiries by call center representatives; and
1.D. One hundred (100) percent of call center open inquiries are resolved within seventy-two (72) hours.

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 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's performance in 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 the 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 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,

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sanitation, and fire and safety procedures applicable to healthcare facilities. The Contractor shall cooperate with the 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:

2.A. Ensuring that Enrollees are informed of their rights and responsibilities;
2.B. Ensuring each Enrollee is free to exercise his or her rights without the Contractor or its Providers treating the Enrollee adversely;
2.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;
2.D. Collecting updated demographic information for Enrollees, including but not limited to address and phone numbers;
2.E. Monitoring the selection and assignment process of PCPs;
2.F. Identifying, investigating, and resolving Enrollee Grievances about healthcare services;
2.G. Assisting Enrollees with filing formal Appeals regarding plan determinations;
2.H. Providing each Enrollee with an identification card that identifies the Enrollee as a participant with the Contractor, unless otherwise approved by the Department;
2.I. Explaining rights and responsibilities to Enrollees or to those who are unclear about their rights or responsibilities, including reporting suspected Fraud and Abuse;
2.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;
2.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);
2.L. Explaining or answering any questions regarding the Enrollee Handbook;
2.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 in making 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;
2.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.
2.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;
2.P. Providing Enrollees with education and information about or referring to support services offered outside the Contractor's Network such as WIC, SNAP and child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;
2.Q. Facilitating direct access to primary care vision services; primary dental and oral surgery services; 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

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screening, evaluation, and treatment; and testing for HIV, HIV-related conditions, and other communicable diseases; all as further described in **Appendix E "Covered Services;"**

2.R. Facilitating access to Behavioral Health Services and pharmaceutical services;

2.S. Facilitating access to the services of public health departments, CMHCs, RHCs, FQHCs, the OCSHCN, and charitable care providers, such as Shriners Hospital for Children;

2.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;

2.U. Assisting Enrollees in obtaining transportation for both emergency and appropriate non-emergency situations;

2.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;

2.W. Facilitating access to Enrollee Health Education Programs;

2.X. Assisting Enrollees in completing the Health Risk Assessment (HRA) as outlined in **Appendix E "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 PHM Program; and

2.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 via the Regulatory Report Package.

20.2 Enrollee Website

The Contractor shall develop and maintain a user-friendly website for Enrollees and the general public to access current and accurate information about the Kentucky Medicaid Managed Care program and the Contractor's services. Contractor developed materials, including the Enrollee handbook and provider directory, shall be searchable and include the most current revision date.

The Contractor shall provide materials on its website as specified throughout this Contract, including the following:

1.A Enrollee rights and responsibilities;

1.B Information about Covered Services and how to access those services;

1.C Contact information for Enrollee services;

1.D The three-digit 988 mental health crisis and suicide prevention number for call, text, and chat for use by individuals who are experiencing suicidal ideation, mental health and substance use crises, or any type of emotional distress;

1.E A community resource library that provides resource and health educational information in compliance with federal regulations; and

1.F Information about the grievance and appeals process.

No later than January 1, 2027, the Contractor shall provide through its website access to a secure Enrollee portal that is interactive, accessible on mobile devices and has the capability for bi-directional communications (i.e., Enrollees can submit questions and comments to the Contractor and receive responses). The Contractor shall provide a portal that allows Enrollees to log in and access information including, but not limited to:

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2.A Option to complete the health screening questionnaire.

2.B Prior authorization status;

2.C Temporary ID cards;

2.D Confirmation of PCP assignment; and

2.E Cost-sharing information.

The Contractor's website shall comply with:

3.A Section 508 of the Rehabilitation Act. The Contractor shall inform Enrollees that information is available upon request in alternative formats.

3.B HIPAA and Commonwealth of Kentucky privacy and security requirements. The Contractor shall comply with applicable privacy and security requirements when providing Enrollee eligibility or Enrollee identification information on its website.

3.C **Section 20.8 "Enrollee Information Materials" Section 20.9 "Information Materials Requirements," Section 23.2 "Marketing Rules,"** and 42 C.F.R. 438.104 information.

All materials published on the website shall be approved by the Department per **Section 4.4 "Approval of Department."**

20.3 Enrollee Handbook

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

Except for a new Enrollee assigned to the Contractor, the Contractor complies with this requirement if the Enrollee's handbook is:

1.A Mailed within five (5) Business Days by a method that will not take more than three (3) Days to reach the Enrollee;
1.B Provided by email after obtaining the Enrollee's agreement to receive the information by email;
1.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 Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
1.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 hardcopy and online. The electronic format shall be readily accessible, placed in a prominent and easily accessible location on the website, and can be electronically retained and printed. The information shall be available in paper form without charge upon request within five (5) Business Days.

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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 C.F.R. 438.10 and 42 C.F.R. 438.62(b)(3).

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

2.A Information as required by the Department in the model Enrollee Handbook;
2.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. Alternatively, the Contractor may provide the listing on its website with appropriate assurances that the Enrollee is informed of the online location and that Enrollees may continue to request hard copy versions without charge;
2.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);
2.D Any restrictions on an Enrollee's freedom of choice among Network Providers;
2.E Language approved by the Department as provided by the Single MCO PBM about the pharmacy benefit, including how to access a list of Pharmacy Network Providers. The Contractor is not required to request additional Department approval for such language that the Department approved prior to provision to the Contractor.
2.F 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;
2.G 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 HHS, Office for Civil Rights, alternative formats, and other auxiliary aids and services as well as how to access those services;
2.H The name of the Contractor 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;
2.I 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;
2.J Enrollee rights and responsibilities, including reporting suspected Fraud and Abuse and the elements in 42 C.F.R. 438.100;
2.K 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;
2.L Procedures for obtaining transportation for both emergency and non-emergency situations;
2.M Information on the availability of maternity, family planning, and sexually transmitted disease services and methods of accessing those services;
2.N Procedures for arranging EPSDT for persons under the age of twenty-one (21) years;
2.O Procedures for obtaining access to Long Term Care Services;
2.P Procedures for notifying DCBS of family size changes, births, address changes, or death notifications;
2.Q A list of direct access services that may be accessed without PCP authorization;
2.R Information about how to access care before a PCP is assigned or chosen;
2.S 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;
2.T Procedures for obtaining Covered Services from non-Network Providers;
2.U 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 the MCO's decision is to reduce or terminate services;
2.V Information about the independent ombudsman program for Enrollees;

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2.W Information on the availability of and procedures for obtaining behavioral health/substance abuse health services;
2.X Information on the availability of health education services;
2.Y Any cost sharing imposed;
2.Z How to exercise an advance directive;
2.AA Information deemed mandatory by the Department; and
2.BB The availability of 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 necessary updates 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 at 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 prior to printing or distribution. The Department has the authority to review the Contractor's Enrollee Handbook at any time.

20.4 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 education and outreach program shall also include information about support services offered outside the Contractor's Network such as WIC, SNAP and child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health, and substance abuse, including information about the availability of specific programs and how to access them. 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, including but not limited to collaborations with schools, unhoused centers, youth service centers, family resource centers, public health departments, school-based health clinics, chambers 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, how the activities will be documented, and how they will be evaluated for effectiveness and need for change.

20.5 Cultural Consideration and Competency

The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent, equitable manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities regardless of gender, sexual orientation, or gender identity. The Contractor shall address the special healthcare 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 that respect

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Enrollee's cultural background. The Contractor shall communicate such policies to Subcontractors and include requirements in Subcontracts to ensure Subcontractor implementation of such policies.

20. 6 Outreach to Reentry Justice Involved Youth

As directed by the Department, the Contractor shall outreach to correctional facilities to engage and assess the needs of Enrollees who are enrolled in the reentry program and develop a person-centered care plan. The plan shall include:

1.A. Utilizing community-based case management service providers who have expertise working with justice-involved individuals; and
1.B. Virtual and face to face encounters.

20.7 Outreach to Unhoused Persons

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

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

The Contractor shall not differentiate services for Enrollees who are unhoused. Victims of domestic violence and Former Foster Care Youth should be targeted for outreach, as they are frequently unhoused. Assistance with transportation to access healthcare may be provided via bus tokens, taxi vouchers, or other arrangements when applicable.

20.8 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:

1.A. Be written at a sixth (6^{th}) grade reading level determined by Flesch-Kincaid and use easily understood language and format;
1.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;
1.C. Comply with the Americans with Disabilities Act of 1990;
1.D. Be available through auxiliary aids and services, upon request of the Enrollee at no cost;
1.E. Be available in alternative formats, upon request of the Enrollee at no cost;
1.F. Be available in English, Spanish, and each Prevalent Non-English Language;
1.G. Be provided through oral interpretation services for any language; and
1.H. Include taglines in the top fifteen (15) non-English languages as released by the HHS Office for 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.

The Contractor shall provide electronic Enrollee information on its website that is prominent and readily accessible and in a format that can be electronically retained and printed.

The Contractor may only provide information to Enrollees via electronic methods (emails) as set

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forth in 42 C.F.R. 438.10(c)(6).

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

20.9 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 notice of the Enrollee's Enrollment from the Department. Any change in the information listed herein shall be communicated at least thirty (30) Days before the intended effective date of the change.

1.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;
1.B. Any restrictions on the Enrollee's freedom of choice among network Providers;
1.C. Any changes in Covered Services by the Contractor due to moral or religious objections and how to obtain the service;
1.D. Enrollee rights and protections, as in 42 C.F.R. §438.100;
1.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;
1.F. Information on a State Fair Hearing including the right to a hearing; method for obtaining a hearing; and rules that govern representation at the hearing;
1.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;
1.H. Procedures for obtaining benefits, including authorization requirements;
1.I. The extent to which, and how, Enrollees may obtain benefits, including Family Planning Services, from Out-of-Network Providers;
1.J. The extent to which, and how, after-hours and emergency coverage are provided, including:
    1. What constitutes an 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, providers, and hospitals that 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.
1.K. The post-stabilization care services rules set forth at 42 C.F.R. § 422.113(c);
1.L. The Contractor's policy on referrals for Specialty Care and for other benefits not furnished by the Enrollee's PCP;
1.M. Cost sharing, if any;
1.N. How and where to access any benefits that are available under the State Plan but not covered under the Contract;
1.O. Any Appeal rights made available to Providers to challenge the failure of the Contractor to cover a service;

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1.P. Advance directives, as in 42 C.F.R. § 438.6(i)(2);
1.Q. Upon request, information on the structure and operation of the Contractor and physician incentive plans; and
1.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.

20.10 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 42 C.F.R. 438.10. Advance Medical Directives, including living wills or durable powers of attorney for healthcare, allow adult Enrollees to initiate directions about their future medical care in those circumstances where Enrollees are unable to make their own healthcare 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.

20.11 Enrollee Rights and Responsibilities

The Contractor shall have written policies and procedures that comply with Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 80; the Age Discrimination Act of 1975 as implemented by 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 are 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:

1.A. Respect, dignity, privacy, confidentiality, accessibility, and nondiscrimination;
1.B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;
1.C. Consent for or refusal of treatment and active participation in decision choices;
1.D. Ask questions and receive complete information relating to the Enrollee's medical condition and treatment options, including Specialty Care;
1.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;
1.F. Timely access to care that does not have any communication or physical access barriers;
1.G. Prepare Advance Medical Directives pursuant to KRS 311.621 -KRS 311.643;
1.H. Assistance with Medical Records in accordance with applicable federal and state laws;
1.I. Timely referral and access to medically indicated Specialty Care;
1.J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
1.K. Receive information in accordance with 42 C.F.R. 438.10;
1.L. Be furnished healthcare services in accordance with 42 C.F.R. Part 438; and
1.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.

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

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

20.12 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.

20.13 Identification Cards

The Contractor shall issue an identification card for every Enrollee assigned to it. The Identification card will include the Enrollee's Identification Number. The card shall also include information for contacting the Single MCO PBM.

21.0 ENROLLEE SELECTION OF PRIMARY CARE PROVIDER (PCP)

21.1 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).

21.2 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:

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

21.3 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 the 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

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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) PCPs in the Contractor's Network.

The Contractor shall assign the Enrollee to a PCP:

1.A. Who has historically provided services to the Enrollee, meets the PCP criteria, and participates in the Contractor's Network;
1.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 in **Section 26.4 "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 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 of Enrollees who have selected or been assigned to his/her care on the first day of each month.

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.

21.4 Enrollees who are Non-Dual Eligibles with SSI

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 PCP 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:

1.A. Within five (5) Business Days of an Enrollee's enrollment with the MCO, the Contractor shall send the Enrollee a letter explaining the PCP selection process and requesting the Enrollee to select a PCP. This letter may be included in the Enrollee Welcome Kit.
1.B. If the Enrollee does not select a PCP within fifteen (15) Business Days of enrollment with the MCO, the Contractor's Enrollee Services Department shall contact the Enrollee to provide additional information about options to select a PCP and encourage a voluntary selection. The Enrollee Services Department shall make at least three (3) attempts to contact the Enrollee.

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1.C. After the above attempts, if the Enrollee does not select a PCP within twenty (21) Business Days, the Contractor shall select a PCP for the Enrollee and send a letter 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.

21.5 Selection Procedures for Guardianship

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.

21.6 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 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 24.13** "**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 healthcare 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

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the Enrollee's special healthcare 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 disability, race, color, religion, national origin, handicap, age, gender, gender identity, or sexual orientation. The Contractor shall have the 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.

22.0 ENROLLEE GRIEVANCES AND APPEALS

22.1 General Requirements

The Contractor shall have an organized grievance system that shall include a grievance process, an Appeals process, and access for Enrollee State Fair Hearings 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.

22.2 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 and state law 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:

1.A. Provide the Enrollee the opportunity to present evidence, testimony, and allegations of fact or law, in person, orally, 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);

1.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);

1.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;

1.D. Consider the Enrollee, the Enrollee's representative, or the legal representative of the Enrollee's estate as parties to the Appeal;

1.E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access, and utilization;

1.F. Procedures for maintenance of records of grievances separate from medical case records and in a manner that protects the confidentiality of Enrollees who file a Grievance or Appeal;

1.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

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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;

1.H. Ensure individuals and subordinates of individuals who make decisions on grievances and Appeals were not involved in any prior level of review;

1.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 healthcare professionals who have appropriate clinical expertise;

1.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 and on its website, 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;

1.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;

1.L. Include assurance that there will be no discrimination against an Enrollee solely based on the Enrollee filing a grievance or Appeal;

1.M. Include notification to Enrollees in the Enrollee Handbook regarding how to access the Ombudsmen's Office regarding Grievances, Appeals, and hearings;

1.N. Provide oral or written notice of the resolution of the Grievance in a manner to ensure ease of understanding;

1.O. Provide for an Appeal of a Grievance decision if the Enrollee is not satisfied with that decision;

1.P. Provide for continuation of services, in accordance with 42 C.F.R. 438.420, while the Appeal is pending;

1.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;

1.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 that the Contractor confirms the inquiry in writing;

1.S. Not require an Enrollee or an Enrollee's representative to follow an oral request for an expedited Appeal with a written request;

1.T. Inform the Enrollee of the limited time to present evidence and allegations of fact or law in the case of an expedited Appeal;

1.U. Acknowledge receipt of each grievance and Appeal;

1.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. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice;

1.W. Provide for the right to request a hearing under KRS Chapter 13B;

1.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

1.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, 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:

2.A. The Enrollee withdraws the Appeal or request for a State Fair Hearing;

2.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

2.C. A State Fair Hearing decision adverse to the Enrollee is made.

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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, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

The Contractor shall have procedures for ensuring 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.

22.3 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. 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 regarding 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 final 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 if 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.

23.0 MARKETING

23.1 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

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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 Contactor 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 that relate 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 Subcontractor materials as over Contractor materials. The Contractor shall correct problems and errors identified by the Department. Any approval required by **Section 23.1** "**Marketing Activities"** shall be subject to **Section 4.4** "**Approval of Department**" except as outlined below.

The Department designates certain marketing materials as File and Use ("F&U") eligible. F&U eligible marketing materials are low-risk to Enrollees and Providers based on the marketing material's content, audience, and intended use. F&U eligible documents are listed below:

1.A. Materials prepared by community partners or organizations concerning events, classes, or other helpful resources for Enrollees that include the Contractor's logo.
1.B. Information shared on social media concerning events, classes, or other helpful resources for Enrollees, including those that include the Contractor's logo.
1.C. Social media marketing material generated by and shared from trustworthy sources. Official accounts of the Centers for Disease Control and Prevention, CHFS, and the White House are examples of trustworthy sources.
1.D. Cover Letters to Enrollees that accompany General Health Education Materials.
1.E. Previously approved Enrollee or Provider letters or forms, where the only change is the addition of co-branding.
1.F. Emergency notifications to members or providers, when delaying such notification could negatively impact the members or providers (i.e., notifications regarding access to care, business continuity events, system outages).

With the submission of these select F&U documents to the Department, the Contractor certifies that the marketing material complies with all applicable Contract standards as well as any superseding federal or state law. The Contractor is subject to penalty for marketing material use where the Department determines that the marketing material fails to comply with applicable Contract Standards, federal law, or state law.

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.

23.2 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:

1.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

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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 37.4 "Penalties for Failure to Correct;"**

1.B. No fraudulent, misleading, or misrepresentative information shall be used in the Marketing materials;
1.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;
1.D. No offers of material or financial gain shall be made to any person to solicit, refer, or otherwise facilitate the Enrollment of any Enrollee;
1.E. No direct or indirect door-to-door, telephone, email, texting, or other cold-call Marketing activities;
1.F. All Marketing materials comply with the information requirements of 42 C.F.R. 438.10; and
1.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:

2.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;
2.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 fifteen (15) dollars per individual gift or incentive; and (3) do not exceed seventy-five (75) dollars in the aggregate per individual on an annual basis; (4) have been pre-approved by the Department;
2.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 easily converted to cash; and (3) have been pre-approved by the Department;
2.D. Seek to influence a potential Enrollee's Enrollment with the Contractor in conjunction with the sale or offering of any private insurance;
2.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
2.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.

This list provides examples of inappropriate Marketing activities and does not preclude the Department from deeming any activities not specifically listed here as inappropriate. These examples do not preclude the Contractor from offering Value Added Benefits to their Enrollees. Value Added Benefits are encouraged by the Department but must be approved by the Department prior to use.

24.0 ENROLLEE ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

24.1 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.

24.2 Assignments of New Enrollees and 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 effective January

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1, 2021, except for Enrollees who are required to be enrolled in the SKY program. If an MCO currently contracting with the Managed Care Program does not continue with the Managed Care Program, its membership shall be reassigned as indicated below:

1.A. Any new MCO will be assigned 100,000 Enrollees or an even distribution of membership eligible to be reassigned (whichever is less);
1.B. After assigning 100,000 Enrollees to each new MCO, the remaining Enrollees will be assigned to all contracted MCOs using the Department's defined auto assignment process;
1.C. MCOs above the maximum threshold of thirty-five percent (35%) of total MCO membership, by Medicaid region, do not receive Enrollees through the Department's auto assignment process;
1.D. There will be an Open Enrollment period before or after membership reassignment has occurred allowing freedom of choice to the Enrollee;
1.E. All state and federal statutes and regulations will apply.

Due consideration shall be given to the following when making auto assignments for Enrollees who do not select an MCO when enrolling:

2.A. Keeping the family together - Assign Enrollees of a family to the same MCO;
2.B. Continuity of Care - Preserve the family's pre-established relationship with providers to the extent possible;
2.C. Robust MCO Competition - Equitable distribution of the participants among the MCOs.

24.3 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 Contract for newly eligible Enrollees. The Contractor shall not discriminate against potential Enrollees based on an individual's health status, need for health services, race, color, religion, gender, sexual orientation, gender identity, disability, or national origin, and shall not use any policy or practice that has the effect of discriminating based on an Enrollee's health status, need for health services, race, color, religion, gender, 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. If the Contractor is requested to provide information, the Contractor shall provide this information to the Department.

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, shall have the opportunity to change their Contractor and once a year thereafter in accordance with 42 C.F.R. 438.

24.4 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, if already assigned; how to obtain referrals; the role of the Contractor; the benefits of preventive healthcare; an overview of the 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.

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24.5 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 the 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. 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's decision to re-evaluate and/or modify the Auto-Assignment algorithm is final.

The Department may develop specific limitations regarding Enrollee enrollment with the Contractor to take into consideration quality, cost, competition, and adverse selection.

24.6 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 the Disenrollment provisions of this Contract. Applicable state and federal law determine Membership for newborns. Membership begins on the 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. If an Enrollee is receiving Medically Necessary Covered Services the day before Enrollment, the Contractor shall be responsible for the costs of continuation of 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 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.

24.7 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. The Department shall also electronically transmit a monthly HIPAA 834 to the Contractor. 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 promptly notify the Department of Enrollees of whom it has knowledge were not included on the HIPAA 834 transaction file and should 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 (e.g., the DCBS office or SSA). 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. If 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.

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24.8 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

1.A. Temporary Assistance to Needy Families (TANF);
1.B. Children and family related;
1.C. Aged, blind, and disabled Medicaid only;
1.D. Pass through;
1.E. Poverty level pregnant women and children, including Presumptive Eligibility;
1.F. Aged, blind, and disabled receiving State Supplementation;
1.G. Aged, blind, and disabled receiving SSI;
1.H. Under the age of twenty-one (21) years and in an inpatient psychiatric facility;
1.I. Children under the age of eighteen (18) who are receiving adoption assistance and have special needs;
1.J. Dual eligibles;
1.K. Disabled Children;
1.L. Foster Care Children;
1.M. CAA 2023 Required Reentry Justice Involved Juveniles under twenty-one (21) years of age; or former foster care child group between the ages of twenty-one (21) and twenty-six (26) incarcerated in a State Prison, Jail, Youth Detention Center, or Youth Development Center.
1.N 1115 Reentry Waiver Adjudicated Justice Involved Adults and juveniles incarcerated in State Prisons and Youth Development Centers;

1.O. Adults ages nineteen (19) to sixty-four (64) with income under one hundred thirty eight percent (138%) of the Federal Poverty Level; or
1.P. Former Foster Care Children up to age twenty-six (26).

Enrollees eligible to enroll with the Contractor will be enrolled beginning the first day of the application month except for (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 45 C.F.R. 233.100 is met. PE 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 to 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 an SSI Denial, was subsequently approved as of the original application date and was not already assigned to the Contractor.

The Department may remove certain Enrollees from enrollment in the Managed Care Program. The financial impact of such removal will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor will be adjusted, if necessary, according to **Sections 11.2 "Rate Adjustments**" and, if applicable, **38.3 "Amendments**." The Department will provide at

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least sixty (60) Days' written notice prior to the removal of Enrollees from the Managed Care Program. The determination to remove Enrollees or that such action requires an amendment to the Contract is at the discretion of the Department. However, an amendment will be required if the Department carves out an entire eligibility group.

24.9 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 CHFS. The delivery hospital is required to enter the birth record into the KY CHILD system (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 the child.

24.10 Dual Eligibles

The Contractor shall utilize the HIPAA 834 to identify Enrollees who are Dual Eligible within the MMIS. The Contractor and Medicare Advantage Organizations shall work to arrange or coordinate care for covered dual eligible Enrollees.

24.11 Persons Ineligible for Enrollment

Enrollees who are not eligible to enroll in the Managed Care Program are defined below.

INELIGIBLE ENROLLEE CATEGORIES

1.A. Individuals who shall spend down to meet eligibility income criteria;
1.B. Individuals currently Medicaid eligible and have been in a nursing facility for more than thirty (30) Days*;
1.C. Individuals determined eligible for Medicaid due to a nursing facility admission, including those individuals eligible for institutionalized hospice;
1.D. Individuals served under the Supports for Community Living, Michelle P, home and community-based, or other 1915(c) Medicaid waivers;
1.E. Qualified Medicare Beneficiaries (QMBs), specified low income Medicare beneficiaries (SLMBs), or Qualified Disabled Working Individuals (QDWIs);
1.F. Timed limited coverage for illegal aliens for Emergency Medical Conditions;
1.G. Individuals in the Working Disabled Program;
1.H. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);
1.I. Individuals who are eligible for the Breast or Cervical Cancer Treatment Program; and
1.J. Individuals otherwise eligible while incarcerated in a correction facility with the exception of individuals eligible for the CAA 5121 mandatory pre-release benefit or the 1115 Reentry waiver pre-release benefit.

* 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 (30^{th}) Day in the nursing facility, and the monthly Capitation Payment for such an Enrollee shall be prorated based upon the days of eligibility. This

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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.

24.12 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 24.8** "**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, 42 U.S.C. 12101 and applicable related federal regulations, and shall comply with Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against otherwise qualified disabled individuals under any program or activity. The Contractor shall provide reasonable modifications to the obligation to report a change in circumstance for any beneficiary with a disability.

24.13 Enrollee Request for Disenrollment

An Enrollee may request Disenrollment only for cause pursuant to 42 C.F.R. 438.56. The Contractor shall follow the Disenrollment for Cause process as defined by the Department.

24.14 Contractor Request for Disenrollment

The Contractor shall recommend Disenrollment of an Enrollee to the Department when an Enrollee:

1.A. Is found guilty, enters a plea of guilty (including a guilty plea pursuant to *North Carolina v. Alford*, deferred adjudication or diversion), or is administratively determined to have committed Fraud or Abuse related to the Medicaid Program;
1.B. Is abusive or threatening as defined by and reported in Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers to either Contractor, Contractor's agents, or providers;
1.C. Is admitted to a nursing facility for more than thirty-one (31) Days;
1.D. Is incarcerated in a correctional facility;
1.E. No longer qualifies for Medical Assistance under one of the aid categories listed in **Section 24.8 "Persons Eligible for Enrollment or Retroactivity;"** or
1.F. Cannot be located.

In accordance with 42 C.F.R. 438.56, 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, 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

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seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

24.15 Effective Date of Disenrollment

Disenrollment shall be effective on the first (1st) 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.

24.16 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 PCP in transitioning the Enrollee's care, and making the Enrollee's Medical Record available to the new PCP, in accordance with applicable state and federal law. The Contractor shall be responsible for following the Transition/Coordination of Care Plan contained in **Appendix F "Transition/Coordination of Care Plan"** whenever an Enrollee is transferred to another MCO.

24.17 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.

24.18 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.

25.0 PROVIDER SERVICES

25.1 Required Functions

The Contractor shall maintain a Provider Services function that is responsible for the following services and tasks:

1.A. Enrolling, credentialing, and recredentialing of Providers and coordination of these responsibilities with the Department's Credentialing Verification Organization(s) (CVOs) when contracted;
1.B. Providing Provider Service representatives who respond to provider requests and inquiries within two (2) Business Days of a request;
1.C. Performance review of Providers;
1.D. Establishing and operating a Provider Call Center;
1.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;

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4. Coordination of care for child and adult Enrollees with complex and/or chronic conditions.

1.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;

1.G. Developing, distributing, and maintaining a Provider manual;

1.H. Developing and maintaining provider services webpages within the Contractor's website;

1.I. Developing, conducting, and ensuring Provider orientation and ongoing education;

1.J. Encouraging and coordinating the enrollment of PCP in the DPH and Department's 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

1.K. Providing necessary technical support to Providers who experience unique problems with certain Enrollees in their provision of services.

25.2 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, Utilization Management and Prior Authorization calls; however, staffing shall be adequate to ensure qualified and timely responses. Additionally, the Contractor shall operate a phone line as defined in this Contract for 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 at 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 standards as measured by monthly averages for the Provider Services call center:

1.A. Abandonment Rate Less than or equal to five percent (5%);

1.B. Average Speed to Answer less than or equal to thirty (30) seconds;

1.C. Accurate response to call center phone inquiries by call center representatives is ninety percent (90%) or higher; and

1.D. 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.

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25.3 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:

1.A. Capabilities for providers to submit inquiries and receive responses within one (1) Business Day of receipt; and
1.B. Capabilities for Providers to file grievances, Appeals, and supporting documentation electronically in an encrypted format that 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
1.C. Other portals, as determined by the Contractor (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:

2.A. Contact information for Contractor call center(s) and hotline(s);
2.B. Searchable Provider Manual;
2.C. Searchable Provider Directory;
2.D. Current and clearly defined Prior Authorization requirements.
2.E. Pharmacy Preferred Drug List (PDL) and pharmacy conditions for coverage and utilization limits;
2.F. Enrollee rights and responsibilities;
2.G. Information about KHIE;
2.H. What's New updates; and
2.I. Links to other websites such as CHFS, DMS, the Single MCO PBM, 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 of any webpage changes unless otherwise agreed to in writing by both parties. Excluding upgrades that 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.

25.4 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 the Provider's inclusion 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 the Provider Manual, including any provided by a Subcontractor for direct services, and any updates to the Provider Manual, to the Department for approval 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:

1.A. Provider rights and responsibilities;

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1.B. Covered Services;
1.C. Enrollee rights and responsibilities and cost-sharing requirements;
1.D. Information for PCPs about Advance Medical Directives and their responsibilities for informing Enrollees;
1.E. Contractor's Policies and Procedures;
1.F. Information for accessing the Contractor and program materials through the Contractor's call center(s), toll-free hotlines, and website;
1.G. Language approved by the Department as provided by the Single MCO PBM about the administration of the pharmacy benefit and contacting the Single MCO PBM. The Contractor is not required to request additional Department approval for such language that the Department approved prior to provision to the Contractor;
1.H. Provider credentialing and recredentialing;
1.I. Provider and Enrollee Grievances and Appeals process;
1.J. Claims submission process and requirements;
1.K. Provider Program Integrity requirements and reporting suspected Fraud and Abuse;
1.L. Utilization Management and Prior Authorization procedures;
1.M. Medicaid federal and state laws and regulations;
1.N. Overview of the QAPI program;
1.O. Overview of VBP models, when implemented; and
1.P. 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**."

25.5 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 when material changes are made and annually.

The Contractor shall ensure that Provider education includes:

1.A. Contractor coverage requirements for Medicaid services, including information about Prior Authorization requirements, EPSDT preventive health screening services, and EPSDT special services;
1.B. Contractor policies and procedures, Contractor administrative clinical practices, and updated information when modifications to existing services occur;
1.C. Medicaid policies and procedures, including state and federal mandates and any new policies and procedures;
1.D. How to report suspected Fraud and Abuse, and annually address Fraud, Waste, and Abuse with Providers;
1.E. Medicaid populations and eligibility;
1.F. Standards for preventive health services;

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1.G. Telehealth services;
1.H. Special needs of Enrollees in general that affect access to and delivery of services;
1.I. Advance Medical Directives;
1.J. Claims submission and payment requirements;
1.K. Special health/care management programs in which Enrollees may enroll;
1.L. Provider role in Population Health Management (PHM) program;
1.M. Cultural sensitivity;
1.N. Responding to needs of Enrollees with SUD or behavioral health, developmental, intellectual, and physical disabilities;
1.O. Integrated healthcare, addressing SDoH, and population health management initiatives;
1.P. Reporting of communicable disease;
1.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;
1.R. Medical records review;
1.S. Value-based payment;
1.T CAA Section 5121 mandatory pre-release program requirements; and
1.U 1115 Reentry waiver program requirements.

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.

25.6 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 Twenty Thousand ($20,000) Dollars to the Department at the start of each fiscal year under this Contract to support this outreach effort.

25.7 Provider Credentialing and Recredentialing

The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), KRS 205.532, KRS 205.560(12), 907 KAR 1:672, KRS 304.17A-576, or other applicable federal and state laws and regulations unless the Department contracts with a 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 G "Credentialing Process."**

The Contractor and any subcontractor shall complete the Credentialing or Recredentialing of a Provider within thirty (30) Days unless federal or state law or regulation requires a different completion time. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix G** "**Credentialing Process.**"

If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor shall use the format provided in **Appendix G "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 contract with the Provider within thirty (30) Days of credentialing and shall load the contract and configure the system within ten (10) Days of the executed contract. If additional time is needed to load the contract and configure the system, the Contractor may take an additional fifteen

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(15) Days if it has notified the Provider of the need for additional time. The Contractor is not required to contract with a Provider if the Contractor and Provider are unable to 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 or at the date that the Department directs based on when the Provider enrolled in Medicaid. The Contractor shall not require a Provider to appeal or resubmit any clean claim submitted during the period between the Provider's credentialing application date and the completion of the credentialing process. A Provider whose credentialing is denied should be paid on a non-par basis.

The Contractor shall establish and provide the Department with a process for ongoing monitoring of Provider sanctions, complaints, and quality issues between recredentialing cycles by January 31, 2026. The Contractor shall take all appropriate action pursuant to this process. The Contractor shall also submit proposed material process changes to the Department thirty (30) Days prior to implementation.

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.

25.8 Transition to a Credentialing Verification Organization (CVO)

If the Department contracts with one (1) or more CVOs to conduct enrollment, credentialing, and recredentialing services for the Medicaid managed care program, the Contractor shall comply with and take all necessary actions to implement the requirements.

25.9 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 in a timely, legible, current, detailed, and organized manner 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 healthcare 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 be preserved and maintained by the Provider for a minimum of five (5) years unless federal requirements mandate a longer retention period (e.g., 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:

1.A. Enrollee/patient identification information, on each page;
1.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, language spoken and guardianship information;

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1.C. Date of data entry and date of Encounter;
1.D. Provider identification by name;
1.E. Adverse reactions, and any known allergies shall be noted in a prominent location;
1.F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (e.g., documentation of chickenpox);
1.G. Identification of current problems;
1.H. The consultation, laboratory, and radiology reports filed in the Medical Record shall contain the ordering provider's initials or other documentation indicating review;
1.I. Documentation of immunizations pursuant to 902 KAR 2:060;
1.J. Identification and history of nicotine, alcohol use or substance abuse;
1.K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or DPH pursuant to 902 KAR 2:020;
1.L. Follow-up visits provided secondary to reports of emergency room care;
1.M. Hospital discharge summaries;
1.N. Advanced Medical Directives, for adults;
1.O. All written Denials of service and the reason(s) for the Denial; and
1.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 minimum details for individual clinical Encounters:

2.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;
2.B. Unresolved problems, referrals, and results from diagnostic tests, including results and/or status of preventive screening services (e.g., EPSDT) are addressed from previous visits;
2.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 for hospitals and mental hospitals shall include, at a minimum:

3.A. Identification of the Enrollee;
3.B. Physician name;
3.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]);
3.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);
3.E. Reasons and plan for continued stay if applicable;
3.F. Other supporting material, as appropriate;
3.G. For non-mental hospitals only:
1. Date of operating room reservation; and
2. Justification of emergency admission if applicable.

25.10 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

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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.

The Contractor shall allow Providers to have the right to file an internal appeal with the Contractor regarding the Denial of the following:

1.A. A healthcare service;
1.B. Claim for reimbursement;
1.C. Provider payment;
1.D. Contractual issues.

Provider grievances may involve, but not be limited to the following:

2.A. Process/policies;
2.B. Claims Processing (not an appeal);
2.C. Communications;
2.D. Fraud/waste/abuse;
2.E. Contracting/Credentialing.

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 22.0 "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:

3.A. A grievance process for providers to submit complaints or disputes to the Contractor and the use of standard grievance reasons. A Provider Grievance Form may be utilized by the Contractor to initiate its Provider grievance process. However, grievances received by the Contractor via email, mail, fax, or telephone call should be included and tracked and trended;
3.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.
3.C. Requirements for recording all grievances and appeals filed by a provider to include the date filed, type of issue, identification, 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;
3.D. Requirements that any form of correspondence with the provider about the appeal be directed to the designee who filed the appeal;
3.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. The written notification shall be 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 Contractor shall approve the extension. The Contractor shall ensure that there is no discrimination against a Provider

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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 the DMS MMC Program Reporting Package.

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 Kentucky Office of the Attorney General Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulations. 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.

25.11 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 a contract.

25.12 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 or religious 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 or religious 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.

26.0 PROVIDER NETWORK

26.1 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 in **Section 26.0 "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's Provider Network shall support the Department's quality and health outcomes goals and requirements. The Department may request information about the VBP arrangements the Contractor includes in its provider contracts. The Contractor shall have Network Providers of sufficient

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types, numbers, specialties, and sub-specialties to ensure quality and access to healthcare services.

The Contractor shall develop a Provider Network that complies with KRS 304.17A-515, 42 C.F.R. 438.206, and other applicable state and federal regulations. When establishing and maintaining a Provider Network, the Contractor shall consider the anticipated Medicaid enrollment; the expected utilization of services given the characteristics and healthcare 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.

26.2 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 requirements as described in 907 KAR 1:672 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:

1.A. Hospitals and ambulatory surgical centers
1.B. Physicians, advanced practice registered nurses, physician assistants, and family planning providers
1.C. Free standing birthing centers, primary care centers, local health departments, home health agencies, FQHCs, RHCs, and private duty nursing agencies
1.D. Behavioral health and substance abuse providers
1.E. Opticians, optometrists, audiologists, hearing aid vendors, and speech language pathologists
1.F. Physical therapists, occupational therapists, and chiropractors
1.G. Dentists
1.H. Suppliers of medical supplies, equipment, and appliances (MSEA)
1.I. Podiatrists
1.J. Renal dialysis clinics
1.K. Transportation providers
1.L. Laboratory and radiology providers
1.M. Individuals and clinics providing EPSDT services and EPSDT Special Services (EPSDT) services and EPSDT Special Services

The Contractor may also contract with other providers that meet the credentialing requirements if necessary to provide Covered Services to Enrollees. Enrollment forms shall include those used by the Kentucky Medicaid Program for each 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 appropriate, to conduct this process.

26.2.1 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 neonatal, 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.

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26.2.2 Primary Care Providers

The Contractor shall have an adequate number of accessible 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 both Contractor and Enrollee responsibility. 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 healthcare 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:

1.A. Maintaining continuity of the Enrollee's healthcare;
1.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;
1.C. Maintaining a current Medical Record for the Enrollee, including documentation of all PCP and Specialty Care services;
1.D. Discussing Advance Medical Directives with all Enrollees as appropriate;
1.E. Providing primary and preventative care, recommending or arranging for all necessary preventive healthcare, including EPSDT for persons under the age of twenty-one (21) years;
1.F. Documenting all care rendered in a complete and accurate Medical Record that meets or exceeds the Department's specifications;
1.G. Arranging and referring Enrollees (when clinically appropriate), to behavioral health providers; and
1.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 unacceptable arrangements are not implemented:

2.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; or
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.

2.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

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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.

26.2.3 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 an agreement on terms and conditions with these providers, it shall submit to the Department, for approval, documentation that describes the good faith contracting attempts that supports 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."**

26.2.4 Department for Public Health

DPH 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 DPH for local health department services. Such participation agreement shall include, but not be limited to, the following provisions:

1.A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360; and
1.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 that 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."**

26.2.5 Family Planning Services

The Contractor shall contract with Network Providers qualified by experience and training to provide Family Planning Services.

26.2.6 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:

1.A. Psychiatrists, Psychologists, and Licensed Clinical Social Workers;
1.B. Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, and Licensed Clinical Alcohol and Drug Counselors;
1.C. Targeted Case Managers and Certified Family, Youth, and Peer Support Providers;
1.D. Behavioral Health Multi-Specialty Groups and Behavioral Health Services Organizations;
1.E. Chemical Dependency Treatment Centers;
1.F. Psychiatric Residential Treatment Facilities (PRTFs) and Residential Crisis Stabilization Units;
1.G. Community Mental Health Centers (CMHCs);
1.H. Multi-Therapy Agencies providing physical, speech, and occupational therapies, which include Comprehensive Outpatient Rehabilitation Facilities, Special Health Clinics, Mobile

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Health Services, Rehabilitation Agencies and Adult Day Health Centers; and

1.I. Other independently licensed behavioral health professionals.

26.2.7 Dental Providers

The Contractor shall enroll providers of dental services in accordance with 907 KAR 1:126.

26.2.8 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.

26.2.9 Telehealth

The Contractor may in accordance with KRS 205.559 and KRS 205.5591, 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.

Telehealth providers must be licensed in Kentucky to receive reimbursement for telehealth services under Medicaid.

The Contractor shall not:

1.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;

1.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;

1.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 of 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.

26.2.10 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 will make Enrollees aware of how to access NEMT services. The Contractor shall contract with providers of transportation of an emergency nature, including emergency ambulance and ambulance stretcher services.

26.2.11 Charitable Providers

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The Contractor may include any charitable providers that serve Enrollees within a Medicaid Region, provided that such providers meet credentialing standards.

26.2.12 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.

26.2.13 Out-of-Network Providers

If the Contractor is unable to provide necessary Covered Services within its network, it shall timely and adequately cover these services out of network for the Enrollee for as long as the 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.

26.3 Additional Network Providers Requirements

The Contractor shall attempt to contract with the following providers:

1.A. Teaching Hospitals;
1.B. The Office for Children with Special Health Care Needs;
1.C. Community Mental Health Centers; and
1.D. Pediatric Prescribed Extended Care Providers.

If the Contractor is unable to reach an agreement on terms and conditions with these specified providers, it shall submit to the Department for approval, documentation that 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 and who are willing to meet the terms and conditions for participation established by the Contractor.

26.4 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 in **Section 26.0 "Provider Network."** Any exceptions shall be justified and documented by the Contractor in accordance with **Section 26.9 "Exceptions to Provider Network."** Significant changes in the 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

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sufficient to provide Covered Services consistent with the requirements in this subsection.

Consistent with KRS 304.17A-515, the Contractor shall have a Provider Network that meets the following accessibility requirements:

1.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;
1.B. For areas other than urban areas, a Provider Network that makes available PCP and hospital 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

In addition, the Contractor shall meet the following as required by the Department:

2.A. Enrollee to PCPs ratios shall not exceed 1500:1 FTE Provider for children under twenty-one (21) and adults;
2.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;
2.C. Appointment and wait times shall not exceed thirty (30) Days from the 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.
2.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;
2.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;
2.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 the Contractor's Network.
2.G. A ninety percent (90%) appointment wait time standard shall be achieved to ensure compliance with the above standards; and
2.H. The Contractor shall monitor appointment wait time compliance through Secret Shopper surveys.

The Contractor shall monitor Emergency Room usage in each Medicaid Region by Enrollees for non-emergent visits, 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 submit to the Department in the format and frequency required, reports listing Providers that have not submitted a claim for three hundred sixty-five (365) Days or longer. The Contractor shall collaborate with the Department and other contracted MCOs, as required by the Department, to establish a strategy for outreach to identified Providers to determine reasons the Providers have not filed claims. The Department shall review the Provider's' enrollment, all MCO

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contractors' reports, and direct the Contractors to outreach to specific Providers to determine the Provider's reason for not billing for three hundred sixty-five (365) Days, to encourage increased participation, and to determine if they no longer want to participate and should be terminated from MCO networks.

The Contractor shall develop and provide GeoAccess reports to the Department in accordance with the DMS MMC Program Reporting Package 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 have submitted claims within a three hundred sixty-five (365) Day period and 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.

26.5 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 26.4 "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:

1.A. Annually;
1.B. 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
1.C. At other times as requested by the Department throughout the Contract Term.

The Provider Network Plan shall address the following at a minimum:

2.A. Overall approach, including:
1. Activities to establish and maintain a Provider Network that meets the standards in **Section 26.4 "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 healthcare 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;

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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 ensuring the sufficiency of the Provider Network to meet the healthcare 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 26.4 "Provider Network Access and Adequacy;"** and
8. Methods the Contractor will use to analyze access to specific provider types upon Department request.

2.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;

2.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.

2.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).

26.6 Provider Contracting

The Contractor shall offer to contract with providers in writing. All Network Provider contracts shall include the standard provisions in **Appendix B "Required Standard Provisions for Network Provider Contracts."** Consistent with 42 C.F.R. Part 438, neither the Contractor nor its Subcontractors shall require a Provider to participate exclusively with its network to provide Covered Services under this Contract.

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 in **Section 25.7 "Provider Credentialing and Recredentialing"** and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid regulatory provider enrollment requirements and the Medicaid policy and procedures manual for FFS providers of the appropriate provider type. The Contractor is responsible for confirming that 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 FFS population; however, such Providers must be enrolled in 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.

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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 in **Section 25.5 "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 Kentucky Office of the Attorney General or other state Medicaid Fraud control unit 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.

26.7 Medicaid Providers Files

The Department will provide the Contractor with access to the Department's Medicaid provider master file by direct online inquiry access, electronic file transfer, or 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 monthly and when any information changes.

26.8 Providers Not Participating in Medicaid Fee-for-Service

A provider is not required to participate in the Kentucky Medicaid FFS 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 been assigned a Medicaid number, the provider shall apply for enrollment with the Department. To be enrolled, the provider must meet the Medicaid regulatory provider enrollment requirements and the Medicaid policy and procedures manual for FFS providers of the appropriate provider type. Upon request of a provider, the Contractor shall provide support to the provider in the 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.

26.9 Exceptions to Provider Network Requirements

Network adequacy measures the Contractor's ability to deliver the Covered Services required under

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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), 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 C.F.R. 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:

1.A. Description of the Region(s) and specific provider type(s) for which the exception is being made;
1.B. Justification for the exception request;
1.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;
1.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
1.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 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 the implementation of its plan to remedy the network deficiency as required by the Department.

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 that the exception is no longer needed. Should the Department receive information at any time questioning the exception, the Department may deem the Contractor to be out of compliance.

26.10 Termination of Network Providers

1.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 against Medicaid providers by the Kentucky Medicaid program within three (3) Business Days via SharePoint. The Contractor shall terminate the Provider upon receipt of notice by the Department.

1.B. The Contractor shall notify the Department via SharePoint of a Provider termination from the

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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.

1.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 SharePoint of such a Provider termination within three (3) Business Days.

1.D. When a Provider elects to terminate its contract with the Contractor, the Contractor shall notify the Department via SharePoint of such a Provider termination, with or without cause, within three (3) Business Days of the contract termination date.

1.E. The Contractor shall survey all Providers who choose to exit the network and use the results of Provider exit surveys to improve Provider retention and recruitment. The Contractor shall use the Provider exit survey template that is developed through the Department and MCO collaboration process described in **Section 35.1 "General Reporting and Data Requirements**." 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's 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:

2.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;

2.B. If the terminated provider was a specialist, information about how the Contractor will assist the Enrollee to transition care to another specialist.

26.11 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 in **Section 26.4 "Provider Network Access and Adequacy."** The Department will provide the Contractor with the MCO Provider Network file layout, which will be stored on SharePoint and available for review and download for implementation. File submission will be monitored and errors with file processing will be communicated using SharePoint or as defined by the Department. The Department will transmit the Provider Master Extract file to the Contractor daily. The Provider Master Extract file is a full extract of Medicaid providers that have been active within the last six (6) months. The Provider Master Extract file layout is stored on SharePoint and available for review and download for implementation. 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

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monthly. Unless the request is as a result of a determination under **Section 26.13 "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.

26.12 Maintaining Current Provider Network Information for Enrollees

The Contractor shall maintain electronic and paper Provider Directories and make those available to Enrollees as required in this Contract. The Contractor shall establish a process that is approved by the Department for monitoring and ensuring the accuracy of its Provider Directory.

In addition to providing changes to the Provider Network to the Department, the Contractor shall ensure that all changes to the Provider Network 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. Correcting the Provider Directory maintained by the Contractor on its website within these required timeframes shall comply with this provision. 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:

1.A. Provider's name and any group affiliation;
1.B. Street address(es);
1.C. Telephone number(s);
1.D. Website URL, as appropriate;
1.E. Specialty(ies), as appropriate;
1.F. Whether the Provider is accepting new Enrollees;
1.G. Provider's cultural and linguistic capabilities including languages (e.g., 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
1.H. Whether the Provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.
1.I. Information for Providers with telehealth capabilities and presentation sites.

For Pharmacy Network Providers, the Contractor will only be required to provide the information in the provider file as designated by the Department.

26.13 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 in **Section 26.4 "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 35.0 "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

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Department or its Agent may also periodically phone Providers to confirm that 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 the assessment of network adequacy and access.

If at any time, the Contractor or the Department determines that the Contractor's Provider Network does not comply with the standards in **Section 26.4 "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 CAP to remedy the deficiency.

CAPs for lack of network adequacy shall include, at a minimum, the following:

1.A. A summary of the deficiency, including provider type, number of additional FTE providers needed to resolve the deficiency, and the Medicaid Region(s) in which the deficiency exists;
1.B. Specific actions and a timeline by which the Contractor anticipates addressing the deficiency;
1.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;
1.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's 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);
1.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;
1.F. Documentation of how these arrangements are communicated to the Enrollee; and
1.G. Documentation of how these arrangements are communicated to the PCPs.

The Contractor shall also develop and maintain a contingency plan if a large Provider of services collapses or is otherwise unable to provide needed services.

The Department will review all CAPs 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 37.3 "Requirement of Corrective Action."**

27.0 PROVIDER PAYMENT PROVISIONS

27.1 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.

The Contractor shall allow the same time period for the filing of claims as the Department's FFS program.

27.2 Prompt Payment of Claims

In accordance with 42 C.F.R. 447.46, the Contractor shall comply with the timely Claims payment

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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 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 (KRS 304.17A-700-730), KRS 205.593, KRS 304.14-135, and KRS 304.99-123. The Contractor shall provide 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 if the denying entity is a Subcontractor.

Any conflict between federal and Commonwealth law will default to the federal law unless the Commonwealth requirements are stricter.

27.3 Payment to Out-of-Network Providers

The Contractor shall reimburse Out-of-Network Providers in accordance with **Section 27.1 "Claims Payments**" for the following Covered Services:

1.A. Specialty care for which the Contractor has approved an authorization for the Enrollee to receive services from an Out-of-Network Provider;
1.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;
1.C. Services provided for family planning;
1.D. Services for children in Foster Care, if applicable; and
1.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.

27.4 Payment to Providers for Serving Dual Eligible Enrollees

The Contractor shall coordinate benefits for Dual Eligible Enrollees by paying the lesser amount of:

1.A. The Contractor's allowed amount minus the Medicare payment, or

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1.B. The Medicare co-insurance, deductible, and copayment up to Contractor's allowed amount.

If 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 the coordination of benefits required under **Section 4.3** "**Delegations of Authority**."

27.5 Payment of Federally Qualified Health Centers ("FQHC"), Rural Health Clinics ("RHC"), and Certified Community Behavioral Health Clinics ("CCBHC")

As required by the Department, the Contractor is responsible for reimbursing, 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 ensure that payment for services provided to FQHCs and RHCs is not less than the level and amount of payment the Contractor would make for the services if the services were furnished by other clinics or PCPs. The Department shall reimburse, by making payments directly to FQHCs and RHCs, the difference if the rate is less than the amount paid under Kentucky's established PPS rate for the federally certified facilities. The Department may not pay an FQHC and RHC in excess of the PPS rate. The Contractor may also limit payment to the PPS rate.

The Contractor shall report to the Department within forty-five (45) calendar 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.

The Department is participating in a Section 223 Waiver Demonstration for CCBHCs. The Contractor shall ensure that payment for services provided to CCBHCs is not less than the level and amount of payment the Contractor would make for the services if the services were furnished by other clinics or PCPs. The Department shall reimburse, by making payments directly to the CCBHCs, the difference if the rate is less than the amount paid under Kentucky's established PPS rate for the certified clinics. The Department may not pay a CCBHC in excess of the PPS rate. The Contractor may also limit payment to the PPS rate.

The Contractor shall report to the Department within thirty (30) Days of the end of each quarter the total amount paid to each CCBHC per month. The report shall include the provider number, name, total number of paid Claims per month, total amount paid by the 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.

27.6 Office for Children with Special Healthcare Needs

The Care Management and Care Coordination needs of the medically complex children serviced by OCSHN must be recognized by the Contractor in that a special payment rate shall be developed for OCSHN through a process of negotiation between the Contractor and OCSHN. 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.

27.7 Intensity Operating Allowance

The Department and the Contractor acknowledge and agree that Contractor is subject to the

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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)

27.8 Urban Trauma

The Contractor agrees 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)

27.9 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.

27.10 Supplemental Payments including State Directed Payments

The Department and Contractor recognize the Department’s desire to provide enhanced reimbursement to provider entities through supplemental payments 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:

1.A. Intensity Operating Allowance for Pediatric Teaching hospitals;
1.B. A State Designated Urban Trauma Center;
1.C. State-Owned or Operated University Teaching Hospital Faculty; and
1.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 **Section 11.1 “Calculation of 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. The 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 to 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. The 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.

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The Contractor agrees, upon notice by the Department, to participate in other State Directed Payment programs as defined in 42 C.F.R. 438.6(c) as they are implemented and as may be required or mandated as a result of legislative, executive, regulatory, or judicial action. Any rate adjustment due to a State Directed Payment will be in accordance with **Section 11.2 "Rate Adjustments."** The Department will provide the Contractor with a copy of any applicable rate certification as well as any approval from CMS of a State Directed Payment.

27.11 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.

27.12 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.

28.0 COVERED SERVICES

28.1 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 to Medicaid recipients under the FFS program, and for Enrollees under the age of twenty-one (21) as 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 laws and 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 healthcare under FFS prior to Enrollment in the Plan. **Appendix E "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, 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 will be adjusted, if necessary, according to **Sections 11.2 "Rate Adjustments"** and, if applicable, **38.3 "Amendments.**" The determination that a Covered Service is a New Covered Service or that it requires an amendment to the Contract 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)

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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 that 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 the 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 regulatory requirements. 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 necessary Covered Services within its network**,** it shall timely and adequately cover these services out of network for the Enrollee for as long as the 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 the 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.

To the extent the Department may remove or carve out certain Covered Services from the Contractor's responsibilities, the financial impact of such removal or carve out will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to the Contractor will be adjusted, if necessary, according to **Sections 11.2 "Rate Adjustments"** and, if applicable, **38.3 "Amendments."** The Department will provide at least thirty (30) Days' written notice prior to the removal or carve out of a Covered Service. The determination to remove or carve out a Covered Service or that such action requires an amendment to the Contract is at the discretion of the Department. However, an amendment will be required if the Department carves out a service category such as pharmacy, dental, or behavioral health.

28.2 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:

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1.A. Primary care vision services, including the fitting of eyeglasses, provided by ophthalmologists, optometrists, and opticians;
1.B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;
1.C. Voluntary family planning in accordance with federal and state laws or court order
1.D. Maternity care for Enrollees under eighteen (18) years of age;
1.E. Immunizations to Enrollees under twenty-one (21) years of age;
1.F. Sexually transmitted disease screening, evaluation, and treatment;
1.G. Tuberculosis screening, evaluation, and treatment;
1.H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;
1.I. Chiropractic services;
1.J. For Enrollees with special healthcare 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
1.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.

28.3 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.

28.4 Telehealth

Covered Services shall be delivered via telehealth according to Kentucky regulations and statutes.

28.5 Billing Enrollees for Covered Services

The Contractor and its Providers and Subcontractors shall not bill an Enrollee for Medically Necessary Covered Services except for 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 in 42 U.S.C. 1320a-7b. 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.

28.6 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 FFS program. The Contractor shall have written policies and procedures for

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the referral of Enrollees for Non-Covered Services that shall provide for the transition to a qualified healthcare 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**."

28.7 Interface with State Behavioral Health Agency

1.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 Agency (SSA) for Substance Abuse Services 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).

1.B. The Contractor shall coordinate:
   1. Enrollee education process for individuals with SMI and children and youth with SED with the Department. The 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.

28.8 Provider-Preventable Diseases

The Contractor shall not pay a Provider for provider-preventable conditions that meet the following criteria:

1.A. Is identified in the State Medicaid plan;
1.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;
1.C. Has a negative consequence for the Enrollee;
1.D. Is auditable; and
1.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.

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28.9 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 apply only to mental health or substance use disorder benefits.

28.10 CAA 2023 Required Section 5121 Mandatory Service Provisions for Pre-release Services

The Department and the Contractor shall comply with the requirements of Section 5121 of the CAA, which establishes Medicaid and Children's Health Insurance Program provisions intended to improve the health of justice-involved youth.

As directed by the Department, the Contractor shall coordinate with Kentucky-based prisons, jails, juvenile detentions, and development centers thirty (30) Days prior to release to support coordination and warm hand-off activities to ensure continuity of care.

The Contractor shall, for a period of thirty (30) Days post-release and as Medically Necessary, provide the following services pursuant to **Appendix E "Covered Services."**

1.A Screening and Diagnostic Services
   1. Early and Periodic Screening, Diagnosis and Treatment (EPSDT);
   2. Behavioral health screenings and diagnostic services;
   3. Dental services; and
   4. Coordination activities to ensure the continuity of care post-release.

1.B Targeted Case Management
   1. Comprehensive assessment of medical, educational, and social needs;
   2. Development of a person-centered care plan; and
   3. Monitoring and follow-up to ensure the care plan is effectively implemented.

1.C Continuity of Care: The Contractor shall take all reasonable and appropriate actions necessary to ensure the continuity of an Enrollee's care upon disenrollment pursuant to "**Section 24.16 Continuity of Care upon Disenrollment"**.

28.11 In Lieu of Services

The Department may allow In Lieu of Services or settings (ILOS) that will be allowable substitutions for services or settings covered under the State Plan or otherwise covered by this Contract. The Contractor shall collaborate with the Department, other MCOs, and other Department vendors as necessary throughout the planning process. The Department will amend this Contract to incorporate the approved ILOS that MCOs may opt to offer to Enrollees in accordance with 42 C.F.R. 438.

When implemented, the Contractor may cover services or settings that are in lieu of services or settings covered under the State Plan. Contract provisions between the Department and the Contractor will address, but not be limited to, the following federal regulations set forth at 42 C.F.R. 438.3(e)(2) that allow for MCOs to cover ILOS:

1.A. The ILOS is a medically appropriate and cost effective substitute for the covered service or setting under the State Plan;

1.B. Enrollees are not required to use the ILOS; they retain all rights and protections under 42 C.F.R. 438.When choosing not to receive an ILOS, they retain the right to receive the services or

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settings covered under the State Plan on the same terms as would apply if an ILOS was not an option;

1.C. The ILOS may not be used to reduce, discourage, or jeopardize an Enrollee's access to services and settings covered under the State Plan, and the MCO may not deny access to a service or setting covered under the State Plan on the basis that the Enrollee has been offered an ILOS as an optional substitute for a service or setting covered under the State Plan, is currently receiving an ILOS as a substitute for a service or setting covered under the State Plan, or has utilized an ILOS in the past; and

1.D. The utilization and actual cost of the ILOS is considered in developing the component of the capitation rates that represents the covered State Plan services and settings, unless a statute or regulation explicitly requires otherwise.

28.12 Institutions for Mental Disease (IMD) Expansion

The Contractor shall cover services under the TEAMKY 1115 SMI Demonstration, including an inpatient stay in an IMD for psychiatric services for Enrollees aged twenty-one (21) through sixty-four (64) for a short-term stay up to the number of days permitted by CMS. The Contractor shall adhere to service delivery and reporting as directed through Department issued written guidance.

1.A. The services and settings will be reimbursable and subject to the requirements of 42 C.F.R. Part 438.

1.B. Per 42 C.F.R. 438.3(e)(2)(v), the Contractor may not require an Enrollee to receive services in an IMD.

1.C. The Contractor shall provide or arrange for the provision of services as defined under the Section 1115 SMI demonstration waiver, not to exceed a statewide thirty (30) Day average length of stay. The Contractor shall track services furnished to Enrollees during IMD stays.

1.D. 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. Demonstration services provided to Enrollees who have stays in IMDs that exceed sixty (60) Days are not eligible under this demonstration.

29.0 PHARMACY BENEFITS

This section provides requirements specifically related to the Contractor's responsibilities for the pharmacy benefits. The Department determines the pharmacy benefit and has sole responsibility for oversight and assessment of the single PDL and the common over-the-counter (OTC) drug list. The Contractor shall comply with KRS 205.510 to 205.560 in administering pharmacy benefits. The Contractor may submit to the Department for review and approval of any value-added pharmacy services or benefits. Additionally, the Department has contracted directly with a Single MCO PBM to provide Medicaid pharmacy benefit management services, and therefore, will provide oversight and monitor the performance of the Single MCO PBM. The Single MCO PBM is not a Subcontractor of the Contractor as defined in this Agreement and, therefore, the Subcontractor requirements contained in this Agreement, including but not limited to, **Section 6.0** "**Subcontracts,"** are not applicable to the Contractor with respect to the Medicaid pharmacy benefit management services provided by the Single MCO PBM. The Contractor may notify the Department of concerns or potential issues with services performed by the Single MCO PBM in accordance with the notification process determined by the Department.

29.1 Pharmacy General Requirements

The Department is contracting with a Single MCO PBM for administration of the pharmacy benefit. The Contractor shall remain responsible and liable for any pharmacy claims on or before the effective date of the Single MCO PBM, and shall comply with the contract requirements established in the Contract that governs that time period. The Contractor shall administer pharmacy benefits and related pharmacy services either directly or through a pharmacy benefit manager or administrator or the like

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Subcontractor in accordance with this section, other requirements specified in this Contract, and in accordance with all applicable state and federal laws and regulations.

The Contractor shall submit to the Department for review and approval any contract between the Contractor and a pharmacy benefit manager or administrator or the like Subcontractor in accordance with **Section 6.0 "Subcontracts**." The Department shall approve any contract, any change in the terms of a contract, or suspension or termination of a contract between a pharmacy benefit manager contracted or administrator or the like Subcontractor with the Contractor to administer Medicaid benefits, or any contract or any change in the terms of a contract, or any suspension or termination of a contract between a pharmacy benefit manager or administrator or the like Subcontractor and a pharmacy or pharmacist.

The Contractor shall sign a Service Agreement with and provide remuneration to the Single MCO PBM secured by the Department. The Contractor shall conduct activities and coordinate with the Single MCO PBM as set forth in the Service Agreement and as approved by the Department. The Contractor shall not make amendments to the Single MCO PBM Service Agreement without Department approval. Modifications may need to be considered in instances including but not limited to an addition, deletion, or other change, or change in interpretation thereof, in laws, or any government, judicial, or legal action, or any drug industry practice, or any policy, underwriting, benefit change, or management practice of a regulatory body, accreditation agency, or MCO. Such changes are subject to Department approval. The Single MCO PBM Services Agreement and changes thereto will be drafted in a manner to preserve each party's anticipated economic benefit under the Agreement.

29.2 Covered Outpatient Drugs

The Contractor will provide access to covered outpatient drugs through the Department-defined pharmacy benefit and use of the Single MCO PBM.

29.3 Physician Administered Drugs

1.A. The Contractor shall develop and maintain the physician administered drug list.
1.B. The Contractor shall be responsible for reimbursement of physician administered drugs and biologics.
1.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.

29.4 Preferred Drug List

The Contractor shall use the single preferred drug list (PDL) that is administered by the Single MCO PBM as described by the Department and in accordance with **Section 29.0, "Pharmacy Benefits."**

29.5 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 for Physician Administered Drugs, pharmacy based programs, and other initiatives.

1.A. The Contractor shall align its criteria for Physician Administered Drugs and processes and comply with such requirements no later than thirty (30) Days after written notification from the Department.
1.B. Any systems or policy and process changes required to implement new alignment requirements

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shall be made at no cost to the Department.

29.6 Reimbursement Rates and Dispensing Fees

1.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, the Single MCO PBM, or administrator, or the like Subcontractor and a Pharmacy Network Provider, or an entity which contracts on behalf of a pharmacy. The Contractor shall be given thirty (30) Days prior notice of any changes to rates.

1.B. Reimbursement rates shall include dispensing fees established by the Department, which consider applicable CMS guidance and any DMS requirements.

29.7 Pharmacy and Therapeutics Committee

The Contractor may continue to utilize a Pharmacy and Therapeutics (P&T) committee that 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 Committee shall meet at least quarterly and make recommendations to the Department for changes to the PDL. If the Contractor utilizes a P&T Committee, the Contractor is encouraged to maintain Enrollee representation.

29.8 Pharmacy Claims Payment Administration

The Contractor shall contract with the Single MCO PBM through a Service Agreement approved by the Department for pharmacy claims payment administration.

29.9 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, 42 C.F.R. 438.3(s), and 42 C.F.R. 456, Subpart K.

As part of its DUR activities, the Contractor shall work collaboratively with the Department and the Department's designated Single MCO PBM 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 work with the Department and the Single MCO PBM to develop a process for providing required data and producing the CMS Annual DUR report. The Contractor shall coordinate with the Single MCO PBM to establish 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 timely submit the CMS Annual DUR report. At the Department's request, quarterly written reports of DUR activities shall be provided to the Department.

The Contractor must have a program in place to monitor antipsychotic medications by children and document the appropriate actions taken based on the program. All MCOs must have in place a process that identifies fraud or abuse of controlled substances by individuals enrolled, healthcare providers prescribing drugs to individuals so enrolled, and pharmacies dispensing drugs to individuals so enrolled.

29.10 Pharmacy Drug Rebate Administration

Pursuant to the Affordable Care Act and 42 C.F.R. 438.3(s), CMS requires States to collect CMS-

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level rebates on all Medicaid MCO utilization.

1.A. The Contractor shall be required to report timely physician administered and outpatient facility 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 the Department and the Department's contractors to ensure file transmissions are complete, accurate, and delivered by the specified deadlines.

1.B. Physician administered and outpatient facility drugs adjudicated by the Contractor, including but not limited to drug products administered by non-Pharmacy 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 drug, and amount paid by the Contractor's plan.

1.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.

1.D. The Contractor shall assist and provide detailed physician administered and outpatient facility 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.

29.11 340B Transactions

1.A. The Contractor shall submit all physician administered and outpatient facility drug Encounters, except for in-patient hospital drug Encounters, to the Department pursuant to this Contract.

1.B. The Contractor shall maintain the systems capability and methodology to appropriately identify 340B Claims in real time, prospectively, and retrospectively.

1.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.

1.D. 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.

29.12 Physician Administered Drug Prior Authorizations

The Contractor shall conduct a Prior Authorization (PA) program for physician administered drugs that complies with Department requirements.

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:

1.A. Clinical PA review criteria shall be evidence-based and follow best clinical practice standards, and/or other national standards.

1.B. Physician Administered Drug Prior Authorization Denials must be made by a registered pharmacist or physician.

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1.C. A physician peer review shall be available upon a physician's request for any Denial made at a pharmacist review level.
1.D. Contractor's physician administered drug list 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 22.2 Enrollee Grievance and Appeal Policies and Procedures**" and "**Section 25.10 Provider Grievances and Appeals."**

29.13 Medicaid Necessity Determinations

The Single MCO PBM will make an independent determination of the appropriateness of pharmacy services for which the Single MCO PBM is responsible based on DMS-approved written protocols. The Contractor shall provide medical necessity determinations in accordance with **Section 18.4 "Medical Necessity Criteria"** for physician administered and outpatient facility covered services.

29.14 Call Center Services

The Contractor's Provider and Enrollee call centers should transfer calls about pharmacy services to the Single MCO PBM for response. The Contractor shall coordinate a warm transfer process with the Single MCO PBM and as agreed upon by the Department.

29.15 Kentucky Pharmacy Director Workgroup

Pursuant to **Section 9.3 "Monthly Meetings"** and as directed by the Department, Contractor's Pharmacy Director shall meet, at a minimum, 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.

29.16 Pharmacy Network Provider Orientation and Education

The Contractor shall collaborate and participate with the Single MCO PBM to develop, implement, and conduct ongoing educational programs for the Kentucky Medicaid Pharmacy Provider community. These educational initiatives shall include, but not be limited to:

1.A. Provider letters and bulletins;
1.B. PDL drug changes and distribution;
1.C. POS messaging;
1.D. Training sessions, webinars, quarterly newsletters, and other training activities as requested by the Department;
1.E. Billing instructions and Claim resolution;
1.F. Website postings of the PDL; and
1.G. PA processes and procedures.

The Single MCO PBM is responsible for implementing and administering the educational initiatives.

29.17 Pharmacy Benefit Manager or Administrator Reporting Requirements

The Contractor shall comply with all pharmacy reporting requirements and ad hoc requests for reports and data of this Contract made by the Department and those in applicable statutory or regulatory authority. The Department will coordinate with the Contractor and the Single MCO PBM to determine which pharmacy reports the Single MCO PBM will develop and submit to the Department and which reports the Contractor will continue to provide. The Contractor shall use data it receives to develop

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such reports and/or utilize the Single MCO PBM reporting platform. At the request of the Department, the Contractor shall provide both summary and detailed reports to the extent the Single MCO PBM has provided the necessary information to the Contractor. Detailed reports shall include Claim level details at the Department's request, and to the extent the Single MCO PBM has provided the necessary information to the Contractor. The Department recognizes the Single MCO PBM is the system of record for pharmacy information.

29.18 High Cost Drug Stop Loss Pool

DMS will establish a High Cost Drug Stop Loss Pool (Stop Loss Pool) for all managed care Contractors. Except for the dual eligible population, all Kentucky Medicaid managed care populations and regions are subject to the Stop Loss Pool. Funding and payment from the stop loss pool will be done in a one-time transaction among the MCOs following the end of each Calendar Year. The Stop Loss Pool will be budget-neutral to the Department.

For eligible claims, the Stop Loss Pool will reimburse an MCO based on the prescribed stop loss formula illustrated by the Department's actuaries. Six (6) months after the end of CY 2021, a comparison will be made between each MCO's contributions to the Stop Loss Pool (via PMPM amounts in each rate cell) and eligible reimbursement. Based on Stop Loss Pool contributions and payments, either a recoupment will be required from the MCO or the MCO will receive additional revenue. Additional adjustments to the stop loss pool payment methodology when actual drug costs are above or below estimated amounts will be described by the Department's actuaries to all MCOs. Drug products eligible for the Stop Loss Pool will be determined by the Department and provided to all MCOs.

For claims to be eligible for Stop Loss Pool reimbursement, the Contractor must submit proof of the acquisition cost of the drug paid by the provider. Documentation must include: 1) the Medicaid member ID; 2) incurred date of the claims; 3) actual cost paid to the provider; 4) actual acquisition cost with the invoice amount from the manufacturer or buyer of the drug provided to the Contractor by the provider; 5) applicable NDC or J-code identifying the drug; 6) quantity of the drug. Note, as MCOs are not allowed to retain any pharmaceutical rebates, except for supplemental rebates for medically billed drugs, rebates do not need to be considered in the stop loss pool calculation. If a rebate is obtained, the amount must be reported to the Department.

A pharmacy benefits claim is required to have the NDC billed through a retail or specialty pharmacy. A medical benefits claim is required to be billed through a CMS 1500 form or 837P electronic claim. All medical benefits claims are required to have the NDC and its corresponding HCPCS code that begins with the letter "J" (drugs administered other than oral method, chemotherapy drugs).

The Department, at its discretion, may choose to carve-out certain drug therapies and/or therapeutic drug classes from managed care to be covered by the FFS pharmacy benefit or the FFS medical benefit. The MCOs will be notified in writing thirty (30) Days prior to the change in coverage of products moving from managed care to FFS.

In lieu of a carve out to FFS, the Department may identify certain drug therapies and/or therapeutic drug classes that are not part of the high cost drug pool that would be reimbursed by the Department directly to the Contractor through an invoice after the close of the calendar year. The Department will provide the Contractor with the criteria to identify the applicable drug as well as the process to request reimbursement.

30.0 SPECIAL PROGRAM REQUIREMENTS

30.1 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

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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 timeframes required by the terms of this Contract as in **Appendix H "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program."** The Contractor shall comply with 907 KAR 11:034, which sets forth the requirements for all EPSDT providers participating in the Medicaid program. Healthcare professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:

1.A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements in 907 KAR 11:034 and who are supported by adequately equipped offices to perform EPSDT services.

1.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 healthcare, 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.

1.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 H "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program."**

1.D. Provide all needed initial, periodic, and inter-periodic health assessments in accordance with 907 KAR 11:034. The PCP 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.

1.E. Provide all needed diagnosis and treatment for eligible Enrollees in accordance with 907 KAR 11:034. The PCP 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.

1.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 H "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program."**

1.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.

1.H. Establish and maintain an effective and ongoing Enrollee Services function for eligible Enrollees and their families to provide education and counseling about 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 healthcare, 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 PHM Program.

1.I. Maintain a consolidated record for each eligible Enrollee, including reports of informing about EPSDT, information received from other providers, 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.

1.J. Establish and maintain a protocol for the 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

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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, or DCBS.

1.K. Participate in any state or federally required chart audit or quality assurance study.

1.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.

1.M. Submit an Encounter Record for each EPSDT service provided according to Department requirements, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.

1.N. Provide an EPSDT Coordinator staff function with adequate staff or Subcontract personnel to serve the Contractor's enrollment or projected enrollment.

30.2 Dental Services

The Contractor shall provide timely preventive and primary care dental services for oral health conditions and illness 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 1:126.

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 FFS 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 healthcare needs.

The Contractor shall have the 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**."

30.3 Emergency Care, Urgent Care, and Post Stabilization Care

Emergency Care, as defined in 42 U.S.C. 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

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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.

30.4 Out-of-Network Emergency Care

In compliance with 42 C.F.R. 438.114,the Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network .

Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid FFS 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 FFS payments.

30.5 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. The 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. The Contractor will also demonstrate efforts to address known disparate outcomes or barriers to access breastfeeding support through participation in established interventions or new collaborations. All newborn Enrollee's newborn screening shall be covered as specified in the Commonwealth of Kentucky metabolic screen.

30.6 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 E "Covered Services"**. 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 court orders for Enrollees less than eighteen (18) years of age pursuant to Title X, 42 C.F.R. 59.10, 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 et seq., and KRS 214.185.

All information shall be provided to the Enrollee in a confidential manner. Adolescents shall be assured that Family Planning Services are confidential and that any necessary follow-up will ensure the Enrollee's privacy.

30.7 Nonemergency Medical Transportation

The Department contracts with the Kentucky Transportation Cabinet, Office of Transportation Delivery to provide NEMT services to select Medicaid Enrollees. Through the NEMT program, certain eligible Enrollees receive safe and reliable transportation to Medicaid Covered Services. The Contractor shall provide educational materials regarding the availability of transportation services and

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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.

30.8 Pediatric Interface

School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the Department through FFS Medicaid.

Preventive and remedial care services, as defined in 907 KAR 1:360 and the Kentucky State Medicaid Plan, provided by DPH through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised healthcare 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.

30.9 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.

30.10 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 Department will ensure that the Single MCO PBM provides the necessary support required for the Contractor to administer the lock-in program. The program shall include:

1.A. Criteria for identification and enrollment of an Enrollee in the lock-in program;
1.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;
1.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;
1.D. Length of enrollment in the program and ongoing assessment process;
1.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**."

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30.11 1115 Reentry Waiver Population

The Contractor shall provide or arrange for the provision of Section 1115 Reentry waiver pre-release services to eligible Enrollees as defined in **Section 24.8 Persons Eligible for Enrollment and Retroactivity** 1.N, commencing sixty (60) Days prior to their release. Section 1115 Reentry Waiver services are as follows:

1.A Case Management: The Contractor shall provide case management services to address physical health, behavioral health, educational, and health-related social needs for up to sixty (60) Days prior to release, and a minimum of thirty (30) Days post-release. Enrollees may receive case management services up to twelve (12) months post-release as needed. Minimum service requirements include:

1. Comprehensive assessment of medical, educational, and social needs.
2. Development of a person-centered care plan.
3. Notification of immediate clinical, behavioral, educational, or social needs to the correctional staff.
4. Referrals and linkages to appropriate care post-release.
5. Monitoring and follow up to ensure the care plan is effectively implemented.

1.B Medication-assisted Treatment (MAT) services with accompanying counseling for individuals diagnosed with a substance use disorder up to sixty (60) Days prior to release.

1.C Pursuant to **Section 29.0 "Pharmacy Benefits"**, thirty (30) Day supply of all clinically required prescription medication (inclusive of over-the-counter medications) and, if applicable, a prescription/written order for Medical Supplies, Equipment, and Appliances immediately upon release.

The Contractor shall take all reasonable and appropriate actions necessary to ensure the continuity of an Enrollee's care upon disenrollment pursuant to **Section 24.16 "Continuity of Care upon Disenrollment"**.

The Contractor shall provide reports pursuant to **Section 35.0 "Contractor Reporting Requirements**."

30.12 Health Related Social Needs-Recuperative Care (HRSN-RC) Pilot Program

The Contractor shall provide or arrange for the provision of services as defined under the Department's Section 1115 HRSN-Recuperative Care (HRSN-RC) Pilot Program waiver. The Contractor shall provide short-term clinically appropriate housing and support services (e.g., medical respite) for up to six (6) months per rolling year for eligible Enrollees experiencing or at risk of homelessness who need recovery support following hospitalization or planned medical procedures.

Eligible Enrollees are adults aged eighteen (18) years of age and older who are independently mobile and able to perform activities of daily living (ADL), require primary medical needs for post-acute care, episodic treatments and pre/post procedure care, and are homeless or at-risk of becoming homeless

30.13 Recovery Residence Support Services (RRSS)

The Contractor shall provide or arrange for the provision of services as defined under the Department's Section 1115 Recovery Residence Support Services (RRSS) Program waiver. The Contractor shall provide non-clinical support services that help Enrollees with substance use disorders (SUD) stabilize in community-based recovery residences. Non-clinical support services, such as skills training, coaching, and recovery focused case management shall be provided for up to ninety (90) Days per rolling year.

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Eligible Enrollees are individuals with a SUD diagnosis who meet the appropriate American Society for Addition Medicine (ASAM) level of care, Enrollees participating in the Behavioral Health Conditional Dismissal program, and Enrollees transitioning from pre-release services under the Reentry demonstration initiative.

31.0 BEHAVIORAL HEALTH SERVICES

31.1 Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) Responsibilities

DBHDID works 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 Behavioral Health Services. The Contractor shall comply with standards identified in the "Interoperability Standards Advisory—Best Available Standards and Implementation Specifications" (ISA) and 45 C.F.R. 170 Subpart B in complying with the Commonwealth's behavioral health policies.

31.2 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:

1.A. Enrollees have the right to retain the fullest control possible over their behavioral health treatment. Behavioral Health Services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare.
1.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.
1.C. The Contractor shall measure Enrollees' satisfaction with the services they receive.
1.D. The Contractor's Behavioral Health Services shall be trauma-informed, recovery and resiliency-focused.
1.E. The Contractor's Behavioral Health Services shall be delivered in a culturally competent manner with the application of a health equity lens to the provision of services.

31.3 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 E "Covered Services."** All Behavioral Health Services shall be provided in conformance with Department access standards. 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 the 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.

31.4 Behavioral Health Provider Network

The Contractor shall provide access to Psychiatrists, Psychologists, and other Behavioral Health Service providers. CMHCs shall be offered participation in the Contractor provider network. Other eligible providers of Behavioral Health Services include Licensed Professional Clinical Counselors,

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Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavioral Health Services Organizations, Licensed Clinical Social Workers, and other independently licensed behavioral health professionals. 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.

31.5 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 a continuum of care to ensure the Enrollee has access to care at the appropriate level, including but not limited to:

1.A. Care for non-life threatening emergencies within six (6) hours.
1.B. Urgent care within 48 hours.
1.C. Initial visit for routine care within ten (10) Business Days.
1.D. Follow-up routine care.

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 to be 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 healthcare, 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.

31.6 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 key performance indicators. Chat and text options may be included in the Contractor's hotline offerings.

Key Performance Indicators	Definition	Target	Action
Calls Received	Total number of contacts received	Not applicable	Monthly report out and ad hoc

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Key Performance Indicators	Definition	Target	Action
Calls Answered	Total number of contacts answered	Greater than ninety percent (90%)	Monthly report out and ad hoc, track state transition rates, and provide action plans for improvement of response as required
Phone Average Speed to Answer	Speed to answer contact	Of contacts answered, ninety-five percent (95%) answered in twenty (20) seconds, ninety percent (90%) answered in fifteen (15) seconds (network target)	Monthly report out and ad hoc
Abandonment Rate	Percentage of contacts received versus disconnected prior to answer	Less than five percent (5%)	Monthly report and ad hoc
Direct/Rollover Calls to Backup Centers	Total number of phone contacts sent to Lifeline Centers	Less than ten percent (10%)	Monthly report and ad hoc

No incoming calls may receive a busy signal. 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 required by the Department.

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.

31.7 Coordination between the Behavioral Health Provider and the PCP

The Contractor shall require, through contract provisions, that PCPs have screening and evaluation

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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 them 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 healthcare 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 Enrollee's 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.

31.8 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 through contract provisions, sampled audits, and Provider education that Behavioral Health Service Providers contact Enrollees who have missed an appointment within twenty-four (24) hours to reschedule appointments.

31.9 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 or KRS 202A.

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.

31.10 Continuity of Care Upon Discharge from a Psychiatric Hospital

1.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 federal *Olmstead* law. At a minimum,

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the agreement shall include the 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.

1.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 and identified SDoH 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.

31.11 Program and Standards

Appropriate information sharing and careful monitoring of diagnosis, treatment, follow-up, and medication usage are especially important when Enrollees use physical and behavioral health systems simultaneously. The Contractor shall:

1.A. Establish guidelines and procedures to ensure accessibility, availability, referral, and triage to effective physical and behavioral healthcare, including Emergency Behavioral Health Services (e.g., Suicide Prevention and community crisis stabilization);
1.B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;
1.C. Identify a method to evaluate the continuity and coordination of care, including Enrollee-approved communications between behavioral healthcare providers and PCPs;
1.D. Protect the confidentiality of Enrollee information and records; and
1.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. The Department shall closely monitor drug utilization patterns of psychopharmacological medications. The findings of these evaluations will be provided to the Contractor.

31.12 NCQA/MBHO Accreditation Requirements

The Contractor shall demonstrate to the Department its compliance with NCQA/MBHO accreditation requirements, at a minimum, by meeting the following standards:

1.A. The availability of behavioral healthcare practitioners and providers within its network;
1.B. The development of preventive behavioral health programs;
1.C. The development of Self-Management Tools for Use by Enrollees;
1.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;
1.E. The adoption of Clinical Practice Guidelines specific to the needs of behavioral health clients;
1.F. The establishment of a process for Data Collection and Integration between the Contractor and the MBHO;

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1.G. Identify and report on critical Performance Measures that are specific to behavioral health Enrollees;
1.H. Establish a written program description for the MBHO's Utilization Management Program; and
1.I. Establish a collaborative process between behavioral healthcare and medical care.

31.13 Coordination and Collaboration with Behavioral Health Providers

The Contractor shall identify and develop community alternatives to inpatient hospitalization for Enrollees currently receiving inpatient psychiatric facility services that could be discharged from the facility if an appropriate treatment alternative were made available in the community. If 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.

32.0 POPULATION HEALTH MANAGEMENT PROGRAM

32.1 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 needs, equity, and SDoH.

To drive improved outcomes for its Enrollees, the Contractor shall establish and operate an integrated PHM Program that incorporates components of NCQA's PHM Program.

The Contractor shall implement a PHM Program that supports Enrollees across the care continuum, promoting healthy behaviors and self-management as well as providing, as needed, Care Coordination and Complex Care Management 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 annually no later than June 30 of each year. The PHM Program Plan must address all program elements 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 following three risk levels, at a minimum, in the most cost-effective manner possible.

1.A. **Health Promotion and Wellness**. The Contractor shall provide comprehensive wellness and prevention support to Enrollees with little or no risk factors. The Contractor shall provide services and supports to encourage Enrollees to become proactive participants in their health and well-being and 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 DPH, on joint preventive health and wellness initiatives, as appropriate.

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1.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 the quality of life for Enrollees who have a chronic condition through integrative care. Care Coordination should help Enrollees address potential co-morbidities or other complications and help avoid complications.

1.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 the 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 the implementation of the Care Plan and to facilitate the 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 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:

2.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;
2.B. Templates for PHM Program tools, where applicable (e.g., Health Risk Assessment, Enrollee Needs Assessment, Care Plans)
2.C. Risk stratification methodology, including types of data used;
2.D. Services and information available to Enrollees within the risk level, including service tiers, if applicable;
2.E. Description of the care planning process;
2.F. Stakeholder engagement strategies, including those for Enrollees, Providers, community resources, and social services agencies;
2.G. Methods the Contractor will implement to engage Enrollees and encourage participation;
2.H. Methods for information exchange, as applicable;
2.I. Frequency of provision of services;
2.J. Priority areas (e.g., specific health risks, conditions, SDoH);
2.K. Description of staffing, including qualifications;
2.L. If applicable, VBP or incentive models included in Provider agreements to support involvement in the PHM Program;
2.M. Methods for evaluating the success of services provided; and
2.N. Equity plan to address disparities in care for identified sub-populations.

32.2 Conditions and Populations

The Department has identified the following conditions and populations as priorities for the PHM Program. To improve the completeness of the PHM program, race, ethnicity, and language shall be incorporated into the Contractor's 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 later identified.

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1.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.

1.B. Population priorities, include:
1. Adults and Children with Special Healthcare Needs, as in **Section 33.0 "Enrollees with Special Health Care Needs;"**
2. Maternal Health (pre and postpartum), including high-risk pregnant women per the American College of Obstetricians and Gynecologists (ACOG); and
3. Other populations as determined by the Contractor and/or the Department.

1.C. Provide assertive engagement to underserved and disenfranchised communities, including Black, Indigenous, and People of Color (BIPOC), and sexual orientation and gender identification (SOGI).

1.D. Establish a process for continuous quality improvement, including:
1. Disaggregate data to identify existing disparities, including any racial/ethnic/social inequities;
2. Select and engage in at least two (2) data-driven activities to reduce racial/ethnic/social disparities; and
3. Monitor equitable access to and utilization of services within communities of color, individuals who are currently unhoused, and others who are at an increased risk due to related health disparities.

1.E. Explore and develop pathways to increase equitable treatment access for identified at risk populations in each of the member agencies through newly developed or equity-enhanced policies.

1.F. Collaborate with the Department on any health equity initiatives, including participation in workgroups or committees**.**

32.3 Population Health Management Program Tools

The Contractor shall use a variety of tools to support the 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.

1.A. Risk Stratification and Service Tiers

The Contractor shall implement a risk stratification methodology to determine the risk of its overall population and to identify individual Enrollee risk levels. The Contractor's methodology should include the use of integrated data to support the identification of an Enrollee's need for specific services. The risk stratification process should identify and predict which beneficiaries are at high risk. The Contractor should use disease, comorbidity, health assessments, healthcare costs, as well as other criteria (such as age and gender), to stratify members. The methodology should rely on claims and demographic data to determine risk score.

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.

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1.B. Health Risk Assessments (HRA)

The Contractor shall utilize a standardized Health Risk Assessment (HRA) tool, as approved by the Department, to determine an Enrollee's general needs for participation in the PHM Program. The completion rate of an initial and annual HRA should be twenty percent (20%) or greater for each and identify Enrollees who may require an Enrollee Needs Assessment. The information to be collected shall include, at a minimum: 1) General characteristics and health needs; 2) Health status and behaviors; 3) Health education and cultural and linguistic needs; 4) Health Disparities; 5) SDoH; 6) Behavioral health status; 7) Any gaps in needed services and resources even if they are not Covered Services; and 8) race, ethnicity, and gender. 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 SDoH, health equity, 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, to assess the Enrollees' healthcare needs within ninety (90) Days of Enrollment or earlier if the Enrollee is identified via other information or self identifies as having specific healthcare or social needs.
2. Within thirty (30) Days of when the Contractor can determine an Enrollee is pregnant. If determined pregnant, the Contractor shall refer the Enrollee for appropriate prenatal care.
3. Annually to assess Enrollees for any new healthcare 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 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 (3) 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 healthcare providers, if applicable, to try to obtain a usable number.

1.C. The Contractor shall use Government Alliance on Race and Equity (GARE) Tool or other evidence-based tools or approaches to assist in the development of strategies and actions that reduce racial disparities in service access. Additional evidence-based tools to assist in the development of strategies and actions that reduce access disparities among LGTBQIA+ individuals should also be explored and used, as appropriate.

1.D. 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 healthcare, mental health, and SUD needs;
2. Psychosocial, functional, and cognitive needs;
3. SDoH;
4. Health equity risk factors;
5. Ongoing conditions or needs that require treatment or care monitoring;
6. Current care being received, including healthcare services or other care management;
7. Current medications, prescribed and taken;
8. Support network, including caregivers and other social supports; and
9. Other areas as identified by the Contractor or Department.

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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 ninety (90) 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 healthcare 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, unhoused);
2. At least annually;
3. At the Enrollee's request; and
4. Upon referral from a provider, caregiver, or social services agency.

32.4 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 the development of the care team and Care Plan.

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:

1.A. Appropriate medical, behavioral, and social services and be consistent with the PCP's medical diagnosis and clinical treatment plan;
1.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;
1.C. Description of Enrollee's psychosocial needs and SDoH; how such needs will be addressed to ensure the Enrollee's ability to live safely in the community;
1.D. Social, educational, and other services needed by the Enrollee;
1.E. Enrollee risk factors and measures in place to minimize them; and
1.F. Planned Interventions.

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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 is to be routinely updated, and include input from the multidisciplinary care team, as applicable, and the Enrollee in accordance with the Contractor's policies and procedures.

32.5 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 MCOs 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, allergies or intolerance that affects nutritional status, tobacco product use, anemia, diabetes, low birth weight, failure to thrive, pre-term babies, infants of mothers with substance use disorder, persons with an identified developmental or intellectual disability, or auto-immune deficiency (AIDS). The Contractor shall educate Enrollees about the WIC program, services provided, and how to access services.

32.6 Program Evaluation

The Contractor shall conduct ongoing review of its PHM Program and report to the Department based on agreed upon performance measures and targets and reporting requirements. The Contractor shall highlight the status and progress of its PHM Program services in achieving improved outcomes, as well as knowledge gained, 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 any need for modification of priorities, measures, and targets.

33.0 ENROLLEES WITH SPECIAL HEALTH CARE NEEDS

33.1 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 conditions 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 individuals so the Contractor can facilitate access to appropriate services.

As per 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 that govern how Enrollees with these multiple and complex physical and behavioral healthcare needs are further identified. The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Enrollees for screening and identifying ISHCNs. 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 ISHCNs based on the following populations:

1.A. Children in/or receiving Foster Care or adoption assistance, if applicable.

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1.B. Blind/Disabled Children under age nineteen (19) and Related Populations eligible for SSI;
1.C. Adults over the age of sixty-five (65);
1.D. Unhoused (upon identification);
1.E. Individuals with chronic physical health illnesses;
1.F. Individuals with chronic behavioral health illnesses;
1.G. Children receiving EPSDT Special Services; and
1.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.

For ISHCN, Enrollees who are Blind/Disabled Children under age nineteen (19) and Related Populations eligible for SSI or Children receiving EPSDT Special Services, the Contractor shall, as part of the required assessment, identify whether a caregiver, parent and/or guardian is also an Enrollee. In cases where the caregiver, parent and/or legal guardian is an Enrollee, the Contractor shall identify any caregiving needs the Enrollee may have in supporting the specified ISHCN in their care. The Contractor shall report the number of these Enrollees with any caregiving needs to the Department on a quarterly basis.

The Contractor shall have policies governing the mechanisms utilized to identify, screen, and assess individuals with special healthcare needs. The Contractor will produce a treatment plan for Enrollees with special healthcare 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 the needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral healthcare services to this population.

33.2 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 the Department for Aging and Independent Living (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 the Department thirty (30) Days after the end of each month.

The Contractor shall develop and implement policies and procedures to ensure all DAIL clients have access to Care Coordination. The Contractor shall track, analyze, report, and when indicated, develop CAPs 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's 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.

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33.3 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 (under 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 those statutes, and a person authorized to make healthcare 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.

33.4 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 an 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 the 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.

34.0 PROGRAM INTEGRITY

The Contractor shall have arrangements, 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 to comply with all applicable requirements and standards under the Contract and federal and state requirements and standards to detect Fraud, Waste, and Abuse. The Department has defined minimum standards for the Contractor's Program Integrity Unit (PIU) as follows:

1.A. Identification of a minimum of one percent (1%) in provider Overpayments identified or recovered annually;
1.B. Conducting a minimum of three (3) on-site visits per quarter;
1.C. Coordinate all outpatient pharmacy audits with the Single MCO PBM and the Department;
1.D. Attending any training or meeting given by the Commonwealth on the topic of the detection and prevention of Fraud, Waste, and Abuse;
1.E. Collecting outstanding debt owed to the Department;
1.F. Responding to informational or reporting requests timely;
1.G. Requesting permission to administratively collect Overpayments over five hundred dollars ($500);
1.H. Ensuring formal case tracking and case management of provider and Enrollee cases;
1.I. Maintaining two (2) full-time investigators with a minimum of three (3) years healthcare Fraud, Waste, and Abuse investigatory experience located within the United States dedicated one hundred percent (100%) to the Kentucky Medicaid Program. The Contractor shall notify 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
1.J. Meeting the requirements of **Appendix I "Program Integrity Requirements."**

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34.1 Program Integrity Plan

The Contractor shall develop, in accordance with the Contract requirements in this Section and **Appendix I "Program Integrity Requirements**," a Program Integrity plan for the Commonwealth of internal controls, 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. The Contractor shall submit the Program Integrity Plan at a minimum of one (1) time each calendar year, the first of which is due by January 31, to the Division of Program Integrity. The plan shall also be submitted for approval in accordance with **Section 4.4 "Approval of Department."** This plan shall include, at a minimum:

1.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 and all federal and state requirements and standards;

1.B. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the Board of Directors;

1.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 Contract's requirements;

1.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, including 42 U.S.C. 1396a(a)(68);

1.E. Effective lines of communication between the Compliance Officer and the Contractor's employees;

1.F. Enforcement of standards through written and well-publicized disciplinary guidelines;

1.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 FCA;
4. Provision for reporting to the Department of all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, within thirty (30) Days 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 through 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 the Contractor in writing of the reason for the Overpayment;
7. Suspension and escrow of payments to Network Providers the Department has notified the Contractor that there is a credible allegation of Fraud in accordance with 42 C.F.R. 455.23. The Contractor shall escrow the Network Provider's fully processed adjudicated claims and only adjust funds/claims at the end of each calendar quarter or if an Escrow

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Balance Verification (EBV) has been requested per the Department's instructions. The Contractor shall 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 Enrollee's death;
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. The regular application of methods 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;
11. In accordance with 42 C.F.R. 455, ensure all of the Contractor's Network Providers are enrolled with the Department consistent with the provider disclosure, screening, and enrollment requirements;
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.

1.H. Contractor shall be subject to on-site review and comply with the Department's requests to supply documentation and records;

1.I. Contractor shall comply with 42 C.F.R. 455.20 by employing a method of verifying with Enrollees whether the services billed by the provider were received by randomly selecting a minimum sample of five hundred (500) Claims every month;

1.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;

1.K. The Contractor shall follow cases from the time they are opened until they are closed following written protocol regarding submission of the investigative reports to the Department; and

1.L. 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 the 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."**

34.2 Prepayment Review

The Contractor shall have written policies, procedures, and standards of conduct for a Prepayment Review process in accordance with this Contract. The Contractor shall perform a review when there is a sustained or high level of payment error or data analysis identifies possible Fraud, Waste, and Abuse. Prior to placing a provider under Prepayment Review that the Contractor plans to conduct prior to issuing payment, the Contractor shall submit a written request via SharePoint to the Division of Health Plan Oversight for approval with a copy to the Division of Program Integrity. The request shall include at a minimum the following:

1.A. Case Number;
1.B. Provider Name;
1.C. Medicaid Provider ID;
1.D. NPI;

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1.E. Summary of Concern;
1.F. Draft of the provider notice;
1.G. Start date of review;
1.H. Background information on attempts to educate the Provider;
1.I. Past improper payment rate of the Provider;
1.J. Length of time Provider is expected to be on Prepayment Review;
1.K. Expected number of claims and dollar value of claims expected to be reviewed per month; and
1.L. Criteria for removing the Provider from Prepayment Review.

The Department will respond to requests for Prepayment Review within ten (10) Business Days. The Department may, at its discretion, exempt a Contractor from requirements to seek prior approval. If prior approval is no longer required, the Department will send a written notice to the Contractor.

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 indefinitely. 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.

Written notice shall be sent to the provider two (2) Business Days before the date a Prepayment Review is started through multiple modes of communication, including certified mail, fax and/or email, if an email address is on file. The written notice shall contain the following:

2.A. Specific reason for the review;
2.B. Complete description of the specific documentation needed for the review and method of submission;
2.C. Timeframe for returning the documentation, and information that the Claim will be denied if the documentation is not returned timely;
2.D. Length of time the Prepayment Review will be conducted if the Contractor has determined one at its discretion;
2.E. Contact information if there are questions related to the Prepayment Review; and
2.F. Information on how the provider may request removal of a Prepayment Review.

The Contractor shall ensure the documentation is readily available during the investigative progression from referral (external or internal) to closure and ensure the investigation meets Departmental requirements and 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. Within the forty-five (45) Day period the Contractor shall withhold payment until the Provider produces the record or information or the Provider notifies the Contractor in writing that the record or information cannot be produced.. If the Provider notifies the Contractor in writing that the record or information cannot be produced, the Contractor may deny the Claims under Prepayment Review. The Contractor shall deny claims under Prepayment Review if the Provider does not submit records or respond to requests for information from the Contractor . The Contractor shall deny a Claim when the submitted documentation lacks evidence to support the service or code.

The Contractor shall follow **Section 25.10 “Provider Grievances and Appeals”** for any Appeals related to the prepayment process. The Contractor may extend the length of a Prepayment Review when necessary to prevent improper payments. If the Contractor extends a Provider on Prepayment

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Review for longer than one (1) year, the Contractor shall submit a request and rationale for the extension to the Department for review and approval. 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 the Prepayment Review from the Director of Program Integrity (or designee) and the Director of Health Plan Oversight (or designee).

The Contractor shall notify the Director of Program Integrity (or designee) and the Director of Health Plan Oversight (or designee) when a provider is no longer under Prepayment Review.

The Contractor shall submit an annual listing of providers placed under Prepayment Review during the calendar year in a manner prescribed by the Department.

34.3 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, Waste, or Abuse recovered by the Commonwealth or designees shall be retained by the Commonwealth or its designees.

34.4 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.

34.5 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 designee, within thirty (30) 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, overturn, or amend an identified Overpayment disputed by the Contractor. The Contractor shall be notified of the Department's decision in writing within ninety (90) Days of receipt.

35.0 CONTRACTOR REPORTING REQUIREMENTS

35.1 General Reporting and Data Requirements

The Contractor shall comply with all Contract reporting requirements and comply with state and federal guidance and regulations, including 42 C.F.R. 438.604. The Contractor shall also support the Department in providing required and ad hoc reporting to CMS or other state or federal agencies. The Contractor shall attest to 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 transparent, responsive, and without material omission.

The Contractor shall submit all required reports included in this Contract and the DMS Medicaid

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Managed Care (MMC) Program Reporting Package within the required timeframes. The Contractor shall follow the standardized reporting templates and specifications for reports as provided by the Department without modification. 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. For any reports for which the Department does not provide templates and specifications, the Department may request the MCO to submit its template and specifications for review and approval.

The Department reserves the right to introduce new reports and modify the form, nature, content, instructions, and timetables for the collection and reporting of data throughout the Contract Term, including modification to the required reporting package. The Department has final approval for all reporting requirements, specifications, data definitions, and submission timeframes. When introducing a new report or making material changes to an existing report, the Department shall provide written notice, including timeframes for implementation, to the Contractor and make reasonable efforts to collaborate with the Contractor and other MCOs to confirm understanding of the new requirements and the feasibility of implementing the requirements of the report within the timeframes provided. Any requested modification will take cost into consideration.

The Department may require the Contractor to prepare and submit ad hoc reports. The Contractor shall provide such additional data and reports as may be reasonably requested by the Department. 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.

The Contractor shall respond to any Department request for information or documents within the specified timeframe. 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.

If report deliverables are returned to the Contractor due to errors or incomplete information, the Contractor agrees to correct the report and resubmit within five (5) Business Days. The Contractor shall be subject to penalties for failure to provide complete and accurate data or failure to provide required reports as in **Appendix A** "**Remedies for Violation, Breach, or Non-Performance of Contract**."

35.2 Medicaid Managed Care (MMC) Program Reporting Package and Report Submission to the Department

The Department will post the current version of the MMC Program Reporting Package, inclusive of standardized reporting templates and specifications, on the Kentucky MMC SharePoint site. The Department will update the version number of the MMC Program Reporting Package for any change made and will document each change in the 'Version Change Summary' section at the beginning of the document.

The Department and the Contractor will follow the Standard Operating Procedure (SOP)posted on the Kentucky MMC SharePoint site when the Department revises or adds new reporting requirements.

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Except as otherwise provided in this Contract, the Contractor shall submit all reports to the Department's Division of Health Plan Oversight via the Kentucky MMC SharePoint site.

35.3 Reporting Requirements for Specific Operational Areas

Below are reporting requirements for specific operational areas that the MCO must develop and submit as indicated for each report. The Department may amend these requirements as needed, based on collaboration with the MCOs.

35.3.1 Paid Claims Report

The Contractor shall provide a paid Claims report, in a manner and format as required by the Department, to each of the Contractor's Network hospitals as outlined in **Appendix J "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.

35.3.2 COB Reporting Requirements

The Contractor shall submit a monthly Coordination of Benefits Report for Enrollee activity to comply with CMS reporting requirements. Additionally, the Contractor shall submit a report that includes but is not limited to subrogation collections from auto, homeowners, or malpractice insurance.

35.3.3 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 the HIPAA 820 transaction. Adjustments shall be made to the next HIPAA 820 transaction and/or next available HIPAA 834 transactions to reflect corrections.

35.3.4 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 KRS 205.559 and KRS 211.334. Information and data provided by the Contractor shall be sufficient to enable the Department to analyze and report on the following:

1.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;
1.B. The quality of care as a result of Telehealth Consultations; and
1.C. Any other issues deemed relevant by the CHFS.

In addition to this analysis, 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 CHFS for the administration or provision of the Medicaid program.

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35.3.5 Grievance and Appeal Reporting Requirements

The Contractor shall submit reports of Enrollee Grievances and Appeals and their disposition as described in the DMS MMC Program Reporting Package.

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.

35.4 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 Department's requirements, including the use of specified EPSDT procedure codes and referral codes.

35.5 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 systems 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 (120) Days following the end of each fiscal year an annual audited financial statement 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 require an audit of paid claim costs, other costs, including administrative costs, revenue, and membership reported in MRTs, at the Contractor's expense. The Contractor will have sixty (60) Days to supply the audit report to the Department.

The Contractor shall complete an Encounter Data Monitoring template quarterly to assist the Department in monitoring emerging utilization and cost data for each category of service and for each population enrolled with the Contractor. Additionally, the Encounter Data Monitoring template will be used to evaluate the Contractor's Encounter data submissions for completeness. The Encounter Data Monitoring template shall contain reporting of the Contractor's eligibility, revenue, medical expense, medical expense adjustments, estimated unpaid claim liabilities, quality improvement expenses, operating expenses, taxes, fees, and assessments. These items will be reported at the population,

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rate cell, region, and eligibility month for each month requested in the Encounter Data Monitoring template. The Department reserves the right to modify the Encounter Data Monitoring template to collect additional information.

For each contract year, the Department will produce documentation titled Encounter Data Monitoring Requirements to outline expectations for the Encounter Claims completeness scoring process. The Department will provide the template and reporting instructions at least thirty (30) Days prior to the first quarterly submission for the calendar year. The Department reserves the right to modify the Encounter Data Monitoring template throughout each contract year.

The Contractor will submit each Encounter Data Monitoring template to the Department by the submission deadlines stated in the Encounter Data Monitoring Requirements document, which will be updated annually. The Department will review the submissions and provide the Contractor with written observations that require either a response from the Contractor addressing the issue or providing further explanation regarding the issue, or an adjustment requiring a resubmission of the Encounter Data Monitoring template. The Contractor shall provide these responses in written electronic communication.

An executive officer of Contractor shall attest to the accuracy and completeness of each quarterly Encounter Data Monitoring template submission provided to the Department. This attestation can be provided electronically.

For one of the quarterly Encounter Data Monitoring template submissions in each calendar year, the Contractor shall provide a reconciliation of its audited financial statement to the Encounter Data Monitoring template in a format specified by the Department. The Contractor shall have the reconciliation reviewed and certified by an executive officer of the Contractor.

Additionally, the Encounter Data Monitoring template will include a worksheet for the Contractor to submit the necessary information to calculate and report its Medical Loss Ratio (MLR) in accordance with 42 C.F.R. §438.8 and **Section 11.4 "Medical Loss Ratio Adjustment."** The Contractor will identify and include any adjustments to the MLR formula, material claims liabilities, and non-finalized provider payments in this calculation.

35.6 Federal Reports

The Contractor shall provide data and reporting to the Department or its designee to support required and ad hoc reporting to CMS or other state or federal agencies. The Contractor shall provide such data and reporting as directed by the Department for the following but not limited to:

1.A **Managed Care Program Annual Report (MCPAR)**: As required by 42 C.F.R. 438.66(e), the Department must submit this report to CMS within one hundred eighty (180) Days after the end of each contract year. This report provides comprehensive information for managed care program operations, including performance metrics and oversight activities.

1.B **Statistical Enrollment Data System (SEDS) Annual Enrollment Reports**: As required by Section 2107(b)(1) of the Social Security Act, the Department must report the number of children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) during the federal fiscal year. These reports capture data for children enrolled for at least one (1) day within the fiscal year.

1.C **Medical Loss Ratio (MLR) Reports:** The Department must submit MLR reports to CMS to demonstrate the percentage of managed care premiums spent on clinical services and quality improvement versus administrative costs or profits. See **Section 11.4 "Medical Loss Ratio Adjustment"** for additional information.

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1.D **Program Integrity Reports**: The Department must provide CMS with reporting for Medicaid Program Integrity efforts as CMS conducts focused reviews to assess effectiveness, evaluate compliance with federal requirements, and identify areas for improvement. Reports addressing the following information must be submitted by the Contractor to the Department:

a. Investigations
b. Overpayments identified or Recovered Annually
c. Cost Avoidance
d. Member Lock-In
e. Explanation of Member Benefits
f. Division of Program Integrity Monthly Dashboard
g. Pharmacy Fraud, Waste, and Abuse.

See **Section 34.0 "Program Integrity"** for additional information.

1.E **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Reporting**: The Department submits an EPSDT CMS-416 report to CMS annually, including data on screening, diagnostic, and treatment services to ensure that children receive appropriate preventive and developmental care. See **Sections 30.1 "EPSDT: Early and Periodic Screening, Diagnostic and Treatment"** and **35.4 "EPSDT Reports"** for additional information.

1.F **Electronic Visit Verification**: See **Section 16.3 "Electronic Visit Verification"** for additional information.

1.G **Payment of Abortion Procedures**.

1.H **Drug Utilization Review**. See **Section 29.9** "**Drug Utilization Review (DUR) Program"** for additional information.

1.I **Performance Improvement Projects Status Report.** See **Section 17.6 "Performance Improvement Projects"** for additional information.

Additionally, the Contractor shall provide other information as required by the Department for other CMS required reports such as the CMS-64, CMS-37, and CMS-21, which pertain to financial budget and expenditure data for Medicaid and CHIP programs.

35.7 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 that affects the most recent disclosure report, or (5) within thirty-five (35) Days following the date of each written request for such information:

1.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;
1.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;
1.C. The same information requested in subsections (A) and (B) for any Subcontractors or suppliers

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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;

1.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-year period;

1.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;

1.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

1.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 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.

35.8 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:

1.A. Administrative costs and expenses incurred pursuant to this Contract;

1.B. Enrollee enrollment status;

1.C. Provision of Covered Services;

1.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;

1.E. Quality Improvement and utilization;

1.F. All financial records, including all financial reports required under **Section 35.5 "Financial Reports,"** A/R activity, rebate data, or DSH requests;

1.G. Performance reports to indicate the Contractor's compliance with Contract requirements;

1.H. Fraud and Abuse;

1.I. Enrollee/Provider satisfaction; and

1.J. Managerial reports.

All records shall be maintained and available for review by authorized federal and state personnel during this Contract and for a period of ten (10) years after termination of this Contract, except when an audit has been conducted, or audit findings are unresolved. In such case, records shall be retained for ten (10) years in accordance with 42 C.F.R. 483.3(h) and 907 KAR 1:672or until all issues are fully resolved, whichever is later.

36.0 RECORDS MAINTENANCE AND AUDIT RIGHTS

36.1 Medical Records

If maintained by the Contractor, 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 healthcare professionals' findings, appointment

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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 in **Section 36.2 "Confidentiality of Records"** and **Appendix M "Cabinet for Health and Family Services Contractor 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 or federal agents, for 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 corrective 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 specialists, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:

1.A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;
1.B. Allow for the tracking and trending of individual and plan wide provider performance over time;
1.C. Include mechanisms and processes that allow for the identification, investigation, and resolution of quality of care concerns; and
1.D. Include mechanisms for detecting over-utilization, under-utilization, and mis-utilization.

36.2 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 those in **Section 38.15 "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 ensuring 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 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.

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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 to perform their duties related to the administration of the Department, including but not limited to HHS, U.S. Attorney's Office, the Office of the Inspector General, the Office of Attorney General, and others as may be required by the Department.

Any data, information, records, or reports that 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 61.870-61.884. 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 61.870-61.884) or 200 KAR 5:314. The Contractor understands that it must designate information 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 in **Section 38.16** "**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 the 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, CMS, or applicable laws or regulations, shall not be considered confidential.

36.3 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 comply 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.

36.4 Identity Theft Prevention and Reporting Requirements

In the delivery and/or provision of Information Technology hardware, software, systems, and/or services through this Contract, 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:

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1.A. Social Security Number;
1.B. Driver's License Number;
1.C. System Access IDs and associated passwords; and
1.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.

36.5 Compliance

The Contractor shall agree to use and disclose Protected Health Information in compliance with HIPAA. 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. The Contractor shall perform an analysis during the System Design phase to ensure the 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 CHFS security policies and procedures. Below is a listing of additional applicable policies, procedures, and laws for which the Contractor must comply:

1.A. Computer Fraud and Abuse Act [18 U.S.C. 1030]
1.B. Privacy Act of 1974 [5 U.S.C. 552a]
1.C. Protection of Sensitive Agency Information [OMB M-06-16]
1.D. NIST 800-53 [Moderate]
1.E. IRS Publication 1075
1.F. Centers for Medicare and Medicaid Services requirements
1.G. Federal Information Processing Standards (FIPS) Publications

36.6 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 of 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

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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:

1.A. Injection;
1.B. Broken Authentication and Session Management;
1.C. Cross-Site Scripting (XSS);
1.D. Insecure Direct Object References;
1.E. Security Misconfiguration;
1.F. Sensitive Data Exposure;
1.G. Missing Function Level Access;
1.H. Cross-Site Request Forgery (CSRF);
1.I. Using Known Vulnerable Components; and
1.J. Invalidated Redirects and Forwards.

CHFS shall have a copy of the application vulnerability assessment within fourteen (14) Business Days of its execution. The Contractor will provide a mediation plan that meets risk assignment and Commonwealth approval.

37.0 REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

37.1 Contract Violations, Breach, or Non-Performance

The Contractor shall comply with all terms, conditions, requirements, performance standards, and applicable Commonwealth and federal laws necessary in the performance of 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 if 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.

37.2 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:

Category 1: Action(s) or inaction(s) that seriously jeopardize the health, safety, or welfare of Enrollee(s); reduces Enrollees' access to care; and/or jeopardize the integrity or viability of Kentucky's Medicaid Managed Care program;

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, or welfare or reduce access to care; or

Category 3: Action(s) or inaction(s) that diminish the efficient operation and effective oversight and administration of the Kentucky Medicaid Managed Care program.

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37.3 Requirement of Corrective Action

1.A. Department Decisions to Impose Remedies

The Department will consider some or all of the following factors in determining the 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.

1.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 designated representative within seven (7) Days of receipt of the Letter of Concern, or within an earlier timeframe if specified by the Department based on the nature, severity, and duration of the 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.

1.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 CAP 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 CAP.
2. A description of the deficiency(ies) and the cause of the deficiency(ies) that resulted in the need for corrective action.

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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 CAP shall be subject to approval by FAC or the Department, which may accept the plan as submitted, accept the plan with specified modifications, or reject the plan within ten (10) Business Days of receipt. FAC or the Department may reduce the time allowed for corrective action depending on the nature of the deficiency.

37.4 Penalties for Failure to Correct

Except for failure to substantially provide Medically Necessary items and services that are required under law and this Contract, following the Contractor's failure to cure a default in accordance with a plan of correction under **Section 37.3 "Requirement of Corrective Action,"** or as otherwise required by the Department, Contractor will be subject to penalties as in this Contract.

A penalty for failure to substantially provide Medically Necessary items and services that are required under law and this Contract may be assessed simultaneously with a request for CAP.

If the Department elects not to exercise any of the penalty clauses 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.

1.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 based on their health status or need for healthcare 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 the Commonwealth.	Up to $100,000 per determination.

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Circumstance	Penalty Amounts
Misrepresents or falsifies information furnished to an Enrollee, potential Enrollee, or a healthcare 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.

1.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 A** "**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 the DMS MMC Program Reporting Package shall not require a Letter of Concern or a CAP before fines are imposed as in **Appendix A** "**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.

1.C. Sanction

If a Contractor, in the sole determination of CHFS, fails to complete a CAP or engages in a pattern of behavior requiring multiple CAPs 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 34, inclusive.

Type B deficiencies shall be a written deficiency in the requirements in the following Contract sections: 3-15, 17-21,35, and 38.

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

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Department's satisfaction. The Department shall impose a nonrefundable penalty of $10,000 for each Type B deficiency.

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 deficiency.

If the deficiency is not remedied within three (3) months from acceptance of the CAP, 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 CAP, all of the funds withheld shall be forfeited in addition to the nonrefundable penalty referenced above.

37.5 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 37.3 "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 to the satisfaction of the Department, may lead to the imposition of any sanction or combination of sanctions provided by this Contract, or otherwise provided by law, including but not limited to all of the following:

1.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;
1.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 the imposition of the sanction no longer exists and is not likely to recur;
1.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;
1.D. A claim against Contractor's Performance Bond;
1.E. Appointment of temporary management;
1.F. Grant Enrollees the right to disenroll without cause and notifying the affected Enrollees of their right to disenroll; and
1.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).

37.6 Violation of State or Federal Law

A finding by any authorized agency that the Contractor has violated any state or federal law related 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 CAP.

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37.7 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 37.3** "**Requirement of Corrective Action**."

37.8 Performance Bond

The Contractor shall maintain a $30,000,000 performance bond payable to the Kentucky Department for Medicaid Services throughout the Contract. The 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 the 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 38.12 "Disputes**."

37.9 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).

37.10 Appeal of Penalties

Prior to exercising the dispute provision of **Section 38.12 "Disputes"**, the Contractor may request reconsideration of a penalty imposed in accordance with **Section 37.0 "Remedies for Violation, Breach, or Non-Performance"** and **Appendix A "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, or his/her designee, within thirty (30) Days of receipt of notification of the penalty.

37.11 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 monetary damages and any of the other remedies in the Contract are available to FAC and CHFS, as well as a remedy of immediate termination of this Contract if the breach is not cured in the specified timeframe:

1.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;
1.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;
1.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 healthcare services as in this Contract to Enrollees;
1.D. The Contractor fails to maintain protection against fiscal Insolvency as required under state or federal law, or as required by 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;
1.E. The Contractor fails to or knowingly permits any Subcontractor, supplier, or any other person or entity who receives compensation pursuant to this Contract, to fail to comply with the nondiscrimination and affirmative action requirements of **Section 5.3 "Nondiscrimination and**

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Affirmative Action";

1.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 this Contract;

1.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;

1.H. The Contractor violates any of the confidentiality provisions of this Contract; or

1.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 **Section 38.12 "Disputes."**

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 the 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.

37.12 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. 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.

Upon final notice of termination, on the date, and to the extent specified in the notice of termination, the Contractor shall:

1.A. Provide a written Transition Plan for the Department's approval within ten (10) Days of receiving the Notice of Termination from the Commonwealth. The Contractor will revise and resubmit the Transition Plan to the Department regularly, the frequency of which will be determined by the Department. In developing the Transition Plan, the Contractor shall include activities to 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 after the request;

The Transition Plan shall include the following at a minimum:

1. Transition goals and steps the Contractor will take to support goals;

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2. A statement that the Contractor agrees to comply with all duties and obligations incurred prior to the effective date of the termination, including the performance of ongoing functions, and the submission of all reports and deliverables;

3. Transition staffing information, including the following:
   a. A listing of key points of contact, roles, and responsibilities;
   b. An appointed liaison for post-transition concerns; and
   c. Sufficient staff in all operational areas across all Enrollee populations to ensure a smooth transition;

4. A communication plan and timeline, including but not limited to notifications to Enrollees and providers, Prior Authorization redirection notifications, and Enrollee outreach workflow. Timeframes for Enrollee and provider notices must assure sufficient time to process returned notices;

5. Data exchange requirements, which must address the following:
   a. The types of data to be shared and the formats in which the data should be shared;
   b. Receiving parties for each type of data;
   c. Timeframes for when the data will be provided to receiving parties and frequency;
   d. When the data sharing will be considered complete;

   The Contractor shall collaborate with the Department and its designees to finalize data exchange requirements, data to be exchanged, and timeframes for completion. The Department will define the metrics it will use to evaluate the success or quality of the data transfer.

6. A listing of all required data reports and deliverables and timelines for submission, including but not limited to the following:
   a. Ongoing status reporting at a frequency determined by the Department. Reporting will detail progress in completing transition obligations, anticipated risks, and mitigation strategies;
   b. Encounter data for all Claims incurred for dates of service prior to contract termination;
   c. Care coordination data in compliance with **Appendix F "Transition/Coordination of Care Plans"** and including data such as assessments of Enrollees' health risks, care needs, or functional status; care plan information, and service authorizations;
   d. 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 physician administered and outpatient facility Claims incurred prior to the contract termination date;
   e. Promptly supplying to the Department such information as it may request on any unpaid Claims submitted by Out-of-Network Providers and arrange for the payment of such Claims within the time periods provided herein;
   f. 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;
   g. Final report that assures the Contractor has fulfilled all obligations. The Contractor shall modify the report as needed until the Department is satisfied that all obligations have been met;

7. Enrollee transition of care plan, including narrative, timeline, and Enrollee services workflow, and identification of at-risk populations. The transition of care plan must comply with the requirements in **Appendix F "Transition/Coordination of Care Plans"** and allow that the Contractor shall:
   a. Continue providing Covered Services to all Enrollees until midnight on the last day of the calendar month for which the Department has made a Capitation Payment;
   b. 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,

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or for the period specified in (a) above, whichever period is shorter;

c. 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; and
d. Arrange for the transfer of Enrollees and Medical Records to other appropriate Providers;

8. Plan for resolving all outstanding grievances and appeals in compliance with **Section 22.0** "**Enrollee Grievances and Appeals"** and **Section 25.10 "Provider Grievances and Appeals."** The Contractor shall:
   a. Be responsible for resolving Enrollee Grievances and Appeals for 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. The Contractor shall be financially responsible for Enrollee Appeals of adverse decisions rendered by the Contractor concerning the 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;
   b. Be responsible for resolving all Provider Grievances and Appeals. This includes Grievances and Appeals for Claims with dates of service prior to the date of contract termination or expiration, including those filed on or after the day of termination or expiration.

1.B. 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

1.C. Provide for the maintenance of all records for audit and inspection by the Department, CMS and other authorized government officials, in accordance with 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 Department policies and procedures.

The Contractor shall fulfill all obligations post-transition to support continuity of care for transitioned Enrollees.

The Contractor may be requested to continue in place for two (2) additional months.

The covenants in this Section shall survive the termination of this Contract and shall remain fully enforceable by FAC and CHFS against the Contractor. If the Contractor fails to fulfill each covenant 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.

37.13 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 that will be incurred by the Department if this Contract is terminated prior to the end of the Contract term and actual or consequential money damages cannot be demonstrated.

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If this Contract is terminated by FAC for convenience as specified in **Section 37.15 "Termination for Convenience"**, the Contractor may seek a remedy pursuant to 200 KAR 5:312.

37.14 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.

37.15 Termination for Convenience

Upon thirty (30) Days prior written notice to the Contractor, FAC 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 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 the Capitation Rate set forth herein for, each Enrollee up to and including the date of transition of such Enrollee.

37.16 Funding Out Provision

The Contractor agrees that if funds are not appropriated to the Department or are not otherwise available for 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, including cancellation or termination charges that may be specified in this Contract.

38.0 MISCELLANEOUS

38.1 Documents Constituting Contract

This Contract shall include:

1.A. This Medicaid Managed Care Contract and any subsequent amendments;
1.B. The Appendices to this Contract;
1.C. The Request for Proposal and all attachments and addendums thereto;
1.D. General Conditions contained in 200 KAR 5:021 and Office of Procurement Services' FAP110-10-00; and
1.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 materials including but not limited to plans, programs, policies, procedures, forms, or documents, 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.

38.2 Definitions and Construction

The terms used in this Contract shall have the definitions in **Section 1.0 "Definitions,"** unless expressly provided 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.

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38.3 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. If changes in state or federal law require the Department to amend its Contract with the Contractor, written notice shall be made to the Contractor 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.

38.4 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:

1.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;
1.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;
1.C. Any notice received from the DOI or CHFS related to this Contract;
1.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;
1.E. The filing of a petition in bankruptcy by or against a Subcontractor or supplier, or the insolvency of a Subcontractor or supplier; and
1.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 a 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 U.S.C. 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.

38.5 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 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.

38.6 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, CHFS, 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 37.11 "Termination for Default,"** 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.

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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 this paragraph, “it” is construed to mean any person with an interest therein, as required by applicable law.

38.7 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.

38.8 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 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 that 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.

38.9 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.

38.10 Severability

If 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 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 this Contract.

38.11 Force Majeure

Events or conditions beyond the reasonable control of the Parties shall not be construed as non-performance, nor shall reductions be applied as a result of such events. Events or conditions beyond the Parties’ reasonable control include, but are not limited to, natural or man-made disasters, weather events, transportation crashes, labor strike or shortage, war, riot or other civil unrest, or state or

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national declared emergency, including a pandemic, or public utility failures. However, CHFS retains the right to obtain any necessary services elsewhere in the event of such non-performance by the Contractor. In this event, the Parties shall negotiate in good faith any appropriate offset to the compensation payable under this Contract. The Contractor shall cooperate and shall require that any Subcontractor cooperate with CHFS in such event. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other, orally or in writing with confirmation of receipt, as soon as possible of the existence of a force majeure event. To preserve this right as a defense, each Party must inform the other in writing, with confirmation of receipt, within twenty (20) Business Days of the force majeure event or otherwise waive this right as a defense to a claim by the other Party of non-performance.

38.12 Disputes

Any disputes arising under this Contract which cannot be disposed of by agreement between the parties shall be decided by the Secretary of CHFS or his/her duly authorized representative. Such decision shall be in writing and sent via first-class mail to the Contract Compliance Officer for the Contractor at the address specified in **Section 38.16 "Notices"**. 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 CHFS until the Secretary of FAC renders a final decision.

The Contractor acknowledges that, pursuant to KRS Chapter 45A.230 et seq., the Secretary of FAC 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.

38.13 Modifications or Rescission of Section 1915 Waiver / State Plan Amendment

It is understood Contractor operates 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 37.1 through 37.13 "Remedies for Violation, Breach or Non-Performance of Contract"**.

38.14 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.

38.15 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 HIPAA and 45 C.F.R. Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this Contract shall mandate that the

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Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of PHI as the Contractor.

38.16 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.

38.17 Survival

The provisions of this Contract that relate to the obligations of the Contractor to maintain records and reports shall survive the expiration or earlier termination of this Contract for a period of five (5) years or such other period as may be required by Commonwealth or CMS record retention policies or 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 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 the expiration or earlier termination of this Contract until such time as the Contractor has satisfactorily complied with the terms thereof.

38.18 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.

38.19 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.

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38.20 Review of Distributions

The Contractor agrees to seek approval from the Department prior to submitting a request for DOI approval for any distributions of capital and surplus that are subject to the provisions of KRS Chapter 304. The parties agree that capital and surplus amounts above 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 to benefit 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 if the Contractor is not domiciled in the Commonwealth of Kentucky. However, on a semi-annual basis, the Contractor shall provide the Department with Medical Loss Ratio calculations relating specifically to this Contract and risk-based capital calculations. Quarterly, the 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.

38.21 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 that are directly pertinent to this contract for 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.

38.22 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.

38.23 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 note the appropriate exemption when providing the documents or records and, if necessary, take the appropriate legal actions to defend such exemption.

38.24 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 the DMS MMC Program Reporting Package. The Contractor agrees to provide any information requested by the Department regarding

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expenditures related to this Contract, including but not limited to any findings of the Medicaid Managed Care Operations Examination.

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APPENDICES

APPENDIX A. 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 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 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 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 in addition to 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 thirty (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.

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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 37.3** "**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 to an LOC request.
9.	Failure of the Contractor to submit a CAP within ten (10) Business Days following the date of the Written Deficiency Notice or to provide an acceptable CAP as set forth in **Section 37.3 "Requirement of Corrective Action**."	$1000.00 per day for each day until the CAP is received. $5,000.00 for failure to provide an acceptable initial CAP as determined by the Department and $500.00 per day from the date of the Written Deficiency Notice for each day the CAP remains deficient.
10.	Failure to timely implement and comply with an accepted CAP as set forth in **Section 37.3** "**Requirement of Corrective Action**."	$500.00 per day for each day the Contractor fails to comply with an accepted CAP 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 38.0 "Miscellaneous**."	One hundred ten percent (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
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.

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No.	Deficiencies	Penalty Amounts
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 27.5 "Payment of Federally Qualified Health Centers ("FQHC"), Rural Health Clinics ("RHC") and Certified Community Behavioral Health Clinic ("CCBHC")."**	$500.00 per day until the information is received.
17.	Failure to submit the required report of the total amount paid to each CCBHC per month within the required timeframe, and as set forth in **Section 27.5 "Payment of Federally Qualified Health Centers ("FQHC"), Rural Health Clinics ("RHC") and Certified Community Behavioral Health Clinic ("CCBHC")."**	$500.00 per day until the information is received.
18.	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 34.2 "Audit by Department or its Designee**."	$500.00 per incident.
	Information Systems	
19.	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.
20.	Failure of the Contractor to provide notice to the Department, as set forth in **Section 15.0 "Management Information System"** at least thirty (30) 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 personnel changes.	Up to $5,000.00 per day of non-compliance.
	Encounter Data	
21.	Timeliness of Encounter Files. 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 thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.

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No.	Deficiencies	Penalty Amounts
22.	Timeliness of Encounters from Adjudication Date. 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 five dollars ($5.00) per encounter is then assessed for each day over the thirty (30) Days. Penalties for encounter timeliness shall be capped at thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.
23.	Timely Resubmission of Erred Encounters. Failure to resubmit erred encounter records within one hundred twenty (120) 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 one hundred twenty (120) Days. An additional penalty for CCBHC, FQHCs and RHCs encounters of eleven dollars ($11.00) per day shall be assessed for each day greater than one hundred twenty (120) Days. Penalties for encounter timeliness shall be capped at thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.
24.	Accuracy: Threshold Error. 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 thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.
25.	Accuracy: File Not in Required Format. 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 thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.
26.	Accuracy: Duplicates. Submission of duplicate encounter submissions as set forth in **Section 16.0** "**Encounter Data**."	Monthly five dollar ($5.00) per duplicate encounter fee. Penalties for encounter accuracy shall be capped at thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.

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No.	Deficiencies	Penalty Amounts
27.	Accuracy: Failure to Submit Required Attestation. Failure of the Contractor to submit the required attestation showing all failed files were successfully resubmitted and accepted within sixty (60) 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 accuracy shall be capped at thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.
28.	Completeness: Failure to Submit All Claims as Encounters. Failure of the Contractor to submit at least ninety-eight (98%) percent of all encounterable Claims as reported in the Encounter Data Monitoring template as Encounters in aggregate as in **Section 16.0 "Encounter Data."** Completeness penalties will be measured quarterly and assessed four times annually.	$50,000.00 per scored period not meeting the completeness standard in aggregate. Penalties for encounter completeness shall be capped at thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.
29.	Completeness: Failure to Submit Claims by Service Subcategory as Encounters. Failure of the Contractor to submit at least eighty-eight (88%) percent of all encounterable Claims (excluding claims processed by the Single MCO PBM) as reported in the Encounter Data Monitoring template as Encounters by subcategory as in **Section 16.0 "Encounter Data."** Completeness penalties will be measured quarterly and assessed four times annually.	$50,000.00 per scored period not meeting the completeness standard for each subcategory. Penalties for encounter completeness shall be capped at thirty-three hundredths of a percent (0.33 %) of the Contractor's monthly capitation rate.
	Quality and Health Outcomes	
30.	Failure to submit quality measures including audited HEDIS and CAHPS results within required timeframes, as in **Section 17.0 "Quality Management and Health Outcomes"**	$1,000.00 per day for every day reports are late.
31.	Failure to obtain and/or maintain NCQA accreditation within the timeframes specified in **Section 17.0 "Quality Management and Health Outcomes."**	$100,000.00 per month for every month beyond the month NCQA accreditation must be obtained.
32.	Failure to achieve performance targets for each quality performance measure as in **Section 17.0 "Quality Management and Health Outcomes."**	Up to $100,000.00 per violation.
33.	Failure to achieve annual targeted health outcomes measures as in **Section 17.0 "Quality Management and Health Outcomes."**	Up to $100,000.00 per violation.

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No.	Deficiencies	Penalty Amounts
34.	Failure to timely submit appropriate PIPs to the Department as in **Section 17.0 "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	
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 18.0 "Utilization Management**."	$500.00 per day Contractor is in default.
	Enrollee Services	
37.	Failure to obtain approval of Enrollee materials, as in **Section 20.0 "Enrollee Services**."	$500.00 per day for each day that the Department determines the Contractor has provided Enrollee materials that the Department has not approved.
38.	Failure to comply with timeframes for providing Enrollee materials to Enrollees as in **Section 20.0 "Enrollee Services**."	$250.00 per occurrence per Enrollee.
39.	Engaging in prohibited marketing activities or discriminatory practices or failure to market statewide, as in **Section 23.0 "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 in **Section 26.10 "Termination of Network Providers**."	$1,000.00 per occurrence.
	Complaints, Grievances and Appeals	
41.	Failure to resolve at least ninety-nine percent (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.

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No.	Deficiencies	Penalty Amounts
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 twenty percent (20%) of Appealed cases during a sixty (60)-Day period.	$500.00 per day Contractor is in default until an approved CAP is fully implemented by the Contractor.
43.	Failure to maintain a Grievance or Appeal System as in **Section 22.0 "Enrollee Grievances and Appeals**."	$500.00 per day Contractor is in default.
44.	Failure to resolve Enrollee appeals and grievances within required timeframes as in **Section 22.0 "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 Hearings as issued or as directed by the Department and as in **Section 22.0 "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 22.0 "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 in **Section 24.0 "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 in **Section 25.8 "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 in **Section 25.8 "Transition to a Credentialing Verification Organization (CVO)."**	$5,000.00 per incident.
50.	Failure to maintain provider agreements as in **Section 26.0 "Provider Network**."	Up to $5,000.00 per provider agreement found to be non-compliant.

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No.	Deficiencies	Penalty Amounts
51.	Failure to provide an adequate provider network of physicians, hospitals, and other specified healthcare providers for 95% of Enrollees as in **Section 26.0 "Provider Network**."	Up to $10,000.00 per violation.
52.	Failure to provide covered services within the timely access, distance, and wait-time standards as described in **Section 26.0 "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 in **Section 26.0 "Provider Network**."	Up to $5,000.00 per incident.
54.	Failure to submit a Provider Enrollment File that meets the Department's specifications, as in **Section 26.0 "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 in **Section 26.0 "Provider Network**."	$500.00 per confirmed incident.
	Claims Processing	
56.	Failure to comply with prompt pay requirements as in **Section 27.0 "Provider Payment Provisions"** and as required in Kentucky law.	As in KRS 304.99-123, Contractor is subject to the following: A fine of $1,000.00 per day or ten percent (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 and 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.
	Covered Services	

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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 $500.00 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).	$500.00 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. $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.
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 30.5** "**Maternity Care."**	$500.00 per day, per occurrence, for each day that care is not provided in accordance with the terms of this Contract.
	EPSDT	
62.	Failure to comply with obligations and timeframes in the delivery of EPSDT services as in **Section 30.1** "**EPSDT, Early and Periodic Screening, Diagnosis and Treatment."**	$1,000.00 per violation.
	Children in Foster Care	
63.	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.

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No.	Deficiencies	Penalty Amounts
64.	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	
65.	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.
66.	Failure to remit an amount or balance of a provider overpayment within the timeframes set forth in **Section 34.4 "Audit by Department or its Designee**."	$500.00 per incident.
67.	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.	$5,000.00 on the first monthly occurrence, $10,000.00 on the second occurrence, and $15,000.00 on the third and subsequent occurrence.
68.	Failure of the Contractor's PIU to conduct a minimum of three (3) site visits per calendar quarter.	$10,000.00 per visit not conducted per calendar quarter.
69.	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.	$1,000.00 penalty per occurrence.
70.	Failure to collect an outstanding debt owed to the Department from providers and releasing payments to the providers.	$1,000.00 penalty if disclosed by the Contractor, a $10,000.00 penalty per occurrence if discovered by the Department.
71.	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.	$500.00 per day penalty until the information is received. The Contractor may request an extension prior to the deadline of the request(s).
72.	Failure to meet the provisions regarding two (2) full time investigators located in the United States with their caseload 100% dedicated to the Kentucky Medicaid Market.	$5,000.00 on the first monthly occurrence, a penalty of $10,000.00 on the second occurrence, and $15,000.00 on the third and subsequent occurrences.
73.	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 $10,000.00 penalty per occurrence.

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No.	Deficiencies	Penalty Amounts
74.	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	
75.	Failure to submit complete and accurate data except for encounter submission or if otherwise addressed in the Contract.	$1,000.00 per determination.
76.	Failure of the Contractor to provide a paid claims listing by the required date as in **Section 35.1 "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.
77.	Failure to provide a required report or deliverable set forth in the DMS Medicaid Managed Care (MMC) Program Reporting Package 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	$250.00 per day until the violation is remedied, deducted from the next month's Capitation Payment.
	Enrollee Confidentiality and Protected Health Information	
78.	Failure to ensure client confidentiality in accordance with 45 C.F.R. 160 and 45 C.F.R. 164; and an incident of non-compliance will be assessed as per member and/or per HIPAA regulatory violation, as in **Section 36.0 "Records Maintenance and Audit Rights."**	Up to $5,000.00 for each breach.
79.	Failure to ensure that all Kentucky Medicaid data containing protected health information (PHI), as defined by HIPAA, is secured as in **Section 36.0 "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.
80.	Failure to seek express written approval from the Department prior to the use or disclosure of Enrollee data or Kentucky Medicaid confidential information as in **Section 36.0 "Records Maintenance and Audit Rights."** (See Business Associate Agreement).	$1,000.00 per Enrollee or per occurrence.

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No.	Deficiencies	Penalty Amounts
81.	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.

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APPENDIX B. 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 C.F.R. 434, 42 C.F.R. 438.214, 42 C.F.R. 438.6 and 42 C.F.R. 438.808. The Contractor shall include provisions to address the following 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 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;

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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; 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 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;

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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 CAPs 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 C.F.R. 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, 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 an Enrollee's treatment by the provider.

L. Addressing Health Disparities

1. Recognize that population health management and quality interventions are designed to address SDoH, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve health equity.

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2. Provide quality services to all individuals, which will ultimately help reduce health disparities and achieve health equity by tailoring services to an individual's culture and language preferences through implementation of the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare.

3. Recognize the role of SDoH on Enrollees' overall health outcomes. Identify and report the effectiveness of SDoH initiatives, including Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level. Utilize stratified data to include demographics, population sub-sets, and geographic regions to create innovative interventions aimed at reducing disparate outcomes, including the utilization of value-added benefits.

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APPENDIX C. THIRD PARTY PAYMENTS/COORDINATION OF BENEFITS

I. To meet the requirements of 42 C.F.R. 433.138 through 433.139, the Contractor shall be responsible for the following for any Enrollees assigned to Contractor:

A. Maintaining an MIS that includes:

1. Third Party Liability (TPL) Resource File

a) Cost Avoidance - Use automated daily and monthly TPL files to update the Contractor's MIS TPL files as appropriate. This information is to cost avoid claims for members who have other insurance.

The Contractor shall obtain subscriber data and perform data matches directly with insurance companies.

The Contractor shall consider documentation from the insurance carrier, and segments marked as Valid from the MMIS TPL file as verified.

b) Department for Community Based Services (DCBS) - Apply TPL information provided electronically daily 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 quarterly. 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 or Part C (Medicare Advantage) Billing - The Contractor'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 Contractor's MIS that was unknown to the Contractor 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 the health plan should have paid. 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 Contractor'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 Contractor's MIS that was unknown to the Contractor at the time of payment of a claim. Providers who do not dispute the Medicare coverage should be instructed to bill Medicare immediately. The Contractor'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

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- 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. 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 Contractor shall notify Medicaid, only if the Department has a claim for the same accident, within five (5) Days of identifying such information so that recovery efforts can be coordinated with the Department.

C. Claims

1. Processing
   a) Contractor 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 Contractor'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, and policy #;
      - 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 to identify whether other third party resources may be liable to pay for these medical bills;
      - Claims shall be paid and chased when the source of the insurance coverage was due to a court order except for claims for services involving prenatal, hospital labor and delivery, and post- partum, which 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 Contractor'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 Contractor with an initial third party information file;
2. Provide electronic computerized files of third party information transmitted from IEES;
3. Provide the Contractor with a file of the information received from the Labor Cabinet quarterly;
5. Refer calls from attorneys to the Contractor for their Claims to be included in casualty settlements; and
6. Monitoring Encounter Claims and reports submitted by the Contractor to ensure that the Contractor

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performs all required activities.

APPENDIX D. MANAGEMENT INFORMATION SYSTEM REQUIREMENTS

The Contractor's MIS must enable the Contractor to provide format and file specifications for all data elements 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 TPL processing, and reporting functions. The major source of enrollment/member data will be electronically transmitted by the Department to the Contractor daily 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 include maintenance of demographic data, matching Primary Care Providers with Members, maintenance information on Enrollments/Disenrollments, identification of TPL information, and 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. After initial Implementation of the Contract, the following additional inputs shall be provided to the Contractor:
   - Initial Member assignment file (sequential file; format to be supplemented at contract execution); a file will be sent approximately sixty (60) 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 online 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.

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8. Maintain identification of Member eligibility in special eligibility programs, such as but not limited to hospice 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 functions such as but not limited to Claims processing, Prior Authorization processing, managed care processing.
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 the DMS Medicaid Managed Care (MMC) Program Reporting Package.

D. Online Inquiry Screens

Online 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) with the Department.

Third Party Liability (TPL) Subsystem

To ensure that federal TPL 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 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 the application of edits and audits that 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

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data, health plan coverage data, threshold information, and post payment recovery tracking data. The TPL processing function will ensure 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 for 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, 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, 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
   - BIN/PCN 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 that 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

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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 online 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, in an agreed upon format and media, every month.

C. Reports

The Contractor shall submit a cost-avoidance summary savings report, including Medicare but identifying it separately, from the TPL Processing function by the last day of the month for the previous month.

D. Online Inquiry Screens

Online 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 monthly, by the first Friday of the month following the month reported.

The Contractor's provider subsystem shall include demographic data, identification of provider type, specialty codes, maintenance of payment information, identification of licensing, credentialing/re-credentialing information, and monitoring of PCP 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

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Covered Services on an emergency or urgent care basis, twenty-four (24) hours a day, seven (7) 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 PCP 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 online 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 online 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 and 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 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 online audit trail of Provider names, Provider numbers (including old and new numbers and 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

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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:
    (s) Application pending;
    (t) Limited time-span enrollment;
    (u) Enrollment suspended;
    (v) Terminated-voluntary/involuntary.
19. Maintain Provider NPIs and taxonomies;
20. Maintain specific codes for restricting the services for which Providers may bill to those for which they have the proper certifications (e.g., 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 the DMS MMC Program Reporting Package.

C. Online Inquiry Screens

Online 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; and
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.

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The Contractor's reference subsystem shall contain such items as maintenance of procedure codes/NDC codes and diagnosis codes, identification of pricing files, and maintenance of edit and audit criteria.

The Contractor must maintain sufficient reference data (e.g., NDC codes, HCPCS, CPT4, Revenue codes) to accurately process FFS 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, ensuring 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.
6. Maintain a drug data set of the eleven (11) digit 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.

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- 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 FFS, capitation and carve-outs from Capitated or other "all inclusive" rate systems, and DRG reimbursement for inpatient hospital care.
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. Online Inquiry Screens

Maintain online access to all Reference files with inquiry by the appropriate service code, depending on the file or table being accessed.

Maintain online 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 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.

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A. Inputs

The Financial Processing function must accept the following inputs:

1. Online entered, non-claim-specific financial transactions, such as but not limited to recoupments, mass adjustments, cash transactions;
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 FFS 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 process 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 that indicates who initiated the adjustment, the reason for the adjustment, and the disposition of the claim (e.g., additional payment, recovery, history only) 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 that 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 (e.g., TPL recovery, rate adjustment);
- Transaction source (e.g., system generated, refund, Department generated);
- Provider number/entity name and identification number;
- Payment/recoupment detail (e.g., dates, amounts, cash or recoupment);
- Account balance;
- Reason indicator for the transaction (e.g., returned dollars from provider for TPL, unidentified returned dollars, patient financial liability adjustment);

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- Comment section;
- Type of collection (e.g., 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 online 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 online 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, including 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 the DMS MMC Program Reporting Package.

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

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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 C.F.R. 455.20 (a) by employing a selected sample method approved by CMS and the Department of verifying with Members whether the services billed by the provider were received.

The utilization/quality improvement subsystem combines data from other subsystems, and/or external systems, to produce reports for analysis that 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 include 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 C.F.R. 455, the Contractor shall establish a SURS function, capable of identifying potential fraud and/or abuse of providers or Members. The SURS component supports profiling, random sampling, groupers (e.g., 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 that 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, and 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; and
3. Member data from the Member subsystem.

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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 the use of but not limited to Member surveys and Grievance/Appeals processes.
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 accurately. Claims must be adjudicated in accordance with the 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/FFS). The Contractor shall be required to electronically transmit Encounter Records to the Department weekly or on a Department approved schedule 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

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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 ensure that the services for which payment is requested are covered.
3. Edit to ensure 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 ensure that a Prior Authorization number is present on the Claim and matches 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 remaining to be used.
9. Perform relationship and consistency edits on data within a single Claim for all Claims.
10. Edit for TPL.
11. Perform automated audit processing (e.g., duplicate, conflict) using history Claims, suspended Claims, and same cycle Claims.
12. Edit for potential duplicate claims by taking into account group and rendering Provider, multiple Provider locations, and across Provider and Claim types.
13. Identify exact duplicate claims.
14. Perform automated audits using duplicate and suspect-duplicate criteria to validate against history and same cycle claims.
15. Perform all components of NCCI edits
16. Maintain audit trail of all error code occurrences linked to a specific Claim line or service, if appropriate.
17. Edit and suspend each line on a multi-line Claim independently.
18. 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.
19. Identify and track all edits and audits posted to the claim from suspense through adjudication.
20. Update Claim history files with both paid and denied Claims from the previous audit run.
21. 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).
22. Edit fields in Appendices D and E for validity (e.g., numerical field, appropriate dates, values).

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 considers 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) or provider-specific rate files and are date-specific.

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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 FFS contracts that 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 payment amounts.
6. Provide adjustment processing capabilities.

Claims Operations Management

The Claims Operations Management function provides the overall support and reporting for all 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 online claims information, provide online 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; and
    - 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

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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 (15) 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 QAPI program and managed care operations reporting requirements for the Contractor and the Department. 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.

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APPENDIX E. 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. Medical supplies, equipment, and appliances (MSEA), 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
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, and 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

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

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then current Kentucky Medicaid State Plan 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 the provision of Medicaid services 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 that 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 healthcare generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 U.S.C. 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 healthcare 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 investigating and determines that the examination(s) is necessary.

III. Emergency Care Services (42 C.F.R. 431.52)

The Contractor must provide, or arrange for the provision of, all covered emergency care immediately using healthcare 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 the provision of emergency care are in 42 C.F.R. 438.114.

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 Department approval and as necessary to comply with federal mandates and state laws. Certain Medicaid services are currently excluded from the Contractor

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benefits package, but continue to be covered through the traditional FFS 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.

The following are services currently not covered by the Kentucky Medicaid Program, subject to change based on federal or state laws or regulations:

- 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 sterilization only;
- Medical or surgical treatment of infertility (e.g., the reversal of sterilization, invitro fertilization);
- 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 investigational drugs, primarily for research purposes or experimental in nature;
- Sterilization of a mentally incompetent or institutionalized member;
- Services provided in countries other than the United States, unless approved by the Secretary of CHFS;
- Services or supplies above limitations or maximums 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 healthcare, 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

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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 comply 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, Medical Supplies, Equipment, and Appliances (MSEA), 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 1:047)
- Community Mental Health Center Behavioral Health Services (907 KAR 1:044)
- Dental Health Services (907 KAR 1:126)
- Dialysis Center Services (907 KAR 1:400)
- Medical Supplies, Equipment, and Appliance, 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)
- 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 8:0101)
- 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)

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- 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 (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 the State Plan and all federal and state law, including, but not limited to, 42 C.F.R. 441.250 and KRS 205.560.
- 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)

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APPENDIX F. 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 for contacting the New MCO, the recipient and the recipient's providers to transition existing care. A Prior Authorization (PA) shall be honored by the New MCO for ninety (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.

The Former MCO shall also provide the following information to the New MCO:

1. **Care coordination data**, including data from assessments of Enrollees' health risks, care needs, or functional status; care plan information; and

2. **Rosters of transitioning plan Enrollees** whose health status or care needs may be especially complex, such as individuals who are pregnant, homeless, or individuals with certain disabilities.

3. Any additional information as directed by the Department to support the transition of an Enrollee's care.

The following indicates the responsibilities of the Former MCO and New MCO for various transitions:

Inpatient Hospital Admission Prior to the Member's Transition.
If an enrolled Member is in-patient in an acute care hospital, critical care hospital, acute rehabilitation facility, psychiatric hospital or long term acute care 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) Days of discharge for the same diagnosis shall be considered a "current admission." The "same diagnosis" is defined as the first five (5) 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 (8) Business Days before the end of the month, managed care ends on the last day of the 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 pharmaceutical charges, and the Department will reimburse for those services billed by the NF. 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 Waiver 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 LOC. The LOC is passed electronically to the DCBS eligibility worker; receipt of the LOC 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 (8) Business Days before the end of the month, managed care ends on the last day of the current month. If the action is after cut off, managed care ends on the last

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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 FFS. Coding in the 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, the Contractor 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. If a member with no prior or other coverage becomes eligible during a hospital stay, the Contractor is responsible for the hospital stay on the day of eligibility.

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APPENDIX G. 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 (five percent [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 Providers regarding credentialing and recredentialing of providers. 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 conform with the Department's policies and procedures. The Contractor shall meet requirements under KRS 205.532, KRS 205.560(12), KRS 304.17A-576, 907 KAR 1:672, or other applicable state and

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federal credentialing law. 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 that 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.

Verification of the 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 healthcare 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. Information available from the HHS OIG.
P. Information available from the 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. Applicant's attestation 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:

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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 C.F.R. 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 recredentialed;
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.
G. The Health and Human Services Office of Inspector General (HHS OIG)
H. 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 ongoing assessment of organizational providers with whom it intends to contract or Providers with 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 practitioner's 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.

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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

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APPENDIX H. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

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
-- 7 years
-- 8 years
-- 9 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 twenty-one (21) indicated as the result of an EPSDT health assessment or any other encounter with a licensed or certified healthcare 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 U.S.C. Section 1396 and 907 KAR

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11:034, Section 7 and Section 8.

The Contractor shall provide the following Medically Necessary healthcare, diagnostic services, preventive services, rehabilitative services, treatment, and other measures, described in 42 U.S.C. Section 1396d(a), to all members under the age of twenty-one (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 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, 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 Personal Care Services in a Recipient's Home.

Those EPSDT diagnosis and treatment services and EPSDT Special Services that are not otherwise covered by the Kentucky Medicaid Program shall be covered subject to Prior Authorization by the Contractor, as specified in 907 KAR 11:034, Section 9. Approval of requests for EPSDT Special Services shall be based on the standard of Medical Necessity specified in 907 KAR 11:034, Section 9.

The Contractor shall be responsible for identifying Providers who can deliver the EPSDT special services needed by Members under the age of twenty-one (21), and for enrolling these Providers into the Contractor's Network, consistent with requirements in this Contract.

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APPENDIX I. PROGRAM INTEGRITY REQUIREMENTS

I. ORGANIZATION

The Contractor shall establish a Program Integrity Unit (PIU) to identify Fraud, Waste, and Abuse and refer any suspected Fraud or Abuse of Members and Providers to the Department. The 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 ongoing 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 cases with the greatest potential program impact. 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 healthcare fraud, waste, and abuse investigatory experience

(2) Located in the United States; and

(3) Dedicated one hundred percent (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 algorithms, investigations, and record reviews;

(c) Determine the factual basis of Fraud or Abuse allegations made by Members, Providers, and other sources;

(d) Initiate appropriate administrative actions to collect overpayments, adhering to state requirements;

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(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 prompt response to detected offenses and develop corrective action initiatives related to the Contractor's contract;

(i) Provide 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 Department requests 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 outstanding Provider overpayments if the Contractor has not recovered the overpayment after one hundred and eighty (180) Days;

(m) As requested by the Department, remit the amount of Provider overpayments not identified by the Contractor within ninety (90) Days of notification by the Department unless otherwise notified in writing by the Department or its contracted entity;

(n) Conduct continuous and ongoing reviews of all MIS data, including Member and Provider Grievances and appeals, to identify 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 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 Department agent or contractor;

(s) Ensure the integrity of PIU referrals to the Department and not subject referrals to the approval of the Contractor's management or officials;

(t) Comply with 42 C.F.R. 455.20 by employing a method of verifying with a Member whether the services billed by the Provider were received by randomly selecting a minimum sample of 500 claims every month;

(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) Administratively collect overpayments from Members that were declined prosecution for Medicaid

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Program Violations (MPV);

(w) Comply with the program integrity requirements in the Patient Protection and Affordable Care Act, specifically 42 C.F.R. 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 C.F.R. 455.106, within five (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. To meet this requirement, for each on-site visit the Contractor shall make contact with the Provider and/or Provider staff, be provided entry and access to the site location, and access MCO-specific Medicaid records on-site, including electronic information, to obtain information related to the investigation. During the on-site visit, if the investigators do not gain entry into the Provider's office or do not have access to the Provider, the MCO shall immediately notify the Department's Division of Program Integrity. The Department shall approve the site visit shall be approved within a minimum of ten (10) Days;

(bb) Conduct a second review after six (6) months on all cases approved for education and case closure to determine the impact of educational efforts on Provider behavior;

(cc) 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

(dd) Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or any other state or federal agency that has oversight of the Medicaid program. Corrective action shall be completed within thirty (30) Days or by the timeframes established by federal and state laws and regulations, whichever is sooner.

III. PATIENT ABUSE/MEMBER SAFETY

Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to DCBS in accordance with state law with a 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 Quality and Population Health 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 that may be made against the Contractor, Providers, or Members. The system shall include 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 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;

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(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 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 ("MFCU"), 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 the Department's approval, Contractor shall suspend and escrow Provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of the credible allegation of fraud. The Department will coordinate these efforts;

(k) Upon completion of the PIU's initial investigation, the PIU shall provide the Department a copy of its 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 number of claims;
(10) The issues identified;
(11) Methodology used during the investigation;
(12) Facts discovered by the investigation as well as the initial case report and supporting documentation;
(13) Attach all exhibits or supporting documentation, including all education related materials provided during the course of the investigation;
(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 monthly 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

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(n) The Contractor's PIU shall ensure 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 on the evidence in the case file,
(14) PIU action(s) taken and date(s),
(15) Amount of overpayment if any (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 on 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.

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VI. REPORTING

(a) The Contractor's PIU shall report monthly provider internal referrals (tips) and the disposition of the prior month's internal referrals, and quarterly, or 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, overpayments 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 35.0 "Contractor Reporting Requirements;"**

(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 quarterly, 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 for all Providers and subcontractors, including, but not limited to, ownership disclosure, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters, and subcontracts for five (5) years after contract end date;

(b) Regularly report enrollment, Provider, and Encounter data in a format that is usable by the Department, the OIG, and any other Department agent or contractor;

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(c) Backup, store and be able to recreate reported data upon demand for the Department the OIG, and any other Department agent or contractor;

(d) Permit reviews, investigations, or audits of all books, records, or other data, at the discretion of the Department, the OIG, any other Department agent or contractor, or other authorized federal or state agency; and 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 use by the Department, the OIG, and any other Department agent or contractor;

(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 to carry out the functions and responsibilities in this Contract;

(h) Fully cooperate with the Department, the OIG, any other Department agent or contractor, the United States Attorney's Office, and other law enforcement agencies in the investigation of Fraud or Abuse cases; and

(i) Provide identity and other documents and information for undercover law enforcement investigators.

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APPENDIX J. PAID CLAIMS LISTING REQUIREMENTS

Hospitals:

1. The Contractor shall supply a paid claims listing to each contracted Hospital and 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 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.

Upon request the Contractor shall supply a paid claims listing to each contracted CCBHC to 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.

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APPENDIX K. 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 a capitation payment has not been received.

'Report 250': Contains all Members and capitation months 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

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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

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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

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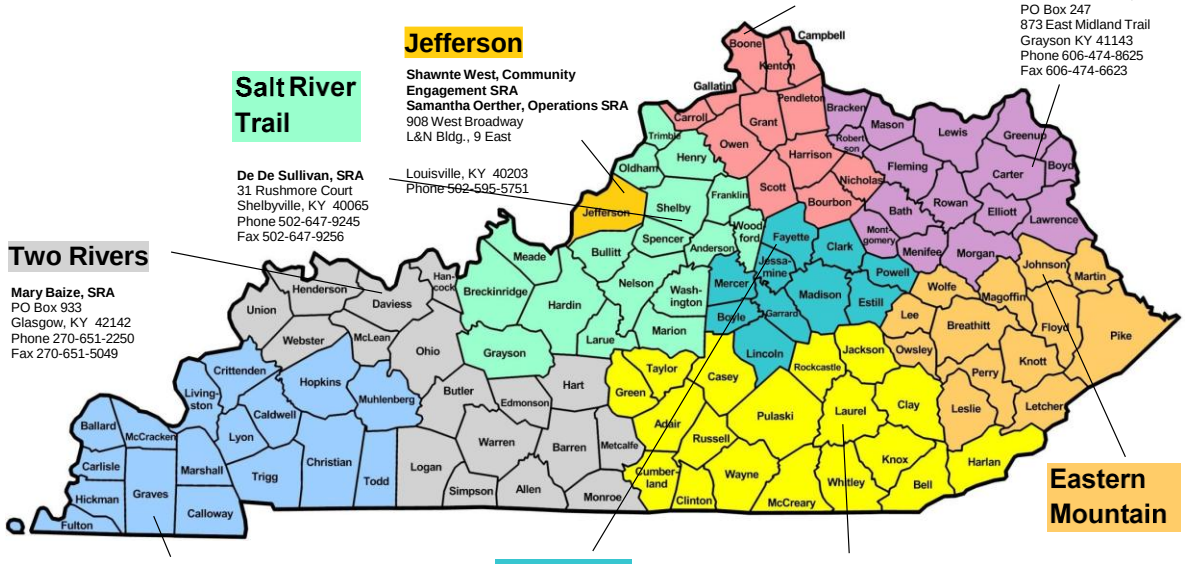
APPENDIX L. DEPARTMENT FOR COMMUNITY BASED SERVICES AND DEPARTMENT OF JUVENILE JUSTICE MAPS

DCBS Service Regions



Northern Bluegrass

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Jefferson

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Eastern Mountain

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The Lakes

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Mayfield, KY 42066
Phone 270-247-5126
Fax 270-247-2007

Southern Bluegrass

April Davis, SRA
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Suite 120A
Lexington, KY 40511
Phone 859-246-2298
Fax 859-246-2515

Cumberland

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London, KY 40741
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Fax 606-330-2138

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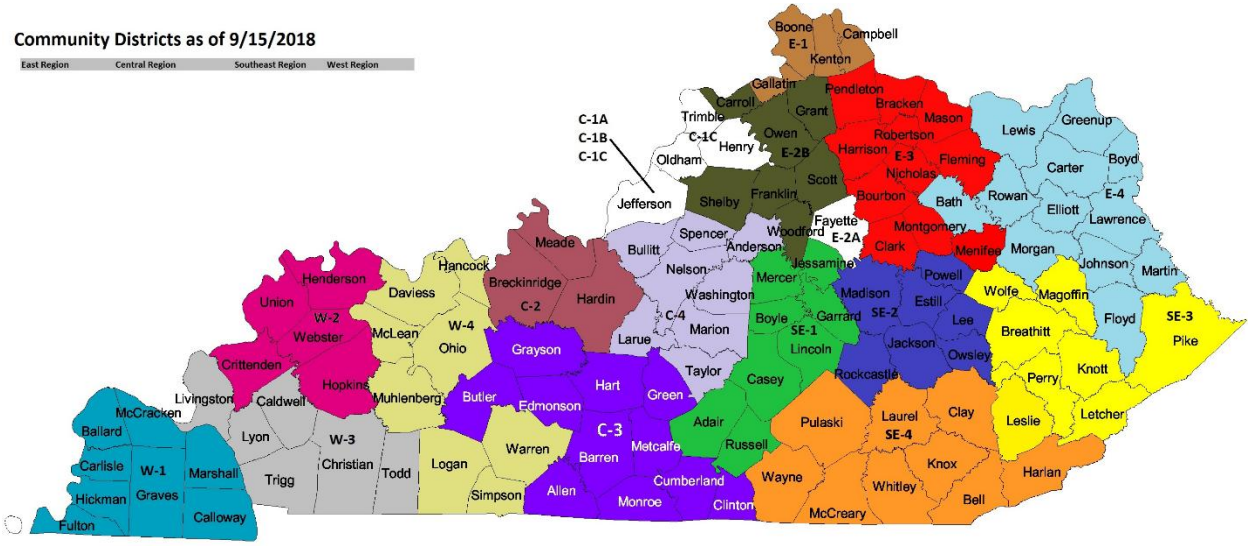
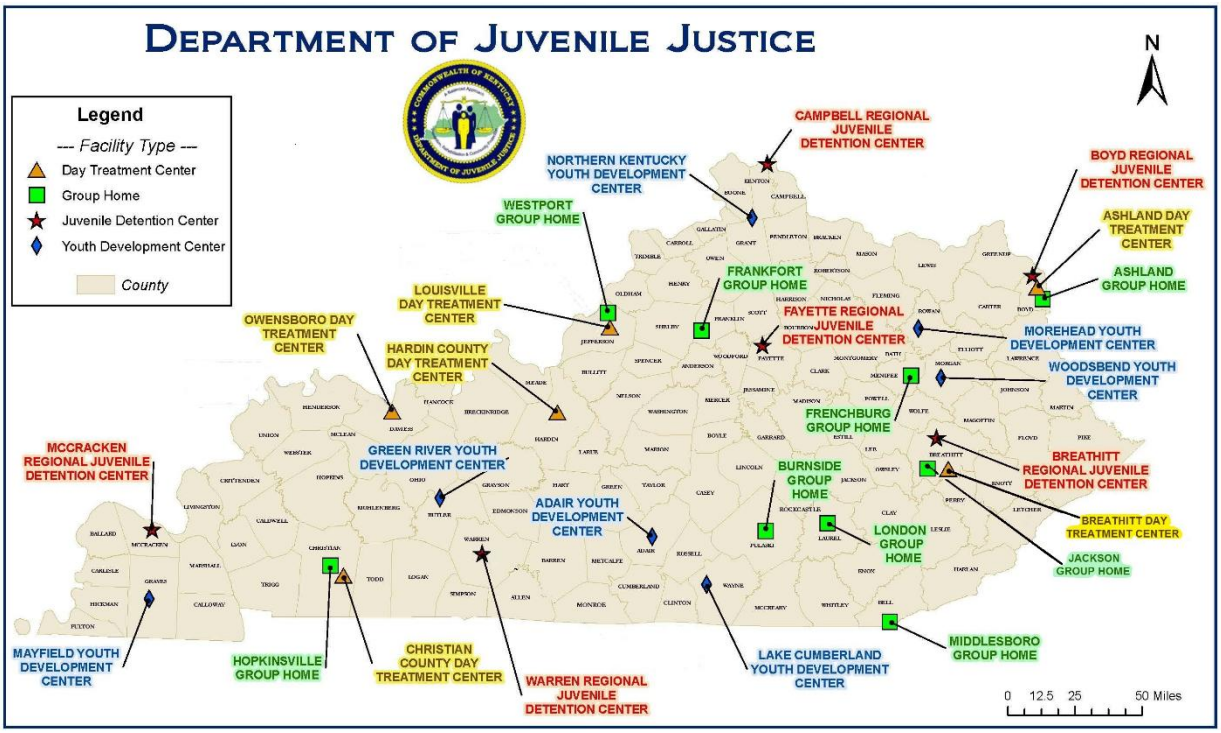
Department of Juvenile Justice Community Districts



Department of Juvenile Justice Facilities Map



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APPENDIX M. CABINET FOR HEALTH AND FAMILY SERVICES CONTRACTOR SECURITY REQUIREMENTS

The Contractor is required to constantly assess their security program, adhere to the most recent security standards, practices, rules, regulations, laws, and best practices, and adapt as these may change or present new requirements. This includes, but is 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 on the COT webpage at: https://technology.ky.gov/Pages/index.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 the Contractor. CHFS OATS also has standards any solution that will be hosted and maintained by the 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. If the Contractor solution components hosted and maintained by Contractor deviate from the Policies and Standards referenced above, the 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. 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 Office of the National Health Coordinator for Health Information Technology
- HIPAA and any related regulations and guidance
- Medicaid Information Technology Architecture (MITA) CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E) v2.0
- 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

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Attestation Report

The Contractor shall provide a copy of the SOC2 type 2 (or by its superseded standard) report to OATS Security at least annually by the date required by the Department.

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 comply 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 at the Contractor's 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, the 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. The 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

HIPAA Risk Assessment

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 HIPAA Security Rules, 45C.F.R.164.308(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

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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, assess the risk, and take steps to reduce the risk to an acceptable level.

Critical systems that store HIPAA, IRS, 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 SDLC and systems that have major system change/modifications. These ongoing risk 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 for 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.

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 of whether the drill was a success.

Contractor must create a Business Continuity Plan (BCP) and a 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) that aligns 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 the 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

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- 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 the Contractor Incident Report is, 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

OATS reserves the right to update these policies at any time throughout 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 outlined policies would follow the contract modification procedures.

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APPENDIX N. VALUE-BASED PAYMENT MEASURES

This Appendix defines the specific measures, weights, targets, and withhold payment calculation process that comprise the VBP Program. The program requirements listed below are for the Current Measurement Year, defined as HEDIS™ Measurement Year (MY) 2026. The Baseline Year for the Current Performance Period is HEDIS™ MY2024, unless otherwise specified below.

Core Measures

1. **Glycemic Status Assessment for Patients With Diabetes (GSD):** The percentage of members eighteen (18) to seventy-five (75) years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:
   - Glycemic Status <8.0%.

   Amount of Performance Withhold at risk: 15%

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile, but below the HEDIS™ fiftieth (50) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

2. **Postpartum Care (PPC) Postpartum Care**: The percentage of deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) Days after delivery.

   Amount of Performance Withhold at risk: 15%

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the

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measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile, but below the HEDIS™ fiftieth (50) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

3. **Child and Adolescent Well Care Visits Three (3) to Twenty-one (21) Years of Age (WCV) Sum of Stratifications (Total)**: The percentage of members **three (3) to twenty-one (21)** years of age who had one (1) or more well-child visits with a PCP or an OB/GYN practitioner during the measurement year.

Amount of Performance Withhold at risk: 20%

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile, but below the HEDIS™ fiftieth (50^{th}) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

4. **Immunization for Adolescents (IMA-E Combo 2)**: The percentage of adolescents thirteen (13) years of age who had one-dose of meningococcal vaccine, and one-dose of tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap), and have completed the human papillomavirus (HPV) vaccine series by their thirteenth (13th) birthday.

Amount of Performance Withhold at risk: 20%

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the

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measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile, but below the HEDIS™ fiftieth (50) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

5. **Breast Cancer Screening (BCS-E):** The percentage of persons forty (40) to seventy-four (74) years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Amount of Performance Withhold at risk: 20%

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile but below the HEDIS™ fiftieth (50th) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

6. **Controlling Blood Pressure (CBP)**: The percentage of persons eighteen (18) to eighty-five (85) years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.

Amount of Performance Withhold at risk: 10%

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

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If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile but below the HEDIS™ fiftieth (50th) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

Bonus Pool Measures

1. **Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)**: The percentage of children and adolescents one (1) to seventeen (17) years of age with ongoing antipsychotic medication use who had metabolic testing during the year.

   Bonus Pool Weight: 20%

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile but below the HEDIS™ fiftieth (50th) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

2. **Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) Counseling for Nutrition Total**: Percentage of children and adolescents

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three (3) to seventeen (17) years of age who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of counseling for nutrition.

Bonus Pool Weight: 10%

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile but below the HEDIS™ fiftieth (50th) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

3. **Childhood Immunization Status (CIS-E Combo 10)**: The percentage of children two (2) years of age who had combination ten (10) vaccines by their second (2nd) birthday.

Bonus Pool Weight: 20%

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile but below the HEDIS™ fiftieth (50th) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

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4. **Social Need Screening and Intervention (SNS-E)**: The percentage of members who were screened using pre-specified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.

   Bonus Pool Weight: 10%

   For MY2026, the Department will consider improvement of three (3) percentage points on any three (3) of the six (6) sub-measures for the measure to be determined fully met and earn the associated Bonus Pool amount.

5. **Follow-Up After Emergency Department Visit for Mental Illness (FUM)**:The percentage of emergency department (ED) visits for persons six (6) years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. The percentage of ED visits for which the person received follow-up within seven (7) days of the ED visit (eight (8) total days).

   Bonus Pool Weight: 20%

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile but below the HEDIS™ fiftieth (50th) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

   If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

6. **Oral Evaluation, Dental Services (OED)**: The percentage of persons under twenty-one (21) years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement period.

   Bonus Pool Weight: 20%

   If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ ninetieth (90th) percentile, the Contractor must maintain the measure performance as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

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If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ seventy-fifth (75th) percentile but below the HEDIS™ ninetieth (90th) percentile, the Contractor must improve the measure performance by one (1) percentage point as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ fiftieth (50th) percentile but below the HEDIS™ seventy-fifth (75th) percentile, the Contractor must improve the measure performance by two (2) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is at or above the HEDIS™ twenty-fifth (25th) percentile but below the HEDIS™ fiftieth (50th) percentile, the Contractor must improve the measure performance by three (3) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

If Contractor's Baseline Year rate for the measure is below the HEDIS™ twenty-fifth (25th) percentile, the Contractor must improve the measure performance by four (4) percentage points as of the Current Measurement Year reporting to earn back the withhold associated with this measure.

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Signature Page

Medicaid Managed Care Contract

January 1, 2026-December 31, 2026

This contract is subject to the terms and conditions stated herein. By affixing signatures below, the parties verify that they are authorized to enter into this contract and that they accept and consent to be bound by the terms and conditions stated herein. In addition, the parties agree that (i) electronic approvals may serve as electronic signatures, and (ii) this contract may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all counterparts together shall constitute a single contract.

CHFS Cabinet Approval:

Signed by:
Steven Stack
A6C077BED9A2471...
Signature

Secretary
Title

Steven Stack
Printed Name

12/19/2025
Date

Contractor Approval:

Signed by:
Krista Brinly Hensel
BB404F8A44D344E...
Signature

CEO, UnitedHealthcare Community Plan of Kentucky
Title

Krista Hensel
Printed Name

12/18/2025
Date

CHFS Department Review:

DocuSigned by:
Lisa Lee
7CB878DB215D44E...
Signature

Commissioner
Title

Lisa Lee
Printed Name

12/18/2025
Date

Approved as to form and legality:

DocuSigned by:
Wesley Duke
D38FF6B4FC274A6...
Attorney

12/11/2025
Date

NO. DO 748 2500017559

Issue Date:
01/02/25

Commonwealth of Kentucky
DELIVERY ORDER

Document Description: Medicaid Managed Care Organization (MCO) (UnitedHealthcare)

Vendor Contact:
Name: Keith C. Payet
Phone: 615-493-9614 **Extension:**
E-mail: keith_c_payet@uhc.com

Issuer Contact:
Name: Marianne Johns
Phone: 502-564-7736 **Ext.:**
E-mail: Marianne.Johns@ky.Gov

Vendor Name:
UnitedHealthcare of Kentucky, Ltd.
230 Lexington Green Circle

Lexington KY 40503

Vendor No. KS0004505

Master Agreement: 2000000678 **Award Date:**

Service From: 01/01/2025 **Service To:** 12/31/2026

Line Item	Supplier Part Number	Quantity	Unit	Description	Due Date	Unit Price	Contract Amount	Total Price
1		0.00000		Medicaid Managed Care Organization (MCO) - All Regions	01/02/2025	$0.000000	$4,586,400,000.0	$4,586,400,000

Extended Description:
Provided managed care services for Kentucky Medicaid recipients.

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.

Shipping Information:	Billing Information:
CHFS DMS Division of Fiscal Management 275 E Main Street 6W-C Frankfort KY 40621	CHFS DMS Division of Fiscal Management 275 E Main Street 6W-C Frankfort KY 40621

TOTAL ORDER AMOUNT:	$4,586,400,000.00