ADDENDUM 1

MASTER SERVICE AGREEMENT

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SECTION 1 DEFINITIONS

The following terms shall have the meaning stated, unless the context clearly indicates otherwise. To improve the readability of this Contract, in general the initial letter of each word in a defined term is capitalized. Specific exceptions to this approach are identified below; however, the lack of capitalization of the initial letter of a word does not mean that the word or term is not a defined term. Also, the initial letter of some words that are not defined terms may be capitalized.

1115(a) Demonstration – The State of Delaware's Medicaid demonstration project, authorized by CMS pursuant to Section 1115(a) of the Social Security Act.

Abuse – For purposes of program integrity, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid and CHIP program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. Abuse also includes client/member practices that result in unnecessary cost to the Medicaid and CHIP program (see 42 CFR 455.2).

Access (as it pertains to external quality review) – The timely use of services to achieve optimal outcomes, as evidenced by the Contractor successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services).

Adverse Benefit Determination – In accordance with 42 CFR 438.400(b), the denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for medical necessity (see Section 3.4.5 of this Contract), appropriateness, setting, or effectiveness of a covered service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the Contractor to act within timeframes provided in this Contract regarding the standard resolution of Grievances and Appeals; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, and other member financial liabilities. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of "clean claim" is not an adverse benefit determination.

Activities of Daily Living (ADLs) – A personal or self-care skill performed, with or without the use of assistive devices, on a regular basis that enables the individual to meet basic life needs for food, hygiene, and appearance, including bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility.

Actuary – An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. For purposes of developing and certifying capitation rates, an Actuary refers to an individual who is acting on behalf of the State.

Adult – An individual age 18 years of age or older.

Advance Directive – Written instructions (such as an advance health directive, a mental health advance directive, a living will, including Five Wishes, or a durable health care power of attorney) recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when an individual is incapacitated.

Affiliate – Any person, firm, corporation (including, without limitation, service corporation and processional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity or organization that now or in the future directly or indirectly controls, is controlled by or is under common control with the Contractor.

Annual Open Enrollment Period – The period designated by the State from October 1 to October 31 when members can elect to Transfer from one MCO to another MCO without good cause.

Appeal – A review by the Contractor of an Adverse Benefit Determination.

Assisted Living Facility – A licensed entity that provides assisted living services in a homelike and integrated community setting. Assisted living services are defined in State law as a special combination of housing, supportive services, supervision, personalized assistance and health care designed to respond to the individual needs of those who need help with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs). (The initial letter of each word in this term is not capitalized in this Contract.)

Attendant Care Employee – An individual who has been hired by a member participating in Self-Directed Attendant Care Services or his/her Employer Representative to provide Self-Directed Attendant Care Services to the member in an integrated community setting. Attendant Care Employee does not include an employee of a provider that is being paid by the Contractor to provide attendant care services to a member.

Authorized Certifier – The Contractor's CEO, COO, CFO, or an individual with delegated authority to sign for and who reports directly to the CEO and/or CFO. If an individual is delegated authority, the CEO, COO or CFO is ultimately responsible for the certification.

Automatic Assignment – The enrollment of a client in an MCO chosen by the State in the event the client does not choose an MCO. Automatic Assignment is pursuant to the provisions of Section 3.2.2 of this Contract.

Bed Hold Day – A day that a nursing facility holds/reserves a bed for a resident while the resident is temporarily absent from the nursing facility for hospitalization.

Behavioral Health – The umbrella term for mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health conditions and substance use disorders (SUDS). (The initial letter of each word in this term is not capitalized in this Contract.)

Business Days – Monday through Friday, except for State of Delaware holidays. (The initial letter of each word in this term is not capitalized in this Contract.)

Calendar Days – All seven days of the week, including State of Delaware holidays. (The initial letter of each word in this term is not capitalized in this Contract.)

Capitation Payment – The per member per month payment, including any adjustments, that is paid by the State to the Contractor for each client enrolled under this Contract for the provision of Covered Services during the payment period. The payment is based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular client receives services during the period covered by the payment.

Caregiver – A person who is a family member or is unrelated to the member and is routinely involved in providing unpaid support and assistance to the member.

Children with Special Health Care Needs – Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related service of a type or amount beyond that required by children generally.

Children's Health Insurance Program (CHIP) – The joint Federal/State program of medical assistance for uninsured children established by Title XXI of the Social Security Act, which in Delaware is administered by DMMA. See DHCP.

Claim – (i) A bill for services submitted to the Contractor manually or electronically, (ii) a line item of service on a bill, or (iii) all services for one member within a bill, in a format prescribed by the State. (The initial letter of this term is not capitalized in this Contract.)

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for Fraud, Waste or Abuse, or a claim under review for Medical Necessity. (The initial letter of each word in this term is not capitalized in this Contract.)

Client – An individual determined eligible by the State and enrolled in Delaware Medicaid or CHIP. (The initial letter of this term is not capitalized in this Contract.)

Cold Call Marketing – Any unsolicited personal contact by the Contractor with a potential member for the purpose of Marketing.

Contract – The agreement between the Contractor and the State of Delaware.

Contractor – The MCO that contracts hereunder with the State of Delaware to provide the services specified by this Contract to DSHP and DSHP Plus members in accordance with Contract requirements. Includes all Subcontractors, providers, employees, agents, and anyone acting for or on behalf of the Contractor.

Coordination of Benefits Agreement (COBA) – The standard contract between CMS and health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data.

Copayment – A fixed dollar amount that a member must pay when he/she receives a particular Covered Service, as specified by the State in this Contract.

Covered Services – The physical, behavioral health and long term services and supports (LTSS) included in the DSHP and DSHP Plus LTSS benefit packages (see Section 3.4 of this Contract).

Critical Incidents – Critical Incidents shall include but not be limited to the following incidents:

a) Unexpected death of a member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended by a physician;
b) Suspected physical, mental or sexual mistreatment, abuse and/or neglect of a member;
c) Suspected theft or financial exploitation of a member;
d) Severe injury sustained by a member;
e) Medication error involving a member; or
f) Inappropriate/unprofessional conduct by a provider involving a member.

Cultural Competence – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance of and respect for cultural differences and similarities within, among and between groups and the sensitivity to how these differences influence relationships with members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Days – Calendar days unless otherwise specified. (The initial letter of this term is not capitalized in this Contract.)

DDDS Lifespan Waiver (Lifespan Waiver) - A Medicaid waiver authorized under section 1915(c) of the Social Security Act administered by the Division of Developmental Disabilities Services (DDDS) that provides HCBS to individuals with intellectual disabilities (IID) (including brain injury), autism spectrum disorder, and Prader-Willi Syndrome. It is designed to enable individuals to live safely in the community and to respect and support their desire to work or engage in other productive activities.

Delaware Health Information Network (DHIN) – Delaware's integrated, Statewide health information network through which health care providers share real-time clinical information and have secure, immediate access to patient medical histories and individual medical needs.

Delaware Health Insurance Marketplace – The State of Delaware's health insurance exchange/marketplace developed pursuant to the ACA and operated in partnership with the Federal government to create a central place for individuals and employers to purchase health insurance.

Delaware Healthy Children Program (DHCP) – The State's CHIP program, which provides health insurance for Delaware's uninsured children pursuant to Title XXI of the Social Security Act. Also see CHIP.

Delaware Prescription Monitoring Program (PMP) – A system that collects information on all prescriptions for controlled substances (schedules II-V) reported by Delaware-licensed pharmacies and prescribers who dispense controlled substances.

Department of Justice (DOJ) Settlement Agreement – A binding legal agreement entered into by the State of Delaware and the U.S. Department of Justice on July 6, 2011 to ensure compliance with the Americans with Disabilities Act (1990) and the integration mandate in the U.S. Supreme Court decision, Olmstead v. L.C., 527 U.S. 581 (1999).

Diamond State Health Plan (DSHP) – The program that provides services through a managed care delivery system to individuals who receive TANF (including children who qualify for Title IV-E foster care and adoption assistance and pregnant women), individuals who receive SSI but are not eligible for Medicare, adults age 19 to 64 who are not eligible for Medicare with income levels up to 133% FPL, and children in DHCP.

Diamond State Health Plan Plus (DSHP Plus) – The program that provides services through a managed care delivery system to SSI children and adults with Medicare, and individuals participating in the Medicaid for Workers with Disabilities (Medicaid Buy-in) program.

Diamond State Health Plan Plus Long Term Services and Supports (DSHP Plus LTSS) – The program that provides services, including long term services and supports, through a managed care delivery system to DSHP Plus members who meet nursing facility level of care or are "at risk" for nursing facility level of care, DSHP Plus members who meet the hospital level of care criteria and have HIV/AIDS, and DSHP Plus members under age 21 who meet nursing facility level of care and reside in a nursing facility.

Disenroll/Disenrollment – The removal of a member from participation in DSHP or DSHP Plus.

Dual Eligible – An individual who is enrolled in both Medicare and Delaware Medicaid and is eligible for full Medicaid benefits.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – The Federally required program for clients under the age of 21, as defined in Section 1905(r) of the Social Security Act and 42 CFR Part 441, Subpart B. It includes periodic comprehensive screening and diagnostic services to determine health care needs as well as the provision of all Medically Necessary services listed in Section 1905(a) of the Social Security Act even if the service is not available under the State's Medicaid plan.

Electronic Funds Transfer (EFT) – Transfer of funds between accounts using electronic means such as a telephone or computer rather than paper-based payment methods such as cash or checks.

Electronic Health Record (EHR) – A record in digital format that is a systematic collection of electronic health information. EHRs may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an Emergency Medical Condition.

Employer Representative – For Self-Directed Attendant Care Services, the representative designated by a member to assume the employer responsibilities on the member's behalf.

Enroll/Enrollment – The process by which a client becomes a member of an MCO.

Encounter Data – The information relating to the receipt of any item(s) or service(s) by a member under the Contract that is subject to the requirements of 42 CFR 438.242 and 438.818.

Enrollment Files – 834 files sent by the State's Fiscal Agent to the Contractor to provide the Contractor with its official client Enrollment information. Supplemental Enrollment Files are provided by the HBM; these files contain additional demographic data and provider choice data not available on the 834 Enrollment Files.

Excluded Parties List System (EPLS) – An electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits.

Executive Management – The Contractor's senior management, including, at a minimum, the Contractor's CEO, CFO, and CMO.

External Quality Review (EQR) – The analysis and evaluation by an EQRO of information on quality, timeliness, and access to the Health Care Services that are furnished to members by the Contractor.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other EQR-related activities as set forth in 42 CFR 438.358, or both.

Federally Qualified Health Center (FQHC) – An entity that is receiving a grant under Section 330 of the Public Health Service Act.

Fee-for-Service (FFS) – A method of making payment for health services based on a fee schedule that specifies payment for defined services.

Fiscal Agent – The organization contracted by the State to operate the State's Delaware Medicaid Enterprise System (DMES).

Fraud – An intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law.

Grievance – An expression of dissatisfaction about any matter other than an Adverse Benefit Determination Grievances may include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

Grievance and Appeal System – The process the Contractor implements to handle Grievances and Appeals of an Adverse Benefit Determination, as well as the processes to collect and track information about Grievances and Appeals.

Health Benefits Manager (HBM) – The organization contracted by the State to perform functions related to outreach, education, Enrollment, Transfer and Disenrollment of clients/members.

Health Care Effectiveness Data and Information Set (HEDIS) – A set of standardized measures developed by the National Committee for Quality Assurance (NCQA) to measure and compare MCO performance.

Health Care Services – All Medicaid services provided by the Contractor in any setting, including but not limited to medical care, behavioral health and LTSS.

Health Education – Programs, services or promotions that are designed or intended to inform the Contractor's members about issues related to healthy lifestyles, situations that affect or influence health status, or methods or modes of health care treatment.

Health-Related Social Need (HRSN) – An individual member need related to social determinants of health. Examples include: housing instability and quality (e.g., homelessness, poor housing quality, inability to pay mortgage/rent); utility needs (e.g., difficulty paying utility bills); food insecurity; interpersonal violence (e.g., intimate partner violence, elder abuse, child maltreatment); transportation needs beyond medical transportation; family and social supports (e.g., prenatal support services, child care, social isolation, respite services, caregiver support); education (e.g., English as a Second Language (ESL), General Education Development (GED), or other education programs impacting social determinants of health); and employment and income.

Home and Community Based Services (HCBS) – Services that are provided to DSHP Plus LTSS members residing in homelike and integrated community settings as an alternative to long term care institutional placement.

Implementation Period – From the Contract effective date through the six-month period after the Start Date of Operations.

Indian – as defined in 42 CFR 438.14(a), any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian under 42 CFR 136.12.

Indian Health Care Provider – as defined in 42 CFR 438.14(a), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Individualized Education Program (IEP) – A written education plan for children with disabilities, as defined in Part B of the Individuals with Disabilities Education Act (IDEA). The IEP contains information on a child's present level of academic performance, annual academic and functional goals, and the special education and related services, supplementary aids and appropriate accommodations to be provided to the child.

Individualized Family Services Plan (IFSP) – A written plan for special services for children with disabilities, as defined in Part C of the Individuals with Disabilities Education Act (IDEA). The IFSP contains information on the child's present level of development, outcomes for the child and family, and the services the child and family will receive to help them achieve the outcomes.

Information System(s) – A combination of computing and telecommunications hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information (i.e., structured data (which may include digitized audio and video) and documents as well as non-digitized audio and video) and/or (b) the processing of information and non-digitized audio and video for the purposes of enabling and/or facilitating a business process or related transaction.

Instrumental Activities of Daily Living (IADLs) – Activities related to independent living which include, but are not limited to: light housekeeping chores, shopping, and meal preparation.

Law – Statutes, codes, rules, regulations, and/or court rulings. (The initial letter of this term is not capitalized in this Contract.)

Level of Care (LOC) – The type of long term services and supports required by a member based on the member's medical and functional needs as determined by the State's Pre-Admission Evaluation (PAE), which includes nursing facility level of care, level of care for individuals at-risk of institutionalization and acute hospital level of care.

Limited English Proficiency (LEP) – The restricted ability to read, speak, write or understand English by individuals who do not speak English as their primary language.

Limited English Proficient – Potential member or member who does not speak English as their primary language and who has a limited ability to read, write, speak, or understand English, and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

List of Excluded Individuals and Entities (LEIE) – A database of individuals and entities excluded from Federally funded health care programs maintained by the Department of Health and Human Services Office of the Inspector General.

Long Term Services and Supports (LTSS) – The services and supports described in Section 3.4.3 provided to DSHP Plus LTSS members who have functional limitations and/or chronic illness that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Organization (MCO) – Any entity that meets the requirements of 42 CFR 438.2 and is under contract with the State of Delaware to provide services to DSHP and DSHP Plus members.

Marketing – Any communication from the Contractor to a client who is not Enrolled in that Contractor's MCO, that can reasonably be interpreted as intended to influence the client to Enroll in the Contractor's MCO, or wither to not Enroll in, or to Transfer from another MCO. Marketing does not include communication to a client from the issuer of a qualified health plan, as defined in 45 CFR 155.20 about the qualified health plan.

Marketing Materials – Materials that are produced in any medium by or on behalf of the Contractor that can reasonably be interpreted as intended to Market to potential members.

Mass Marketing – Any communication or activity that can reasonably be interpreted as intended to promote the Contractor, including, but not limited to, advertising, publicity and positioning.

Medicaid – The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 USC 1396 et seq., which in Delaware is administered by DMMA.

Medicaid Drug Rebate Program – A partnership between CMS, state Medicaid agencies, and participating drug manufacturers that helps to offset the Federal and State costs of outpatient prescription drugs used by Medicaid patients.

Medicaid State Plan (State Plan) – A comprehensive written plan submitted by the State and approved by CMS that describes the nature and scope of the State's Medicaid program, including, but not limited to, eligibility standards, provider requirements, payment methods, and Health Care Services.

Medically Necessary or Medical Necessity – See Section 3.4.5 of this Contract.

Medicare – The medical assistance program authorized by Title XVIII of the Social Security Act.

Member – A Medicaid or DHCP client who Enrolls in the Contractor's MCO under the provisions of this Contract (see Section 3.2 of this Contract). Includes both DSHP and DSHP Plus members and their representatives. (The initial letter of this term is not capitalized in this Contract.)

Members with Special Health Care Needs (SHCN) – Members 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 and amount beyond that generally required by members. Includes Children with Special Health Care Needs.

National Committee for Quality Assurance (NCQA) – A private, not for profit organization dedicated to improving health care quality.

National Provider Identifier (NPI) – A 10-position all numeric identification number assigned by the National Plan and Provider Enumeration System to uniquely identify a health care provider.

Notice of Adverse Benefit Determination – A written notice from the Contractor to a member to advise the member of an Adverse Benefit Determination. A Notice of Adverse Benefit Determination shall comply with the requirements in Section 3.15.2 of this Contract.

Notice of Deficiency – A written notice from the State to the Contractor notifying the Contractor of non-compliance with the requirements of this Contract.

Nursing Facility (NF) – A facility that meets the requirements of Sections 1819 or 1919 of the Social Security Act and 42 CFR Part 483 and is licensed and certified as Medicaid nursing facility. (The initial letter of each word in this term is not capitalized in this Contract.)

Overpayment – Any payment made to a participating provider by the Contractor to which the participating provider is not entitled to under Title XIX of the Social Security Act or any payment to a Contractor by the State to which the Contractor is not entitled.

Outcomes – Changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

Participating Provider – Any provider, group of providers, or entity that is employed by or has signed a provider participation agreement with the Contractor or Subcontractor, and receives Medicaid funding directly or indirectly to order, refer, or provide Health Care Services. A Participating Provider is not a Subcontractor by virtue of the participation agreement.

Pathways to Employment (Pathways) – A program developed and administered by various divisions within Delaware State government, with oversight by DMMA, to provide clients with disabilities the option and supports they need to work.

Patient Liability – The amount of a member's income, as determined by the State, to be collected each month to help pay for the member's LTSS.

Pediatric – Care for individuals age 0 to 17 years of age.

Peer Review – An evaluation of the professional practices of a provider by the provider's peers. The evaluation assesses the necessity, appropriateness and quality of care furnished by the provider in comparison to care customarily furnished by the provider's peers and consistency with recognized health care standards.

Performance Improvement Projects (PIPs) – Projects consistent with 42 CFR 438.330

Pharmacy Benefits Manager (PBM) – An entity responsible for the provision and administration of pharmacy services, whether part of the Contractor's organization or Subcontracted with the Contractor.

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

Potential Member – In accordance with 42 CFR 438.2, a client who is subject to mandatory Enrollment in DSHP or DSHP Plus, but who is not yet a member of a specific MCO. (The initial letter of each word in this term is not capitalized in this Contract.)

Pre-Admission Screening and Resident Review (PASRR) – A Federal requirement (see Section 1919(e)(7) of the Social Security Act and 42 CFR Part 483, Subpart C) to help ensure that individuals are not inappropriately placed in nursing facilities for long term services and supports. PASRR requires that (i) all applicants to a Medicaid certified nursing facility be evaluated for mental illness and/or intellectual disability; (ii) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (iii) receive the services they need in those settings.

Preferred Drug List (PDL) – A listing of prescription products selected by a pharmaceutical and therapeutics committee as being safe, efficacious and cost-effective choices for clinician consideration when prescribing.

Prevalent Non-English Language – A non-English language spoken by a significant number or percentage of potential members and members in the State who are limited English proficient, as determined by the State.

Primary Care – All Health Care Services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist (OB/GYN), pediatrician, or other licensed practitioner as authorized by the State, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP) – A provider that has the responsibility for coordinating and providing Primary Care to members, initiating referrals for specialist care and maintaining the continuity of the member's care, as further described in Section 3.9.8 of this Contract.

Program of All-Inclusive Care for the Elderly (PACE) – A program that is operated by an approved PACE organization and that provides comprehensive services to PACE enrollees in

accordance with a PACE program agreement. PACE provides a capitated benefit for individuals age 55 and older who meet nursing facility level of care. It features a comprehensive service delivery system and integrated Medicare and Medicaid financing. (See Sections 1894 and 1934 of the Social Security Act and 42 CFR 460.)

Promoting Optimal Mental Health for Individuals through Supports and Empowerment (PROMISE) – A program administered by the Division of Substance Abuse and Mental Health (DSAMH) that provides home and community based services (HCBS) in the most integrated setting to adults meeting targeted behavioral health diagnostic and functional limitations.

Protected Health Information (PHI) – Per 42 CFR 160 and 42 CFR 164, individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Provider – Any individual or entity that is engaged in the delivery of Health Care Services, or ordering or referring of Health Care Services, and is legally authorized to do so by the State in which it delivers the services. Provider does not include Attendant Care Employees; nor does provider include the provider of support for Self-Directed Attendant Care Services**.**

Provider Participation Agreement – An agreement, using the provider agreement template prior approved by the State, between the Contractor and a provider or between the Contractor's Subcontractor and a provider that describes the conditions under which the provider agrees to furnish Health Care Services to members. (The initial letter of each word in this term is not capitalized in this Contract.)

Provider Preventable Conditions (PPCs) – The minimum set of conditions, including infections and events, which have been identified for non-payment according to the State's Medicaid State Plan.

Quality Improvement Initiative Task Force (QII Task Force) – A multidisciplinary Statewide group that is involved in reviewing and updating the State's Quality Management Strategy (QMS) and other quality initiatives in the State. Additional information on the QII Task Force is available in the State's QMS.

Quality Management/Quality Improvement (QM/QI) – The process of developing and implementing strategies to ensure the delivery of available, accessible, timely, and Medically Necessary Health Care Services that meet optimal clinical standards. This includes the identification of key measures of performance, discovery and data collection processes, identification and remediation of issues, and systems improvement activities.

Rate Cell – A set of mutually exclusive categories of members that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area.

Rating Period – A period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR 438.7(a).

Readily Accessible – Electronic information and services that comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

Representative – A person who has the legal right to make decisions on behalf of a member, including parents of un-emancipated minors, guardians, and agents designated pursuant to a power of attorney for health care. For DSHP Plus LTSS members, this includes a person empowered by law, judicial order or power of attorney, or otherwise authorized by the DSHP Plus LTSS member to make decisions on behalf of the member. For members enrolled in the DDDS Lifespan Waiver, this term includes persons empowered by law, judicial order or power of attorney, through a supported decision-making agreement, or otherwise authorized by the member to make decisions on behalf of the member. (The initial letter this term is not capitalized in this Contract.)

Routine Care – The treatment of a condition that would have no adverse effects if not treated within 48 hours or could be treated in a less acute setting (e.g., physician's office) or by the patient.

Self-Directed Attendant Care Services – Attendant care services that are provided by attendant care workers to members residing in homelike and integrated community settings who have opted to self-direct their attendant care services.

Social Security Administration Death Master File (SSA DMF) – An extract file made available by the Social Security Administration that contains information about deaths reported to the Social Security Administration.

Specialized Services for Nursing Facility Residents (Specialized Services) – Any service or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness or to intellectual disability or related condition, that supplements the scope of services that the facility must provide under reimbursement as nursing facility services and is authorized by the State. Includes both Specialized Services for Nursing Facility Residents with Mental Illness and Specialized Services for Nursing Facility Residents with Developmental Disabilities.

Specialized Services for Nursing Facility Residents with Mental Illness – Any service or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness that supplements the scope of services that the facility must provide under reimbursement as nursing facility services and is authorized by DSMAH.

Specialized Services for Nursing Facility Residents with Developmental Disabilities – Any service or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to intellectual disability or related condition that supplements the scope of services that the facility must provide under reimbursement as nursing facility services and is authorized by DDDS.

Start Date of Operations – The date, as determined by the State, when the Contractor shall begin providing services to members.

State – The State of Delaware, including, but not limited to, any entity or agency of the State.

State Fair Hearing –The process set forth in 42 CFR Part 431, Subpart E.

Subcontract – An agreement entered into by the Contractor or the Contractor's parent, subsidiary or Affiliate, with any organization or person, including the Contractor's parent, subsidiary or Affiliate, to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's administrative obligations to the State under the terms of this Contract (e.g., claims processing) when the intent of such an agreement is to delegate the responsibility for any administrative functions required by this Contract. This shall include any and all agreements with any and all Subcontractors related to securing or fulfilling the Contractor's administrative obligations to the State under the terms of this Contract. If the Subcontract includes the provision or securing the provision of Health Care Services to members, the Contractor shall ensure that all requirements described in Section 3.10 of this Contract are included in the Subcontract and/or a separate provider participation agreement is executed by the appropriate parties. A provider participation agreement is not considered a Subcontract.

Subcontractor – Any individual or entity, including the Contractor's parent, subsidiary or Affiliate, that provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the State under the terms of this Contract. Subcontractor does not include a provider unless the provider is responsible for services other than providing Health Care Services pursuant to a provider participation agreement.

Supplemental Drug Rebate – A monetary amount negotiated between DMMA and manufacturers for products on the State's Preferred Drug List that is above the minimum amount required by the State's Federal rebate agreement.

Telemedicine – The use of telecommunications technology to provide, enhance or expedite Health Care Services, as by accessing off-site data bases, linking clinics or physicians' offices to a central hospital, or transmitting x-rays or other diagnostic images for examination at another site.

Therapeutic Leave Day – A day that a resident is temporarily absent from a nursing facility for reasons other than hospitalization, such as to visit family or friends in the community, as long as such absences are provided for in the resident's plan of care. During a therapeutic leave day the nursing facility holds/reserves a bed for the resident.

Third Party – For purposes of the definition of Third Party Liability (TPL), any individual, entity or program that is or may be liable to pay all or part of the expenditures for Health Care Services.

Third Party Liability (TPL) – Any amount due for all or part of the cost of Health Care Services from a Third Party.

Tier 3 Standards – Data center standards that meet the Telecommunications Industry Association (TIA) Tier 3 requirements as follows: (i) meets or exceeds all Tier 1 and Tier 2 requirements, (ii) multiple independent distribution paths serving the information technology

equipment, (iii) all information technology equipment must be dual-powered and fully compatible with the topology of a site's architecture, and (iv) concurrently maintainable site infrastructure with expected availability of 99.982%.

Transfer – A member's change from Enrollment in one MCO to Enrollment in a different MCO.

Urgent Care – Treatment of a condition that is potentially harmful to a patient's health and for which it is Medically Necessary for the patient to receive treatment within 48 hours to prevent deterioration.

Utilization Management (UM) – A system for reviewing the appropriate and efficient allocation of Health Care Services that are provided, or proposed to be provided, to a member.

Vaccines for Children (VFC) – A Federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay.

Warm Transfer – A telecommunications mechanism in which the person answering the call facilitates the transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

Waste – Health care spending that can be eliminated without reducing quality of care.

Acronyms List

ABI – Acquired Brain Injury

ACA – Patient Protection and Affordable Care Act Public Law 111-148 (2010) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152 (2010)

ACO – Accountable Care Organization

ACT – Assertive Community Treatment

AIDS – Acquired Immunodeficiency Syndrome

ADLs – Activities of Daily Living

ASAM – American Society of Addiction Medicine

BC-DR – Business Continuity and Disaster Recovery

CAP – Corrective Action Plan

CBC – Criminal Background Check

CDW – Child Development Watch

CEO – Chief Executive Officer

CFO – Chief Financial Officer

CFR – The Code of Federal Regulations

CHIP – Children's Health Insurance Program

CLIA – The Clinical Laboratory Improvement Amendments of 1988

CMO – Chief Medical Officer/Medical Director

CMS – The Centers for Medicare & Medicaid Services

COBA – Coordination of Benefits Agreement

COBC – Coordination of Benefits Contractor

CQM – Clinical Quality Measure

DCAP – Directed Corrective Action Plan

DDDS – Division of Developmental Disabilities Services

DFS – Delaware Division of Family Services

DESI – Drug Efficacy Study Implementation

DHCP – Delaware Healthy Children Program

DHIN – Delaware Health Information Network

DHSS – Delaware Department of Health and Social Services

DMAP – Delaware Medical Assistance Program

DME – Durable Medical Equipment

DMES – Delaware Medicaid Enterprise System

DMMA – Delaware Division of Medicaid and Medical Assistance

DOI – Delaware Department of Insurance

DOJ – Department of Justice

DPBHS – Division of Prevention and Behavioral Health Services

DPH – Division of Public Health

DSAAPD – Division of Services for Aging & Adults with Physical Disabilities

DSAMH – Delaware Division of Substance Abuse and Mental Health

DSCYF – Department of Services for Children, Youth and Families

DSHP – Diamond State Health Plan

DSHP Plus – Diamond State Health Plan Plus

DSHP Plus LTSS – Diamond State Health Plan Plus Long Term Services and Supports

DTI – Department of Technology & Information

DUR – Drug Utilization Review

EEO – Equal Employment Opportunity

EFT – Electronic Funds Transfer

EHR – Electronic Health Record

EPA – Environmental Protection Agency

EPLS – Excluded Parties List System

EPSDT – Early and Periodic Screening, Diagnostic and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

FAR – Federal Acquisition Regulation

FDA – Food and Drug Administration

FFS – Fee-for-Service

FMS – Financial Management Services

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

HBM – Health Benefits Manager

HCBS – Home and Community Based Services

HEDIS – Health Care Effectiveness Data and Information Set

HHS – The United States Department of Health and Human Services

HHS-OIG – The United States Department of Health and Human Services Office of the Inspector General

HIE – Health Information Exchange

HIPAA – The Health Insurance Portability and Accountability Act of 1996, 42 USC 160, et seq.

HITECH – The Health Information Technology for Economic and Clinical Health Act of 2009, 42 USC 17931 et seq.

HIV – Human Immunodeficiency Virus

HMO – Health Maintenance Organization

IADLs – Instrumental Activities for Daily Living

IBNR – Incurred But Not Reported Costs

ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities

ICM – Intensive Case Management

IDEA – Individuals with Disabilities Education Improvement Act of 2004

IEP – Individualized Education Program

IFSP – Individualized Family Services Plan

IHCP – Indian Health Care Provider

LEIE – List of Excluded Individuals and Entities

LEP – Limited English Proficiency

LOC – Level of Care

LTSS – Long Term Services and Supports

MAC – Medical Advisory Committee

MAT – Medication Assisted Treatment

MCO – Managed Care Organization

MFCU – Delaware's Medicaid Fraud Control Unit

MLR – Medical Loss Ratio

MOU – Memorandum of Understanding

MTM – Medication Therapy Management

NCPDP – The National Council of Prescription Drug Programs

NCQA – National Committee for Quality Assurance

NQTL – Non-quantitative Treatment Limitation

NPI – National Provider Identifier

OEID – Other Entity Identifier

OTC – Over the Counter

P&T – Pharmacy and Therapeutics

PACE – Program of All-Inclusive Care for the Elderly

PAE – Delaware's Pre-Admission Evaluation

PASRR – Pre-Admission Screening and Resident Review

PBM – Pharmacy Benefits Manager

PCMH – Patient-Centered Medical Home

PERS – Personal Emergency Response System

PCP – Primary Care Provider

PDL – Preferred Drug List

PHI – Protected Health Information

PIP – Performance Improvement Project

PL – Public Law

PLUS-QCMMR – Diamond State Health Plan Plus Quality and Care Management Measurement and Reporting

PMP – Delaware Prescription Monitoring Program

PPC – Provider Preventable Condition

PPEC – Prescribed Pediatric Extended Care

PRA Demo – Delaware's Project Rental Assistance Demonstration

Pro-DUR – Prospective Drug Utilization Review

PROMISE – DSAMH's Promoting Optimal Mental Health for Individuals through Supports and Empowerment Program

QCMMR – Quality and Care Management Measurement and Reporting

QII Task Force – Quality Improvement Initiative Task Force

QM/QI – Quality Management/Quality Improvement

QMS – Delaware's Maggie:

QTL – Quantitative Treatment Limitation

SAM – Federal System for Award Management

SBWC – School-Based Wellness Center

SHCN – Special Health Care Needs

SRAP – Delaware's State Rental Assistance Program

SSBG – Social Service Block Grant

SSI – Supplemental Security Income

Stat – United States Statute

SUD – Substance Use Disorder

TANF – Temporary Assistance for Needy Families

TPL – Third Party Liability

UM – Utilization Management

USC – United States Code

VFC – Vaccines for Children

SECTION 2 GENERAL REQUIREMENTS

2.1 GENERAL

2.1.1 The Contractor shall provide an integrated managed care service delivery system for the Delaware Department of Health and Social Services (DHSS), Division of Medicaid & Medical Assistance (DMMA) for the Diamond State Health Plan (DSHP), which includes the Delaware Healthy Children Program (DHCP), and the Diamond State Health Plan Plus program (DSHP Plus), pursuant to the requirements of this Contract.

2.1.2 The Contractor shall be responsible for the administration and management of all aspects of this Contract including all Subcontractors, providers, employees, agents, and anyone acting for or on behalf of the Contractor.

2.1.3 The Contractor shall comply with all the requirements of this Contract, including any Federal or State law or policy incorporated by reference and shall act in good faith in the performance of these requirements. The Contractor acknowledges that failure to comply with a requirement of this Contract may result in the imposition of sanctions and/or termination of the Contract as specified in Sections 5.4 and 5.12 of this Contract.

2.1.4 As directed by the State, the Contractor shall actively participate in the implementation of Delaware's State Health Care Innovation Plan (SHIP), which was developed pursuant to a Model Design grant awarded to the State through the Center for Medicare and Medicaid Innovation's State Innovation Models (SIM) initiative. Delaware's SHIP describes the State's approach to transforming the State's health system, including payment and delivery system models and related initiatives to be implemented by multiple payors, including Medicaid.

2.1.5 The Contractor shall develop policies and procedures that describe, in detail, how the Contractor will comply with the requirements of this Contract, and the Contractor shall administer this Contract in accordance with those policies and procedures.

2.1.6 As specified in this Contract or as otherwise required by the State, the Contractor shall submit policies, procedures, plans and other deliverables for review and prior approval in the format and within the timeframes specified by the State.

2.1.6.1 If this Contract or the State otherwise requires prior approval of a policy, procedure, plan or other deliverable, the Contractor must receive written approval

from the State prior to the policy, procedure, plan or other deliverable taking effect.

2.1.6.2 The Contractor agrees to make changes to policies, procedures, plans or other deliverables requested by the State in order to comply with this Contract and shall make such changes in the timeframes specified by the State.

2.1.6.3 If this Contract or the State otherwise requires prior approval of a policy, procedure, plan or other deliverable, the Contractor shall also submit any substantive changes to the policy, procedure, plan or deliverable to the State for prior approval.

2.1.7 All of the Contractor's responsibilities pursuant to this Contract must be performed in the United States.

2.2 LICENSURE OR CERTIFICATION

2.2.1 Prior to the Start Date of Operations and prior to accepting DSHP or DSHP Plus members, the Contractor shall be licensed by the Delaware Department of Insurance (DOI) as a Health Maintenance Organization or Health Service Corporation or certified by the Department of Health and Social Services (DHSS).

2.2.2 Prior to the Start Date of Operations, the Contractor shall ensure that its staff, all Subcontractors and their staff and all participating providers and their staff are appropriately licensed or certified as required by State law or this Contract.

2.2.3 The Contractor shall ensure that the Contractor and its staff, all Subcontractors and their staff, and all participating providers and their staff retain at all times during the period of this Contract a valid license or certification, as applicable, and comply with all applicable license/certification requirements.

2.3 READINESS REVIEW

2.3.1 Prior to the Start Date of Operations, as determined by the State, the Contractor shall demonstrate to the State's satisfaction that it is able to meet the requirements of this Contract.

2.3.2 The Contractor shall cooperate in a readiness review conducted by the State to review the Contractor's readiness to begin serving DSHP and DSHP Plus members. This review may include, but is not limited to, desk and onsite review of documents provided by the Contractor, a walk-through of the Contractor's operations, system demonstrations (including systems connectivity testing), and interviews with the Contractor's staff. The scope of the review may include any of the requirements specified in this Contract as determined by the State.

2.3.3 Based on the results of the review activities, the State will issue a letter of findings and, if needed, will request a corrective action plan (CAP) or directed corrective action plan (DCAP). The Contractor shall not provide services to members, and the State shall not make payment to the Contractor, until the State has determined that the Contractor is able to meet the requirements of this Contract.

2.3.4 If the Contractor is unable to demonstrate its ability to meet the requirements of this Contract, as determined by the State, within the timeframes specified by the State, the State may terminate this Contract in accordance with Section 5.12 of this Contract and shall have no liability for payment to the Contractor.

SECTION 3 CONTRACTOR'S SCOPE OF WORK

3.1 ELIGIBILITY FOR DSHP AND DSHP PLUS

3.1.1 General

3.1.1.1 Except as provided in Section 3.1.1.2 of this Contract, the State shall determine initial Medicaid and DHCP eligibility and continued eligibility for DSHP and DSHP Plus members in accordance with Federal and State requirements.

3.1.1.2 The Contractor shall re-evaluate the level of care (LOC) for DSHP Plus LTSS members residing in the community (see Section 3.7.2 of this Contract).

3.1.2 DSHP and DSHP Plus Mandatory Enrollment

3.1.2.1 The State will require the following Medicaid and DHCP eligibility groups to Enroll in an MCO:

3.1.2.1.1 TANF children under age 21, including Title IV-E foster care and adoption assistance;

3.1.2.1.2 TANF adults aged 21 and over, including pregnant women;

3.1.2.1.3 SSI children under age 21;

3.1.2.1.4 SSI adults age 21 and older;

3.1.2.1.5 Adults age 19 to 64 not eligible for Medicare with income levels up to 133% FPL (the new adult group);

3.1.2.1.6 DHCP children;

3.1.2.1.7 SSI children with Medicare;

3.1.2.1.8 SSI adults with Medicare;

3.1.2.1.9 Medicaid for Workers with Disabilities (Medicaid Buy-in);

3.1.2.1.10 TEFRA-like children (Katie Beckett) using the "at-risk of nursing facility" LOC criteria in place at time of Medicaid enrollment;

3.1.2.1.11 Individuals with a diagnosis of AIDS or HIV who meet the hospital LOC criteria and who receive HCBS as an alternative;

3.1.2.1.12 Aged and/or disabled individuals over age 18 who meet nursing facility LOC or are "at risk" for nursing facility LOC;

3.1.2.1.13 Individuals under age 21 who meet nursing facility LOC and who reside in a nursing facility; and

3.1.2.1.14 Individuals meeting ICF/IID LOC and enrolled in the DDDS Lifespan Waiver.

3.1.3 Populations Excluded from Enrollment in DSHP or DSHP Plus

3.1.3.1 The State will exclude Medicaid and DHCP clients who are in one of the following categories, regardless of whether they are listed in Section 3.1.2 above, from Enrollment in an MCO:

3.1.3.1.1 Individuals residing in ICF/IIDs (i.e., Stockley Center and Mary Campbell Center);

3.1.3.1.2 Individuals who meet the Federal definition of an "inmate of a public institution," unless the individual is an inpatient in a hospital other than the State Department of Corrections (DOC) infirmary per the exception permitted under 42 CFR 435.1010;

3.1.3.1.3 Aliens who are only eligible for Medicaid to treat an Emergency Medical Condition under Section 1903(v)(2) of the Social Security Act;

3.1.3.1.4 Adults eligible for Delaware Medicaid who were residing outside of the State of Delaware in a nursing facility as of April 1, 2012 as long as they remain in an out-of-State facility;

3.1.3.1.5 Individuals who choose to participate in PACE;

3.1.3.1.6 Individuals receiving Medicare cost sharing only (i.e., Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries, Qualifying Individuals and Qualified and Disabled Working Individuals);

3.1.3.1.7 Presumptively eligible pregnant women;

3.1.3.1.8 Individuals in the Breast and Cervical Cancer Program for Uninsured Women;

3.1.3.1.9 Individuals who are presumptively eligible for the Breast and Cervical Cancer Program for Uninsured Women; and

3.1.3.1.10 Individuals in the 30 Day Acute Care Hospital Program.

3.1.4 **Populations Exempted from Enrollment in DSHP and DSHP Plus**

3.1.4.1 The State may identify members who are exempt from mandatory Enrollment in an MCO on a case by case basis.

3.1.4.2 Neither the Contractor nor clients/members shall be permitted to request exemption from Enrollment in an MCO.

3.2 ENROLLMENT, TRANSFERS AND DISENROLLMENT

3.2.1 **General**

3.2.1.1 The Contractor shall cooperate with the State and the HBM as necessary for Enrollment, Transfer and Disenrollment and related outreach and education activities in accordance with Section 3.2 of this Contract.

3.2.2 **MCO Selection and Assignment**

3.2.2.1 In the event the State contracts with an MCO that was not contracting with the State to provide Medicaid managed care services prior to the effective date of this Contract (a new MCO), the State will implement an automatic assignment mechanism to assign clients to all contracting MCOs such that all contracting MCOs achieve initial minimum membership levels as determined by the State.

3.2.2.2 The State shall Enroll clients required to enroll in DSHP and DSHP Plus in an MCO. Enrollment in an MCO may be the result of a client's selection of a particular MCO or assignment by the State in accordance with this Section 3.2.2 of the Contract.

3.2.2.3 <u>Clients who are Enrolled in an Incumbent MCO</u>

3.2.2.3.1 The State will conduct an open enrollment in October of each year for DSHP and DSHP Plus clients who are already Enrolled in an MCO to select a contracted MCO with enrollment effective the Start Date of Operations.

3.2.2.4 <u>New Members</u>

3.2.2.4.1 All clients who are required to Enroll in an MCO are provided the opportunity to choose an MCO and are made aware of their auto-assigned MCO if they do not voluntarily choose an MCO.

3.2.2.4.2 The HBM will encourage (but not require) all clients within the same household to select the same MCO.

3.2.2.5 DSHP Auto-Assignment

3.2.2.5.1 The State will auto-assign a client to an MCO if (i) a client fails to notify the HBM (either by mail or telephone) of his/her MCO preference within 30 calendar days of the postmark date of an Enrollment letter being sent to the client, or (ii) the client cannot be Enrolled in the requested MCO pursuant to the terms of this Contract (e.g., because Enrollment has been limited pursuant to Section 5.4 of this Contract or the Contractor does not have capacity, as determined by DMMA, to enroll members).

3.2.2.5.2 The DSHP auto assignment process will consider the following:

3.2.2.5.2.1 If the client's head of household is Enrolled in an MCO, the client is auto-assigned to the same MCO. If the client's head of household is not Enrolled in an MCO, but other individuals in the client's case are Enrolled in an MCO, then the client is Enrolled in the same MCO as the other individuals in the client's case.

3.2.2.5.2.2 If the client was Disenrolled from an MCO due to loss of Medicaid eligibility within the previous two months, the client will be auto-assigned to that same MCO;

3.2.2.5.2.3 If the client is a newborn, the client will be Enrolled in his/her mother's MCO (see Section 3.2.2.7 of this Contract, below); and

3.2.2.5.2.4 If none of the above applies, a client will be assigned to an MCO using a rotation order that alternately assigns members to one MCO, then the other(s), and so on.

3.2.2.5.3 The provisions relating to auto-assignment in Section 3.2.2.5 of this Contract are subject to the Contractor's compliance with all other provisions of the Contract. The State reserves the right to change the auto-assignment process as described above to change or add criteria including, but not limited to, quality or cost measures.

3.2.2.5.4 The State's auto-assignment process will not restrict in any way the freedom of every client to choose an MCO.

3.2.2.5.5 The HBM will notify members about the MCO to which they have been assigned under the auto-assignment process.

3.2.2.6 DSHP Plus Auto-Assignment

3.2.2.6.1 DSHP Plus full Dual Eligible clients who are not eligible for DSHP Plus LTSS will be assigned to an MCO according to the auto-assignment process in Section 3.2.2.5 of this Contract.

3.2.2.6.2 DSHP Plus LTSS clients residing in nursing facilities, DSHP Plus LTSS clients with a diagnosis of HIV/AIDS who meet hospital LOC, and DSHP Plus LTSS clients living in the community will be auto-assigned evenly among the MCOs such that there is an equal distribution in each MCO of:

3.2.2.6.2.1 DSHP Plus LTSS clients residing in nursing facilities, by nursing facility;

3.2.2.6.2.2 DSHP Plus LTSS clients with a diagnosis of HIV/AIDS who meet hospital LOC, by county; and

3.2.2.6.2.3 DSHP Plus LTSS clients who live in the community, by county.

3.2.2.6.3 When a DSHP member is found to meet the criteria for DHSP Plus, the individual will remain with the same MCO. However, the member may request a Transfer to another MCO for good cause pursuant to Section 3.2.7 of this Contract.

3.2.2.7 Newborns

3.2.2.7.1 Newborns born to mothers who are DSHP or DSHP Plus members at the time of the child's birth will be Enrolled in their mother's MCO. If the mother is not Enrolled with an MCO but the child is eligible for Medicaid or CHIP, the birth is covered by fee-for-service Medicaid or CHIP, and the child and the mother will be Enrolled in the same MCO.

3.2.2.7.2 The Contractor shall provide Covered Services for eligible newborns retroactive to the date of birth.

3.2.2.7.3 The newborn's mother or guardian may request the newborn's Transfer without cause within the first 90 calendar days (see Section 3.2.6.2 of this Contract) and for good cause at any time in accordance with Section 3.2.7.4.4 of this Contract.

3.2.2.8 Automatic Re-Enrollment

3.2.2.8.1 Members who are Disenrolled from DSHP or DSHP Plus solely due to loss of Medicaid eligibility and are re-Enrolled within two months are automatically re-Enrolled with the same MCO with

which they had previously been Enrolled. If a member has been Disenrolled for a period of time in excess of two months, he/she will be considered a new member and the standard Enrollment process will apply (see Section 3.2.2 of this Contract).

3.2.2.8.2 Re-Enrollment of DHCP members will be contingent on the payment of a monthly premium, unless waived by DMMA.

3.2.3 Non-Discrimination

3.2.3.1 The Contractor shall accept members without restriction in the order in which applications are approved and members are assigned to the Contractor (whether by selection or assignment).

3.2.3.2 The Contractor shall accept members in accordance with 42 CFR 438.3(d) and will not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of (i) health status or need for services or (ii) race, color, or national origin, sex, sexual orientation, gender identity, or disability.

3.2.4 Effective Date of Enrollment with the Contractor

3.2.4.1 A member's effective date of Enrollment in the Contractor's MCO shall be the date provided on the outbound 834 Enrollment File from the State. In general, a member's effective date of Enrollment will be the first day of the month.

3.2.4.2 Except as provided below or in Section 4 of this Contract, the effective date of Enrollment shall not be retroactive.

3.2.4.2.1 The effective date of Enrollment for newborns shall be retroactive to the date of birth.

3.2.4.2.2 The effective date of Enrollment for DSHP Plus LTSS members residing in a nursing facility may be retroactive up to 90 calendar days prior to the member's date of application for Medicaid.

3.2.5 Eligibility and Enrollment Data

3.2.5.1 The Contractor shall receive, process and update daily Enrollment Files from the State. The Contractor shall update or upload Enrollment data systematically to the Contractor's eligibility/Enrollment database within 24 hours of receipt from the State.

3.2.5.2 The Contractor shall establish and maintain access to the State's online system for eligibility records. If the Contractor Subcontracts for behavioral health services or pharmacy management services, the Subcontractor must also establish and maintain access to the State's online system for eligibility records.

3.2.6 **Enrollment Periods**

3.2.6.1 Continuous Enrollment

3.2.6.1.1 The Contractor shall have a continuous Enrollment process for new DSHP and DSHP Plus members such that, as the State determines that clients meet the criteria for Enrollment, they can Enroll in the Contractor's MCO without waiting for the Annual Open Enrollment Period (described in Section 3.2.6.3 of this Contract).

3.2.6.2 90 Day Change Period

3.2.6.2.1 All new members will have the opportunity to change MCOs during the 90 calendar day period immediately following the date of initial Enrollment in the Contractor's MCO.

3.2.6.3 Annual Open Enrollment Period

3.2.6.3.1 The State will provide an opportunity for members to change MCOs during an Annual Open Enrollment Period which, unless otherwise specified by the State, shall be the month of October for Enrollment during the calendar year that begins the following January 1. All DSHP or DSHP Plus members may choose a new MCO during this Annual Open Enrollment Period.

3.2.6.3.2 Members who decide to change MCOs during the Annual Open Enrollment Period must inform the HBM. The HBM will process the Transfer request and update the Enrollment Files so that both the old and the new MCOs are informed of the Transfer.

3.2.6.3.3 Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

3.2.6.3.4 The HBM will mail an advance notice postcard annually to members at the end of August or as otherwise specified by the State. This notice will include a description of DSHP and DSHP Plus and the role and responsibility of the HBM and will alert members that they will be receiving Enrollment information from the HBM. The HBM will then mail Enrollment materials to members approximately five business days before open enrollment begins. This information will include the Contractor's approved Marketing Materials pursuant to Section 3.3 of this Contract.

3.2.6.3.5 The HBM will inform each member in writing at the time of Enrollment and at least 60 calendar days before the start of each Annual Open Enrollment Period of the right to Transfer to another MCO in accordance with Section 3.2.7 of this Contract.

3.2.7 **Transfers between MCOs**

3.2.7.1 The member or the Contractor can initiate the process of requesting a member's Transfer to another MCO.

3.2.7.2 The Contractor must have written policies and procedures for Transferring relevant member information, including medical records and other pertinent materials, when a member is approved by the State to be Transferred to or from another MCO (see Section 3.8.1 of this Contract).

3.2.7.3 The State will approve or disapprove within 10 business days of receipt all member and Contractor requests to Transfer members to another MCO.

3.2.7.4 Member-Initiated Transfers

3.2.7.4.1 Members may initiate Transfer requests by submitting an oral or written request to the State. The State must approve all member-initiated Transfer requests before a member can be Transferred to another MCO.

3.2.7.4.2 *Member-Initiated Transfers Not Requiring Good Cause*

3.2.7.4.2.1 Members may initiate a Transfer for any reason during the Annual Open Enrollment Period (see Section 3.2.6.3 of this Contract, above).

3.2.7.4.2.2 Members may initiate Transfer for any reason during the 90 calendar days following the member's initial Enrollment pursuant to Section 3.2.6.2 of this Contract.

3.2.7.4.2.3 Members may initiate Transfer for any reason if the member's temporary loss of Medicaid eligibility caused the member to miss the Annual Open Enrollment Period.

3.2.7.4.3 Members may initiate Transfer when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(3) (granting members the right to Transfer without cause; see Section 5.4.3 of this Contract).

3.2.7.4.4 *Member-Initiated Transfers Requiring Good Cause*

3.2.7.4.4.1 Members may request Transfers between MCOs at any time for good cause, as determined by the State. There is no limit on the number of Transfer requests that a member can initiate for good cause.

3.2.7.4.4.2 Reasons considered by the State to be good cause for member Transfers include:

3.2.7.4.4.2.1 The member requires specialized care for a chronic condition and the member, Contractor and State agree that reassignment to another MCO will result in better or more appropriate care;

3.2.7.4.4.2.2 The member has a documented, long standing relationship with a provider that is not a participating provider with the Contractor but is a participating provider with another MCO;

3.2.7.4.4.2.3 The Contractor does not, because of moral or religious objections, cover some or all the services the member seeks (in accordance with 42 CFR 438.56(d)(2));

3.2.7.4.4.2.4 The member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk (see 42 CFR 438.56(d)(2);

3.2.7.4.4.2.5 Poor quality of care, lack of access to Covered Services, or lack of access to providers experienced in dealing with the member's health care needs; or

3.2.7.4.4.2.6 Other circumstances that the State determines justify a Transfer.

3.2.7.5 Contractor-Initiated Transfers

3.2.7.5.1 The Contractor shall submit all Transfer requests to the State, and the State must approve all Contractor-initiated Transfer requests before a member can be Transferred to another MCO.

3.2.7.5.2 *Valid Reasons for Contractor-Initiated Transfers*

3.2.7.5.2.1 Valid reasons for Contractor-initiated Transfers include but are not limited to:

3.2.7.5.2.1.1 A persistent and documented refusal by the member to follow prescribed treatments or comply with Contractor requirements that are consistent with State and Federal law and policy;

3.2.7.5.2.1.2 Abusive or threatening conduct by the member;

3.2.7.5.2.1.3 Contractor concerns regarding the ability to safely and effectively care for a DSHP Plus LTSS member in the community and/or ensure the member's health, safety and welfare including, but not limited to, the following:

3.2.7.5.2.1.3.1 A member for whom the Contractor has determined that it cannot safely and effectively meet the member's needs.

3.2.7.5.2.1.3.2 A member repeatedly refuses to allow a Contractor case manager entrance into his/her place of residence.

3.2.7.5.2.2 A DSHP Plus LTSS member has to change their residential, institutional, or employment supports provider based on that provider's change in status from a participating provider to a non-participating provider and, as a result, experiences a disruption in their residence or employment.

3.2.7.5.3 The Contractor shall demonstrate at least three attempts, through education and/or case management, to resolve any difficulty leading to a Contractor-initiated request for Transfer, over a period of 90 consecutive calendar days before requesting a Transfer. The Contractor shall make the attempts at least every 30 calendar days of that consecutive 90 calendar day period. The Contractor shall document evidence of the attempts made to resolve the difficulty in the Transfer request. In cases involving abusive or threatening behavior, only one attempt is required. The Contractor's request to Transfer a member must cite at least one example of the difficultly leading to the Contractor's request to Transfer the member.

3.2.7.5.4 The Contractor must notify the member in writing of its intent to request that the State Transfer the member to another MCO.

3.2.7.5.5 Members have the right to Appeal a Contractor-initiated request for Transfer through the Contractor's Grievance and Appeal System within 10 calendar days of receipt of notice from the Contractor of the Contractor's intent to request that the State Transfer the member. If the member files a Grievance, the Contractor must hear the Grievance within 10 calendar days of receipt of the Grievance. The Grievance must be resolved prior to the Contractor submitting a request to the State to Transfer the member.

3.2.7.5.6 *Limit on Contractor-Initiated Transfers*

3.2.7.5.6.1 Members that have been Transferred between MCOs as a result of a MCO-initiated Transfer request, to such an extent that they

have been Enrolled in every contracted MCO, will remain Enrolled in one MCO until the next Annual Open Enrollment Period.

3.2.7.5.7 *Invalid Reasons for Contractor-Initiated Transfers*

3.2.7.5.7.1 The Contractor shall not request, and the State will not approve, Transfer of a member for any of the following reasons:

3.2.7.5.7.1.1 Adverse changes in a member's health;

3.2.7.5.7.1.2 Pre-existing health care conditions;

3.2.7.5.7.1.3 High cost health care bills;

3.2.7.5.7.1.4 Failure or refusal of a member to pay applicable DSHP Plus Patient Liability responsibilities, except as waived by the State;

3.2.7.5.7.1.5 A member's high utilization of Health Care Services;

3.2.7.5.7.1.6 A member's diminished mental capacity;

3.2.7.5.7.1.7 A member's uncooperative or disruptive behavior resulting from his/her special needs (except when his/her continued Enrollment in the Contractor's MCO seriously impairs the Contractor's ability to furnish services to either this particular member or other members);

3.2.7.5.7.1.8 A member's medical diagnosis or health status; and

3.2.7.5.7.1.9 A member's attempt to exercise his/her rights under the Contractor's Grievance and Appeal System or the State's Fair Hearing process, or the demands of a member for referrals to specialists, or for information regarding their health care condition.

3.2.7.6 <u>Effective Date of Transfers</u>

3.2.7.6.1 All approved Transfers will become effective no later than the first day of the second month after the Transfer was requested.

3.2.7.6.2 The Contractor will be notified of the member's Transfer via the Contractor's 834 Enrollment File from the State.

3.2.8 **Disenrollment from DSHP/DSHP Plus**

3.2.8.1 General

3.2.8.1.1 Members may request Disenrollment from DSHP/DSHP Plus. The Contractor may not request member Disenrollment from DSHP/DSHP Plus.

3.2.8.1.2 A member may be Disenrolled from DSHP/DSHP Plus only when authorized by the State.

3.2.8.2 Acceptable Reasons for Disenrollment from DSHP/DSHP Plus

3.2.8.2.1 A member may request Disenrollment or be Disenrolled by the State from DSHP/DSHP Plus for the following reasons:

3.2.8.2.1.1 The member's loss of Medicaid or DHCP eligibility;

3.2.8.2.1.2 The member's placement in an ICF/IID for more than 30 calendar days;

3.2.8.2.1.3 The member is found to have been Enrolled in error (this may occur if the member was classified into the wrong eligibility category);

3.2.8.2.1.4 Upon the member's death;

3.2.8.2.1.5 The member moves outside of the State of Delaware of his/her own volition (i.e., is not placed in an out-of-State placement by the Contractor);

3.2.8.2.1.6 The member becomes an inmate of a public institution; or

3.2.8.2.1.7 The member meets any of the criteria for exclusion from DSHP/DSHP Plus as provided in Section 3.1.3 of this Contract.

3.2.8.3 Informing the State of Potential Acceptable Reasons for Member Disenrollment from DSHP/DSHP Plus

3.2.8.3.1 Although the Contractor may not request Disenrollment of a member from DSHP/DSHP Plus, the Contractor shall inform the State promptly when the Contractor knows or has reason to believe that a member may satisfy any of the conditions for Disenrollment from DSHP/DSHP Plus as described in Section 3.2.8.2 of this Contract.

3.2.8.4 Effective Date of Disenrollment from DSHP/DSHP Plus

3.2.8.4.1 All Disenrollments will become effective no later than the first day of the second month after the Disenrollment was requested by the member or initiated by the State.

3.2.8.4.2 The Contractor will be notified of the member's Disenrollment via the 834 Enrollment File from the State.

3.3 MARKETING

3.3.1 General

3.3.1.1 The HBM shall be responsible for educating potential members about DSHP and DSHP Plus and assisting members with their MCO selection.

3.3.1.2 The Contractor will provide the HBM with Marketing Materials that comply with the requirements of 42 CFR 438.104. The Marketing Materials are subject to prior approval by the State in accordance with the requirements in Section 3.3.3 of this Contract. If the Contractor develops new or revised Marketing Materials, it shall submit them to the State for review and prior approval. The HBM will use the Marketing Materials provided by the Contractor and approved by the State without alteration or supplementation.

3.3.1.3 Except during the Annual Open Enrollment Period, the Contractor shall not conduct any Mass Marketing to individuals or the general public with the intention of inducing clients to join a particular MCO or Transfer from one MCO to another. Mass Marketing includes the use of mass media outlets such as radio, television and newspaper advertisements. This prohibition includes all Mass Marketing activities whether the activity is performed by the Contractor directly or by its participating providers, Subcontractors, agents, consultants or any other party affiliated with the Contractor.

3.3.1.4 The prohibition on Mass Marketing in Section 3.3.1.3 of this Contract shall not apply to Health Education and outreach activities, including public service announcements, Health Education and wellness messages transmitted via television and radio, health fairs, community outreach events and wellness classes. Any materials or messages distributed to the public through these activities must be Health Educational in nature. The Contractor's participation in Health Education and outreach activities is subject to the requirements described in Section 3.14 of this Contract.

3.3.1.5 The prohibition on Mass Marketing in Section 3.3.1.3 of this Contract shall not apply to the Contractor's sponsorship (including, but not limited to, the use of the Contractor's logo, promotional language, etc.) of a printed material or event produced by a community partner or provider. The Contractor's sponsorships must be reviewed and prior approved by the State in writing, and notification of the sponsored event or printed material must be included in the Contractor's

annual Marketing plan (see Section 3.3.1.7 of this Contract, below). The State will consider ad hoc approval for sponsorships throughout the year that are not included in the annual Marketing plan through the Contractor's notification to the State of anticipated sponsorships via the Weekly Events Calendar described below.

3.3.1.6 On a weekly basis, the Contractor shall submit to the State a Weekly Events Calendar of all events and activities that the Contractor plans to sponsor and/or participate in, including events materially directed toward DMMA clients which are sponsored by corporate partners during the upcoming week on the day specified by the State. For each event, activity, or sponsorship, the Contractor shall specify the name of the event, activity or sponsorship and include a description that includes the location, the cost to the Contractor of its sponsorship or participation, the estimated number of attendees, and the materials to be distributed (including any giveaways). The State will review the Contractor's planned events and activities as specified in the Weekly Events Calendar and provide approval in writing for all.

3.3.1.7 The Contractor shall submit to the State for prior approval a complete annual Marketing plan that includes written policies and procedures governing the development of Marketing Materials that, among other things, include methods for quality control to ensure that Marketing Materials are accurate and do not mislead, confuse, or defraud a client, member or the State. The annual Marketing plan must also include information regarding the events and activities that the Contractor plans to sponsor and/or participate in during the upcoming year. The Contractor's annual sponsorship budget may not exceed $15,000.

3.3.2 Marketing Materials Requirements

3.3.2.1 The Contractor shall ensure that Marketing Materials use language and a format that is easily understood and are worded at a sixth grade reading level.

3.3.2.2 The Contractor shall ensure that Marketing Materials are available in Spanish and any other Prevalent Non-English Languages specified by the State.

3.3.2.3 All Marketing Materials shall comply with the information requirements in 42 CFR 438.10 to ensure that, before Enrolling, the client receives from the Contractor and the State all information needed to make an informed decision regarding MCO selection.

3.3.2.4 The Contractor shall develop Marketing Materials for distribution throughout the entire Enrollment area (i.e., Statewide).

3.3.2.5 All video or print material will carry the DHSS logo, which will be provided to the Contractor by the State.

3.3.3 Prior Approval Process for Marketing Materials

3.3.3.1 The Contractor is prohibited from releasing any Marketing Materials without prior approval from the State.

3.3.3.2 The Contractor shall submit all Marketing Materials to the State for prior approval. This includes all Marketing Materials that use electronic media (e.g., e-mail and websites) including Marketing Materials for use via social media. The Contractor shall submit Marketing Materials in electronic format and shall provide paper copies upon State request in the format prescribed by the State. The Contractor's paper copies shall be on non-glossy paper.

3.3.3.3 The State will review the Contractor's Marketing Materials and provide its findings to the Contractor in writing within 45 calendar days of receipt of the Marketing Materials by DMMA.

3.3.3.4 The State will not approve Marketing Materials that contain inaccurate, misleading or otherwise misrepresentative assertions or statements (either written or oral).

3.3.4 **Prohibited Marketing Activities**

3.3.4.1 In addition to the general prohibition on Mass Marketing (in Section 3.3.1.3 of this Contract, above), the following Marketing activities are prohibited:

3.3.4.1.1 Marketing to individuals or the general public with the intention of inducing clients to join a particular MCO or to switch membership from one MCO to another;

3.3.4.1.2 Asserting or implying that the client/member must Enroll in the Contractor's MCO in order to obtain Medicaid benefits or in order not to lose Medicaid benefits;

3.3.4.1.3 Discouraging or encouraging MCO selection based on health status or risk;

3.3.4.1.4 Suggesting that the Contractor is endorsed by CMS, the Federal Government, the State or a similar entity;

3.3.4.1.5 Directly or indirectly engaging in door-to-door, telephone, email, texting or other Cold Call Marketing activities;

3.3.4.1.6 Seeking to influence Enrollment in conjunction with the sale or offering of any private insurance (private insurance does not include a qualified health plan, as defined in 45 CFR 155.20); and

3.3.4.1.7 Offering gifts, rewards or material or financial gains as incentives to Enroll.

3.3.4.2 The State reserves the right to prohibit additional Marketing activities at its discretion.

3.4 COVERED SERVICES

3.4.1 General

3.4.1.1 The Contractor shall cover physical health, behavioral health, and LTSS as specified in this Section 3.4.

3.4.1.2 The Contractor shall ensure continuity, coordination and integration of physical health, behavioral health and LTSS and ensure collaboration among providers, including those providing Medicaid benefits provided by the State (see Section 3.4.10 below).

3.4.1.3 The Contractor shall furnish Covered Services in an amount, duration and scope that is no less than the amount, duration and scope for the same benefit/service as specified in Delaware's Medicaid State Plan (for Medicaid members) or CHIP State Plan (for DHCP members) (see 42 CFR 438.210).

3.4.1.4 Per 42 CFR 438.210, the Contractor may place appropriate limits on a service:

3.4.1.4.1 On the basis of criteria such as Medical Necessity (described in Section 3.4.5 of this Contract, below); or

3.4.1.4.2 For utilization control, provided that:

3.4.1.4.2.1 Services furnished can be reasonably expected to achieve their purpose;

3.4.1.4.2.2 Services supporting individuals with ongoing or chronic conditions or who require DSHP Plus LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports; and

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

3.4.1.5 The Contractor shall ensure that Covered Services are available 24 hours a day, seven days a week, when Medically Necessary.

3.4.1.6 The Contractor shall cover DSHP benefit package and the DSHP Plus LTSS benefit package services provided outside of the State of Delaware pursuant to 42 CFR Part 431, Subpart B. This includes services that, as determined on the

basis of medical advice, are more readily available in other states and services needed due to an Emergency Medical Condition.

3.4.1.7 The Contractor shall not cover any services provided outside of the United States.

3.4.2 **DSHP Benefit Package**

3.4.2.1 All DSHP and DSHP Plus members are eligible to receive the DSHP benefit package. DSHP members who are in the new adult group are eligible to receive an alternative benefit plan that is the same as the DSHP benefit package. DSHP Plus LTSS members are eligible for the DSHP Plus LTSS benefit package as described in Section 3.4.3 below. DSHP members who are in DHCP are eligible to receive the DSHP benefit package except as described in Section 3.4.4 below.

3.4.2.2 The Contractor shall provide the following DSHP benefit package services as Medically Necessary (as defined in Section 3.4.5 of this Contract, below) and subject to the listed limitations herein.

Service	**Limitations**
Inpatient hospital services	
Inpatient behavioral health services in a general hospital; in a general hospital psychiatric unit; in a psychiatric hospital (including an institution for mental disease) for members over age 65 and under age 21; and in a private residential treatment facility (PRTF) for under age 21 and substance use disorder (SUD) treatment to members who are primarily receiving treatment for SUD who are short-term residents in an institution for mental disease (IMD) (See Section 3.4.8 of this Contract, provide mental health services in an IMD as an "in lieu of" service)	• For members age 18 and older (inpatient behavioral health services to members under age 18 are provided by DSCYF)
Outpatient hospital services, including emergency rooms	
Behavioral health crisis intervention services, including facility-based crisis services and mobile crisis teams	• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF)
Pharmacy including physician administered drugs	• Pharmacy does not include Medication Assisted Treatment (MAT) for substance use disorders (SUDs); MAT is included in the SUD benefit below
Clinic services including ambulatory surgical centers and end stage renal disease clinics	
Federally Qualified Health Center services	

Service	Limitations
Substance use disorder services, including all levels of the American Society of Addiction Medicine (ASAM), including residential services to members who are primarily receiving treatment for SUD who are short-term residents in an IMD, Medication Assisted Treatment (MAT) and licensed opioid treatment programs	• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF) • For members participating in PROMISE, these services, except for medically managed intensive inpatient detoxification, are the responsibility of the State and paid through the State's DMES
Licensed behavioral health practitioner services, including licensed psychologists, clinical social workers, professional counselors and marriage and family therapists	• 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF) • For members participating in PROMISE, these services are the responsibility of the State and paid through the State's DMES
Laboratory and radiology services, including invasive and non-invasive imaging	
Nursing facility services	• Up to 30 calendar days, then services are covered by the Contractor as part of the DSHP Plus LTSS benefit package
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including periodic preventive health screens and other necessary diagnostic and treatment services for members under age 21	
Preventive services, including the services specified in 45 CFR 147.30	
Outpatient behavioral health services for members under age 18, including assessment, individual/ family/group therapy, crisis intervention, intensive outpatient and behavioral health rehabilitative services for children	• For members under age 18 • 30 unit behavioral health benefit for members under age 18 (thereafter provided by DSCYF) • See Appendix 1
Family planning services (including voluntary sterilization if consent form is signed after member turns age 21)	

Service	Limitations
Physician services, including certified nurse practitioner services	• For members participating in PROMISE, the following physician oversight and direct therapy that is considered to be a part of the following PROMISE services are included in the PROMISE rates and paid FFS through the State's DMES: Assertive Community Treatment (ACT) services, Intensive Case Management (ICM) services, and supervision of group home services.
Administrative fee for vaccines to children	
Podiatry services	
Optometry/optician services	
Home health services	
Private duty nursing	
Physical and occupational therapy and speech, hearing and language therapy	
Durable medical equipment (DME) and supplies including prosthetic and orthotic devices	
Rehabilitation agency services	
Nurse-midwife services	
Hospice services	
Emergency medical transportation services	
Extended services for pregnant women to assure they receive the medical and social support positively impacting on the outcome of their pregnancies (known as "Smart Start" in Delaware)	
Medicare deductible/co-insurance and remainder up to the Medicaid allowed amount	

Service	Limitations
Organ transplants	• Heart, heart/lung, liver, cornea, bone marrow, pancreas, kidney with prior authorization and documentation that the following conditions were met: – Current medical therapy has failed and will not prevent progressive disability and death; – The patient does not have any other major systemic disease that would compromise that transplant outcome; – There is every reasonable expectation, upon considering all circumstances involving the patient, that there will be strict adherence by the patient to the long term difficult medical regimen which is required; – The transplant is likely to prolong life for at least two years and restore a range of physical and social function suited to the ADLs; – The patient is not both in an irreversible terminal state (moribund) and on a life support system; – The patient has a diagnosis appropriate for the transplant; and – The patient does not have multiple uncorrectable severe major system congenital anomalies.
School-Based Wellness Center (SBWC) Services	

Service	Limitations
Chiropractic Services include only services that are provided by a chiropractor who is licensed by the State and consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform. Services may be subject to prior authorization and/or medical review.	Manipulation associated with the treatment of neck, back, and pelvic/sacral pain. Necessity for Treatment *The patient must have a significant neuromusculoskeletal condition necessitating treatment. Evaluation and management services. X-rays may be used to diagnose spinal subluxation. Coverage of spinal x-rays is limited to one set per member in a rolling twelve-month period. Additional x-rays may be taken within the same calendar year to document a new condition or an exacerbation/re-injury. X-rays used to determine progress are limited to one study per calendar year. Progress x-rays, beyond the first in a calendar year, may be pre-authorized.

3.4.3 **DSHP Plus LTSS Benefit Package**

3.4.3.1 General

3.4.3.1.1 The Contractor shall provide the DSHP Plus LTSS benefit package to all State-identified DSHP Plus LTSS members.

3.4.3.1.2 The Contractor shall ensure that any services covered in the Contract that could be authorized through a 1915(c) Waiver or a State plan amendment authorized though sections 1915(i) or 1915(k) of the Social Security Act shall be delivered in settings consistent with 42 CFR 441.301(c)(4). The Contractor shall monitor the provision of HCBS, as directed by DMMA, to ensure provider compliance with all applicable Federal HCB settings requirements.

3.4.3.2 Case Management Services

3.4.3.2.1 The Contractor shall provide case management services as outlined in Section 3.7 of this Contract to DSHP Plus LTSS members.

3.4.3.3 The Contractor shall provide the following long term services and supports to DSHP Plus LTSS members when the services have been determined by the Contractor to be Medically Necessary:

Service	**Definition/Limitation**
Nursing facility services	The services provided by a nursing facility to residents of the facility, including skilled nursing care and related services, rehabilitation services, and health-related care and services.
Community-based residential alternatives that include assisted living facilities	• Community-based residential services offer a cost-effective, community based alternative to nursing facility care for persons who are elderly and/or adults with physical disabilities. This includes assisted care living facilities. Community-based residential services include personal care and supportive services (homemaker, chore, attendant services, and meal preparation) that are furnished to participants who reside in a homelike, non-institutional setting. Assisted living includes a 24-hour onsite response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). As needed, this service may also include prompting to carry out desired behaviors and/or to curtail inappropriate behaviors. Services that are provided by third parties must be coordinated with the assisted living provider. Personal care services are provided in assisted living facilities as part of the community-based residential service. To avoid duplication, personal care (as a separate service) is not available to persons residing in assisted living facilities.
Attendant care services	• Attendant care services includes assistance with ADLs (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility). • Not available to persons residing in assisted living or nursing facilities.

Service	Definition/Limitation
Respite care, both at home and in nursing and assisted living facilities	• Respite care includes services provided to members unable to care for themselves furnished on a short-term basis because of the absence or need for relief for the member's caregiver. • Limited to no more than 14 calendar days per year. The Contractor's case manager may authorize service request exceptions above this limit when it determines that: (i) no other service options are available to the member, including services provided through an informal support network; (ii) the absence of the service would present a significant health and welfare risk to the member; or (iii) respite service provided in a nursing facility or assisted living facility is not utilized to replace or relocate an individual's primary residence.
Adult day services	• Services furnished in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service. The service is reimbursed at two levels: the basic rate and the enhanced rate. The enhanced rate is authorized only when staff time is needed to care for members who demonstrate ongoing behavioral patterns that require additional prompting and/or intervention. Such behaviors include those which might result from an acquired brain injury (ABI). The behavior and need for intervention must occur at least weekly. • Not available to persons residing in assisted living and nursing facilities. • Meals provided as part of this service are only provided when the member is at the adult day care center. The cost of such meal is rolled into the adult day care provider's reimbursement rate. The provider does not bill separately for the meal.

Service	Definition/Limitation
Day habilitation	• Day habilitation includes assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the member's private residence. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Day habilitation services focus on enabling the member to attain or maintain his/her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings. This service is provided to members who demonstrate a need based on cognitive, social, and/or behavioral deficits such as those that may result from an ABI. • Not available to persons residing in non-ABI assisted living and nursing facilities.
Cognitive services	• Cognitive services are necessary for the assessment and treatment of individuals who exhibit cognitive deficits or interpersonal conflict, such as those that are exhibited as a result of a brain injury. • Cognitive services include two key components: – Multidisciplinary assessment and consultation to determine the member's level of functioning and service needs. This cognitive services component includes neuropsychological consultation and assessments, functional assessment and the development and implementation of a structured behavioral intervention plan; and – Behavioral therapies include remediation, programming, counseling and therapeutic services for members and their families which have the goal of decreasing or modifying the member's significant maladaptive behaviors or cognitive disorders that are not covered under the Medicaid State Plan. These services consist of the following elements: individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law), services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness, individual activity therapies that are not primarily

Service	Definition/Limitation
	recreational or diversionary, family counseling (the primary purpose of which treatment of the member's condition) and diagnostic services. • Not available to persons residing in assisted living and nursing facilities. Limited to 20 visits per year plus an assessment.
Personal emergency response system (PERS)	• A PERS is an electronic device that enables a member to secure help in an emergency. As part of the PERS service, a member may be provided with a portable help button to allow for mobility. The PERS device is connected to the member's phone and programmed to signal a response center and/or other forms of assistance once the help button is activated. • Not available to persons residing in assisted living and nursing facilities.
Support for self-directed attendant care services	• Support for Self-Directed Attendant Care Services combines two functions: financial management services (FMS) and information and assistance in support of consumer direction (support brokerage). Providers of support for Self-Directed Attendant Care Services carry out activities associated with both components. The support for self-directed attendant care services provides assistance to members who elect to self-direct their attendant care services.
Independent activities of daily living (Chore) service	• Chore services constitute housekeeping services that include assistance with shopping, meal preparation, light housekeeping, and laundry. This is an in-home service for frail older persons or adults with physical disabilities. The service assists them to live in their own homes as long as possible. The service must be provided through licensed providers or self-directed care services. • Not available to persons residing in assisted living or nursing facilities.

Service	Definition/Limitation
Nutritional supplements for individuals diagnosed with HIV/AIDS that are not covered under the State Plan	• This service is for individuals diagnosed with HIV/AIDS to ensure proper treatment in those experiencing weight loss, wasting, malabsorption and malnutrition. Such oral nutritional supplements are offered as a service to those identified at nutritional risk. This service covers supplements not otherwise covered under State Plan service. The service does not duplicate a service provided under the State Plan as an EPSDT service. The service must be prior authorized by a case manager in conjunction with the consultation of a medical professional's recommendation for service. The standards for assessing nutritional risk factors: – Weight less than 90% of usual body weight; – Experiencing weight loss over a one to six month period; – Losing more than five pounds within a preceding month; – Serum albumin is less than 3.2 or very high indicating dehydration, difficulty swallowing or chewing, or persistent diarrhea; or – Wasting syndrome affected by a number of factors including intake, nutrient malabsorption and physiological and metabolic changes. • Not available to persons residing in assisted living or nursing facilities.

Service	Definition/Limitation
Specialized medical equipment and supplies not covered under the Medicaid State Plan	• This service includes: – Devices, controls, or appliances specified in the plan of care that enable the member to increase his/her ability to perform ADLs; – Devices, controls, or appliances that enable the member to perceive, control, or communicate with the environment in which he/she lives; – Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; – Such other DME and non-DME not available under the State Plan that is necessary to address participant functional limitations; and – Necessary medical supplies not available under the State Plan. Items reimbursed under the DSHP Plus LTSS benefit package are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the member. • Does not duplicate a service provided under the State Plan as an expanded EPSDT service.

Service	Definition/Limitation
Minor home modifications	• Provision and installation of certain home mobility aids (e.g., a wheelchair ramp and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a member's place of residence which are necessary to ensure the health, welfare and safety of the member, or which increase the member's mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement of heating or cooling units or systems, installation or purchase of air or water purifiers or humidifiers and installation or repair of driveways, sidewalks, fences, decks and patios. Adaptations that add to the total square footnote of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. • Up to $6,000 per project; $10,000 per benefit year; and $20,000 per lifetime. The Contractor's case manager may authorize service request exceptions above this limit when it determines the expense to be cost-effective. Not available to persons residing in assisted living or nursing facilities.

Service	Definition/Limitation
Home-delivered meals	• Up to two meals per day. Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act or through Social Service Block Grant (SSBG) funds, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research Council) and that will be served in the member's home. Special diets shall be provided in accordance with the member's plan of care when ordered by the member's physician. These meals are delivered to the member's community residence and not to other settings such as adult day programs or senior centers. • The Contractor must coordinate the delivery of these meals with staff within DSAAPD that authorize home-bound meals utilizing Title III (Older Americans Act) and SSBG funds. • Not available to persons residing in assisted living or nursing facilities.
Transition services for those moving from a nursing facility to the community	• Can include security deposit, telephone connection fee, groceries, furniture, linens, etc., up to $2,500 per transition. The Contractor's case manager may authorize service request exceptions above this limit.
Workshops for those moving from a nursing facility to the community	• These workshops prepare the individual and their families and other Caregivers for community living.

3.4.4 Exceptions to the DSHP Benefit Package for DHCP Members

3.4.4.1 DHCP members are eligible for the DSHP benefit package except as follows:

3.4.4.1.1 DHCP members are eligible for the family planning benefit but do not have freedom of choice of providers and must receive family planning services from participating providers.

3.4.4.1.2 The State will not provide non-emergency medical transportation as a benefit provided by the State (see Section 3.4.10 below) to DHCP members.

3.4.5 **Medical Necessity Determination**

3.4.5.1 The Contractor shall provide Covered Services consistent with the State's definition of Medical Necessity, as provided below.

3.4.5.1.1 Medical Necessity is defined as the essential need for health care or services which, when delivered by or through authorized and qualified providers, will:

3.4.5.1.1.1 Be directly related to the prevention, diagnosis and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability (the physical or mental functional deficits that characterize the member's condition), and be provided to the member only;

3.4.5.1.1.2 Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the member and the member's family;

3.4.5.1.1.3 Be primarily directed to the diagnosed medical condition or the effects of the condition of the member, in all settings for normal activities of daily living (ADLs);

3.4.5.1.1.4 Be timely, considering the nature and current state of the member's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;

3.4.5.1.1.5 Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of funds;

3.4.5.1.1.6 Be the most appropriate care or service that can be safely and effectively provided to the member, and will not duplicate other services provided to the member;

3.4.5.1.1.7 Be sufficient in amount, scope and duration to reasonably achieve its purpose;

3.4.5.1.1.8 Be recognized as either the treatment of choice (i.e., prevailing community or Statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of other care and services that are commonly provided; and

3.4.5.1.1.9 Be rendered in response to a life threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has resulted in or

could result in a physical or mental limitation, including loss of physical or mental functionality or developmental delay.

3.4.5.1.1.10 For members enrolled in DSHP Plus LTSS, provide the opportunity for members to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

3.4.5.1.2 In order that the member might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community and facility environments, and activities.

3.4.5.2 In accordance with 42 CFR 438.210, the Contractor shall not arbitrarily deny or reduce the amount, duration or scope of a Medically Necessary service solely because of member's diagnosis, type of illness or condition.

3.4.5.3 The Contractor shall determine Medical Necessity on a case by case basis and in accordance with this Section of the Contract.

3.4.6 **Special Services**

3.4.6.1 Emergency Services

3.4.6.1.1 Emergency Services shall be available 24 hours a day, seven days a week and provided in accordance with 42 CFR 422.113(c).

3.4.6.1.2 The Contractor shall have policies that address emergency and non-emergency use of services provided in an outpatient emergency setting.

3.4.6.1.3 The Contractor shall review and approve or disapprove claims for Emergency Services based on whether the member had an Emergency Medical Condition.

3.4.6.1.4 The Contractor shall not deny payment for treatment obtained when a representative of the Contractor instructed the member to seek Emergency Services.

3.4.6.1.5 The Contractor shall base coverage decisions for Emergency Services on the severity of symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. The Contractor shall not impose restrictions on the coverage of Emergency Services that are more restrictive than those permitted by the prudent layperson standard.

3.4.6.1.6 The Contractor shall provide coverage for inpatient and outpatient Emergency Services, furnished by a qualified provider, regardless of whether the member obtains the services from a participating provider, that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard. These services shall be provided without prior authorization in accordance with 42 CFR 438.114.

3.4.6.1.7 The Contractor and/or its authorized representative may not:

3.4.6.1.7.1 Refuse to cover Emergency Services based on the emergency room physician, hospital, or Fiscal Agent not notifying the member's PCP, the Contractor or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for Emergency Services;

3.4.6.1.7.2 Deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition;

3.4.6.1.7.3 Hold a member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member;

3.4.6.1.7.4 Disagree with the judgment of the attending emergency physician, or the provider actually treating the member in determining when the member is sufficiently stabilized for transfer or discharge; that determination is binding on the Contractor with respect to coverage and payment; or

3.4.6.1.7.5 Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

3.4.6.2 <u>Post Stabilization Services</u>

3.4.6.2.1 The Contractor shall cover Post Stabilization Services, pursuant to 42 CFR 438.114(e) and 42 CFR 422.113(c)(2) without requiring authorization, and regardless of whether the member obtains the services within or outside the Contractor's provider network if any of the following circumstances exist:

3.4.6.2.1.1 The Post Stabilization Services were pre-approved by the Contractor;

3.4.6.2.1.2 The Post Stabilization Services were not pre- approved by the Contractor because the Contractor did not respond to the provider's request for these Post Stabilization Services within one hour of the request;

3.4.6.2.1.3 The Post Stabilization Services were not pre- approved by the Contractor because the Contractor could not be reached by the provider to request pre- approval for these Post Stabilization Services; or

3.4.6.2.1.4 The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a participating provider is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a participating provider and treating physician may continue with care of the patient until a participating provider is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

3.4.6.2.2 The Contractor's financial responsibility for Post Stabilization Services that have not been pre-approved shall end when: (i) a participating provider with privileges at the treating hospital assumes responsibility for the member's care; (ii) a participating provider assumes responsibility for the member's care through transfer; (iii) a representative of the Contractor and the treating physician reach an agreement concerning the member's care; or (iv) the member is discharged.

3.4.6.2.3 The Contractor must limit charges to members for Post Stabilization Services received from non-participating providers to an amount no greater than what the Contractor would have charged the member if he/she she obtained the services from a participating provider.

3.4.6.3 <u>Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services</u>

3.4.6.3.1 The Contractor shall perform EPSDT screens to ascertain physical and mental defects and provide Medically Necessary treatment to correct or ameliorate defects and chronic conditions found for all members under age 21 in accordance with State and Federal requirements.

3.4.6.3.2 The Contractor shall provide treatment for a condition found as a result of an EPDST screen within ninety (90) days after a screening.

3.4.6.3.3 The Contractor shall notify PCPs of screening due dates and ensure that the screens are performed.

3.4.6.3.4 The Contractor shall ensure that necessary referrals are made, track referrals and treatments, and report the results via the provision of Encounter Data and HEDIS reporting.

3.4.6.3.5 The Contractor shall have written policies and procedures to provide the full range of EPSDT services, including services that are not otherwise included in the DSHP benefit package.

3.4.6.3.6 *Required EPSDT Activities*

3.4.6.3.6.1 The Contractor shall provide for a combination of written and oral methods designed to effectively inform all members under the age of 21 (or their families) about EPSDT using clear and non-technical language that includes the following:

3.4.6.3.6.1.1 The benefits of preventive health care;

3.4.6.3.6.1.2 The services available under EPSDT and where and how to obtain those services;

3.4.6.3.6.1.3 EPSDT screens and services are provided without cost to members under 21 years of age;

3.4.6.3.6.1.4 Appointment scheduling assistance and necessary transportation is available to members upon request. (Non-emergency medical transportation is paid for by the State for non-DHCP members. DHCP members are not eligible for non-emergency medical transportation.)

3.4.6.3.7 *EPSDT Screen*

3.4.6.3.7.1 The Contractor shall provide screenings (periodic, comprehensive child health assessments), to all members eligible for EPSDT, no more than two weeks after the initial request. Inter-periodic exams must be promptly provided when needed. These are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children and youth. At a minimum, these screenings shall include, but are not limited to:

3.4.6.3.7.2 A comprehensive medical and developmental history, including anticipatory guidelines/Health Education, nutrition assessment, developmental assessment (social, personal, language) and fine/gross motor skills;

3.4.6.3.7.2.1 An unclothed physical exam;

3.4.6.3.7.2.2 Laboratory tests;

3.4.6.3.7.2.3 Vision testing;

3.4.6.3.7.2.4 Hearing testing;

3.4.6.3.7.2.5 Dental screening (furnished by direct referral to a dentist for children at the eruption of the first tooth, or no later than 12 months of age);

3.4.6.3.7.2.6 Blood lead testing using the blood lead test or other test approved by the CDC;

3.4.6.3.7.2.7 Behavioral health screening; and

3.4.6.3.7.2.8 Nutritional assessment.

3.4.6.3.8 *EPSDT Diagnostic and Treatment Services*

3.4.6.3.8.1 In addition to any diagnostic and treatment services included in the DSHP benefit package that are available to adults, the Contractor shall provide the following services to members eligible for EPSDT, if the need for such services is indicated by screening:

3.4.6.3.8.1.1 Diagnosis of and treatments for defects in vision and hearing;

3.4.6.3.8.1.2 Information on the availability of dental care (at as early an age as necessary) needed for relief of pain and infections, restoration of teeth, and/or maintenance of dental health; and

3.4.6.3.8.1.3 Appropriate immunizations.

3.4.6.3.8.2 If a suspected problem is detected during a screening examination, the child must be evaluated as necessary for further diagnosis, and that diagnosis shall be used to determine treatment needs.

3.4.6.3.9 *EPSDT Tracking, Follow Up and Outreach*

3.4.6.3.9.1 The Contractor shall establish a tracking system that provides up-to-date information on compliance with EPSDT screening and service provision requirements. The Contractor must also have an established process for reminders, follow-ups, and outreach to members eligible for EPSDT.

3.4.6.4 School-Based Wellness Centers (SBWCs)

3.4.6.4.1 The Contractor shall cover services provided to members by any SBWC recognized by DPH.

3.4.6.4.2 SBWCs provide primary prevention, early intervention and treatment services, including physical examinations, treatment of acute medical conditions, community referrals, counseling and other supportive services to children in school settings. However, they are not a substitute for the member's PCP, and the Contractor shall support coordination of services provided by SBWCs and services provided by the member's PCP.

3.4.6.5 Family Planning

3.4.6.5.1 All members, except DHCP members (see Section 3.4.4 of this Contract, above), shall be allowed freedom of choice of family planning providers and may receive such services from any family planning provider, including non-participating providers who are DMAP-enrolled providers.

3.4.6.6 Prenatal Care

3.4.6.6.1 The Contractor shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. The Contractor's program shall include participation and coordination with Smart Start.

3.4.6.7 Pharmacy Services

3.4.6.7.1 The Contractor shall comply with the requirements in Section 3.5 of this Contract regarding coverage of pharmacy services.

3.4.6.8 Opioid Treatment Programs

3.4.6.8.1 The Contractor shall cover opioid treatment programs meeting Federal certification and treatment standards per 42 CFR Part 8 (Certification of Opioid Treatment Programs) and State licensing standards per 16 DE Admin Code 6001 (Substance Abuse Facility Licensing Standards). Services provided in opioid treatment programs, including medication, medical monitoring/management, methadone dispensing physical examinations, counseling, laboratory work (including urinalysis), and other assessment and treatment services provided by or required for admission to or continued stay in opiate treatment programs are included in the DSHP benefit package.

3.4.6.9 Involuntary and Court-Ordered Behavioral Health Services for Adults

3.4.6.9.1 The Contractor must have the capacity to provide for involuntary psychiatric commitments for evaluation and treatment of individuals in accordance with State law, including 16 *Del. C.* § 5121 et seq. regarding emergency detentions.

3.4.6.9.2 The Contractor shall ensure the provision of a 24-hour authorization period for members who have been involuntarily admitted to a State-designated psychiatric treatment facility. The Contractor shall apply utilization review criteria for authorization requests beyond 24 hours.

3.4.6.9.3 The Contractor shall ensure members who have been involuntarily admitted to a State-designated psychiatric treatment facility are transported to the commitment hearing by the treatment provider and shall ensure that the required treatment personnel are present to provide testimony.

3.4.6.9.4 When a member is discharged from an involuntary inpatient commitment to an involuntary outpatient commitment, the Contractor shall ensure continuity of treatment and coordination of care between inpatient and outpatient providers. In addition the Contractor shall ensure that a comprehensive discharge plan and crisis plan is developed prior to discharge and that referral to appropriate community resources, including referral for PROMISE eligibility determination, is made when appropriate.

3.4.6.9.5 For members under involuntary outpatient commitment, the Contractor shall ensure that the member is aware of the time and place of all associated hearings, provide any necessary assistance so that the member is able to be present and ensure that the required treatment personnel are present to provide testimony.

3.4.6.9.6 The Contractor shall be responsible for the provision of all behavioral health services within the DSHP benefit package ordered by a court based on the Contractor's determination of Medical Necessity.

3.4.6.10 Specialized Services for Nursing Facility Residents

3.4.6.10.1 As part of the PASRR Level II process, the State will determine whether and which Specialized Services are necessary to support a member in a nursing facility.

3.4.6.10.2 The Contractor shall be responsible for providing any Specialized Services specified by the State as necessary to support a member in a nursing facility that are included in the DSHP or DSHP Plus

LTSS benefit package (e.g., licensed behavioral health practitioner services) and shall not reduce or limit such services based on the Contractor's determination of Medical Necessity.

3.4.6.10.3 The Contractor shall collaborate with DSAMH and/or DDDS (as applicable) and the nursing facility to develop a plan of care that includes all of the Specialized Services specified by the State.

3.4.6.10.4 The Contractor shall coordinate with DSAMH and/or DDDS (as applicable), the nursing facility and the provider(s) providing Specialized Services to ensure that Specialized Services covered by the Contractor are provided to each member as specified by the State as part of the PASRR Level II process.

3.4.6.10.5 The Contractor shall not provide State or Federal fund payments to a Nursing Facility for all days services were provided to member prior to completion of PASRR, except in emergency placement as the result of State Emergency or Protective Service Agency Intervention in compliance with 42 CFR Subpart C 483.122 (b).

3.4.7 Second Opinions

3.4.7.1 The Contractor shall provide for a second opinion from a qualified participating provider or arrange for the member to obtain one outside the network, at no cost to the member.

3.4.8 Additional Services

3.4.8.1 <u>"In Lieu of" Services</u>

3.4.8.1.1 If the State determines that a service that is in addition to Covered Services is a medically appropriate and cost-effective substitute for a Covered Service, the State will take into account the utilization and actual cost for the "in lieu of" service in rate setting, unless otherwise prohibited by Federal law.

3.4.8.1.2 The Contractor may submit a request to the State to approve an "in lieu of" service using the State's "in lieu of" service request form. The State's form includes information about the proposed "in lieu of" services, including documentation that the proposed "in lieu of" service is a medically appropriate and cost-effective substitute for a Covered Service.

3.4.8.1.3 A service will only be considered an "in lieu of" service if prior approved as such by the State and identified in this Contract.

3.4.8.1.3.1 In lieu of inpatient mental health services in a general hospital or a general hospital psychiatric unit, the Contractor may, consistent with Section 4.1 of this Contract, provide mental health services in an IMD.

3.4.8.1.3.2 In lieu of inpatient medical treatment, the Contractor may, consistent with the requirements specified by DMMA, provide long term acute care (LTAC) in an institutional or facility setting to members who require extended hospital care.

3.4.8.1.4 The Contractor shall not be required to offer approved "in lieu of" benefits to members.

3.4.8.1.5 The Contractor shall not require a member to accept an "in lieu of" service instead of a Covered Service."

3.4.8.2 Value Added Services

3.4.8.2.1 The Contractor may provide "value added" services in addition to Covered Services.

3.4.8.2.2 The cost of a "value added" service provided by the Contractor will not be reflected in rate setting.

3.4.8.2.3 If the Contractor provides a "value added" service on a routine basis and/or includes the service in the member handbook, the "value added" service shall be prior approved in writing by the State. In accordance with Section 2.1.7 of this Contract, any changes to a "value added" service must also be prior approved in writing by the State.

3.4.8.2.4 The Contractor shall not require a member to accept a "value added" service instead of a Covered Service.

3.4.8.3 Services for Parity Compliance

3.4.8.3.1 The Contractor may provide services necessary for compliance with the requirements of 42 CFR Part 438 Subpart K (related to behavioral health parity) only to the extent such services are necessary for the Contractor to comply with 42 CFR 438.910.

3.4.8.3.2 Services necessary for compliance with behavioral health parity shall be identified in this Contract.

3.4.8.4 The Contractor shall not require a member to accept an additional service (in lieu of or extra service) instead of a Covered Service.

3.4.9 **Copayments and Patient Liability**

3.4.9.1 Copayments for Prescription Drugs

3.4.9.1.1 The Contractor shall comply with the requirements in Section 3.5 of this Contract regarding prescription drug Copayment requirements.

3.4.9.1.2 The Contractor shall ensure that any cost sharing complies with the parity requirements for financial requirements in 42 CFR 438.910.

3.4.9.2 Patient Liability (Post-Eligibility Treatment of Income)

3.4.9.2.1 The State calculates the Patient Liability amount, as applicable, for each DSHP Plus LTSS member. The State will notify the Contractor of any applicable Patient Liability amounts via the HIPAA standard 820 Premium Payment file, and the retroactive monthly amounts via the HIPPAA standard 834 Eligibility file.

3.4.9.2.2 For DSHP Plus LTSS members residing in a nursing facility or assisted living facility, the Contractor shall delegate collection of Patient Liability to the facility and shall pay the facility net the applicable Patient Liability amount.

3.4.9.2.3 Per CMS requirements, the Contractor shall ensure that the Patient Liability amount assessed for a member in an assisted living facility is applied only to the cost of HCBS, not to the cost of Covered Services available under the Medicaid State Plan.

3.4.9.2.4 If a member refuses to pay his/her Patient Liability to a facility, the facility may notify the Contractor that it is terminating services to the member. If this occurs, the Contractor shall work to find an alternative facility willing to serve the member. If the Contractor is unable to find an alternative facility, the Contractor shall consult with the State on appropriate next steps.

3.4.9.3 The Contractor and all participating providers and Subcontractors shall not require any cost sharing or Patient Liability responsibilities for Covered Services or additional services except to the extent that cost sharing or Patient Liability

responsibilities are required for those services by the State in accordance with this Contract.

3.4.10 **Medicaid Benefits Provided by the State**

3.4.10.1 General

3.4.10.1.1 Services not covered in the DSHP benefit package or the DSHP Plus LTSS benefit package, but covered under the Delaware Medicaid State Plan or 1115(a) demonstration and provided by the State for DSHP and DSHP Plus members include:

3.4.10.1.1.1 Dental services for children under age 21;

3.4.10.1.1.2 Prescribed pediatric extended care (PPEC) services for children with severe disabilities;

3.4.10.1.1.3 Day habilitation services for persons with developmental disabilities authorized by the Division of Developmental Disabilities Services;

3.4.10.1.1.4 Non-emergency medical transportation;

3.4.10.1.1.5 Specialized Services for Nursing Facility Residents not included in Covered Services;

3.4.10.1.1.6 Employment services and related supports provided through the Pathways program for eligible individuals;

3.4.10.1.1.7 Additional behavioral health services (see Section 3.4.10.8 of this Contract, below); and

3.4.10.1.1.8 DDDS Lifespan Waiver services.

3.4.10.1.2 The Contractor shall coordinate the overall delivery of care with both participating and non-participating providers and State personnel whenever one of its members requires Medicaid benefits provided by the State (see Section 3.8.8 of this Contract for related requirements).

3.4.10.2 Dental Services for Children

3.4.10.2.1 The Contractor is not responsible for dental services except that the Contractor shall provide removal of bony impacted wisdom teeth as a surgery that is a Covered Service under this Contract.

3.4.10.3 Prescribed Pediatric Extended Care (PPEC)

3.4.10.3.1 PPEC is a package of nursing, nutritional assessment, developmental assessment, speech, physical and occupational therapy services provided in an outpatient setting, as ordered by an attending physician.

3.4.10.4 Day Habilitation for Persons with Developmental Disabilities

3.4.10.4.1 Day habilitation services are provided to persons with developmental disabilities under the Rehab Option of the Delaware Medicaid State Plan.

3.4.10.5 Non-Emergency Medical Transportation

3.4.10.5.1 Non-emergency medical transportation is available to all DSHP and DSHP Plus members except DHCP members.

3.4.10.6 Specialized Services for Nursing Facility Residents Not Included in Covered Services

3.4.10.6.1 The State will provide Specialized Services as determined necessary by the State as part of the PASRR Level II process that are not included in the DSHP or DSHP Plus LTSS benefit package.

3.4.10.7 Employment Services and Supports Provided Through Pathways

3.4.10.7.1 The following services are available to members participating in Pathways to supplement Covered Services provided by the Contractor. These services are the responsibility of the State and are paid through the State's DMES.

3.4.10.7.1.1 Career exploration and assessment;

3.4.10.7.1.2 Job placement supports;

3.4.10.7.1.3 Supported employment – individual;

3.4.10.7.1.4 Supported employment – small group;

3.4.10.7.1.5 Benefits counseling;

3.4.10.7.1.6 Financial coaching;

3.4.10.7.1.7 Non-medical transportation;

3.4.10.7.1.8 Personal care (including self-directed option) (for DSHP Plus LTSS members, the Contractor is responsible for attendant care

services that are Medically Necessary per the Contractor's UM guidelines (see Section 3.12 of this Contract)); and

3.4.10.7.1.9 Orientation, mobility and assistive technology.

3.4.10.8 Additional Behavioral Health Services

3.4.10.8.1 *Behavioral Health Services for Children under Age 18*

3.4.10.8.1.1 Behavioral health services provided to members under age 18 beyond those included in the DSHP benefit package are the responsibility of the State. This includes outpatient services beyond what is included in the DSHP benefit package as well as all residential and inpatient behavioral health services.

3.4.10.8.2 *Behavioral Health Services for Members Age 18 and Older who Participate in PROMISE*

3.4.10.8.2.1 As provided in the DSHP benefit package above, the Contractor will no longer be responsible for the following services when a member is participating in PROMISE. For members participating in PROMISE these services become the responsibility of the State and are paid through the State's DMES.

3.4.10.8.2.1.1 Substance use disorder (SUD) services other than medically managed intensive inpatient detoxification; and

3.4.10.8.2.1.2 Licensed behavioral health practitioner services.

3.4.10.8.2.2 The following services are available to members participating in PROMISE to supplement Covered Services provided by the Contractor. These services are the responsibility of the State and are paid through the State's DMES.

3.4.10.8.2.2.1 Care management (for DSHP Plus LTSS members refer to Section 3.7 of this Contract for requirements relating to Contractor coordination with care management provided by DSAMH);

3.4.10.8.2.2.2 Benefits counseling;

3.4.10.8.2.2.3 Community psychiatric support and treatment, including ACT/ICM;

3.4.10.8.2.2.4 Community-based residential supports excluding assisted living;

3.4.10.8.2.2.5 Financial coaching;

3.4.10.8.2.2.6 IADL/chore (for DSHP Plus LTSS members, the Contractor is responsible for IADL/chore services that are Medically Necessary per the Contractor's UM guidelines (see Section 3.12 of this Contract)).

3.4.10.8.2.2.7 Individual employment supports;

3.4.10.8.2.2.8 Non-medical transportation;

3.4.10.8.2.2.9 Nursing that is in addition to nursing services covered in the State Plan and included in the DSHP benefit package;

3.4.10.8.2.2.10 Peer support;

3.4.10.8.2.2.11 Personal Care (for DSHP Plus LTSS members, the Contractor is responsible for attendant care services that are Medically Necessary per the Contractor's UM guidelines (see Section 3.12 of this Contract));

3.4.10.8.2.2.12 Psychosocial rehabilitation;

3.4.10.8.2.2.13 Respite (for DSHP Plus LTSS members, the Contractor is responsible for respite services that are Medically Necessary per the Contractor's UM guidelines (see Section 3.12 of this Contract)); and

3.4.10.8.2.2.14 Short-term small group supported employment.

3.4.10.9 DDDS Lifespan Waiver Services

3.4.10.9.1 The following services are available to members participating in the DDDS Lifespan Waiver to supplement Covered Services provided by the Contractor. These services are the responsibility of the State and are paid through the State's DMES.

3.4.10.9.1.1 Assistive technology that is in addition to assistive technology covered in the State Plan and included in the DSHP benefit package;

3.4.10.9.1.2 Behavioral consultation;

3.4.10.9.1.3 Community participation;

3.4.10.9.1.4 Community transition;

3.4.10.9.1.5 Day habilitation;

3.4.10.9.1.6 Home or vehicle accessibility adaptations;

3.4.10.9.1.7 Nurse consultation (the Contractor is responsible for Care Coordination services in accordance with Section 3.6 of this Contract and nursing services that are Medically Necessary per the Contractor's UM guidelines (see Section 3.12 of this Contract);

3.4.10.9.1.8 Personal care;

3.4.10.9.1.9 Prevocational services;

3.4.10.9.1.10 Residential habilitation, including medical residential habilitation;

3.4.10.9.1.11 Respite;

3.4.10.9.1.12 Specialized medical equipment and supplies that is in addition to specialized medical equipment and supplies covered in the State Plan and included in the DSHP benefit package;

3.4.10.9.1.13 Supported employment (individual and group); and

3.4.10.9.1.14 Supported living.

3.4.11 **Non-Coverable Services**

3.4.11.1 Per Federal requirement, the Contractor shall not cover the following services:

3.4.11.1.1 Services that are not Medically Necessary. This does not include non-medical services that are included as Covered Services.

3.4.11.1.2 Abortion unless the pregnancy is the result or rape or incest, or if the woman suffers a life-endangering physical condition caused by or arising from the pregnancy itself per Section 508 of PL 110-161 (the Hyde Amendment). The Contractor shall have information on file to demonstrate that any abortions performed were in accordance with Federal law.

3.4.11.1.3 Sterilization of a mentally incompetent or institutionalized individual.

3.4.11.1.4 Single-antigen vaccines and their administration in any case in which the administration of the combined antigen vaccine was medically appropriate.

3.4.11.1.5 Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner,

acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular patient's condition.

3.4.11.1.6 Infertility treatments.

3.4.11.1.7 Cosmetic services.

3.4.11.1.8 Christian Science nurses and sanitariums.

3.4.11.1.9 Pharmacy-related services specified in Section 3.5.3 of this Contract.

3.4.12 **Behavioral Health Parity**

3.4.12.1 As required by 42 CFR 438.3(n)(1), the Contractor shall provide services in compliance with the requirements in 42 CFR Part 438, Subpart K regarding parity in behavioral health services. This provision shall be effective no later than October 2, 2017.

3.4.12.2 The Contractor shall not have an aggregate lifetime or annual dollar limit (see 42 CFR 438.905) on any behavioral health service.

3.4.12.3 As specified in 42 CFR 438.910(b)(1), the Contractor shall not apply any financial requirement or treatment limitation to behavioral health services in any classification (impatient, outpatient, emergency care, or prescription drugs) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all physical health services in the same classification furnished to members (whether or not the benefits are furnished by the Contractor). This provision shall be effective no later than October 2, 2017.

3.4.12.4 As specified in 42 CFR 438.910(b)(2), the Contractor shall provide behavioral health services in all benefit classifications (inpatient, outpatient, emergency care, and prescription drugs). For members participating in PROMISE, the Contractor shall ensure that members have access to behavioral health services in all benefit classifications.

3.4.12.5 The Contractor shall not apply any cumulative financial requirements (see 42 CFR 438.910(c)(3)) separately for behavioral health services.

3.4.12.6 In accordance with 42 CFR 438.910(d), the Contractor shall not impose a non-quantitative treatment limitation (NQTL) for behavioral health services in any classification (inpatient, outpatient, emergency care, or prescription drugs) unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to behavioral health benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL for physical

health services in the classification. NQTLs include, but are not limited to, medical management standards; standards for provider participation, including reimbursement rates; fail-first policies; exclusions based on failure to complete a course of treatment; and restrictions based on geographic location, facility type, provider specialty, other criteria that limit the scope or duration of services; and standards for providing access to non-participating providers (see 42 CFR 438.910(d)(2)). This provision shall be effective no later than October 2, 2017.

3.4.12.7 The Contractor shall work with the State, including but not limited to DMMA, DSAMH, and DSCYF, to ensure that all members are provided access to a set of benefits that meets the requirements of 42 CFR Part 438, Subpart K regarding parity in behavioral health services, regardless of what behavioral health services are provided by the Contractor.

3.4.12.8 The Contractor shall cooperate with the State to establish and demonstrate initial and ongoing compliance with 42 CFR Part 438, Subpart K regarding behavioral health parity. This shall include but not be limited to participating in meetings, providing information (documentation, data, etc.) requested by the State to assess parity compliance, working with the State to resolve any non-compliance, and notifying the State of any changes to benefits or limitations that might impact parity compliance.

3.4.12.9 If requested by the State, the Contractor shall conduct an analysis to determine the compliance with 42 CFR Part 438, Subpart K regarding behavioral health parity and provide the results of the analysis to the State.

3.5 PHARMACY

3.5.1 General

3.5.1.1 This Section of the Contract includes requirements specific to pharmacy services. In the event of a conflict between requirement in this Section 3.5 and another Section of the Contract, the requirements in this Section 3.5 of the Contract shall apply.

3.5.1.2 DMMA will continue to have one preferred drug list and will be part of a multi-state collaborative pool for a supplemental rebate above the federally required rebate. The Contractor shall not include Delaware prescriptions in any other contractual rebates, unless it is for a covered outpatient drug that is not included in the DMMA preferred drug list.

3.5.2 General Coverage Provisions

3.5.2.1 The Contractor shall provide access to outpatient pharmacy services eligible for Medicaid coverage as defined under Section 1927(k)(2) of the Social Security

Act and 42 CFR 438.3(s)(1), described in the State's Medicaid State Plan and further described in this Section 3.5 of the Contract.

3.5.2.2 The Contractor may use a formulary as long as the State has prior approved it and it meets the clinical needs of the Contractor's membership.

3.5.2.2.1 The Contractor's formulary must be developed and reviewed at least annually by an appropriate pharmacy and therapeutics (P&T) committee (see Section 3.5.9.7 of this Contract, below).

3.5.2.2.2 The Contractor's formulary shall at a minimum follow the State's PDL available at https://medicaidpublications.dhss.delaware.gov/dotnetnuke/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=420&language=en-US&PortalId=0&TabId=94

3.5.2.2.3 The State shall provide the Contractor with 30 calendar days' notice of any change to the PDL, and the Contractor shall have an additional 30 calendar days to implement the change, including any system changes.

3.5.2.2.4 Drugs included on the State's PDL may still be subject to edits, including, but not limited to, prior authorization requirements for clinical appropriateness. However, the Contractor shall assure that access to pharmacy products covered by a Supplemental Drug Rebate agreement is no more restrictive than the State's PDL requirements applicable to the pharmacy product.

3.5.2.2.5 The Contractor shall ensure that drugs are dispensed in generic form unless the branded product is on the PDL or the prescriber has indicated in writing that the branded product is medically necessary.

3.5.2.2.6 If a branded product is on the PDL, the Contractor shall consider the generic form non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

3.5.2.3 The Contractor may develop a list of approved over-the-counter (OTC) drugs to be covered by the Contractor. A list of OTC drugs previously used in the State's FFS program is available to the Contractor but is not required to be used.

3.5.2.4 The Contractor must allow access to all new prescription drugs approved by the FDA that are distributed by a CMS rebateable labeler and are Medically

Necessary either by addition to the formulary or through prior authorization within 10 calendar days from their availability in the marketplace.

3.5.2.5 The Contractor shall follow the State's guidelines to monitor certain diagnoses for potential off label drug usage.

3.5.2.6 The Contractor must allow access to all restricted or non-preferred drugs, other than those excluded (as defined in Section 3.5.3 of this Contract, below), and may subject them to prior authorization consistent with the requirements of this Contract.

3.5.2.7 The Contractor shall submit its day supply coverage policies to the State for prior review and approval.

3.5.2.8 The Contractor shall submit its policies and procedures on compound drugs to the State for prior review and approval.

3.5.3 **Coverage Exclusions**

3.5.3.1 Except as provided in Section 3.5.3.2 of the Contract below, the Contractor must exclude coverage for the following:

3.5.3.1.1 Any drug or device marketed by a manufacturer who does not participate in the Medicaid Drug Rebate Program;

3.5.3.1.2 Any drug, device, or classes of drugs listed in Section 1927(d)(2)(B), (C), (H), or (K) of the Social Security Act;

3.5.3.1.3 All DESI drugs, as defined by the FDA; and

3.5.3.1.4 Drugs that are life style drugs or are not Medically Necessary.

3.5.3.2 <u>Exceptions to Coverage Exclusions</u>

3.5.3.2.1 The Contractor shall provide coverage for items that are considered exceptions to coverage exclusions as defined in this Section 3.5.3.2 of the Contract.

3.5.3.2.2 The exceptions to pharmacy coverage exclusions include but are not limited to:

3.5.3.2.2.1 Glucose monitors and strips (subject to PDL);

3.5.3.2.2.2 Lancets and associated devices;

3.5.3.2.2.3 Syringes;

3.5.3.2.2.4 Aerochambers;

3.5.3.2.2.5 Heparin and saline flushes; and

3.5.3.2.2.6 Multivitamins and minerals.

3.5.4 Prescription Cost Sharing

3.5.4.1 The Contractor shall impose Copayments on prescription drugs as directed by the State in accordance with 42 CFR 447.50 through 42 CFR 447.82.

3.5.4.2 The Contractor shall track each member's out of pocket costs to ensure that members do not incur out of pocket costs in excess of $15 for every 30 calendar days.

3.5.4.3 The Contractor shall ensure that participating providers do not refuse to fill the prescription(s) and dispense the prescription(s) as written when a member advises a participating provider of an inability to pay the applicable Copayment amount at the time the prescription is filled (see 42 CFR 447.52(e)).

3.5.4.4 Members remain liable for any unpaid Copayment amount and are responsible for paying the provider when financially able. The provider is permitted to pursue reimbursement of the Copayment amount from the member.

3.5.5 Medication Therapy Management (MTM)

3.5.5.1 The Contractor shall implement an MTM program. The MTM program shall include participation from community pharmacists, and include in-person and/or telephonic interventions with trained pharmacists.

3.5.5.2 Reimbursement for MTM services provided by participating pharmacists shall be separate and above dispensing and ingredient cost reimbursement.

3.5.5.3 The Contractor's MTM program shall be developed to identify and target members who would most benefit from these interactions. The Contractor's MTM program shall include coordination between the Contractor, the member, the pharmacist and the prescriber using various means of communication and education.

3.5.6 Transition of New Members

3.5.6.1 The Contractor's continuity of care transition plan (see Section 3.8.1 of this Contract) shall include procedures for continuity of care of prior authorized pharmacy services for new members.

3.5.6.2 The Contractor shall ensure that members can continue treatment of any medications prior authorized by the State through the greater of: (a) the expiration date of active prior authorization by the State's FFS pharmacy program; and (b) the applicable timeframe (60 or 90 calendar days) for

medications not prior authorized by the State (see Sections 3.5.6.3 and 3.5.6.4 of this Contract, below).

3.5.6.3 For non-behavioral health diagnoses, the Contractor must provide a continuity/transition period of at least 60 calendar days for medications prescribed by a treating provider that were not prior authorized by the State's FFS pharmacy program.

3.5.6.4 For behavioral health diagnoses, the Contractor must provide a continuity/transition period of at least 90 calendar days for medications prescribed by the treating provider for the treatment of the specific behavioral health diagnosis that were not prior authorized by the State's FFS pharmacy program.

3.5.7 **Pharmacy Provider Network**

3.5.7.1 The Contractor must contract on an equal basis with any pharmacy qualified to participate in the DMAP pharmacy program that is willing to comply with the Contractor's payment rates and terms and to adhere to quality standards established by the Contractor.

3.5.7.2 The Contractor may utilize specialty pharmacies.

3.5.7.3 The Contractor may utilize a mail-order pharmacy.

3.5.7.4 All newsletters, bulletins, trainings and information the Contractor distributes to pharmacy providers must also be provided to the State either prior to general distribution or at the same time.

3.5.7.5 <u>Provider Suspension and Termination</u>

3.5.7.5.1 The Contractor shall submit, to the State for prior review and approval, policies and procedures to address, among other things, notice, transition and continuity of care issues for providers not eligible for prescribing through suspension or termination by the Contractor or at the State or Federal level.

3.5.7.6 <u>Pharmacy Lock-In</u>

3.5.7.6.1 The Contractor shall have a pharmacy lock-in program that restricts identified members to a single designated participating pharmacy provider to fill all of their prescriptions in order to better manage their medication utilization. The Contractor shall identify members likely to benefit from this program, including but not limited to members with complicated drug regimens who see multiple physicians and members suspected of misusing benefits by seeking duplicate or inappropriate medications, particularly controlled

substances. The sources for member identification shall include data analysis and referrals from providers and the State.

3.5.7.6.2 Prior to placing the member on pharmacy lock-in, the Contractor shall inform the member and/or member representative of the intent to lock-in. The Contractor's grievance process shall be made available to the member being designated for pharmacy lock-in at the time of the lock-in and annually thereafter, when the member may request a review of his/her lock-in. A member may be in both pharmacy lock-in and PCP lock-in (see Section 3.9.8.6 of this Contract, below).

3.5.7.6.3 If a member is locked into a pharmacy that does not have the member's prescribed Medically Necessary drugs or devices, the Contractor shall permit the member to receive such Medically Necessary drugs or devices from another participating pharmacy provider.

3.5.8 **Pharmacy Provider Payment**

3.5.8.1 All prescribing participating providers must have an individual NPI number. This must be the same NPI number(s) used for enrollment in the Delaware Medicaid program if provider is also a DMAP-enrolled provider. This NPI number must be used as the prescriber identifier on the NCPDP claim for drug coverage.

3.5.8.2 The Contractor shall pay at least 90% of all clean claims from pharmacy providers for Covered Services within eight calendar days of receipt and 99% of all clean claims within 14 calendar days of receipt except to the extent providers have agreed to an alternative payment schedule stipulated in the provider participation agreement. Provider payment will be that amount that is the negotiated rate minus any applicable member Copayment amount and TPL. The State will not pay the Copayment amount to the pharmacy where a member declares an inability to pay.

3.5.8.3 The Contractor shall not reimburse for any Part D covered drugs provided to a member who is a Dual Eligible.

3.5.8.4 Rates should be specifically defined, using benchmarks such as by Wholesale Acquisition Cost or Actual Acquisition Cost, on any dispensed products that are excluded from the CMS and DMMA rebates.

3.5.8.5 For any medications acquired via the Federal Supply Schedule, rates must be defined relative to the Federal Supply Schedule.

3.5.8.6 For public health service entities permitted by the State to use the 340B discount drug program, the Contractor's reimbursement methodology shall reflect the lower cost of drugs purchased through this program.

3.5.9 **Utilization Management for Pharmacy Services**

3.5.9.1 Prior Authorization

3.5.9.1.1 The Contractor may require prior authorization as a condition of coverage or payment for an outpatient prescription drug or device provided that:

3.5.9.1.1.1 The Contractor complies with the requirements for prior authorization for outpatient prescription drugs in accordance with Section 1927(d)(5) of the Social Security Act and 42 CFR 438.3(s)(6), including but not limited to:

3.5.9.1.1.1.1 The Contractor provides a response to the request for prior authorization by telephone or other telecommunication device indicating approval or denial of the request within 24 hours of the request; and

3.5.9.1.1.1.2 The Contractor provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation, as described in Section 3.5.9.3 of this Contract.

3.5.9.1.1.2 The State reviews and approves all drugs requiring prior authorization including criteria, evaluation flow charts and process supporting tables.

3.5.9.1.2 The Contractor must submit all pharmacy prior authorization and step therapy policies, procedures and any associated criteria to the State for review and prior approval.

3.5.9.1.3 The Contractor must submit any proposed pharmacy program changes to the State for review and approval prior to implementation of the change.

3.5.9.1.4 Under no circumstances will the Contractor mandate the therapeutic substitution of a prescription drug or device by a pharmacist without explicit authorization from the licensed prescriber.

3.5.9.1.5 The Contractor's guidelines to determine Medical Necessity of all drugs that require prior authorization must be posted for public view on the Contractor's website. This includes, but is not limited to, guidelines to determine Medical Necessity of both specific drugs and entire classes of drugs that require prior authorization for health and safety reasons, non-formulary designations, appropriate utilization, quantity limits, dose optimization or mandatory generic substitution. The guidelines must specify all of the conditions that

the Contractor's reviewers will consider when determining Medical Necessity including requirements for step therapy.

3.5.9.2 Denial of Services

3.5.9.2.1 If the Contractor denies a request for prior authorization, the Contractor must issue a Notice of Adverse Benefit Determination within 24 hours of receiving the request for prior authorization (see Section 3.15.2 of this Contract for Notice of Adverse Benefit Determination requirements).

3.5.9.2.2 In addition to including the minimum information specified in Section 3.15.2.3, the Notice of Adverse Benefit Determination must include information to direct the provider if further information or a change in prescription will allow for the treatment to be covered, including but not limited to: a first line or preferred product that would be covered, any missing documentation, whether the drug is not indicated for the member's diagnosis, and specific elements of the approval criteria not documented on the request form.

3.5.9.3 Emergency Supply

3.5.9.3.1 If required, a 72-hour emergency supply of a covered pharmacy service shall be dispensed if a request is submitted after business hours and the delay in therapy will result in loss of life, limb or organ functions. An emergency supply may only be dispensed once per drug per member during a 60 calendar day period.

3.5.9.4 Notification Requirements

3.5.9.4.1 The Contractor must have policies and procedures for general notification to participating providers and members of revisions to the formulary and prior authorization requirements. Written notification for changes to the formulary and prior authorization requirements and revisions must be provided to all affected participating providers and members 30 calendar days prior to the effective date of the change. The Contractor must provide all other participating providers and members written notification of changes to formulary and prior authorization requirements upon request.

3.5.9.4.2 The Contractor must receive written prior approval of its general notification policies and procedures from the State.

3.5.9.4.3 For all covered outpatient drug prior authorization decisions, the Contractor shall provide notice as described in section 1927(d)(5)(A) of the Social Security Act and 42 CFR 438.3(s)(6).

3.5.9.5 Quantity Limits

3.5.9.5.1 At a minimum, the Contractor's quantity limits and age edits must follow State policy at the Start Date of Operations. Thereafter, any changes to quantity and age edits must be reviewed and prior approved by the State.

3.5.9.5.2 The Contractor must at minimum provide quantity limit and dose optimization editing for the specific drugs and values currently in the DMAP pharmacy program.

3.5.9.6 Weather Emergency Plan for Pharmacy Services

3.5.9.6.1 The Contractor shall submit to the State, for review and prior approval, policies and procedures for providing pharmacy services during emergency weather conditions.

3.5.9.7 MCO Pharmacy & Therapeutics (P&T) Committee

3.5.9.7.1 The Contractor shall have a P&T committee dedicated to this Contract.

3.5.9.7.2 The P&T committee shall serve in an evaluative, educational and advisory capacity to the Contractor's staff and participating providers in all matters including, but not limited to, the pharmacy requirements of this Contract and the use of medications including, but not limited to, ongoing physician and pharmacist educational interventions targeting inappropriate drug or device utilization that is identified by retrospective analysis or claim review.

3.5.9.7.3 Membership of the P&T committee must include (i)Plan Pharmacy Director, (ii) Chief Medical Officer, BH Medical Director, or MCO Staff with expertise in one or more of the following areas:

3.5.9.7.3.1 Clinically appropriate prescribing of covered outpatient drugs or devices;

3.5.9.7.3.2 Clinically appropriate dispensing and monitoring of covered outpatient drugs or devices;

3.5.9.7.3.3 Drug use review, evaluation and intervention; and

3.5.9.7.3.4 Medical quality assurance.

3.5.9.8 Drug Utilization Review (DUR) Programs

3.5.9.8.1 The Contractor shall develop and maintain DUR programs including prospective DUR and retrospective DUR that comply with Section 1927(g) of the Social Security Act, 42 CFR 438.3(s)(4), the mental health parity requirements in 42 CFR Part 456, Subpart K, and Section 1004 of the SUPPORT for Patients and Communities Act.

3.5.9.8.2 *Guidelines for Prospective Drug Utilization Review (Pro-DUR)*

3.5.9.8.2.1 The Contractor's Pro-DUR shall comply with the following requirements:

3.5.9.8.2.1.1 Have a central electronic repository for capturing, storing and updating prospective DUR data; and

3.5.9.8.2.1.2 Assess each active drug regimen of members in terms of ingredient therapy, therapeutic duplication, drug interactions, age precautions, over- and under-utilization, prescribing limits and other clinically appropriate evaluations.

3.5.9.8.3 *Guidelines for Retrospective Drug Utilization Review (Retrospective DUR)*

3.5.9.8.3.1 The Contractor's Retrospective DUR shall comply with the following requirements:

3.5.9.8.3.1.1 Establish and maintain Retrospective DUR exception criteria;

3.5.9.8.3.1.2 Conduct drug criteria interrogation and generate review of member and participating provider profiles;

3.5.9.8.3.1.3 Develop case tracking system and project reports;

3.5.9.8.3.1.4 Implement educational intervention program;

3.5.9.8.3.1.5 Conduct assessment/evaluation of educational intervention program; and

3.5.9.8.3.1.6 Analyze cost outcomes and evaluate the effectiveness of the educational interventions to members, prescribers and pharmacies.

3.5.9.8.4 In order to satisfy the DUR Requirements necessary to comply with Section 1004 of the SUPPORT for Patients and Communities Act, the Contractor's DUR program shall:

3.5.9.8.4.1 Have in place safety edits and a claims review process for subsequent opioid fills (i.e. refills) in excess of any limitations specified by the State and safety edits and a claims review process for any fills that exceed the limitations specified by the State regarding maximum daily morphine equivalent limitations;

3.5.9.8.4.2 Have in place a claims review automated process to monitor concurrent prescribing of opioids and benzodiazepines;

3.5.9.8.4.3 Have in place a claims review automated process to monitor concurrent prescribing of opioids and antipsychotics; and

3.5.9.8.4.4 Include a program to monitor and manage the appropriate use of antipsychotic medications by members under the age of 18.

3.5.9.8.4.5 Comply with applicable State policies, including exempt populations, unless otherwise prior approved by the State.

3.5.9.9 The Contractor shall establish an extensive maximum allowable cost (MAC) program in order to promote generic utilization and cost containment.

3.5.9.9.1 The Contractor shall provide a description of its MAC program for review and prior approval by the State.

3.5.10 **Pharmacy Member and Provider Services**

3.5.10.1 <u>Member and Provider Call Center for Pharmacy Services</u>

3.5.10.1.1 The Contractor shall have a call center with a specific toll-free telephone line dedicated to pharmacy and prescription issues to, among other things:

3.5.10.1.1.1 Respond to member questions, concerns, inquiries, and complaints related to pharmacy and prescription issues; and

3.5.10.1.1.2 Respond to provider questions, concerns, inquiries, and complaints related to among other things prescription prior authorizations and member Copayments.

3.5.10.1.2 The pharmacy services call center may be operated in the same call center as described in Section 3.14.2 of this Contract.

3.5.10.1.3 The Contractor shall develop pharmacy services call center policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including referrals from all sources, monitoring of calls via recording or other means, translation/interpretation and compliance with standards.

3.5.10.1.4 The pharmacy services call center shall have the capacity for the State or its authorized representative to monitor calls remotely.

3.5.10.1.5 The pharmacy services call center shall be equipped to handle calls from Limited English Proficiency (LEP) callers as well as calls from members who are hearing impaired.

3.5.10.1.6 The Contractor shall ensure that the pharmacy services call center is staffed adequately to respond to caller's questions, at a minimum, from 8 a.m. to 7 p.m. eastern time, Monday through Friday, except State of Delaware holidays.

3.5.10.1.7 The Contractor shall ensure that pharmacy services call center staff shall receive ongoing training, at least quarterly, through instructor-led trainings and staff meetings. The pharmacy services information line staff must receive training immediately following changes to the pharmacy benefit or prior authorization requirements. All training materials must be provided to the State.

3.5.10.1.8 The Contractor shall measure and monitor the accuracy of responses provided by pharmacy services call center staff and take corrective action as necessary to ensure the accuracy of responses by staff.

3.5.10.1.9 The Contractor shall have an automated system available during non-business hours, including weekends and State of Delaware holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages. The Contractor shall return all messages by close of business on the next business day.

3.5.10.1.10 The pharmacy services information line staff shall have access to electronic documentation from previous calls made by or on behalf of the member to the pharmacy services information line, member services information line, nurse triage/nurse advice line, and the case managers/care coordinators.

3.5.10.2 Performance Standards for Pharmacy Line

3.5.10.2.1 The Contractor shall adequately staff the pharmacy services call center to ensure that the pharmacy line meets the following performance standards: less than 5% call abandonment rate; 80% of calls are answered by a live voice within 30 seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed 30 seconds.

3.5.10.2.2 The Contractor's pharmacy services call center system shall have the capability to track the metrics as identified above.

3.5.10.3 Website

3.5.10.3.1 The Contractor shall maintain the following information on its website, and such information must be current and searchable:

3.5.10.3.1.1 The Contractor's formulary and the State's PDL;

3.5.10.3.1.2 The Contractor's pharmacy prior authorization requirements; and

3.5.10.3.1.3 The Contractor's MAC pricing.

3.5.10.3.2 The Contractor shall ensure that the Contractor's website and the member handbook include instructions on how and whom to contact for questions regarding refilling a prescription.

3.5.11 **Financial Management**

3.5.11.1 Third Party Liability (TPL)

3.5.11.1.1 The Contractor must comply with the TPL procedures described in Section 3.18.3 of this Contract.

3.5.11.2 Coordination of Benefits Agreement

3.5.11.2.1 The Contractor must comply with the coordination of benefits agreement (COBA) described in Section 3.18.1 of this Contract.

3.5.12 **Claims Management**

3.5.12.1 Pharmacy Rebates

3.5.12.1.1 Pursuant to Section 1927 of the Social Security Act, drug manufacturers must pay rebates for covered outpatient drugs reimbursed under Medicaid, including those provided by MCOs. Pursuant to Section 1927(a)(7) of the Social Security Act, states must collect Medicaid rebates for physician administered drugs. In

addition to the Medicaid Drug Rebate Program required by Section 1927 of the Social Security Act, Delaware has received CMS approval to enter into Supplemental Drug Rebate agreements, and the State has amended these agreements to include utilization from MCOs.

3.5.12.1.2 The Contractor shall provide Encounter Data and supporting information as needed for the State to collect rebates through the Medicaid Drug Rebate Program and Supplemental Drug Rebates. This shall include but not be limited to:

3.5.12.1.2.1 Submitting all pharmacy Encounter Data, with the exception of inpatient hospital pharmacy Encounter Data, to the State in accordance with the requirements in Section 3.5.12.3 of this Contract, below. The State or its vendor will submit appropriate pharmacy Encounter Data for rebate from manufacturers.

3.5.12.1.2.2 Complying with the requirements below regarding NCPDP standards and validation (Section 3.5.12.2 of this Contract, below), disputed Encounter Data submissions (Section 3.5.12.4 of this Contract, below), and repackaged products (Section 3.5.12.5 of this Contract, below).

3.5.12.1.2.3 Assuring that access to pharmacy products covered by a Supplemental Drug Rebate agreement is no more restrictive than the State's PDL requirements applicable to the pharmacy product.

3.5.12.1.2.4 For physician administered (J-code) drugs:

3.5.12.1.2.4.1 Including the NDC, units and the date of payment for all encounters for physician administered (J-code) drugs as specified by the State.

3.5.12.1.2.4.2 Ensuring that the NDC on all encounters for physician administered (J-code) drugs is appropriate for the HCPCS code based on the NDC and units billed. The NDC must represent a drug that was available to the physician in an outpatient setting and was safe to administer (not past its shelf life).

3.5.12.1.2.4.3 Ensuring that, for Long Acting Reversible Contraception (LARC) devices/drugs, the Contractor's reimbursement methodology will pay the provider (for example, a hospital or FQHC) separately at the claim detail level for these devises/drugs and not as part of any bundled rate.

3.5.12.1.2.4.4 Researching any encounters that are identified as a dispute by the manufacturer, which cannot be resolved by the Fiscal Agent, within 30 calendar days. The Contractor shall provide an explanation at the claim level in a spreadsheet. If the claim information is found to be in error, the encounter must be voided within five business days of the determination.

3.5.12.2 NCPDP Standards and Validation

3.5.12.2.1 The Contractor shall edit and validate claim transaction submissions and Encounter Data for completeness and accuracy in accordance with NCPDP standards.

3.5.12.2.2 The Contractor shall use a unique Bank Identification Number (BIN) and Processor Control Number (PCN) combination for DSHP and DSHP Plus members. If the Contractor subcontracts with a PBM to process prescription claims, the Contractor shall ensure that the PBM uses a unique BIN and PCN combination for DSHP and DSHP Plus members.

3.5.12.3 Pharmacy Encounter Data Submission

3.5.12.3.1 The Contractor shall submit a claim level detail file of pharmacy Encounter Data to the State within five calendar days of a payment cycle. The file must include individual claim level detail information on each pharmacy product dispensed to a DSHP or DSHP Plus member, including all required data fields as identified by the State. The MCO shall report the amount paid to the providers on the encounter. The Contractor shall run payment cycles weekly.

3.5.12.3.2 The Contractor must ensure that its pharmacy claims process identifies claims from 340B pharmacies for products purchased through the 340B discount drug program at the claim level utilizing the NCPDP field designed for this purpose and this information is included on each encounter.

3.5.12.4 Disputed Pharmacy Encounter Data Submissions

3.5.12.4.1 On a quarterly basis, the State will review the Contractor's pharmacy Encounter Data and send a file back to the Contractor of disputed encounters that were identified through the drug rebate invoicing process.

3.5.12.4.2 Within 30 calendar days of receipt of the disputed encounter file from the State, the Contractor shall, if needed, correct and resubmit any disputed encounters and send a response file that includes:

3.5.12.4.2.1 Corrected and resubmitted encounters; and/or

3.5.12.4.2.2 A detailed explanation of why the disputed encounters could not be corrected including documentation of all attempts to correct the disputed Encounters at claim level detail.

3.5.12.4.3 For disputed encounters that are not corrected, the Contractor shall void the encounter and recoup the related payment from the provider.

3.5.12.4.4 Failure to submit accurate and complete pharmacy Encounter Data will result in monetary sanctions as described in Section 5.4 of this Contract.

3.5.12.5 Pharmacy Repackaged Products

3.5.12.5.1 The Contractor shall ensure that the manufacturer number, product number and package number for the drug dispensed is provided on all claims and Encounter Data. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia. Repackaged drug products supplied through co-ops, franchises, or other sources not readily available to other providers shall not be used.

3.5.13 **Pharmacy Information System Requirements**

3.5.13.1 The Contractor's system shall provide for, at a minimum, a weekly update to the National Drug Code file including all product, packaging, prescription and pricing information. The system shall provide online access to reference file information. The system shall maintain a history of the pricing schedules and other significant reference data.

3.5.13.2 The Contractor's claims payment system must be available 24 hours a day, seven days a week, except for scheduled downtime as agreed to by the State.

3.5.13.3 Electronic Pharmacy Prescribing

3.5.13.3.1 The Contractor must support electronic prescribing initiatives by exchanging data files through Surescripts or another approved industry standard entity for claims history, PDL, prior authorization and system edits.

3.5.14 **Staffing**

3.5.14.1 As described in Section 3.20 of this Contract, the Contractor shall employ as a part of its key personnel a senior level pharmacist dedicated to this Contract who

is a Delaware licensed pharmacist. This person shall oversee and be responsible for all pharmacy activities related to this Contract.

3.5.15 **Reporting**

3.5.15.1 The Contractor shall provide pharmacy reports to the State as specified in Section 3.21.5 of this Contract.

3.5.16 **Subcontracting**

3.5.16.1 The Contractor may Subcontract with a PBM to process prescription claims only if the PBM has received advance written approval by the State and meets the other requirements for Subcontracting as specified in Section 5.1.2 of this Contract. If the PBM is owned wholly or in part by a retail pharmacy participating provider, chain drug store or pharmaceutical manufacturer, the Contractor must submit a written description of the assurances and procedures that shall be put in place under the proposed PBM Subcontract, such as an independent audit, to assure confidentiality of proprietary information. These assurances and procedures must be submitted and receive prior approval by the State. The State will allow the continued operation of existing PBM Subcontracts while the State is reviewing new contracts.

3.5.16.2 <u>Pricing Transparency and Reporting</u>

3.5.16.2.1 The Contractor must provide the State of Delaware and its agencies with all the following information:

3.5.16.2.1.1 The wholesale acquisition cost negotiated between the pharmacy benefit manager and manufacturer at any point in time for each drug included in the pharmacy services provided to members under this contract.

3.5.16.2.1.2 The dollar amount of rebates, discounts, and price concessions that the pharmacy benefit manager received for each drug included in the pharmacy services provided to members under this contract. The dollar amount of rebates shall include any utilization discounts the pharmacy benefit manager receives from a pharmacy.

3.5.16.2.1.3 The nature, type, and dollar amount of all other payments that the pharmacy benefit manager receives, directly or indirectly, from a manufacturer in connection with a drug switch program, a formulary management program, a mail service pharmacy, educational support, data sales related to a covered individual, or any other function included in the pharmacy services provided to members under this contract.

3.5.16.2.1.4 The dollar amount of any reimbursements the pharmacy benefit manager pays to contracting pharmacies, and the negotiated price covered entities pay the pharmacy benefit manager, for each drug included in the pharmacy services provided to members under the contract.

3.5.17 **Audits**

3.5.17.1 The Contractor shall submit to the State for prior approval the policies and procedures of its pharmacy services audit program.

3.5.17.2 The Contractor shall ensure the PBM, if the Contractor Subcontracts with a PBM, has a network audit program that includes, at a minimum random audits to determine participating provider compliance with the program policies, procedures and limitations outlined in the participating provider's participation agreement.

3.6 CARE COORDINATION

3.6.1 General

3.6.1.1 The Contractor shall develop and implement an integrated care coordination program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize quality of care and member health outcomes.

3.6.1.2 The Contractor's care coordination program shall be based upon risk stratification of the Contractor's member population and shall be rooted in a population health model that supports participating providers and touches members across the entire care continuum, promoting healthy behaviors as well as providing face-to-face care coordination as needed, and shall be supported by evidence-based medicine and national best practices. The Contractor's care coordination program shall be organized into the following levels, which will determine the intensity of interventions provided by the Contractor to meet the member's level of need:

3.6.1.2.1 All-Member Level (all members): Appointment assistance and linkage to services and access to member wellness programs

3.6.1.2.2 Level 1 (moderate risk): Resource coordination

3.6.1.2.3 Level 2 (high risk): Clinical care coordination

3.6.1.3 In implementing its care coordination program, the Contractor may delegate care coordination activities to persons or entities other than the Contractor's care

coordination staff, such as but not limited to the member's PCP, other providers, or a patient-centered medical home.

3.6.1.4 If the Contractor delegates care coordination activities to persons or entities other than the Contractor's care coordination staff, the Contractor maintains responsibility for ensuring that care coordination activities are implemented as specified below. The Contractor shall ensure that any persons or entities that are delegated care coordination activities actively participate in the State's monthly care coordination monitoring activities.

3.6.1.5 If the Contractor delegates care coordination activities to persons or entities other than the Contractor's care coordination staff, the Contractor shall submit a care coordination delegation and oversight plan to the State for review and approval.

3.6.2 **Member Assessment and Identification/Stratification**

3.6.2.1 Within 60 calendar days of the member's Enrollment date, the Contractor shall make best efforts to assess the member's health via a health risk assessment designed for all members. Such health risk assessment shall include screening for physical health conditions and behavioral health conditions and Health-Related Social Needs with a special emphasis on identifying a member's need for resources, referrals, wellness programs and community supports. If the initial attempt to contact the member is unsuccessful, the Contractor shall make subsequent attempts to conduct the health risk assessment. The Contractor shall share the results of the assessment with the State as directed in the QCMMR to prevent duplication of activities. The HRA shall, at minimum, screen for housing, food, and transportation needs, as well as document race, ethnicity, and preferred language. Wherever possible, the Contractor shall use questions from validated, nationally-recognized questionnaires and tools. The Contractor shall submit its HRA to DMMA for review and approval.

3.6.2.2 Subject to State review and approval of the Contractor's methodology, the Contractor shall use predictive modeling utilizing claims data, pharmacy data, and laboratory results, and Health-Related Social Needs data, supplemented by information from providers, referrals, utilization management data, and/or health risk assessment results to stratify the member population into the following risk levels:

3.6.2.2.1 Level 1 – Members eligible to participate at this level shall be determined by predictive modeling to meet any of the following conditions: pregnancy, one or more chronic conditions, gaps in preventive care (shown by HEDIS or other outcome measures), comorbid physical health and behavioral health conditions, high inpatient hospital utilization, polypharmacy, overutilization of prescription drugs, or high rate of low acuity, non-emergent visits to the emergency room. For the purposes of identifying members for this Level, chronic condition(s) shall include but not be limited

to: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, chronic behavioral health condition, and any other chronic condition as directed by the State.

3.6.2.2.2 Level 2 – Members eligible to participate at this level shall be determined by predictive modeling to be at the highest risk for adverse health outcomes. Members determined eligible for Level 2 may include those members who have multiple chronic conditions including substance use disorder or comorbid physical health and behavioral health conditions, complex health conditions, complex service needs requiring supported coordination of care, history of poor outcomes, utilization patterns that suggest inadequate linkage to primary and preventive care or other indicators of high risk or potential for poor health outcomes.

DSHP Plus LTSS members and members participating in PROMISE are excluded from this level unless a member participating in PROMISE would be eligible for this level without regard to the member's behavioral health condition(s).

3.6.2.3 Within 60 calendar days after the Start Date of Operations, the Contractor shall submit for the State's written approval its risk stratification plan, which at a minimum shall include a description of the Contractor's risk stratification methodologies to identify members to Level 1 and Level 2, and projected member volumes for each level.

3.6.2.4 The Contractor shall systematically risk stratify newly enrolled members on a monthly basis.

3.6.2.5 The Contractor shall systematically re-stratify the Contractor's entire population to identify members for Level 2 (as defined in Section 3.6.2.2.2 of this Contract) at a minimum of quarterly intervals to ensure members with increasing health risks and needs are identified for Level 2 care coordination.

3.6.2.6 The Contractor shall identify pregnant members through claims, referrals, and 834 enrollment data, as well as through any other method identified by the Contractor.

3.6.2.7 <u>Care Coordination Program Content and Minimum Interventions</u>

3.6.2.8 The Contractor shall establish and implement program content and interventions, based on program objectives, member assessments (listed in Section 3.6.2.1) and risk stratification, for the levels listed in Section 3.6.1.2 of this Contract. Each

level shall have a minimum standard set of interventions to attain program objectives, as described below.

3.6.2.9 All-Member Level

3.6.2.9.1 *Coordination of Services*

3.6.2.9.1.1 The Contractor shall ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member, such as the member's PCP, other providers, a patient-centered medical home, or the Contractor's care coordination staff. Any person or entity responsible for coordinating the services accessed by the member will be required to participate in the State's care coordination oversight review process. The Contractor shall provide the member with information on how to contact their designated person or entity.

3.6.2.9.1.2 The Contractor shall coordinate services it furnishes to members:

3.6.2.9.1.2.1 Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

3.6.2.9.1.2.2 With the services the member receives from the State's FFS program; and

3.6.2.9.1.2.3 With the services the member receives from community and social support providers.

3.6.2.9.1.2.4 The Contractor shall ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent they are applicable.

3.6.2.9.2 *Appointment Assistance and Linkage to Services*

3.6.2.9.2.1 For the Contractor's entire member population, the Contractor shall provide appointment assistance and linkage to Covered Services and non-Covered Services with the objective of facilitating member access to medically necessary services and identifying members who could benefit from wellness programs or services that address Health-Related Social Needs (these programs or services may be offered by the Contractor, providers or by other community organizations).

3.6.2.9.2.2 Members shall be able to access appointment assistance and linkage to Covered Services and non-Covered Services by calling the Contractor's member service information line. The Contractor's member services information line shall have the ability to assess the member's need for appointment assistance and linkage to Covered Services and non-Covered Services and, when necessary, warm transfer the member's call to the Contractor's appointment assistance and linkage to services program staff (as described in Section 3.6.3.2.1.3 of this Contract, below).

3.6.2.9.3 *Appointment Assistance and Linkage to Services Program Staff*

3.6.2.9.3.1.1 The Contractor shall use field-based staff to provide appointment assistance and linkage to services. The Contractor shall maintain at least one full-time, field-based staff in Delaware's New Castle County and one full-time, field-based staff in Kent or Sussex County who will serve both Kent and Sussex counties. If the Contractor's membership exceeds 75,000 members in New Castle County or a combination of Kent and Sussex counties, the Contractor shall hire a proportionate number of additional field-based staff for that county.

3.6.2.9.4 *Access to Wellness and Community Resources*

3.6.2.9.4.1.1 With the purpose of encouraging member access to needed preventive care, the Contractor shall perform active outreach to members who the Contractor has identified via EPSDT and/or HEDIS measures or other means have missed a preventive care visit. Outreach shall include an alert to the member's PCP and active assistance of the PCP's efforts to re-engage members. With member consent, outreach methods can also include phone calls, SMS text messages, emails, and/or mailers to members, however the primary objective shall be outreach and active coordination with PCPs. Digital outreach methods must be HIPAA and HITECH compliant.

3.6.2.9.4.1.2 With the objective of engaging members in wellness and healthy behaviors, as well as addressing members' Health-Related Social Needs, the Contractor shall maintain an up-to-date registry of all wellness, health education, disease management and self-management programs and activities, and community resources that

address Health-Related Social Needs that are available for members and that are accepting new participants. This registry shall be searchable by type of activity, location, whether the program is a Covered Service, and any additional eligibility criteria that a member must meet to participate in the program. The registry must include contact information for each program as well as the means of accessing the program. The Contractor shall make the registry available in a searchable format on its member and provider websites. The Contractor shall also make this information available in a searchable format to its member services information line, provider service line and pharmacy service line staff. The registry must be reviewed at least every six months for accuracy and to ensure all information is current. The Contractor shall cooperate with DMMA's efforts to develop a unified wellness and community resources registry for the State of Delaware.

3.6.2.9.4.2 With the objective of assisting participating providers in their efforts to offer wellness, disease management and health education programs for their patients, the Contractor shall offer training for participating providers on topics related to developing and implementing these types of programs.

3.6.2.9.4.3 By 180 calendar days after the Start Date of Operations, the Contractor shall submit for State review and written approval a detailed training plan to accomplish the objective stated in Section 3.6.3.2.2.3 of this Contract, above. The training plan shall include proposed methods for educating providers about the Contractor's wellness program training, proposed training content and training methodologies to encourage and support provider developed wellness programs as well as an evaluation plan for assessing training effectiveness.

3.6.2.10 Level 1: Resource Coordination

3.6.2.10.1 The Contractor shall actively assist providers in discharge planning for Level 1 members following acute episodes of care involving at a minimum one of the following services: inpatient psychiatric stay, ambulatory surgery, hospital inpatient stay, and rehabilitation facility services. Contractor assistance shall include but not be limited to: appointment setting, referrals and linkages to services, coordination of DME, and coordination of prior authorizations as needed to support the member's timely access to services in the community.

3.6.2.10.2 When the Contractor identifies a Level 1 member with a high rate of low acuity, non-emergent visits to the emergency room, the Contractor shall actively engage with the member and his/her PCP to identify barriers and coordinate the member's linkage back to primary care services.

3.6.2.10.3 *Resource Coordination Staff*

3.6.2.10.3.1 The Contractor shall maintain full-time resource coordination staff to conduct the resource coordination activities specified above. Non-clinical resource coordination staff shall be supervised by a RN or other qualified clinical supervisor such that the supervisor to non-clinical resource coordination staff ratio is no greater than 1:12.

3.6.2.10.3.2 The Contractor shall ensure that resource coordinators staff are provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor pursuant to this Contract. The Contractor shall maintain documentation of training dates and staff attendance as well as copies of materials used.

3.6.2.11 Level 2: Clinical Care Coordination

3.6.2.11.1 For all Level 2 members, the Contractor shall provide clinical care coordination. Members shall have the right to participate or decline participation in clinical care coordination.

3.6.2.11.2 The Contractor shall maintain clinical care coordination procedures to implement the requirements of this Contract.

3.6.2.11.3 *Clinical Care Coordination Staffing Requirements*

3.6.2.11.3.1 The Contractor shall ensure that individuals hired as clinical care coordinators are either:

3.6.2.11.3.1.1 Individuals with a Bachelor's degree in health, human, social work or education services with one or more years of qualifying experience; or a high school degree or equivalent and three years of qualifying experience with clinical care coordination of individuals with complex health conditions, including clinical care coordination of behavioral health conditions; or

3.6.2.11.3.1.2 Licensed as an RN; or LPN with two years of qualifying experience with appropriate supervision in accordance with Delaware law (see 24 DE Admin Code 1900).

3.6.2.11.3.2 The Contractor shall ensure that clinical care coordinators have:

3.6.2.11.3.2.1 Experience interviewing and assessing member needs;

3.6.2.11.3.2.2 Knowledge and experience regarding caseload management and care coordination practices;

3.6.2.11.3.2.3 Knowledge regarding DHSS programs and how members can access these programs;

3.6.2.11.3.2.4 Knowledge regarding Federal and State law as it applies to DHSS programs;

3.6.2.11.3.2.5 The ability to effectively solve problems and locate community resources;

3.6.2.11.3.2.6 Good interpersonal skills;

3.6.2.11.3.2.7 Fundamental background in cultural and socio-economic diversity; and

3.6.2.11.3.2.8 Knowledge of the needs and service delivery system for all populations in the clinical care coordinator's caseload.

3.6.2.11.3.3 Clinical Care Coordination Staff Training

3.6.2.11.3.3.1 The Contractor shall ensure that clinical care coordinators are provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor pursuant to this Contract. The Contractor shall maintain documentation of training dates and staff attendance as well as copies of materials used.

3.6.2.11.3.4 Clinical Care Coordination Caseload Management

3.6.2.11.3.4.1 The Contractor shall have an adequate number of qualified and trained clinical care coordinators to meet the needs of members who are identified to Level 2 as specified in Section 3.6.2.2.2 of this Contract.

3.6.2.11.3.4.2 The Contractor must maintain a maximum clinical care coordinator caseload ratio of 1:50.

3.6.2.11.3.5 Supervision

3.6.2.11.3.5.1 The Contractor shall establish a supervisor to clinical care coordinator ratio of 1:15.

3.6.2.11.4 *Accessibility of the Clinical Care Coordinator and Initial Outreach to the Member*

3.6.2.11.4.1 Accessibility of the Clinical Care Coordinator

3.6.2.11.4.1.1 The Contractor shall provide members and member representatives with adequate information in order to be able to contact their clinical care coordinator and the Contractor's member services information line for assistance, including what to do in cases of emergencies and/or after hours.

3.6.2.11.4.1.2 The Contractor must have a system of back-up clinical care coordinators in place, and members who contact the Contractor when their clinical care coordinator is unavailable must be given the opportunity to be referred to a back-up clinical care coordinator for assistance.

3.6.2.11.4.1.3 The Contractor shall ensure that clinical care coordinators respond to messages from members, member representatives, State agency representatives (e.g., DSAMH care managers and DDDS case managers) and providers within one business day.

3.6.2.11.4.2 Initial outreach to the member

3.6.2.11.4.2.1 Within 15 business days of a member being identified as eligible for Level 2 clinical care coordination, the assigned clinical care coordinator must initiate contact with the member or member representative. The Contractor shall make at least five outreach attempts to contact each newly identified Level 2 member within the first 90 calendar days of his/her initial identification as Level 2 eligible. The five outreach attempts shall be documented and must continue throughout the 90 day period and include at least one face-to-face outreach attempt.

3.6.2.11.4.2.2 If the Contractor is unable to contact the member within 90 calendar days or if the member opts out of the care coordination program, the Contractor shall note all outreach attempts in the clinical record and/or the member's desire to opt out and close the case except for members identified in 3.6.3.4.4.2.3.

3.6.2.11.4.2.3 If the Contractor is unable to reach a member identified as High Risk for Behavioral Health or Substance Use Disorder, the Contractor shall outreach to DMMA,

DSAMH, DDDS, or any other agencies or providers that service the member prior to closing.

3.6.2.11.5 *Clinical Care Coordination Member Assessment*

3.6.2.11.5.1 Within 30 calendar days of identifying a member as eligible for Level 2, the member's assigned clinical care coordinator shall perform a member assessment that is comprehensive and evaluates the member's physical and behavioral health, social, environmental, cultural, and psychological needs.

3.6.2.11.5.2 The member, member representative, as well as the member's caregivers and family, PCP and other providers as appropriate, must have an opportunity to provide input into the assessment.

3.6.2.11.5.3 Efforts to outreach and coordinate care with the member's PCP and other providers shall be documented in the member's file. Such efforts shall demonstrate good faith efforts to understand the current treatment regimens recommended by the member's providers and demonstrate active efforts to encourage and solicit provider involvement in the care coordination assessment and planning process, and to increase the provider's involvement in care coordination activities for the member.

3.6.2.11.5.4 At a minimum, the clinical care coordinator shall reassess the member's needs on a quarterly basis following the initial assessment upon the member's identification to Level 2.

3.6.2.11.5.5 Any member receiving more than 8 hours of Private Duty Nursing per day will be assigned a Nurse Care Coordinator to assure clinical coordination, and Social Worker Care Coordinator to assist member and member's caregiver with coordination of services and benefits (e.g., DME ordering, nursing agency shift coverage).

3.6.2.11.6 *Clinical Care Coordination Plan of Care*

3.6.2.11.6.1 The clinical care coordinator shall work with the member to develop a clinical care coordination plan of care based on the member assessment. The clinical care coordinator shall use a person-centered process in developing the member's clinical care coordination plan of care. The clinical care coordinator must include the member, and if desired by the member, the member's representative, member's family, and/or significant others, as well as the member's PCP and other providers as appropriate, as partners in the development of the clinical care coordination plan of care.

3.6.2.11.6.2 The member's clinical care coordination plan of care shall include at a minimum the following elements:

3.6.2.11.6.2.1 Prioritized goals and actions with timeframes for completion, and the member's documented progress towards achieving the goals;

3.6.2.11.6.2.2 A plan for effective and comprehensive transitions of care between care settings as needed by the member;

3.6.2.11.6.2.3 A communication plan with the member's PCP and other providers as needed to ascertain the needs that providers have identified for the member, including a process to ensure the provider's treatment plan is reflected in the plan of care;

3.6.2.11.6.2.4 Identification of the providers responsible for delivering services to the member, identification of linkages made to specialists or other providers, and confirmation that the member received the needed service;

3.6.2.11.6.2.5 Identification of any other care coordination or case management services the member may be receiving from other programs, and a plan for coordinating with these services to avoid duplication;

3.6.2.11.6.2.6 A provision to refer the member, if needed, to community or social support services, assist the member in contacting the service provision agency, and validating the member received the needed service;

3.6.2.11.6.2.7 Continuous review and revision of the care plan, which includes follow up contact as needed with the member to ensure the plan of care is adequately monitored, including identification of gaps in care;

3.6.2.11.6.2.8 A communication plan with the member including anticipated frequency and method of contacts; and

3.6.2.11.6.2.9 A provision to share feedback with the member's PCP on member engagement with the plan of care.

3.6.2.11.6.3 Contractor shall ensure that a member's plan of care addresses all of a member's assessed needs and personal goals.

3.6.2.11.6.4 Member goals must be specific and measurable with achievement timeframes identified and the desired outcome clearly identified.

3.6.2.11.6.5 The clinical care coordinator must provide the member or member representative with a copy of his/her clinical care coordination plan of care and maintain a copy in the member's electronic case record.

3.6.2.11.6.6 Within 60 calendar days of the Start Date of Operations, the Contractor shall submit its clinical care coordination plan of care document template to the State for written approval.

3.6.2.11.7 *Member Clinical Care Coordination Plan Monitoring and Revision*

3.6.2.11.7.1 The clinical care coordinator shall provide regular ongoing monitoring of the member's clinical care coordination plan of care in order to assess the continued appropriateness of the plan in meeting the member's needs.

3.6.2.11.7.2 The clinical care coordination plan of care shall be updated as needed and based on the results of the face to face interaction, as set forth in Section 3.6.3.4.7.3, and quarterly re-assessments.

3.6.2.11.7.3 The clinical care coordinator shall complete at least one successful face to face interaction with the member every six months. The State encourages the Contractor to include a face to face contact at the point of care (e.g. the office of the member's PCP). This interaction will establish and solidify a personal relationship between the clinical care coordinator, the member, and the member's PCP. Subsequent ongoing interaction with the member shall include, but not be limited to, telephone calls and face to face visits as needed and shall be based on the member's needs.

3.6.2.11.7.4 All interactions with the member, regardless of contact method, shall be documented in the member's record and should contribute to assisting the member in reaching his/her goals as stated in the plan of care.

3.6.3 Clinical Practice Guidelines

3.6.3.1 The Contractor's care coordination program shall utilize evidence-based practice guidelines.

3.6.3.2 The Clinical care coordination program shall be described and included in the contractor's utilization management program description.

3.6.4 Informing and Educating Members

3.6.4.1 The Contractor shall inform all members of the availability of care coordination program activities at all levels and how to access and use care coordination program services.

3.6.5 Informing and Educating Providers

3.6.5.1 The Contractor shall inform providers regarding the operation and goals of the care coordination programs at all levels. Providers shall be given instructions on how to access appropriate services as well as the benefits to the provider.

3.6.6 Care Coordination System Capabilities

3.6.6.1 The Contractor shall maintain and operate a centralized information system necessary to conduct risk stratification. Systems recording program documentation shall include the capability of collecting and reporting short term and intermediate outcomes such as member behavior change. The system shall be able to collect and query information on individual members as needed for follow-up confirmations and to determine intervention outcomes.

3.6.6.2 The Contractor shall work with DMMA to develop Contractor system capacity around promoting provider level care coordination services.

3.6.7 Evaluation

3.6.7.1 The Contractor shall submit the care coordination reports specified in Section 3.21 of this Contract.

3.7 CASE MANAGEMENT FOR DSHP PLUS LTSS MEMBERS

3.7.1 Administrative Standards

3.7.1.1 General

3.7.1.1.1 The Contractor shall provide case management to DSHP Plus LTSS members. This Section of the Contract does not apply to DSHP members nor to DSHP Plus members who are not DSHP Plus LTSS members.

3.7.1.2 Case Management Staff Qualifications

3.7.1.2.1 The Contractor shall ensure that individuals hired as case managers are either:

3.7.1.2.1.1 Individuals with a Bachelor's degree in health, human, social work or education services with one or more years of qualifying experience; or a high school degree or equivalent

and three years of qualifying experience with case management of the aged, including management of behavioral health conditions, or persons with physical or developmental disabilities, or HIV/AIDS population; or

3.7.1.2.1.2 Licensed as an RN; or LPN with two years of qualifying experience with appropriate supervision in accordance with Delaware law (see 24 DE Admin Code 1900).

3.7.1.2.2 The Contractor shall ensure that case managers have:

3.7.1.2.2.1 Experience interviewing and assessing member needs;

3.7.1.2.2.2 Knowledge and experience regarding caseload management and casework practices;

3.7.1.2.2.3 Knowledge regarding determining eligibility for DHSS programs;

3.7.1.2.2.4 Knowledge regarding Federal and State law as it applies to DHSS programs;

3.7.1.2.2.5 The ability to effectively solve problems and locate community resources;

3.7.1.2.2.6 The ability to collaborate with Caregivers, involved State agency representatives and providers;

3.7.1.2.2.7 Good interpersonal skills;

3.7.1.2.2.8 Fundamental background in cultural and socio-economic diversity; and

3.7.1.2.2.9 Knowledge of the needs and service delivery system for all populations in the case manager's caseload.

3.7.1.3 Case Management Procedures

3.7.1.3.1 The Contractor shall maintain case management procedures to implement the requirements of this Contract.

3.7.1.3.2 Unless otherwise directed by the State, the Contractor shall use standardized forms specified by the State for determining and re-determining level of care (LOC), for the Contingency and Back-Up Plan (back-up plan) and for the Member Change Report.

3.7.1.3.3 The Contractor shall use the State's Pre-Admission Evaluation (PAE) for determining LOC and to support needs assessment.

Upon prior approval of the State, the Contractor may use its own forms and tools to supplement the PAE for assessing members' needs but not determining LOC.

3.7.1.3.4 The plan of care form to be used by the Contractor must be reviewed and prior approved by the State and must include, but not be limited to, a section with the member's service plan. This section must include the type of service, provider, frequency of service, service changes, start/end dates, service plan acknowledgement, including information provided to the member about the specific services, member rights to Appeal if member is not in agreement with the service plan, and contact information if the member needs more or other services. This section must be signed and dated by the member or member representative and case manager.

3.7.1.4 Training

3.7.1.4.1 The Contractor shall ensure that case managers are provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor pursuant to this Contract. The Contractor shall maintain documentation of training dates and staff attendance as well as copies of materials used.

3.7.1.4.2 The Contractor must ensure that there is a structure in place to provide uniform training to all case managers. This shall include a written case management training plan, prior approved by the State, that includes formal initial and ongoing training classes as well as mentoring-type opportunities for newly hired case managers.

3.7.1.4.3 The Contractor shall ensure that newly hired case managers are provided orientation and training in a minimum of the following areas:

3.7.1.4.3.1 The role of the case manager in utilizing a member-centered approach to case management, including involving the member and the member representative in decision-making and care planning;

3.7.1.4.3.2 The principle of most integrated, least restrictive settings for member placement;

3.7.1.4.3.3 Member rights and responsibilities;

3.7.1.4.3.4 Case management responsibilities as outlined in this Section 3.7.2, including, but not limited to care planning, back-up plans, reporting and addressing service gaps;

3.7.1.4.3.5 Case management procedures specific to the Contractor;

3.7.1.4.3.6 An overview of the DSHP Plus LTSS program;

3.7.1.4.3.7 The continuum of services in the DSHP Plus LTSS benefit package, including available service settings and service restrictions/limitations;

3.7.1.4.3.8 The Contractor's provider network by location, service type and capacity;

3.7.1.4.3.9 Information about resources for non-Covered Services including additional services, Medicaid benefits provided by the State (see Section 3.4.10 of this Contract) or other non-Covered Services provided by the State or otherwise available in the community;

3.7.1.4.3.10 Information on local resources for housing (e.g., Delaware State Rental Assistance Program (SRAP) and Delaware's Section 811 Project Rental Assistance Demonstration (PRA Demo) program), education and employment services/programs (e.g., Pathways) that could help members gain greater self-sufficiency in these areas;

3.7.1.4.3.11 Responsibilities related to monitoring for and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect and/or exploitation;

3.7.1.4.3.12 General medical information, such as symptoms, medications and treatments for diagnostic categories common to the DSHP Plus population receiving case management;

3.7.1.4.3.13 General social service information, such as family dynamics, care coordination and conflict resolution;

3.7.1.4.3.14 Behavioral health information, including:

3.7.1.4.3.14.1 Common behavioral health conditions and identification of member's behavioral health needs;

3.7.1.4.3.14.2 Covered behavioral health services and additional services available through DSAMH and DSCYF;

3.7.1.4.3.14.3 How to refer and assist members in accessing behavioral health services;

3.7.1.4.3.14.4 Information on the PROMISE program, including but not limited to services provided, eligibility criteria and referral processes;

3.7.1.4.3.14.5 For members participating in PROMISE, coordination of care requirements, the role of the DSAMH care manager, how to engage the DSAMH care manager in the development of the plan of care and how to align the PROMISE services with the DSHP Plus LTSS benefit package.

3.7.1.4.3.15 The PASRR process that is completed by the State and the requirement for the Contractor to provide Specialized Services as specified by the State as part of the PASRR Level II process that are included in the DSHP or DSHP Plus LTSS benefit package;

3.7.1.4.3.16 EPSDT standards for members under the age of 21;

3.7.1.4.3.17 Case management techniques for managing individuals with special needs; and

3.7.1.4.3.18 Additional topics as directed by the State.

3.7.1.4.4 In addition to review of areas covered in the orientation, the Contractor must ensure that all case managers are provided with regular ongoing training on topics relevant to the population(s) served, including topics identified by the State. The following are examples of topics that could be covered:

3.7.1.4.4.1 Policy updates and new procedures;

3.7.1.4.4.2 Areas found deficient through the Contractor's or the State's monitoring process;

3.7.1.4.4.3 Interviewing skills;

3.7.1.4.4.4 Assessment/observation skills;

3.7.1.4.4.5 Cultural Competency;

3.7.1.4.4.6 Medical/behavioral health issues; and/or

3.7.1.4.4.7 Medications – side effects, contraindications and poly-pharmacy issues.

3.7.1.4.5 Training may be provided by external sources, for example by:

3.7.1.4.5.1 Consumer advocacy groups;

3.7.1.4.5.2 Providers (for example, medical or behavioral health); or

3.7.1.4.5.3 Accredited training agencies.

3.7.1.4.6 The Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources. This expert must assist case managers with up-to-date information designed to aid members in making informed decisions about their independent living options.

3.7.1.5 Caseload Management

3.7.1.5.1 The Contractor shall have an adequate number of qualified and trained case managers to meet the needs of DSHP Plus LTSS members.

3.7.1.5.2 The Contractor must ensure that newly Enrolled DSHP Plus LTSS members are assigned to a case manager immediately upon Enrollment. The case manager assigned to a special subpopulation (e.g., members with HIV/AIDS or ABI or PROMISE participants) must have experience or training in case management techniques for such population.

3.7.1.5.3 Any member receiving more than 8 hours of Private Duty Nursing per day will be assigned a Nurse Care Coordinator to assure clinical coordination and a Social Worker Care Coordinator to assist member and member's caregiver with coordination of services and benefits (e.g.,DME ordering, nursing agency shift coverage).

3.7.1.5.4 The Contractor must maintain case manager staffing ratios of:

3.7.1.5.4.1 1:120 for members living in nursing facilities; and

3.7.1.5.4.2 1:60 for members receiving HCBS (living in their own home or assisted living facility).

3.7.1.5.5 If the Contractor utilize the services of agencies to provide case management services for DSHP Plus LTSS members with HIV/AIDS who meet acute hospital LOC:

3.7.1.5.5.1 The agency's case manager staffing ratio must be 1:60 members; and

3.7.1.5.5.2 The Contractor's case manager staffing ratios must be 1:100 members.

3.7.1.5.6 The Contractor shall ensure that case management is provided at a level dictated by the complexity and required needs of the member, including coordination needed to implement a comprehensive plan of care that addresses all of the member's needs.

3.7.1.5.7 The Contractor shall ensure that each case manager's caseload does not exceed a weighted value of 120. The following formula represents the maximum number of members allowable per case manager:

3.7.1.5.7.1 For nursing facility members, a weighted value of 1 is assigned. Case managers may have up to 120 institutionalized members (120 x 1 =120).

3.7.1.5.7.2 For HCBS members (living in their own home or assisted living facility), a weighted value of 2 is assigned. Case managers may have up to 60 HCBS members (60 x 2 = 120).

3.7.1.5.7.3 If a mixed caseload is assigned, there can be no more than a weighted value of 120. The following formula is to be used in determining a case manager's mixed caseload:

3.7.1.5.7.3.1 (# of NF members x 1) + (# of HCBS members x 2) = 120 or less

3.7.1.5.7.4 The Contractor must receive authorization from the State prior to implementing caseloads whose values exceed those specified above. The Contractor may establish lower caseload sizes at its discretion without prior authorization from the State.

3.7.1.6 <u>Accessibility</u>

3.7.1.6.1 The Contractor shall provide members and member representatives with adequate information in order to be able to contact their case manager and the Contractor's member services information line for assistance, including what to do in cases of emergencies and/or after hours.

3.7.1.6.2 The Contractor must have a system of back-up case managers in place, and members who contact the Contractor when their case manager is unavailable must be given the opportunity to be referred to a back-up case manager for assistance.

3.7.1.6.3 The Contractor shall ensure that case managers respond to messages from members, member representatives, State agency representatives (e.g., DSAMH care managers) and providers within one business day.

3.7.1.7 Time Management

3.7.1.7.1 The Contractor must ensure that case managers are not assigned duties unrelated to member-specific case management for more than 15% of their time if they carry a full caseload.

3.7.1.8 Conflict of Interest

3.7.1.8.1 The Contractor must ensure that case managers do not provide direct, reimbursable services to members.

3.7.1.9 Supervision

3.7.1.9.1 The Contractor shall establish a supervisor to case manager ratio that provides a sound support structure for case managers. This includes having a ratio that provides supervisors with adequate time to train and review the work of newly hired case managers as well as provide support and guidance to established case managers.

3.7.1.10 Inter-Departmental Coordination

3.7.1.10.1 The Contractor shall establish and implement mechanisms to promote coordination and communication across disciplines and departments within its own organization, with particular emphasis on ensuring coordinated approaches with utilization management (UM) and quality management/quality improvement (QM/QI).

3.7.1.10.2 The Contractor must ensure the Long Term Services and Supports Chief Medical Officer (LTSS CMO) is available as a resource to case management and that he/she is advised of medical management issues as needed.

3.7.1.11 Monitoring and Reporting Requirements

3.7.1.11.1 *Case Management Plan*

3.7.1.11.1.1 The Contractor shall submit an annual Case Management Plan to the State (see Section 3.21 of this Contract). The plan must address how the Contractor will implement and monitor the administrative and case management standards outlined in Section 3.7 of this Contract. The plan must also describe the methodology for determining, assigning and monitoring case management caseloads. The plan must also include an evaluation of the Contractor's Case Management Plan from the previous year and highlight lessons learned and strategies for improvement.

3.7.1.11.2 *Monitoring*

3.7.1.11.2.1 The Contractor shall implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of member assessments/service authorizations (inter-rater reliability). The Contractor shall compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the Contractor has taken to resolve identified issues. This information shall be submitted to the State on a quarterly basis as specified in Section 3.21 of this Contract.

3.7.1.11.2.2 As part of the State's monitoring of the Contractor's case management program, the Contractor shall comply with the State's policy on joint visits. A joint visit is a visit with a DSHP member conducted by the Contractor's case manager with State staff in attendance. In accordance with the State's policy on joint visits, the Contractor shall provide complete list of scheduled visits to the State for the following week with the information and within the timeframe specified by the State.

3.7.2 **Case Manager Standards**

3.7.2.1 General

3.7.2.1.1 The Contractor's case managers shall provide case management for DSHP Plus LTSS members that facilitates integration of physical health, behavioral health, and LTSS through care planning to identify a member's needs and the appropriate services to meet those needs; arranging and coordinating services; facilitation and advocacy to resolve issues that impede access to needed services; and monitoring and reassessment of services based on changes in a member's condition.

3.7.2.1.2 For DSHP Plus LTSS members also participating in PROMISE, the DSHP Plus LTSS program case manager is the primary case manager. The DSHP Plus LTSS case manager shall initiate contact with the DSAMH care manager and continually coordinate and collaborate with the DSAMH care manager to ensure the development and implementation of a comprehensive plan of care

that addresses the member's needs, including incorporation of any PROMISE services that are needed by the member.

3.7.2.2 Initial Contact/Visit Standard

3.7.2.2.1 Within seven business days of a new DSHP Plus LTSS member's Enrollment date, the assigned case manager must initiate contact with the member or member representative. In addition, if the member resides in a nursing facility or other residential setting, the case manager, or designee, will contact the facility to inform the facility of the member's Enrollment. Initial contact may be made via telephone, a face-to-face visit or by letter, if the case manager is unable to contact the member by telephone or face-to-face. For PROMISE participants, the Contractor's case manager shall collaborate with the DSAMH care manager.

3.7.2.2.2 The case manager must complete an onsite visit to initiate care planning within 10 business days of the member's Enrollment date. If information obtained during the initial contact or from the PAE completed by the State during the eligibility determination indicates the member has more immediate needs for services, the onsite visit must be completed as soon as possible.

3.7.2.2.3 The onsite visit must be conducted at the member's place of residence or a hospital or nursing facility in order to develop the member's plan of care. The case manager must confirm the scheduled onsite visit with the member or the member representative prior to the meeting.

3.7.2.2.4 The member must be present for, and be included in, the onsite visit. If the member is unable to participate due to cognitive impairment, (e.g., members with ABI), the member is a minor child and/or the member has a legal guardian, the member representative must be present for and participate in the onsite visit.

3.7.2.2.5 The Contractor shall conduct at least three attempts over a period of 30 consecutive calendar days to contact the member. These attempts shall include at least two different methods of contact (telephone, visit, and/or letter) and contacting the member's relatives, neighbors, providers, including physicians, hospitals and nursing facilities or others for member contact information. If the Contractor is unable to contact the member within 30 calendar days from the member's Enrollment date, the Contractor shall complete the Member Change Report and submit it to DMMA's DSHP Plus LTSS eligibility unit for potential loss of contact.

3.7.2.2.6 The Contractor shall ensure that all contact attempted and made with, or regarding, a DSHP Plus LTSS member is documented in the member's electronic case record.

3.7.2.2.7 During the initial onsite visit, the case manager shall, at a minimum:

3.7.2.2.7.1 Conduct an interview and assessment to determine the member's needs and strengths (see Section 3.7.2.3 of this Contract, below).

3.7.2.2.7.2 Develop goals with the member (see Section 3.7.2.3 of this Contract, below).

3.7.2.2.7.3 Develop the member's plan of care (see Section 3.7.2.3 of this Contract, below).

3.7.2.2.7.4 Describe the DSHP Plus LTSS benefit package, including HCBS.

3.7.2.2.7.5 Explain case management services and the role of the case manager including:

3.7.2.2.7.5.1 Performing the needs assessment;

3.7.2.2.7.5.2 Participating in a nursing facility's care planning process;

3.7.2.2.7.5.3 Coordinating the member's physical health, behavioral health, and LTSS needs;

3.7.2.2.7.5.4 Conducting face-to-face visits, including onsite reviews; and

3.7.2.2.7.5.5 Determining the member's interest in transition to the community and the availability of services under the Contractor's nursing facility transition program.

3.7.2.2.7.6 Educate on all other aspects of case management (e.g., back-up plan, emergency contact information, disaster preparedness, obtaining equipment/supplies, etc.).

3.7.2.2.7.7 Provide education and guidance to assist in making informed decisions.

3.7.2.2.7.8 Educate on reporting Critical Incidents, abuse and neglect prevention and reporting, and Fraud, Waste and Abuse prevention and reporting.

3.7.2.2.7.9 Educate on reporting service gaps.

3.7.2.2.7.10 Provide information about how to contact and change the member's case manager, including, but not limited to, the procedure for making changes to the assigned case manager, whether initiated by the Contractor or requested by the member.

3.7.2.2.7.11 Provide information about the DSHP Plus Member Advocate, including, but not limited to, the role of the DSHP Plus Member Advocate and how to contact the DSHP Plus Member Advocate for assistance.

3.7.2.2.7.12 Provide information on the Contractor's member services information line and the 24/7 nurse triage/nurse advice line and the DSAMH behavioral health crisis toll-free hotline(s).

3.7.2.2.7.13 Provide information about the member's right to choose between nursing facility and HCBS if the member qualifies for nursing facility care and if the member's needs can be safely and effectively met in the community.

3.7.2.2.7.14 Explain the member's rights and responsibilities under the DSHP Plus program to the member or member representative, including the procedures for filing a Grievance and/or an Appeal. A copy of these rights and responsibilities must also be provided in writing (generally via the DSHP Plus Member Handbook). The case manager shall have the member or member representative sign and date a statement indicating that he/she has received the member rights and responsibilities in writing, that these rights and responsibilities have been explained to him or her and that he/she clearly understands them.

3.7.2.2.7.15 Obtain the member's or member representative's signature on appropriate forms.

3.7.2.3 Needs Assessment/Care Planning Standard

3.7.2.3.1 The Contractor's case managers shall use a person-centered and directed planning process to identify the strengths, capacities, and preferences of the member, as well as to identify the member's LTSS needs and how to meet those needs. The plan of care shall be developed by the member and/or member representative with the assistance of the case manager and those individuals the member chooses to include in the care planning process. In developing the plan of care, the case manager shall consult with any providers caring for the member, as appropriate. The plan of

care for HCBS members shall identify the services and supports that the member needs to live in the community including both Covered Services and non-Covered Services including additional services, Medicaid benefits provided by the State (see Section 3.4.10 of this Contract) or other non-Covered Services provided by the State or otherwise available in the community. For members residing in nursing facilities, the plan of care shall identify any additional services and supports the member receives in the nursing facility.

3.7.2.3.1.1 For PROMISE participants, the Contractor's case manager shall coordinate and collaborate with the DSAMH care manager to develop a plan of care that addresses all of the member's needs and incorporates services through the PROMISE program that are not available through the DSHP or DSHP Plus LTSS benefit packages. The DSAMH care manager shall be responsible for conducting the initial and annual assessment necessary for PROMISE eligibility determination, developing the member's plan of care for PROMISE, and obtaining authorization for PROMISE services.

3.7.2.3.2 Case managers shall:

3.7.2.3.2.1 Respect the member's rights;

3.7.2.3.2.2 Provide adequate information and guidance to assist the member and/or member representative in making informed decisions and choices;

3.7.2.3.2.3 Provide a continuum of service options that supports the expectations and agreements established through the care planning process;

3.7.2.3.2.4 Educate the member/family on how to report unavailability or other problems with service delivery to the Contractor in order that unmet needs can be addressed as quickly as possible;

3.7.2.3.2.5 Determine whether the member needs non-Covered Services, including additional services, Medicaid benefits provided by the State (see Section 3.4.10 of this Contract) or other non-Covered Services provided by the State or otherwise available in the community and, if so, provide information on the needed benefit(s)/service(s), make the appropriate referral, and facilitate access to such benefit(s)/service(s);

3.7.2.3.2.6 Advocate for the member and/or member representative as the need occurs;

3.7.2.3.2.7 Allow the member and/or member representative to identify his/her role in interacting with the service system;

3.7.2.3.2.8 Provide members with flexible and creative service delivery options;

3.7.2.3.2.9 Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering and monitoring services;

3.7.2.3.2.10 Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member; and

3.7.2.3.2.11 Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in the areas of housing (e.g., SRAP and the PRA Demo), education and employment (e.g., Pathways).

3.7.2.3.3 To the extent possible, the case manager must involve the member and/or member representative and the member's family in strengths/needs identification as well as decision making. The case manager must include the member, member representative, member's family, providers caring for the member, and/or significant others as partners in the development of the plan of care with the case manager as the facilitator.

3.7.2.3.4 The case manager's care planning shall be based on:

3.7.2.3.4.1 Face-to-face discussion with the member and/or member representative that includes a systematic approach to the assessment of the member's strengths and needs in at least the following areas:

3.7.2.3.4.1.1 Functional abilities;

3.7.2.3.4.1.2 Medical conditions;

3.7.2.3.4.1.3 Behavioral health;

3.7.2.3.4.1.4 Social/environmental/cultural factors; and

3.7.2.3.4.1.5 Existing support system.

3.7.2.3.4.2 Recommendations of the member's PCP;

3.7.2.3.4.3 Input from providers, as applicable; and

3.7.2.3.4.4 PAE available electronically from the State.

3.7.2.3.5 The Contractor shall ensure that a member's plan of care addresses all of a member's assessed needs (including health and safety risk factors) and personal goals.

3.7.2.3.6 Together, the case manager and member and/or member representative must develop goals that address the issues that are identified in the care planning process. Goals must be built on the member's strengths and include steps that the member will take to achieve the goal. Goals must be written to outline clear expectations about what is to be achieved through the service delivery and case management processes.

3.7.2.3.7 Member goals must:

3.7.2.3.7.1 Be member specific;

3.7.2.3.7.2 Be measurable;

3.7.2.3.7.3 Specify a plan of action/interventions to be used to meet the goals; and

3.7.2.3.7.4 Include a timeframe for the attainment of the desired outcome.

3.7.2.3.8 The Contractor must assess the cost-effectiveness of the package of services for all members with potential for placement in an HCBS setting and for those members currently placed in an institutional setting who have discharge potential.

3.7.2.4 Placement/Care Planning Standard

3.7.2.4.1 The case manager shall facilitate placement/services based primarily on the member's choice. Additional input regarding placement/services may come from the member's guardian/family/significant other, the case manager's assessment, the PAE, the member's PCP and/or other providers, and/or the DSAMH care manager.

3.7.2.4.2 One of the Contractor's guiding principles shall be that members be placed and/or maintained in the most integrated/least restrictive setting possible that meets all applicable Federal HCB settings requirements (42 CFR 441.301(c)(4).

3.7.2.4.3 After completing the needs assessment, the case manager must discuss needed services with the member and/or member representative, including Covered Services and non-Covered Services (which include additional services, Medicaid benefits

provided by the State (see Section 3.4.10 of this Contract) and other non-Covered Services provided by the State or otherwise available in the community)).

3.7.2.4.4 In determining the most appropriate service placement for the member, the case manager and the member and/or the member representative should discuss the following issues as applicable:

3.7.2.4.4.1 The member's placement choice;

3.7.2.4.4.2 Services necessary to meet the member's needs in the most integrated setting;

3.7.2.4.4.3 HCBS (see Section 3.4.3 of this Contract for a comprehensive list of HCBS);

3.7.2.4.4.4 Acute care services; and

3.7.2.4.4.5 Behavioral health services, including services that may be available under the PROMISE program that are not available through the DSHP Plus LTSS benefit package.

3.7.2.4.5 For members residing in a nursing facility, the case manager shall include documentation in the member's electronic case record to justify the lack of discharge potential and that the nursing facility is the most appropriate placement.

3.7.2.4.6 Using current information regarding the Contractor's provider network, the case manager shall provide the member and/or member representative with a choice of participating providers.

3.7.2.4.7 The case manager shall discuss with the member the option for the member to self-direct his/her attendant care services (see Section 3.8.7 of this Contract) and document the discussion and the member's decision in the electronic case record. The case manager's responsibilities related to Self-Directed Attendant Care Services include:

3.7.2.4.7.1 Informing and educating members and/or member representatives about the option for Self-Directed Attendant Care Services including having the member complete a self-assessment (see Section 3.8.7.2 of this Contract) verifying that members electing this option understand their roles and responsibilities.

3.7.2.4.7.2 Referring interested members and/or member representatives to the Contractor's provider of support for Self-Directed Attendant Care Services (see Section 3.8.7 of this Contract) for

further information about and/or facilitating member participation in Self-Directed Attendant Care Services.

3.7.2.4.7.3 Advising the member as needed regarding the hiring and training of the Attendant Care Employee.

3.7.2.4.7.4 Assisting the member to assess training needs for his/her Attendant Care Employee and authorizing training as appropriate.

3.7.2.4.7.5 Assisting the member as needed in finding a replacement for his/her Attendant Care Employee (generally from an agency) to provide services when the member reports that the Attendant Care Employee is unavailable and the member requests assistance.

3.7.2.4.7.6 Ensuring that services are provided within the timelines specified by the member's schedule of services.

3.7.2.4.7.7 Facilitating any needed transition from the self-directed attendant care service option to traditional service delivery system or transition back to self- directed attendant care when requested and appropriate.

3.7.2.4.8 The case manager shall explain to the member and/or member representative what Covered Services are associated with care in a nursing facility compared to services provided in the member's home or another HCBS setting.

3.7.2.4.9 Upon the member's or member representative's agreement to the plan of care, the case manager is responsible for coordinating the services with the selected providers.

3.7.2.4.10 The Contractor shall ensure that placement in an appropriate setting and/or provision of all services to meet the member's needs occurs as soon as possible. A decision regarding the provision of services requested must be made within 14 calendar days following the receipt of the request/order (three business days if the member's life, health or ability to attain, maintain or regain maximum function would otherwise be jeopardized) (see 42 CFR 438.210).

3.7.2.4.11 Services determined to be Medically Necessary must be provided to the member within 14 calendar days of the onsite visit during which the need for the service was determined.

3.7.2.4.12 The Contractor shall ensure that services are provided in accordance with the member's plan of care, including the type,

scope, amount, and frequency, including the member's service schedule. The Contractor shall develop a standardized system for verifying and documenting the delivery of services with the member and/or member representative after authorization (see Section 3.16.3 of this Contract).

3.7.2.4.13 The case manager must ensure that the member or member representative understands that some services (such as home health nurse, home health aide or DME) must be prescribed by the member's PCP. The Contractor shall not make a decision about the Medical Necessity of these services until the PCP writes an order for them. All orders for medical services must include the frequency, duration and scope of the service(s) required, when applicable.

3.7.2.4.14 If a member does not have a PCP or wishes to change his/her PCP, it is the case manager or designee's responsibility to coordinate the effort to obtain a PCP or to change the PCP.

3.7.2.4.15 The case manager must verify that the needed services are available in the member's community. If a service is not currently available, the case manager must substitute a combination of other services in order to meet the member's needs until such time as the desired service becomes available (for example, a combination of home health aide and homemaker services may substitute for attendant care). A temporary alternative placement may be needed if services cannot be provided to safely meet the member's needs.

3.7.2.4.16 The case manager is responsible for developing a written plan of care that reflects services that will be authorized.

3.7.2.4.17 The plan of care must:

3.7.2.4.17.1 Include an assessment of member's strengths and needs in at least the following areas:

3.7.2.4.17.1.1 Functional abilities;

3.7.2.4.17.1.2 Medical conditions;

3.7.2.4.17.1.3 Behavioral health;

3.7.2.4.17.1.4 Social/environmental/cultural factors; and

3.7.2.4.17.1.5 Existing support system.

3.7.2.4.17.2 Include the member's service plan (see Section 3.7.1.3.4 of this Contract, above).

3.7.2.4.17.3 Identify non-Covered Services such as additional services, benefits/services provided through Medicaid FFS (see Section 3.4.10 of this Contract), another State program, or community resources.

3.7.2.4.17.4 Identify the member's goals.

3.7.2.4.17.5 Document the process for member Grievance and Appeals and clearly explain the timeframes and process to the member.

3.7.2.4.17.6 Note for each service whether the frequency/quantity of the service has changed since the previous plan of care.

3.7.2.4.18 The member or member representative must indicate whether he/she agrees or disagrees with each service authorization and sign the plan of care at initial development, when there are changes in services and at the time of each onsite review (every 90 or 180 calendar days). The case manager must provide a copy of the plan of care to the member or member representative and maintain a copy in the member's electronic case record.

3.7.2.4.19 If the member disagrees with the assessment and/or authorization of placement/services (including the amount and/or frequency of a service), the case manager must provide the member with a written Notice of Adverse Benefit Determination (see Section 3.15.2 of this Contract).

3.7.2.4.20 The case manager shall complete a back-up plan for any member who will receive in-home HCBS or in-home nursing services (in-home services).

3.7.2.4.21 The back-up plan shall be developed to address any gaps in in-home services. A gap in in-home services is defined as the difference between the number of hours of in-home services approved in a member's plan of care for a service and the number of hours of the in-home service that are actually delivered to the member.

3.7.2.4.22 The following situations are not considered gaps:

3.7.2.4.22.1 The member is not available to receive the service when the provider/employee arrives at the member's home at the scheduled time;

3.7.2.4.22.2 The member refuses the provider/employee when he/she arrives at the member's home at the scheduled time, unless the provider/employee's ability to accomplish the assigned duties is significantly impaired by the provider/employee's condition or state (for example, drug and/or alcohol intoxication);

3.7.2.4.22.3 The member refuses services;

3.7.2.4.22.4 The provider agency or case manager is able to find an alternative provider/employee for the scheduled service at the scheduled time when the regular provider/employee becomes unavailable;

3.7.2.4.22.5 The member and regular provider/employee agree in advance to reschedule all or part of a scheduled service; and/or

3.7.2.4.22.6 The provider/employee refuses to go or return to an unsafe or threatening environment at the member's residence.

3.7.2.4.23 The back-up plan must include information about actions that the member and/or member representative should take to report any gaps and what resources are available to the member, including on-call back-up provider/employees and the member's informal support system, to resolve unforeseeable gaps (e.g., regular provider/employee illness, resignation without notice, transportation failure, etc.) within three hours unless otherwise indicated by the member (see "member service preference level" below). The informal support system must not be considered the primary source of assistance in the event of a gap, unless this is the member's/family's choice. An out-of-home placement in a nursing facility or assisted living facility should be the last resort in addressing gaps.

3.7.2.4.24 The back-up plan must include the telephone numbers for the appropriate provider and/or the Contractor's member services information line and nurse triage/nurse advice line that will be responded to promptly 24 hours a day, seven days a week.

3.7.2.4.25 In those instances where an unforeseeable gap in in-home services occurs, the Contractor shall ensure that in-home services are provided within three hours of the report of the gap. If the provider agency or case manager is able to contact the member or member representative before the scheduled service to advise him/her that the regular provider/employee will be unavailable, the member or member representative may choose to receive the service from a back-up substitute provider/employee, at an alternative time from the regular provider/employee or from an alternate

provider/employee from the member's informal support system. The member or member representative has the final say in how (informal versus paid) and when care to replace a scheduled provider/employee who is unavailable will be delivered.

3.7.2.4.26 When the provider or the Contractor is notified of a gap in in-home services, the member or member representative must receive a response acknowledging the gap and providing a detailed explanation as to the reason for the gap, and the alternative plan being created to resolve the particular gap and any possible future gaps.

3.7.2.4.27 The written back-up plan for members receiving in-home services must include a "member service preference level" from one of the four categories shown below:

3.7.2.4.27.1 Needs service within three hours;

3.7.2.4.27.2 Needs service within 24 hours;

3.7.2.4.27.3 Needs service within 48 hours; or

3.7.2.4.27.4 Can wait until the next scheduled service date.

3.7.2.4.28 The member's member service preference levels must be developed in cooperation with the member and/or member representative and be based on the most critical in-home service that is authorized for the member. The member service preference level indicates how quickly the member chooses to have a service gap filled if the scheduled provider/employee of that critical service is not available. The member or member representative must be given the final say about how (informal versus paid) and when care to replace a scheduled provider/employee who is unavailable will be delivered.

3.7.2.4.29 The case manager must assist the member or member representative in determining the member's member service preference level by discussing the member's needs associated with his/her ADLs and IADLs, abilities and cognitive, behavioral and medical status. The case manager should ensure the member or member representative has considered all appropriate factors in deciding the member's member service preference level. The member and/or member representative is not required to take into account the presence of an informal support system when determining the member service preference level.

3.7.2.4.30 The case manager must document the member service preference level chosen in the member's back-up plan and electronic case

record. The documentation in the member's electronic case record must clearly indicate the member's or member representative's involvement in contingency/back-up planning.

3.7.2.4.31 A member or member representative can change the member service preference level from a previously determined member service preference level at the time of the service gap, depending on the circumstances at the time. The provider agency or Contractor must discuss the current circumstances with the member or member representative at the time the gap is reported to determine if there is a change in the member service preference level. The plan to resolve the service gap must address the member's choice of member service preference level and how the service gap will be addressed at the time the gap is reported.

3.7.2.4.32 The back-up plan must be discussed with the member or member representative at least quarterly. A copy of the back-up plan must be given to the member when developed and at the time of each review visit. The member or member representative may change the member service preference level and his/her choices for how service gaps will be addressed at any time.

3.7.2.4.33 The case manager shall encourage, and assist as needed, members receiving HCBS to have a disaster/emergency plan for their household that considers the special needs of the member. Informational materials are available at the Federal Emergency Management Agency's website at www.fema.gov or www.ready.gov. The case manager shall also encourage HCBS members to register with the State's Emergency Preparedness Voluntary Registry. For more information go to http://www.de911assist.delaware.gov/.

3.7.2.4.34 The case manager shall regularly assess members who reside in out-of-home residential placements to determine if they are in the most integrated setting possible to meet their needs.

3.7.2.4.35 If a member will be admitted to a nursing facility, the case manager must ensure and document that a PAE and PASRR have been submitted to the State prior to admission.

3.7.2.4.36 If a member does not intend to pursue receiving HCBS or institutional services, the Contractor must encourage the member to withdraw from the DSHP Plus program voluntarily. In addition, the Contractor must immediately notify the State.

3.7.2.4.37 A member's plan of care must include the date range and units for each service authorized.

3.7.2.4.38 Plans of care for members residing in a nursing facility must include the following types of services, as appropriate based on the member's needs:

3.7.2.4.38.1 Nursing facility services – The plan of care must indicate the LOC based on the PAE and any Specialized Services specified by the State as part of the Level II PASRR process;

3.7.2.4.38.2 Hospital admissions (acute and psychiatric);

3.7.2.4.38.3 Temporary absences for hospitalization (Bed Hold Days), which shall be up to seven days within any 30calendar day period;

3.7.2.4.38.4 Temporary absences for reasons other than hospitalization (Therapeutic Leave Days), which shall be up to 18 calendar days per year;

3.7.2.4.38.5 DME not included in the institutional facility per diem;

3.7.2.4.38.6 Hospice services;

3.7.2.4.38.7 Therapies (occupational, physical and speech);

3.7.2.4.38.8 Medically Necessary non-emergency medical transportation;

3.7.2.4.38.9 Behavioral health services, including Specialized Services for Nursing Facility Residents with Mental Illness that are specified by the State as part of the Level II PASRR process;

3.7.2.4.38.10 Other services listed in Section 3.4.3 of this Contract (the DSHP Plus LTSS benefit package); and

3.7.2.4.38.11 Title XIX Covered Services as noted above if provided by other funding sources, for example, Medicare and other insurance sources.

3.7.2.4.39 Plans of care for members residing in an HCBS setting must include the following types of services, as appropriate, based on the member's needs:

3.7.2.4.39.1 Adult day services;

3.7.2.4.39.2 Hospital admissions (acute and psychiatric);

3.7.2.4.39.3 Attendant care services (including Self-Directed Attendant Care Services);

3.7.2.4.39.4 DME not included in the facility's per diem;

3.7.2.4.39.5 Emergency response systems;

3.7.2.4.39.6 Day Habilitation;

3.7.2.4.39.7 Home delivered meals;

3.7.2.4.39.8 Home health aide;

3.7.2.4.39.9 Hospice;

3.7.2.4.39.10 Respite care, including nursing facility respite;

3.7.2.4.39.11 Therapies (occupational, physical, speech, and/or respiratory);

3.7.2.4.39.12 Behavioral health services, including PROMISE services for members also participating in the PROMISE program;

3.7.2.4.39.13 Services provided through Pathways for members participating in Pathways;

3.7.2.4.39.14 Medically Necessary non-emergency medical transportation;

3.7.2.4.39.15 Non-Covered Services, such as additional services, Medicaid benefits to be provided by the State (see Section 3.4.10 of this Contract) and other non-Covered Services to be provided by the State or in the community;

3.7.2.4.39.16 Home modifications;

3.7.2.4.39.17 Cognitive services;

3.7.2.4.39.18 Assisted living facility services;

3.7.2.4.39.19 Nutritional supplements for individuals diagnosed with HIV/AIDS that are not covered under the State Plan (this service is not available to persons residing in assisted living facilities);

3.7.2.4.39.20 Other services listed in Section 3.4.3 of this Contract (DSHP Plus LTSS benefit package); and

3.7.2.4.39.21 Title XIX services as noted above, if provided by other funding sources, for example, Medicare, other insurance sources.

3.7.2.4.40 The Contractor shall refer to Section 3.4.2 of this Contract for descriptions of the amount, duration and scope of services included in the DSHP Plus LTSS benefit package, including information about restrictions on the combination of services.

3.7.2.5 Plan of Care Monitoring and Revision

3.7.2.5.1 The case manager shall provide ongoing monitoring of the services and placement of each member in order to assess the continued appropriateness of the services and placement in meeting the member's needs, monitor appropriate implementation of the member's plan of care, including the type, scope, amount and frequency of services; and monitor the quality of the care delivered by the member's providers.

3.7.2.5.2 The case manager shall review member placement and services onsite, with the member and/or member representative present, within the following timeframes:

3.7.2.5.2.1 At least every 180 calendar days for a member in an institutional setting (this includes members receiving hospice services and those in a nursing facility).

3.7.2.5.2.2 At least every 90 calendar days for a member receiving HCBS, including members residing in assisted living facilities.

3.7.2.5.2.3 At least every 90 calendar days for a community-based DSHP Plus LTSS member with HIV/AIDS receiving acute care services only. Monitoring of acute care services for these members may be conducted onsite, via telephone or by certified letter. However, an onsite visit with the member must be completed at least once a year.

3.7.2.5.3 The Contractor may develop standards for more frequent onsite reviews of specific types of members/placements at its discretion but may not determine members to need less frequent visits than specified above.

3.7.2.5.4 The case manager must attend all nursing facility care conferences as an opportunity to discuss the member's needs and services jointly with the member, providers and the member's family.

3.7.2.5.5 During the onsite review for a member in an institutional setting, the case manager shall consult with facility staff to assess changes in member needs.

3.7.2.5.6 The case manager must conduct onsite reviews at the member's residence. A review conducted at a site other than the member's place of residence must be at the request of the member or member representative, not just for the convenience of the case manager. If an alternate site is used, the rationale must be documented in the member's electronic case record. The case manager should make every effort to see members in their homes in order for the case

manager to assess the living environment and evaluate potential barriers to quality care. Reviews at an alternative site should be the exception.

3.7.2.5.7 The case manager must follow up with members between onsite reviews to monitor the status of the delivery of approved services and any changes to the member's needs or circumstances. This shall include, at a minimum, monthly contacts by telephone.

3.7.2.5.8 The case manager shall conduct more frequent case monitoring when the case manager is notified of an urgent/emergent need or a change in the member's needs or circumstances that might require revisions to the existing plan of care.

3.7.2.5.9 The case manager shall conduct an emergency visit/onsite review when the situation is urgent and cannot be handled over the telephone or when the case manager has reason to believe that the member's health or safety is endangered.

3.7.2.5.10 If a member's Pathways employment navigator contacts the Contractor/the case manager about a member, the case manager shall coordinate with the employment navigator to exchange information about the member's needs (e.g., from the member's LOC and/or needs assessment) and services and coordinate coverage of services provide by Pathways that are included in the DSHP Plus LTSS benefit package (e.g., personal care/attendant care services). The case manager shall include information on the member's Pathways services in the member's plan of care.

3.7.2.5.11 If the Contractor or case manager is notified that a member is participating in PROMISE, the case manager must contact the DSAMH care manager within five business days of notification to exchange information about the member's needs and services and to coordinate and collaborate on the development and implementation of a comprehensive plan of care, including the provision of Covered Services that are also provided through PROMISE. As appropriate, the case manager shall schedule a call or onsite visit with the member and/or member representative and the DSMAH care manager within 15 business days of notification to update the member's plan of care.

3.7.2.5.12 The case manager must conduct an onsite review within 10 business days following a member's change of placement type (for example, from HCBS to an institutional setting, own home to assisted living facility or institutional setting to HCBS) or a change in a member's needs or circumstances that might require revisions to the member's plan of care or from the date the case

manager is made aware of such a change. The case manager shall conduct this review to ensure that appropriate services are in place and that the member agrees with the plan of care as authorized.

3.7.2.5.13 The Contractor shall ensure that a member is not discharged to his/her own home until adequate services can be arranged to begin at the time of the transition to home.

3.7.2.5.14 The case manager shall conduct at least three attempts over a period of 30 consecutive calendar days to contact the member to schedule an onsite review in accordance with Section 3.7.2.2.5 of this Contract, above. If the Contractor is unable to contact the member within 30 calendar days, the Contractor shall complete the Member Change Report and submit it to DMMA's DSHP Plus LTSS eligibility unit for potential loss of contact. Disenrollment will not occur if the State is able to make contact with the member or member representative and confirm that the member does not wish to withdraw from DSHP Plus.

3.7.2.5.15 During the onsite reviews the case manager shall meet with the member and/or member representative in order to:

3.7.2.5.15.1 Discuss the type, scope, amount, frequency and providers of authorized services.

3.7.2.5.15.2 Assess the member's current functional, medical, behavioral and social strengths and needs.

3.7.2.5.15.3 Re-evaluate the LOC of HCBS members at least annually using a LOC re-evaluation form prior approved by the State.

3.7.2.5.15.4 Determine the appropriateness of the member's current placement/services in meeting his/her needs, including the discharge potential of members residing in a facility.

3.7.2.5.15.5 Review non-Covered Services that the member is receiving, such as additional services, Medicaid benefits being provided by the State (see Section 3.4.10 of this Contract) and non-Covered Services being provided by the State or in the community.

3.7.2.5.15.6 Assess the member's family/informal support system, or community resources and their availability to assist the member, including barriers to assistance and any changes to the member's support system or community supports.

3.7.2.5.15.7 Assess the member's living environment and evaluate potential barriers to quality care and any modifications necessary to ensure the member's health and safety.

3.7.2.5.15.8 Revise/update the member's plan of care (see Section 3.7.2.5 of this Contract).

3.7.2.5.15.9 Discuss the member's progress toward established goals.

3.7.2.5.15.10 Identify any barriers to the achievement of the member's goals.

3.7.2.5.15.11 Evaluate the member's goals for appropriateness.

3.7.2.5.15.12 Adjust or develop new goals or interventions as needed.

3.7.2.5.15.13 For members receiving in-home HCBS or in-home nursing services, review the Contractor's process for the member or member representative to immediately report any gaps in service delivery to the Contractor and/or provider and the member's back-up plan.

3.7.2.5.15.14 Review, at least annually, the Contractor's member handbook to ensure members and member representatives are familiar with the contents, especially as related to Covered Services and their rights/responsibilities.

3.7.2.5.15.15 Identify any issues, including service issues and/or unmet needs and develop an action plan to address them promptly. The case manager must quickly assess/identify a problem or situation as urgent or as a potential emergency and take appropriate action.

3.7.2.5.15.16 Assess that members continue receiving services in appropriate HCB settings using the process and/or tools prescribed by DMMA.

3.7.2.5.16 The member representative must be involved in the onsite review if the member is unable to participate due to a cognitive impairment, if the member is a minor child and/or if the member has a legal guardian.

3.7.2.5.17 If the member is not capable of making his/her own decisions, but does not have a representative, the case manager must refer the case to the Public Guardian or other available resource. If a representative is not available, the reason must be documented in the member's electronic case record.

3.7.2.5.18 The case manager must complete a written plan of care at the time of the initial visit and must update the plan of care (i) when there are any changes in the member's circumstances or needs, (ii) at the request of the member, and (iii) at the time of each onsite review (every 90 or 180 calendar days). The member or member representative must indicate whether he/she agrees or disagrees with each service authorization and must sign the plan of care each time it is updated. The member must be given a copy of each signed plan of care.

3.7.2.5.19 The Contractor shall permit members to request a change to their plan of care at any time.

3.7.2.5.20 The State will re-evaluate the LOC for members residing in a nursing facility. The case manager shall assess HCBS members at least annually to re-evaluate their LOC. If the case manager determines that a member no longer meets LOC, the Contractor shall provide the LOC re-determination documentation to the State for review.

3.7.2.5.21 Prior to an HCBS member being admitted to a nursing facility, the case manager shall complete the PAE and submit it to the State to determine whether the member meets the nursing facility LOC and may be admitted.

3.7.2.5.22 The case manager shall contact the member's PCP at least quarterly to discuss the PCP's assessment of the member's needs and status. However, if an issue is identified by the member or member representative or case manager, the case manager shall contact the member's PCP within 24 hours or as expediently as needed to address the issue.

3.7.2.5.23 The case manager shall contact the member's HCBS providers at least annually to discuss their assessment of the member's needs and status. However, if an issue is identified by the member or member representative or case manager, the case manager shall contact the member's HCBS providers as soon as possible to address the issue.

3.7.2.5.24 If a member is receiving skilled nursing care from a home health agency, the case manager shall contact the home health provider every 60 calendar days.

3.7.2.5.25 If a member is receiving behavioral health services, and not participating in the PROMISE program, the case manager shall contact the behavioral health provider at least quarterly to discuss the provider's assessment of the member's needs and status. The

case manager must ensure there is communication between the PCP and behavioral health providers involved in the member's care at least annually and that care is coordinated with other agencies and involved parties.

3.7.2.5.26 For PROMISE participants, the Contractor's DSHP Plus LTSS case manager shall contact the member's DSAMH care manager at least quarterly to collaborate and to coordinate services necessary to meet the member's needs. However, if an issue is identified by the member, member representative, or DSHP Plus LTSS case manager, the case manager shall contact the member's DSAMH care manager within 24 hours or as expediently as needed to address the issue.

3.7.2.5.27 The case manager is responsible for coordinating physician's orders for those medical services requiring a physician's order.

3.7.2.5.28 If the case manager and PCP or attending physician do not agree regarding the need for a change in level of services, placement or physician's orders for medical services, the case manager shall refer the case to the Contractor's LTSS CMO for review. The LTSS CMO is responsible for reviewing the case, discussing it with the PCP and/or attending physician if necessary, and making a determination in order to resolve the issue.

3.7.2.5.29 If the case manager determines that changes in placement or services are indicated, the case manager must discuss the indicated changes with the member and/or member representative before any changes are initiated. This is especially critical if the changes result in a reduction or termination of services.

3.7.2.5.30 The Contractor shall notify a member or member representative in writing of any denial, reduction, termination or suspension of services, when the member or member representative has indicated, on the plan of care, that he/she disagrees with the type, amount, or frequency of services to be authorized (see Section 3.15 of this Contract).

3.7.2.5.31 The case manager must be aware of the following regarding members eligible to receive hospice services:

3.7.2.5.31.1 Members may elect to receive hospice services. These services may be covered by private insurance or Medicare, if the member has Part A, or by the Contractor if there is no other payor source available.

3.7.2.5.31.2 The Medicare hospice benefit is divided into two 90-calendar day election periods. Thereafter, the member may continue to

receive hospice care in 60-calendar day increments. A physician must recertify hospice eligibility at the beginning of each election period.

3.7.2.5.31.3 The member has the right to revoke the election of Medicare hospice care at any time during the election period and resume DSHP Plus coverage; however, any remaining days of coverage are then forfeited for that election period.

3.7.2.5.31.4 A member may at any time elect to receive Medicare hospice coverage for any other hospice election periods for which he/she is eligible.

3.7.2.5.31.5 The hospice agency is responsible for providing Covered Services to meet the needs of the member related to the member's hospice-qualifying condition. The Contractor shall not provide Covered Services to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits. Attendant care services (including Self-Directed Attendant Care Services) is not considered a duplicative service. If the hospice agency is unable or unwilling to provide or cover Medically Necessary services related to the hospice diagnosis, the Contractor must provide the services. The Contractor may report such cases to the State's licensing agency.

3.7.2.5.31.6 The case manager must communicate with the hospice case manager on transition and end of life care needs as needed to ensure coordination and continuity of services.

3.7.2.5.32 For members receiving HCBS, the case manager shall assess member experience and provider compliance with Federal HCB settings requirements during quarterly face-to-face touch point meetings with members, using the process and tools prescribed by DMMA. The case manager's assessment is intended to determine ongoing provider compliance with Federal HCB settings requirements and shall touch on issues including but not limited to: members' community access, services, living space, and interactions with provider staff.

3.7.2.5.32.1 If a case manager determines that a member may be receiving HCBS in a setting that is not compliant with the Federal HCB settings requirements (42 CFR 441.301(c)(4)), the case manager shall notify the appropriate Contractor staff within 24 hours of identifying potential non-compliance.

3.7.2.5.32.1.1 The Contractor shall ensure that the setting is reviewed to determine if it is compliant with all applicable Federal HCB settings requirements, using the process developed by DMMA.

3.7.2.5.32.1.2 In the event the Contractor confirms the provider is not compliant:

3.7.2.5.32.1.2.1 The Contractor shall report the non-compliant provider to DMMA in writing within 48 hours of confirmation of the compliance issue(s), using the Move IT file transfer system.

3.7.2.5.32.1.2.2 The Contractor shall document the identified compliance issue(s) and notify the provider of the Contractor's findings. The Contractor shall work with the provider to develop a corrective action plan to address the compliance issue(s).

3.7.2.5.32.1.2.3 The Contractor shall provide a full written report to DMMA within 10 business days of identifying the non-compliant provider including, at minimum, information regarding the identified issue(s), the Contractor's findings by the Contractor, and any corrective action plan to remediate the issue(s). DMMA shall review and approve all provider corrective action plans.

3.7.2.5.32.1.2.4 The Contractor shall monitor the provider's implementation of the corrective action plan to ensure timely and appropriate action is taken. Upon completion of the corrective action plan, the Contractor shall ensure the setting is reviewed to determine if it is compliant with all applicable Federal HCB settings requirements. DMMA will develop the monitoring process and provide it to the Contractor.

3.7.2.5.32.1.2.5 The Contractor shall cooperate with the State in documenting, reviewing and addressing non-compliant providers.

3.7.2.5.32.1.2.6 The Contractor shall work with the provider to ensure that the non-compliant issue(s) is completely remediated within 60 calendar days of identifying the issue(s).

3.7.2.5.32.1.3 The Contractor shall collect and analyze data regarding non-compliant providers, track and identify trends, identify root causes, and make necessary changes in order to prevent reoccurrence.

3.7.2.5.32.2 In the event the compliance issue(s) cannot be resolved, and the Contractor determines the setting is not compliant with the Federal HCB settings requirements:

3.7.2.5.32.2.1 The case manager shall work with the member to ensure continuity of care and transition to a new provider as appropriate.

3.7.2.5.32.2.2 The case manager shall educate the member about the relocation process, timeframes and the member's rights. The case manager shall work with the member to find alternative placements. The case manager shall support the member in making an informed choice of providers from alternatives that comply with the Federal HCB settings requirements and provide the necessary assistance to ensure this occurs. In determining alternative placements, the case manager shall consider the member's preferences, interests and needs.

3.7.2.5.32.2.3 The Contractor shall send to the member and/or the member's caregiver or member's representative a formal notification letter no less than 30 calendar days prior to relocation that outlines the specific reason for the relocation and the relocation process and timeline. The notification letter shall follow the guidelines for member materials in Section 3.14.1.2. The Contractor shall also send the member's current provider a notification letter no less than 45 calendar days prior to relocation indicating the intent to relocate the member. The letter shall direct the provider to participate with DMMA, the Contractor, and other entities, as appropriate, in activities related to relocating the member.

3.7.2.5.32.2.4 The case manager shall ensure that all services are in place in advance of the member's relocation and then monitor the transition to ensure successful placement and continuity of services. The case manager shall conduct an onsite review of the member's new setting prior to the member's relocation. The case manager shall touch base with members within the first 30 calendar days following transition, 90 calendar days after transition and ongoing

as part of regularly scheduled visits to monitor the success of the transition.

3.7.2.5.32.2.5 The case manager shall update the service plan as appropriate at all stages of the relocation process to note any identified issues and follow-up activities required with the member or the member's providers.

3.7.2.6 Electronic Case Record Standards

3.7.2.6.1 The Contractor shall maintain an electronic case management system and ensure that a member's electronic case record is complete and accurate. The Contractor's electronic case record system must be capable of printing out complete case records in a specified order for purposes of case file review by the Contractor or the State.

3.7.2.6.2 The Contractor must adhere to State and Federal confidentiality, privacy and security standards, including HIPAA.

3.7.2.6.3 The Contractor's case management system shall document the beginning and end dates of Covered Services and additional services listed in a member's plan of care. This documentation shall include the renewal of services and the number of units authorized for services.

3.7.2.6.4 A member's electronic case record must include, at a minimum:

3.7.2.6.4.1 Member demographic information, including residence address and telephone number, and the emergency contact person and his/her telephone number.

3.7.2.6.4.2 Identification of the member's PCP.

3.7.2.6.4.3 Information from 90/180 day onsite reviews (see Section 3.7.2.5 of this Contract), including, but not limited to:

3.7.2.6.4.3.1 Member's current functional, medical, behavioral and social strengths, needs, goals and plans.

3.7.2.6.4.3.2 The appropriateness of member's current placement/services in meeting his/her needs, including the discharge potential of members residing in a facility.

3.7.2.6.4.3.3 Identification of family/informal support system or community resources and their availability to assist the member, including barriers to assistance and any changes to the member's support system or community supports.

3.7.2.6.4.3.4 Identification of any issues, including service issues and/or unmet needs, an action plan to address them and documentation of timely follow-up and resolution.

3.7.2.6.4.3.5 Documentation of progress towards each goal.

3.7.2.6.4.3.6 Member's ability to participate in the review and/or who the case manager discusses service needs and goals with if the member was unable to participate.

3.7.2.6.4.3.7 Environmental and/or other special needs.

3.7.2.6.4.4 Information from the initial onsite assessment that includes all items listed in Section 3.7.2 of this Contract, above.

3.7.2.6.4.5 Copies of the member's placement history and plans of care/authorizations. The plan of care must be signed by the member or member representative at each service review visit (every 90 or 180 calendar days) and a copy kept in the file.

3.7.2.6.4.6 A copy of the back-up plan and other documentation that indicates the member or member representative has been advised regarding how to report unplanned gaps in authorized services to the Contractor and/or provider.

3.7.2.6.4.7 Documentation of the choice of Self-Directed Attendant Care Services.

3.7.2.6.4.8 Notices of Adverse Benefit Determination sent to the member regarding denial or changes of services (discontinuance, termination, reduction or suspension).

3.7.2.6.4.9 Member-specific correspondence.

3.7.2.6.4.10 Physician's orders for medical services and equipment.

3.7.2.6.4.11 A copy of the member's PAEs and PASRR, if applicable.

3.7.2.6.4.12 Provider evaluations/assessments and/or progress reports (for example, home health, therapy, behavioral health).

3.7.2.6.4.13 Case notes including documentation of the type of contact made with the member and/or all other persons who may be involved with the member's care (for example, providers).

3.7.2.6.4.14 Documentation of the quarterly contact with the behavioral health provider and with the DSAMH care manager if the member is also participating in the PROMISE program.

3.7.2.6.4.15 Documentation of any coordination with the Contractor's DSHP Plus Member Advocate on behalf of the member.

3.7.2.6.4.16 Other documentation as required by the Contractor.

3.7.2.6.5 The Contractor shall maintain electronic case records for a minimum of ten years and in accordance with State and Federal confidentiality, privacy, and security law, including, but not limited to, HIPAA.

3.7.2.7 Service Closure Standard

3.7.2.7.1 Closure of a member's service(s) may occur for several different reasons. The following is a list of the most common reasons. This list is not meant to be all- inclusive:

3.7.2.7.1.1 The member is no longer DSHP Plus eligible, as determined by the State.

3.7.2.7.1.2 The member is deceased.

3.7.2.7.1.3 The case manager and/or physician determine that a service is no longer necessary.

3.7.2.7.1.4 The member or member representative requests discontinuance of the service(s) or refuses services.

3.7.2.7.1.5 The member moves out of State.

3.7.2.7.1.6 Contact has been lost with the member (see Sections 3.7.2.2.5 and 3.7.2.5.14 of this Contract).

3.7.2.7.2 The case manager shall provide community referral information on available services and resources to meet the needs of members who are no longer eligible for DSHP Plus.

3.7.2.7.3 If the member has been determined ineligible for DSHP Plus, the member or member representative will be informed of this action and the reason(s), in writing, by the State. This notification will provide information about the member's rights regarding that decision.

3.7.2.7.4 If a service is closed because the Contractor has determined that it is no longer Medically Necessary, the member must be given a written Notice of Adverse Benefit Determination that complies with Section 3.15.2 of this Contract.

3.7.2.7.5 When a member Transfers to another MCO, the case manager must coordinate a Transfer to the receiving MCO. This includes completing and providing the member transfer form specified by the State and transferring electronic case records from the prior 12 months to the receiving MCO.

3.7.2.7.6 The case manager shall notify and coordinate with the member's providers to assure a thorough discharge planning process.

3.7.2.7.7 The case manager shall update the member's electronic case record to reflect service closure activity, including, but not limited to:

3.7.2.7.7.1 Reason for the closure;

3.7.2.7.7.2 Member's status at the time of the closure; and

3.7.2.7.7.3 Referrals to community resources if the member is no longer DSHP Plus LTSS eligible.

3.7.2.7.8 A member who is Disenrolling from DSHP Plus as no longer eligible will remain Enrolled in the Contractor's MCO through at least the end of the month in which Medicaid eligibility is terminated.

3.7.2.7.9 The Contractor is responsible for a Disenrolling member until the Disenrollment is processed by the State and shall provide Medically Necessary Covered Services through the member's Disenrollment date.

3.7.2.7.10 When the reason for Disenrollment is the member's death, the case manager must end date the service authorization(s) with the actual date of death.

3.8 SERVICE COORDINATION

3.8.1 Transition of New Members

3.8.1.1 The Contractor shall ensure that, in accordance with this Contract, all new members (either as a new DSHP/DSHP Plus member or Transferring from another MCO) are assessed to identify needed services and are provided Medically Necessary Covered Services in a timely manner.

3.8.1.2 If a member is Transferring from the Contractor to another MCO, the Contractor shall cooperate with the receiving MCO to ensure a seamless transition. If the

member is hospitalized at the time of Enrollment with the other MCO, the Contractor shall be responsible for inpatient facility payment until discharge.

3.8.1.3 If a new member Transferring from another MCO is hospitalized at the time of Enrollment, the originating MCO shall be responsible for inpatient facility payment until discharge, but the Contractor shall be responsible for payments for professional services as of the member's Enrollment date, shall participate in discharge planning, and shall be responsible for all services upon discharge.

3.8.1.4 The Contractor shall implement a continuity of care transition plan to provide continuity of care for new members.

3.8.1.4.1 For members Transferring from another MCO, the Contractor shall immediately contact the Transferring MCO and request the completed member transfer coordination of care form (specified by the State) and transfer of relevant information and data in order to facilitate continuity of care (e.g., the member's treatment plan or plan of care and identification of the member's providers).

3.8.1.4.2 For members Transferring from another MCO who also participate in PROMISE, the Contractor shall contact DSAMH, in accordance with DSAMH's processes, within two business days in order to provide the name and contact information of the Contractor's point of contact to facilitate seamless transition, care coordination, integrated physical and behavioral health care, and continuity of care.

3.8.1.4.3 For treatment (other than prenatal services to a pregnant member in the second or third trimester and the provision of services in the DSHP Plus LTSS benefit package) of a medical or behavioral health condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, the Contractor must cover the service from the treating provider if located within the distance standards specified in Section 3.9.17.2 of this Contract for a lesser of: a period of 90 calendar days or until the treating provider releases the patient from care. If the member is a pregnant woman in her second or third trimester, the Contractor shall cover prenatal services from the treating provider if located within the distance standard in Section 3.9.17.2 of this Contract through 60 calendar days post-partum. If the treating provider is not located within the distance standards specified in Section 3.9.17.2 of this Contract, the Contractor must cover the service but after a period of 30 calendar days may require the member to transfer to a qualified provider that is located within the distance standards specified in Section 3.9.17.2 of this Contract.

3.8.1.4.4 See Section 3.5.6 of this Contract for requirements regarding continuity/transition for medications.

3.8.1.4.5 For services in the DSHP Plus LTSS benefit package, the Contractor shall continue the services authorized by the Transferring MCO, in accordance with the approved nursing facility level of service/plan of care, regardless of whether the providers are participating or non-participating providers, for a minimum of 30 calendar days after the member's Enrollment date and thereafter shall not reduce these services unless a case manager has conducted a comprehensive needs assessment and developed a plan of care, and the Contractor has authorized and initiated services in the DSHP Plus LTSS benefit package in accordance with the member's new plan of care, which may include transition from non-participating to participating providers.

3.8.1.4.6 For members Transferring from another MCO who are enrolled in the DDDS Lifespan Waiver, the Contractor shall contact DDDS, in accordance with DDDS' processes, within two business days in order to provide the name and contact information of the Contractor's point of contact to facilitate seamless transition, care coordination, and continuity of care.

3.8.1.4.7 For members enrolled in the DDDS Lifespan Waiver who are living in a provider-managed residential setting:

3.8.1.4.7.1 The Contractor shall provide continuation of the member's FFS PCP, regardless of whether the provider is a participating or non-participating provider, for the lesser of: the period from July 1, 2019 to December 31, 2019; or until the treating provider releases the patient from care.

3.8.1.4.7.2 The Contractor shall continue any Covered Services provided by Medicaid FFS, regardless of whether the providers are participating or non-participating providers, from July 1, 2019 through September 30, 2019.

3.8.1.4.7.3 For the period from July 1, 2019 through June 30, 2020, the Contractor shall not deny or reduce the amount, duration or scope of any non-institutional Covered Services that the member was receiving FFS, unless the denial or reduction is based on an assessment conducted by the MCO or the member's provider and reviewed with DMMA prior to final decision.

3.8.1.5 Except as provided below regarding members Enrolling as of the Start Date of Operations, for new DSHP Plus LTSS members, the Contractor shall conduct an

onsite visit, develop a plan of care and initiate (begin delivery of) new services in the DSHP Plus LTSS benefit package in accordance with the timeframes specified in Section 3.7.2 of this Contract.

3.8.1.5.1 For members Enrolling as of the Start Date of Operations:

3.8.1.5.1.1 If the initial onsite visit will not occur within 10 business days of the Start Date of Operations, the Contractor shall send the member written notification within 10 business days of the Start Date of Operations that explains how the member can reach the Contractor's case management unit for assistance with questions or concerns pending the face-to-face visit.

3.8.1.5.1.2 The Contractor shall conduct the initial onsite visit for new HCBS members within 90 calendar days of the Start Date of Operations, develop and approve a plan of care and provide services in the member's new plan of care, within 14 calendar days of the initial onsite visit.

3.8.1.5.1.3 The Contractor shall conduct the initial onsite visit for new DSHP Plus LTSS members residing in a nursing facility within six months of the Start Date of Operations.

3.8.1.5.1.4 The Contractor shall also meet with nursing facilities and assisted living facilities to discuss the current status and needs (if any) of new members within 30 calendar days of the Start Date of Operations.

3.8.1.5.2 The Contractor shall facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care developed by the Contractor without any disruption in services.

3.8.1.5.3 If at any time before the face-to-face visit occurs the Contractor becomes aware of an increase in a member's needs, for example, from the State's PAE or the Contractor's initial contact with the member, a case manager shall immediately conduct a comprehensive needs assessment and update the member's plan of care, and the Contractor shall initiate the change in services within 10 business days of becoming aware of the change in the member's needs. In emergency situations (e.g., the member's informal Caregiver is admitted to hospital), the Contractor shall initiate immediate, necessary changes in service.

3.8.2 **Transition between Providers**

3.8.2.1 The Contractor shall actively assist members with chronic or acute medical or behavioral health conditions, members who are receiving LTSS and members who are pregnant in transitioning to another provider when there is a change in

providers. For DSHP Plus LTSS members, this assistance shall be provided by the member's case manager. For PROMISE participants, the Contractor shall coordinate with the DSAMH care manager as appropriate to assist the member to transition between providers. For members enrolled in the DDDS Lifespan Waiver, the Contractor shall coordinate with the DDDS case manager as appropriate to assist the member to transition between providers.

3.8.2.2 Except in cases where the provider was terminated by the Contractor for cause, if a provider is no longer a participating provider, the Contractor shall provide continuation of such provider for a lesser of: a period of 90 calendar days or until the treating provider releases the patient from care.

3.8.2.3 The Contractor shall ensure that, at a minimum, its provider transition process includes the following:

3.8.2.3.1 A process that ensures a transfer does not create a lapse in services;

3.8.2.3.2 A requirement that an HCBS provider that is no longer willing or able to provide services to a DSHP Plus LTSS member to cooperate with the member's case manager to facilitate a seamless transition to another HCBS provider and continue to provide services to the member until the member has been transitioned to the other provider;

3.8.2.3.3 A mechanism for timely information exchange;

3.8.2.3.4 A mechanism for assuring confidentiality; and

3.8.2.3.5 A mechanism for allowing a member to request and be granted a change of provider.

3.8.2.4 <u>For DSHP Plus LTSS members:</u>

3.8.2.4.1 The Contractor shall not transition residents of a nursing facility or assisted living facility to another facility unless:

3.8.2.4.1.1 The member or member representative specifically requests to transition to another facility, which shall be documented in the member's file;

3.8.2.4.1.2 The member or member representative provides written consent to transition to another facility based on quality or other concerns raised by the Contractor, which shall not include the facility's rate of reimbursement; or

3.8.2.4.1.3 The facility where the member resides is not a participating provider.

3.8.2.4.1.3.1 If the Contractor intends to transfer a member because the facility where the member currently resides is not a participating provider, the Contractor shall provide continuation of services in such facility for at least 30 calendar days, which shall be extended as necessary to ensure continuity of care pending the facility's becoming a participating provider or the member's transition to a participating facility.

3.8.2.4.2 The Contractor shall not transition nursing facility residents to a community-based setting unless the member chooses, as part of the placement process, to receive HCBS as an alternative to nursing facility care.

3.8.3 Coordination Between DSHP, DSHP Plus and DSHP Plus LTSS

3.8.3.1 The Contractor shall ensure that if a member transitions between DSHP, DSHP Plus and/or DSHP Plus LTSS the process is seamless to the member. This includes but is not limited to:

3.8.3.1.1 Transferring all member information as necessary so that Contractor staff interacting with a member who has transitioned between programs have access to all available information about the member as needed to provide appropriate assistance and to limit requests for information from members;

3.8.3.1.2 Ensuring that authorizations for services in the DSHP benefit package continue when a member transitions between programs;

3.8.3.1.3 Informing members of any changes as a result of transition to another program, including, but not limited to, Covered Services and additional services and access to a case manager; and

3.8.3.1.4 Identifying when a DSHP member is reaching the 30 calendar day nursing facility limit in the DSHP benefit package and coordinating with the nursing facility to assist the member in applying for DSHP Plus LTSS.

3.8.4 Coordination of Behavioral Health Services

3.8.4.1 The Contractor shall, in collaboration with DSAMH, establish a protocol to be implemented as of the Start Date of Operations to appropriately identify and refer members to DSAMH for PROMISE eligibility determination.

3.8.4.2 For members who are not participating in PROMISE (including members who are not referred to the program, members who are determined by DSAMH to not meet eligibility criteria for PROMISE or determined at the time of the annual re-determination to no longer meet eligibility criteria), the Contractor shall be solely

responsible for the provision and coordination of behavioral health services, including, but not limited to:

3.8.4.2.1 The Contractor shall have the necessary resources and capacity to appropriately refer to and receive referrals from DSAMH and DSCYF in order to coordinate behavioral and physical health care.

3.8.4.2.2 The Contractor shall identify behavioral health needs, coordinate referrals for covered behavioral health services, and monitor that necessary services have been received.

3.8.4.2.3 The Contractor shall actively assist with discharge planning when members are receiving behavioral health services within higher levels of care including institutional or residential settings.

3.8.4.2.4 The Contractor shall work with Treatment Access Center case managers in providing treatment for drug court related cases.

3.8.4.3 Upon determination that a member is participating in PROMISE, the Contractor shall provide services as set forth in Section 3.8.8.9 of this Contract; Section 3.7 of this Contract; and Section 3.4 of this Contract, Covered Services.

3.8.5 **Nursing Facility Diversion**

3.8.5.1 The Contractor shall implement a nursing facility diversion process that has been prior approved by the State.

3.8.5.2 The Contractor's policies and procedures for its nursing facility diversion process shall describe how the Contractor will work with providers (including hospitals regarding notice of admission and discharge planning) to ensure appropriate communication among providers and between providers and the Contractor, training for key Contractor and provider staff, early identification of DSHP and DSHP Plus members who may be candidates for diversion, and follow-up activities to help sustain community living. The description shall identify key activities and associated timeframes.

3.8.5.3 The nursing facility diversion process shall not prohibit or delay a member's access to nursing facility services when nursing facility services are Medically Necessary and requested by the member.

3.8.5.4 At a minimum, the Contractor's nursing facility diversion process shall be tailored to meet the needs of each of the following groups:

3.8.5.4.1 DSHP and DSHP Plus members who are waiting for admission to a nursing facility;

3.8.5.4.2 DSHP and DSHP Plus members residing in their own homes who have a negative change in circumstances and/or deterioration in

health or functional status and who request nursing facility services;

3.8.5.4.3 DSHP and DSHP Plus members residing in assisted living facilities who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services;

3.8.5.4.4 DSHP and DSHP Plus members who are admitted to an inpatient hospital or inpatient rehabilitation facility who are not residents of a nursing facility; and

3.8.5.4.5 DSHP and DSHP Plus members who are placed on a short-term basis in a nursing facility regardless of payor source.

3.8.5.5 If a member is already working with the DSAAPD Aging & Disability Resource Center's (ADRC's) Diversion program, the Contractor shall partner with the Diversion program to support a successful diversion.

3.8.6 **Nursing Facility Transition**

3.8.6.1 The Money Follows the Person Rebalancing Demonstration (MFP) is now Delaware's nursing facility transition program, as outlined below.

3.8.6.2 The Contractor shall implement methods for identifying members residing in nursing facilities who may have the ability and/or desire to transition to the community. Such methods shall include, at a minimum:

3.8.6.2.1 Accepting referrals for transition from the treating physician, nursing facility, other providers, family, the State, and self-referrals; and

3.8.6.2.2 Identification, through the case management process, including, but not limited to: assessments and information gathered from nursing facility staff.

3.8.6.3 Within 14 calendar days of receiving a referral/identification, the Contractor shall conduct an in-facility visit with the member in order to determine the member's interest in and potential ability to transition to the community, and provide orientation and information to the member regarding transition activities. The member's case manager shall document in the member's electronic case record that transition was discussed with the member, the member's expressed wishes as well as the member's potential for transition. The Contractor shall not require a

member to transition when the member expresses a desire to continue residing in a nursing facility.

3.8.6.4 If a member expresses an interest in transition, the case manager shall explain the Contractor's nursing facility transition process.

3.8.6.5 If the member elects to use the Contractor's nursing facility transition process, the following shall occur:

3.8.6.5.1 If the member wishes to pursue transition to the community through the Contractor's process, within 14 calendar days of the initial visit the case manager shall conduct an in-facility assessment of the member's ability and/or desire to transition using tools and protocols specified or prior approved by the State. This assessment shall include the identification of any barriers to a safe transition.

3.8.6.5.2 For those members whose transition assessment indicates that they are not candidates for transition to the community, the case manager shall notify them in accordance with the Contractor's policies and procedures.

3.8.6.5.3 For those members whose transition assessment indicates that they are candidates for transition to the community, the case manager shall facilitate the development of and complete a transition plan within 14 calendar days of the member's transition assessment. The case manager shall include other individuals such as the member representative, member's family and/or Caregiver in the transition planning process if the member requests and/or approves those individuals, and such persons are willing and able to participate.

3.8.6.5.4 The case manager or the Contractor's housing specialist shall refer potentially eligible members to the SRAP and Delaware's Section 811 PRA Demo program and participate in the SRAP and/or PRA Demo program process, including, but not limited to, assisting the member with completing the application and other required forms and attending briefings and meetings with the applicable State agency.

3.8.6.5.5 The Contractor shall provide assistance to members who have been institutionalized, but wish to return home, in overcoming housing barriers associated with their transition to the community, including but not limited to: covering housing application fees security deposit, utilities home furnishings and household essentials including food supplies. This assistance can be provided

through connecting the member to community resources or directly by the Contractor.

3.8.6.5.6 As part of transition planning, prior to the member's physical move to the community, the case manager shall visit the residence where the member will live to conduct an onsite evaluation of the physical residence and meet with the member's family or other Caregiver or individuals who will be residing with the member (as appropriate). The case manager shall include in the transition plan activities and/or services needed to mitigate any perceived risks in the residence including, but not limited to, an increase in face-to-face visits beyond the minimum required contacts in Section 3.7.2.5 of this Contract.

3.8.6.5.7 The transition plan shall address all services necessary to safely transition the member to the community and include at a minimum member needs related to housing, transportation, availability of Caregivers to meet the member's needs, and other transition needs and supports. The transition plan shall also identify any barriers to a safe transition and strategies to overcome those barriers.

3.8.6.5.8 The Contractor shall approve the transition plan and authorize any Covered Services or additional services included in the plan within 10 business days of completion of the plan. The transition plan shall be fully implemented within 90 calendar days from approval of the transition plan, except under extenuating circumstances which must be documented in writing.

3.8.6.5.9 The member's case manager shall also complete a plan of care that meets all criteria described in Section 3.7.2 of this Contract. The plan of care shall be authorized and initiated prior to the member's transition to the community. HCBS service referral and coordination must be completed prior to a member's transition from a nursing facility to the community in order to ensure the member's health and safety upon transition (e.g., minor home modifications or PERS installation).

3.8.6.5.10 Ongoing HCBS and any Medically Necessary covered home health services needed by the member shall be initiated immediately upon transition from a nursing facility to the community and as of the effective date of transition with no gaps between the member's receipt of nursing facility services and ongoing HCBS.

3.8.6.5.11 The case manager shall monitor all aspects of the transition process and take immediate action to address any barriers or issues that arise during transition.

3.8.6.5.12 For members who will live independently in the community or whose onsite visit during transition planning indicated an elevated risk, the case manager shall visit the member in his/her residence within 24 hours of discharge from the nursing facility. During the initial 90 day post-transition period, the case manager shall conduct monthly face-to-face in-home visits to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community.

3.8.6.5.13 For members transitioning to an assisted living facility or who will live with a relative or other Caregiver, within the first 24 hours of discharge the case manager shall contact the member and within seven calendar days after the member has transitioned to the community, the case manager shall visit the member in his/her new residence. During the initial 90 calendar day post-transition period, the case manager shall, at a minimum, contact the member by telephone each month to ensure that the plan of care is being followed, that the plan of care continues to meet the member's needs, and the member has successfully transitioned to the community; and conduct additional face-to-face visits as necessary to address issues and/or concerns and to ensure that the member's needs are met.

3.8.6.5.14 The Contractor shall monitor any hospitalizations and/or nursing facility re-admissions for members who transition from a nursing facility to the community to identify issues and implement strategies to improve transition outcomes and prevent hospitalizations and nursing facility re-admissions.

3.8.6.5.15 The Contractor shall develop and implement any necessary assessment tools, transition plan templates, protocols, or training necessary to ensure that issues that may hinder a member's successful transition are identified and addressed. Any tool, template, or protocol must be prior approved by the State.

3.8.7 Self-Directed Attendant Care Services for DSHP Plus LTSS Members

3.8.7.1 General

3.8.7.1.1 DSHP Plus LTSS members may opt to self-direct their attendant care services. Self-directed attendant care affords members the opportunity to have choice and control over how attendant care services are provided and who provides the services.

3.8.7.1.2 The Contractor shall ensure that members who elect Self-Directed Attendant Care Services have decision-making authority over

Attendant Care Employees. This shall include but not be limited to recruiting Attendant Care Employees, selecting Attendant Care Employees from an Attendant Care Employee roster, hiring Attendant Care Employees as the common law employer, verifying Attendant Care Employee qualifications, obtaining criminal history and/or background investigation of Attendant Care Employees, specifying additional Attendant Care Employee qualifications based on member needs and preferences, evaluating Attendant Care Employee performance, verifying time worked by Attendant Care Employees and approving timesheets, and discharging Attendant Care Employees.

3.8.7.1.3 The Contractor shall provide support for Self-Directed Attendant Care Services by contracting with a qualified entity to provide support for Self-Directed Attendant Care Services. Support for Self-Directed Attendant Care Services shall include two functions: financial management services (FMS) and information and assistance in support of Self-Directed Attendant Care Services (support brokerage). The provider of support for Self-Directed Attendant Care Services shall carry out activities associated with both components to assist members who elect to self-direct their attendant care services. The provider of support for Self-Directed Attendant Care Services performs various functions to support members in planning for and carrying out their responsibilities as common law employers of Attendant Care Employees.

3.8.7.1.4 Member participation in Self-Directed Attendant Care Services is voluntary. Members may participate in or withdraw from Self-Directed Attendant Care Services at any time. (See Section 3.8.7.8 of this Contract for additional requirements regarding disenrollment from Self-Directed Attendant Care Services.)

3.8.7.2 Self-Assessment

3.8.7.2.1 As specified in Section 3.7.2 of this Contract, the case manager shall inform and educate members and member representatives about the option to self-direct their attendant care services. As part of this discussion the case manager shall obtain from the member a signed statement regarding the member's decision to participate or not participate in Self-Directed Attendant Care Services.

3.8.7.2.2 If a member elects Self-Directed Attendant Care Services, the case manager shall provide the member with a self-assessment instrument and instructions that have been prior approved by the State. The self-assessment instrument shall be completed by the member with assistance from the case manager as appropriate. The

case manager shall file the completed self-assessment in the member's electronic case record.

3.8.7.2.3 If, based on the results of the self-assessment, the case manager determines that a member requires assistance to direct his/her attendant care services, the case manager shall inform the member that he/she needs to appoint a representative to perform the employer responsibilities on his/her behalf (Employer Representative). The case manager shall ensure that an Employer Representative agreement is completed and signed by the Employer Representative and the member and that the Employer Representative is neither an Attendant Care Employee for that member nor related to an Attendant Care Employee for that member.

3.8.7.3 Financial Management Services

3.8.7.3.1 The Contractor's provider of support for Self-Directed Attendant Care Services shall be an IRS-approved Fiscal/Employer Agent that functions as the member's agent in performing payroll and other employer responsibilities that are required by Federal and State law.

3.8.7.3.2 At a minimum, the Contractor's provider of support for Self-Directed Attendant Care Services shall conduct the following FMS functions:

3.8.7.3.2.1 Assist members in verifying Attendant Care Employees' citizenship status;

3.8.7.3.2.2 Collect and process Attendant Care Employees' timesheets;

3.8.7.3.2.3 Assist members in ensuring that workers compensation insurance is purchased and maintained;

3.8.7.3.2.4 Process payroll, withholding, filing and payment of applicable Federal, State and Local employment-related taxes and insurance;

3.8.7.3.2.5 Execute and hold Medicaid provider agreements; and

3.8.7.3.2.6 Receive funds from the Contractor and disburse funds for payment of Attendant Care Employees.

3.8.7.4 Supports Brokerage Functions

3.8.7.4.1 The Contractor's provider of support for Self-Directed Attendant Care Services shall perform, at a minimum, the following supports brokerage functions:

3.8.7.4.1.1 Coordinate with the member's case manager to develop, sign and update the member's plan of care to include Self-Directed Attendant Care Services;

3.8.7.4.1.2 Recruit Attendant Care Employees;

3.8.7.4.1.3 Maintain a roster of Attendant Care Employees;

3.8.7.4.1.4 Assist with developing and posting job descriptions for Attendant Care Employees;

3.8.7.4.1.5 Secure and pay for background checks on prospective Attendant Care Employees on behalf of members;

3.8.7.4.1.6 Assist with hiring, supervising, evaluating and discharging Attendant Care Employees;

3.8.7.4.1.7 Assist with completing forms related to employers;

3.8.7.4.1.8 Assist with approving timesheets;

3.8.7.4.1.9 Provide information on employer/employee relations;

3.8.7.4.1.10 Provide training to members and Attendant Care Employees (see Section 3.8.7.4 of this Contract);

3.8.7.4.1.11 Provide assistance with problem resolution;

3.8.7.4.1.12 Maintain member files; and

3.8.7.4.1.13 Provide support to the member as an employer in executing the member's back-up plan for Self-Directed Attendant Care Services.

3.8.7.4.2 The Contractor shall ensure that support brokers and case managers work collaboratively and do not duplicate activities or functions. See Section 3.7.2 of this Contract for additional requirements for case managers.

3.8.7.5 Training

3.8.7.5.1 The Contractor shall require all members electing Self-Directed Attendant Care Services and/or their Employer Representatives to

receive relevant training. The Contractor's provider of support for Self-Directed Attendant Care Services shall be responsible for arranging/providing for initial and ongoing training of members or Employer Representatives.

3.8.7.5.2 At a minimum, Self-Directed Attendant Care Services training for members and/or Employer Representatives shall address the following issues:

3.8.7.5.2.1 Understanding the role of members or Employer Representatives with Self-Directed Attendant Care Services;

3.8.7.5.2.2 Understanding the role of the provider of support for Self-Directed Attendant Care Services;

3.8.7.5.2.3 Selecting Attendant Care Employees;

3.8.7.5.2.4 Reporting Critical Incidents, abuse and neglect prevention and reporting, and Fraud, Waste and Abuse prevention and reporting, as each relates to Self-Directed Attendant Care Services;

3.8.7.5.2.5 Being an employer, evaluating Attendant Care Employee performance and managing Attendant Care Employees;

3.8.7.5.2.6 Performing administrative tasks such as reviewing and approving timesheets; and

3.8.7.5.2.7 Scheduling Attendant Care Employees and contingency planning.

3.8.7.5.3 The Contractor shall arrange for ongoing training for members and/or Employer Representatives upon request and/or if a support broker, through monitoring, determines that additional training is warranted.

3.8.7.5.4 The Contractor shall arrange for initial and ongoing training of Attendant Care Employees, which shall be provided by the Contractor's provider of support for Self-Directed Attendant Care Services with the member in attendance. At a minimum, training shall consist of the following:

3.8.7.5.4.1 Overview of DSHP, DSHP Plus LTSS and Self-Directed Attendant Care Services;

3.8.7.5.4.2 Caring for elders and persons with disabilities;

3.8.7.5.4.3 Abuse and neglect identification and reporting;

3.8.7.5.4.4 Fraud, Waste and Abuse prevention and reporting;

3.8.7.5.4.5 Critical Incident reporting; and

3.8.7.5.4.6 Submission of required documentation and withholdings.

3.8.7.5.5 The Contractor's provider of support for Self-Directed Attendant Care Services shall assist the member or Employer Representative in determining to what extent the member or Employer Representative shall be involved in the above-specified Attendant Care Employee training. The member or Employer Representative shall provide additional training to the Attendant Care Employee regarding individualized service needs and preference.

3.8.7.5.6 The Contractor shall verify that Attendant Care Employees have successfully completed all required training prior to service initiation and payment for services.

3.8.7.5.7 Additional training and refresher components may be provided to an Attendant Care Employee to address issues identified by the provider of support for Self-Directed Attendant Care Services, member or Employer Representative or at the request of the Attendant Care Employee.

3.8.7.6 Attendant Care Employee Qualifications

3.8.7.6.1 The Contractor shall verify that potential Attendant Care Employees meet all applicable qualifications prior to delivering services including the following minimum qualifications: at least 18 years of age, have the skills necessary to perform the required services, possess a valid Social Security number and willing to submit to a criminal record check.

3.8.7.6.2 For each potential Attendant Care Employee the Contractor shall conduct a criminal history check pursuant to 16 DE Admin Code 3110, a check of the Delaware's Adult Abuse Registry (see 11 DE Admin Code 8564; registry is available on the DHSS website), a check of the national and the Delaware sex offender registry and a check of the excluded provider list.

3.8.7.6.3 The Contractor shall notify the member of the findings of the checks as applicable to his/her potential Attendant Care Employee(s).

3.8.7.6.3.1 If a member wants to employ a person who does not pass the criminal history check, the Contractor shall educate the member of the risk. If the member insists on hiring a person who does not pass the criminal history check, the Contractor

shall have the member sign a waiver of liability stating that they understand the risks and want to hire the person despite his/her failure to pass the criminal history check and will hold the State and Contractor harmless from any claims or responsibility for any injury, loss or damage as a result of hiring the person.

3.8.7.6.3.2 A person who is listed on the Delaware Adult Abuse Registry, the national or Delaware sex offender registry or the excluded provider list shall not provide Self-Directed Attendant Care Services.

3.8.7.6.4 Members shall have the flexibility to hire persons with whom they have a close personal relationship to serve as an Attendant Care Employee, such as a neighbor, friend, or family member.

3.8.7.6.5 The Contractor shall ensure that each member has an employment agreement with an Attendant Care Employee prior to services being provided by that Attendant Care Employee. The Contractor shall not pay an Attendant Care Employee for the provision of Self-Directed Attendant Care Services unless the Attendant Care Employee has a signed employment agreement with the member.

3.8.7.6.6 The Contractor shall ensure that employment agreements are updated anytime there is a change in any of the terms or conditions specified in the agreement. The Contractor shall ensure employment agreements are signed by the new Employer Representative when there is a change in Employer Representative.

3.8.7.6.7 The Contractor shall provide a copy of each employment agreement to the member and/or Employer Representative. The Contractor shall also give a copy of the employment agreement to the Attendant Care Employee and shall maintain a copy for its files.

3.8.7.7 <u>Monitoring</u>

3.8.7.7.1 The case manager shall monitor the quality of service delivery and the health, safety and welfare of members electing Self-Directed Attendant Care Services.

3.8.7.7.2 The Contractor shall develop a system for case managers to verify that Self-Directed Attendant Care Services are provided in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service, in accordance with the member's service schedule. This shall not be limited to asking the member if they are receiving the services they need.

3.8.7.7.3 The case manager shall monitor implementation of the back-up plan by the member or Employer Representative.

3.8.7.7.4 The case manager shall monitor a member's participation in Self-Directed Attendant Care Services to determine, at a minimum, the success and the viability of the service delivery model for the member. The case manager shall note any patterns, such as frequent turnover of Employer Representatives that may warrant intervention by the case manager. If problems are identified, a case manager should also ask a member to complete a self-assessment to determine what additional supports, if any (such as designating an Employer Representative), could be made available to assist the member.

3.8.7.8 Disenrollment from Self-Directed Attendant Care Services

3.8.7.8.1 The Contractor shall ensure that members are informed of their right to voluntarily disenroll from Self-Directed Attendant Care Services at any time and return to the traditional service delivery system. To the extent possible, the member shall provide his/her Attendant Care Employee 10 calendar days advance notice regarding his/her intent to disenroll from Self-Directed Attendant Care Services. The Contractor shall educate and assist the member in providing such disenrollment.

3.8.7.8.2 The Contractor may involuntarily disenroll a member from Self-Directed Attendant Care Services for the following for cause reasons:

3.8.7.8.2.1 Continued participation in Self-Directed Attendant Care Services would not permit the member's health, safety or welfare needs to be met;

3.8.7.8.2.2 The member demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct attendant care services and refuses to appoint an Employer Representative;

3.8.7.8.2.3 There is fraudulent use of funds such as substantial evidence that a member has falsified documents related to Self-Directed Attendant Care Services.

3.8.7.8.3 If a member is disenrolled voluntarily or involuntarily from Self-Directed Attendant Care Services, the Contractor shall transition the member to the traditional service delivery system and shall have safeguards in place to ensure continuity of services.

3.8.8 **Coordination of Benefits Provided by the State**

3.8.8.1 General

3.8.8.1.1 Although the Contractor is not responsible for the provision or payment of Medicaid benefits provided by the State (see Section 3.4.10 of this Contract), the Contractor is responsible for coordinating these services to ensure proper management of its members.

3.8.8.2 Dental Services for Children

3.8.8.2.1 The Contractor shall coordinate dental services for children to ensure that members receive appropriate dental services as needed. At a minimum, this shall include educating members about the availability and importance of dental services and implementing processes for referring children for dental services and for exchanging necessary member information with treating dental providers consistent with State and Federal confidentiality and privacy requirements.

3.8.8.3 Prescribed Pediatric Extended Care (PPEC)

3.8.8.3.1 The Contractor shall coordinate services for children receiving PPEC services. At a minimum, this shall include implementing processes for referring children to PPEC as needed, exchanging necessary member information with PPECs consistent with State and Federal confidentiality and privacy requirements, and coordinating Covered Services and PPEC services.

3.8.8.4 Day Habilitation Services for Persons with Developmental Disabilities

3.8.8.4.1 The Contractor shall coordinate Covered Services and day habilitation services for members with developmental disabilities.

3.8.8.5 Non-Emergency Medical Transportation

3.8.8.5.1 The Contractor shall coordinate non-emergency medical transportation for members to ensure that members receive non-emergency medical transportation as needed. At a minimum, this shall include providing information to members on how to access non-emergency medical transportation, referring members to the State's non-emergency medical transportation vendor, and providing information and assistance as necessary to ensure that members receive appropriate transportation to Covered Services.

3.8.8.5.2 For members enrolled in the DDDS Lifespan Waiver who live in a provider-managed residential setting, the Contractor shall refer

members to the provider-managed residential setting for provision of non-emergency medical transportation.

3.8.8.6 Specialized Services Not Included in Covered Services

3.8.8.6.1 The Contractor shall include all Specialized Services specified by the State as part of the Level II PASRR process in the member's plan of care, including Specialized Service that are not Covered Services, and shall coordinate with DSAMH and/or DDDS (as applicable) and nursing facilities to ensure that members receive Specialized Services specified by the State as part of the Level II PASRR that are not included in the DSHP or DSHP Plus LTSS benefit package.

3.8.8.7 Employment Services Provided through Pathways

3.8.8.7.1 If contacted by an employment navigator, the Contractor shall provide the name and contact information of the Contractor's point of contact for coordination of services, and the Contractor shall coordinate Covered Services and services provided through Pathways. See Section 3.7 of this Contract for coordination requirements specific to DSHP Plus LTSS members.

3.8.8.8 Behavioral Health Services for Children

3.8.8.8.1 If a member under age 18 is determined, using a protocol provided by DPBHS of DSCYF, to require additional units beyond those included in the DSHP benefit package or more intensive services than the Contractor must provide as part of the DSHP benefit package, then the Contractor shall refer the member to DPBHS so that his/her behavioral health needs can be met. Should any disagreement arise concerning the referral, the dispute will be resolved by a committee that includes the Contractor's medical/clinical director and appropriate State staff as determined by the State.

3.8.8.9 Behavioral Health Services Provided to Adults through PROMISE

3.8.8.9.1 For DSHP and DSHP Plus members participating in PROMISE, DSAMH has primary responsibility for PROMISE eligibility determination and re-determination.

3.8.8.9.1.1 For members other than DSHP Plus LTSS members, DSAMH has primary responsibility for plan of care development, revision and monitoring, but the Contractor is responsible for coordination as specified below.

3.8.8.9.1.2 For DSHP Plus LTSS members participating in PROMISE, the Contractor shall have primary responsibility for plan of care development, revision and monitoring but shall involve the DSAMH care manager as specified in Section 3.7 of this Contract.

3.8.8.9.2 Upon determination that a member is eligible for PROMISE, DSAMH will notify the member of the decision. Additionally, DSAMH will inform the Contractor of the determination decision and provide the name and contact information of the assigned DSAMH care manager. The Contractor shall provide the DSAMH care manager with the name and contact information of the Contractor's point of contact for coordination of services to be provided by the Contractor.

3.8.8.9.3 The Contractor shall work with DSAMH to develop a collaboration protocol that includes strategies and activities to effectively communicate and coordinate care for members who are participating in PROMISE. The collaboration protocol, which shall be implemented as of the Start Date of Operations, shall include at a minimum:

3.8.8.9.3.1 How the Contractor will ensure its staff are adequately trained regarding the PROMISE program, including eligibility criteria, referral processes, services provided by PROMISE, the services that are the responsibility of the Contractor (see Section 3.4 of this Contract), and coordination with the DSMAH care manager;

3.8.8.9.3.2 How the Contractor will ensure adequate resources and capacity to participate in service coordination with DSAMH for services provided by the Contractor, including when members are being discharged from an inpatient or residential behavioral health setting to a community placement;

3.8.8.9.3.3 How the Contractor's point of contact for collaboration and the member's DSAMH care manager will work together to develop, implement and update plans of care that address all of the member's needs and include all services to be provided by the Contractor and DSAMH; and

3.8.8.9.3.4 How the Contractor's point of contact for collaboration and the member's DSAMH care manager will work together to track and monitor implementation of the plans of care and member outcomes.

3.8.8.10 DDDS Lifespan Waiver Services

3.8.8.10.1 The Contractor shall work with DDDS to develop a collaboration protocol that includes strategies and activities to effectively communicate and coordinate care for members who are enrolled in the DDDS Lifespan Waiver. The collaboration protocol shall include, at a minimum:

3.8.8.10.1.1 The Contractor's designated point of contact for collaboration and DDDS' designated point of contact;

3.8.8.10.1.2 How the Contractor's point of contact and DDDS' point of contact will work together to effectively communicate and collaborate;

3.8.8.10.1.3 How the Contractor will work with, as applicable, the member's DDDS case manager, nurse consultant and/or DDDS Lifespan Waiver provider to ensure appropriate discharge planning supports when needed; and

3.8.8.10.1.4 How the Contractor will ensure its staff are adequately trained regarding disability competent care, the DDDS Lifespan Waiver, DDDS Lifespan Waiver services, non-duplication with services that are the responsibility of the Contractor, and coordination with, as applicable, the member's DDDS case manager, nurse consultant and/or DDDS Lifespan Waiver providers.

3.8.9 **Coordination with Medicare**

3.8.9.1 The Contractor shall accept Medicare data for its members and load the data into the Contractor's system for use by, at a minimum, case management, care coordination, member services, claims processing, and UM staff.

3.8.9.2 The Contractor shall be responsible for coordination of benefits with Medicare for members who are also enrolled in Medicare in accordance with the State's payment guidelines. See Section 3.18.3 of this Contract for Third Party Liability (TPL) requirements.

3.8.9.3 The Contractor shall provide Medically Necessary Covered Services to full benefit Dual Eligible members (members enrolled in both Medicare and Medicaid and entitled to full Medicaid benefits, not just Medicare cost sharing) if the service is not covered by Medicare.

3.8.9.4 The Contractor shall coordinate with Medicare payors, Medicare Advantage plans and Medicare providers as appropriate to coordinate the care of members who are also enrolled in Medicare.

3.8.10 **Members with Special Health Care Needs (SHCN)**

3.8.10.1 General

3.8.10.1.1 In accordance with 42 CFR 438.208(c)(2), the Contractor shall comprehensively assess each member identified as having SHCN in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers.

3.8.10.1.2 In accordance with 42 CFR 438.208(b)(4), the Contractor shall share with other MCOs and managed care entities serving the member with SHCN the results of its identification and assessment of any member with SHCN so that those activities need not be duplicated.

3.8.10.1.3 In accordance with 42 CFR 438.208(c)(3), the Contractor shall ensure that members determined to need a course of treatment or regular care monitoring have a treatment plan/plan of care. The treatment plan shall be developed by the member's PCP with member participation, and in consultation with any specialists caring for the member. The plan of care for DSHP Plus LTSS members shall be developed in accordance with Section 3.7 of this Contract. If the Contractor requires approval of the treatment plan/plan of care, the Contractor shall approve the treatment plan/plan of care in a timely manner. The Contractor shall ensure that the treatment plan/plan of care complies with any applicable State quality and UM standards. The Contractor shall ensure that the plan of care is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change, or at the request of the member.

3.8.10.1.4 In accordance with 42 CFR 438.208(c)(4), the Contractor shall have a mechanism in place to allow members determined to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the member's condition and identified needs.

3.8.10.1.5 The Contractor shall allow for the continuation of existing relationships with non-participating providers, when considered to be in the best interest of the member with SHCN.

3.8.10.1.6 The Contractor shall assure that members with serious, chronic and rare disorders receive appropriate diagnostic work ups on a timely basis using nationally recognized, evidence-based tools.

3.8.10.1.7 The Contractor must have a written protocol describing its coordination system for members with SHCN who are not DSHP

Plus LTSS members, which should include the Contractor's approach to care coordination, utilization review and assuring continuity of care, such as verifying Medical Necessity, service planning, channeling to appropriate levels of treatment and development of treatment alternatives when effective, less intensive services are unavailable (see definition of Medical Necessity in Section 3.4.5 of this Contract).

3.8.10.2 Children in the Care or Custody of DSCYF

3.8.10.2.1 *Foster Children*

3.8.10.2.1.1 In cases where a child protective worker of the Division of Family Services (DFS) of the DSCYF suspects physical and/or sexual abuse, the Contractor must ensure the child has access to an appropriate examination within 24 hours of notification that the child was removed from the home.

3.8.10.2.1.2 In cases in which the removal is for a reason other than suspected physical and/or sexual abuse, the Contractor must ensure that the child is screened within five calendar days of notification the child was removed from the home.

3.8.10.2.1.3 In all cases, the Contractor must ensure the child is screened within 30 calendar days of notification the child was removed from the home. Whenever possible this screening should be completed within a five-calendar day timeframe to reduce stress on the child.

3.8.10.2.2 *Adoptive Children*

3.8.10.2.2.1 The Contractor shall work with the DFS to assure appropriate coordination and delivery of services to members who are Adoption Assistance children covered under Title IV-E of the Social Security Act.

3.8.11 **Coordination with Division of Public Health (DPH)**

3.8.11.1 General

3.8.11.1.1 The Contractor must demonstrate effective coordination and linkages with the Delaware DPH.

3.8.11.1.2 The Contractor shall develop a memorandum of understanding (MOU) with DPH that defines communication and coordination between DPH and PCPs regarding community outreach and family support.

3.8.11.1.3 The Contractor must participate with DPH in the design and implementation of ongoing (periodic) community needs assessment to monitor access to health care and health status. The Contractor shall develop a coordinated plan with DPH regarding population-based and community prevention strategies.

3.8.11.1.4 The Contractor shall coordinate with DPH programs as described below.

3.8.11.2 Public Health Laboratory Services

3.8.11.2.1 Disease surveillance and disease control are core functions of the DPH and are supported by the Delaware Public Health Laboratory's testing for infectious and communicable diseases.

3.8.11.2.2 The Delaware Public Health Laboratory has identified the following critical public health tests:

3.8.11.2.2.1 Mycobacteriology;

3.8.11.2.2.2 Gonorrhea;

3.8.11.2.2.3 Chlamydia;

3.8.11.2.2.4 Human Immunodeficiency Virus I;

3.8.11.2.2.5 Viral Hepatitis;

3.8.11.2.2.6 Human Electrophoresis;

3.8.11.2.2.7 Viral Isolation and Identification; and

3.8.11.2.2.8 Blood Lead.

3.8.11.2.3 The Contractor's MOU with DPH shall specify whether the Contractor will use the services of the Delaware Public Health Laboratory or instead will report all results from the above tests to the Delaware Public Health Laboratory.

3.8.11.3 Universal Immunization Program

3.8.11.3.1 The Contractor shall require its participating PCPs to enroll with DPH to receive vaccines covered by the Vaccines for Children (VFC) program free of charge for both VFC eligible (Medicaid) children (funded by VFC) and DHCP children (paid for with State funds) and to use the free vaccine for its child members. The cost of vaccines covered by VFC is not included in the Contractor's Capitation Payment.

3.8.11.3.2 The Contractor shall pay providers the Regional maximum VFC vaccine administration fee for both Medicaid and DHCP children.

3.8.11.3.3 The vaccine administration fee for VFC covered vaccines for both Medicaid and DHCP children is included in the Contractor's capitation rates.

3.8.11.3.4 The Contractor shall ensure that its providers report all immunizations to the DPH Immunization Registry.

3.8.11.4 Child Development Watch (CDW) and Part C

3.8.11.4.1 CDW is a specialty service operated by the Delaware DPH based on Public Law 94-142, which was amended and reauthorized as Public Law 108-446, the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). CDW carries out the mandate of Part C of IDEA and Delaware Code Title 16, Chapter 2, Section 214 for children birth to three years of age. It includes the functions of early identification, central intake, developmental evaluation and diagnostic assessments, multidisciplinary team case conferences, and development of the Individualized Family Services Plan (IFSP) and services coordination carried out by a multidisciplinary team. The goal of the Part C program is to "enhance the State's capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to infants and toddlers with disabilities and their families."

3.8.11.4.2 The Contractor is responsible for:

3.8.11.4.2.1 Encouraging PCPs to refer to and participate in CDW multidisciplinary assessment teams and coordinating assessments and services with the CDW program. The multidisciplinary assessment is conducted by CDW and is paid for directly by the State.

3.8.11.4.2.2 Accepting the IFSP as documentation of Medical Necessity for assessment and treatment services recommended in the plan.

3.8.11.4.2.3 Paying for necessary assessments and Medically Necessary early intervention treatment services identified during the CDW assessment process and approved by the child's PCP and included on a child's IFSP/IEP.

3.8.11.4.2.4 Accepting a single denial from a commercial insurer on a one-time calendar-year basis for a child for any service recommended in an IFSP (i.e., a single claim denial will be accepted for the entire year for a child, rather than having to be

obtained each time a claim for the service is submitted by that provider for reimbursement) as evidence that other legally liable Third Party resources were exhausted.

3.8.11.4.2.5 Ensuring continuity of services as specified on a child's IFSP. In instances when a family transitions from one commercial insurer to another, the Contractor must continue reimbursement for services so that there is no break in the receipt of services.

3.8.11.4.2.6 In cases where a member who is Dually Eligible for Part C and Medicaid or DHCP Transfers from another MCO to the Contractor, the Contractor shall honor any prescriptions and prior authorizations for services required in the IFSP issued by the Transferring MCO for a 30 calendar day period while the Contractor works to issue such prescriptions and authorizations within its own provider network.

3.8.11.4.3 With parent permission, the CDW can provide the Contractor with a copy of the IFSP.

3.8.11.4.4 The Contractor shall ensure that services specified in the IFSP are provided in the child's natural environment, in accordance with IDEA (i.e., home or community setting, unless there is justification that early intervention cannot be achieved satisfactorily for the infant or child in the natural environment).

3.8.11.5 Coordination with School-Based Services Provided by the State

3.8.11.5.1 The State contracts with Delaware school districts to provide screening and health-related services that the schools must provide to children with special needs under IDEA. Under Part B of IDEA, school districts must prepare an IEP for each child, which specifies all special education and "related services" needed by the child. Per Federal policy the State can pay for some of the health "related services" if they are covered by Medicaid. Examples of health-related services commonly provided under an individualized education program (IEP) and reimbursed by Delaware Medicaid are physical therapy, speech pathology services, occupational therapy, psychological services and medical screening and assessment services. The least restrictive environment requirement has been interpreted to mean that therapy services should be delivered on school premises.

3.8.11.5.2 The State will continue to pay for these health-related services on an FFS basis. The Contractor is not responsible for paying for these services, but the Contractor must work with school districts and their providers to create and implement procedures for linking

and coordinating services for children who attend school and receive health-related services under an IEP. The Contractor must also coordinate with school districts and their providers to prevent the provision of duplicate services.

3.9 PROVIDER NETWORK

3.9.1 General

3.9.1.1 The Contractor must maintain and monitor a network of appropriate providers that is supported by written participation agreements and is sufficient to provide adequate access to all Covered Services in accordance with the access standards in this Contract (see Section 3.9.17 of this Contract). The Contractor's network shall include both in-State and out-of-State providers as necessary to meet these requirements.

3.9.1.2 The Contractor shall:

3.9.1.2.1 Pursuant to Section 1932(b)(7) of the Social Security Act and 42 CFR 438.214(c), not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

3.9.1.2.2 Pursuant to 42 CFR 438.12:

3.9.1.2.2.1 Not discriminate with respect to participation, reimbursement or indemnification of any provider acting within the scope of that provider's license or certification under applicable State law solely on the basis of the provider's license or certification;

3.9.1.2.2.2 Upon declining to include individual or groups of providers in its network, give the affected providers written notice of the reason for its decision;

3.9.1.2.2.3 Be allowed to negotiate different reimbursement amounts for different specialties or for different practitioners in the same specialty; and

3.9.1.2.2.3.1 Negotiate rates specific to physician administered drugs pursuant to section 1927(a)(5)(B) that account for special purchasing arrangements.

3.9.1.2.2.4 Be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to members.

3.9.1.2.3 Not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid or CHIP sanctions, except for Emergency Services.

3.9.1.2.4 In accordance with 42 CFR 438.206, consider, in establishing and maintaining the network of appropriate providers, its:

3.9.1.2.4.1 Anticipated membership;

3.9.1.2.4.2 Expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented in the Contractor's membership;

3.9.1.2.4.3 Numbers and types (in terms of training, experience, and specialization) of providers required to furnish Health Care Services;

3.9.1.2.4.4 Numbers of participating providers who are not accepting new patients; and

3.9.1.2.4.5 Geographic location of participating providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

3.9.1.2.5 Maintain written policies and procedures on provider recruitment, retention, and termination. The recruitment policies and procedures shall describe how the Contractor responds to a change in the network that affects access and its ability to deliver services in a timely manner.

3.9.1.2.6 Ensure that participating providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

3.9.1.2.7 Establish mechanisms such as notices or training materials to ensure that participating providers comply with the timely access requirements, monitor such compliance regularly, and take corrective action if there is a deficiency.

3.9.1.2.8 If the Contractor is unable to provide Medically Necessary Covered Services to a particular member within the access standards specified in this Contract (see Section 3.9.17 of the Contract) using a qualified participating provider, the Contractor shall provide the services using a qualified non-participating provider and shall do so for as long as the Contractor is unable to provide the services through a qualified participating provider within the applicable access standards.

3.9.1.2.9 Require non-participating providers to coordinate with the Contractor with respect to payment and ensure that cost to the member is no greater than it would be if the services were furnished by a participating provider.

3.9.1.2.10 Ensure and demonstrate that its providers are credentialed and recredentialed as required under 42 CFR 438.206(b)(6) and 42 CFR 438.214 and in accordance with Section 3.9.7 of this Contract.

3.9.1.2.11 Ensure that each provider providing services to members under this Contract has an NPI (or OEID or State assigned ID for atypical providers). This must be the same NPI/OEID/State-assigned ID number(s) used for enrollment in the Delaware Medicaid program if the provider is a DMAP-enrolled provider.

3.9.1.2.12 Collect and provide to the State participating provider information for addition to or matching with the DMAP provider file.

3.9.1.2.13 Ensure that all provider facilities are accessible as required by the Americans with Disabilities Act.

3.9.1.2.14 Monitor all provider activities to ensure compliance with State and Federal law and policy and the Contractor's policies and take corrective action if there is a failure to comply.

3.9.1.2.15 Provide quarterly performance reports to providers, built around a common template for all of Medicaid, that provide detail on provider performance on the common set of quality measures specified by the State and on certain utilization and cost measures specified by the State.

3.9.1.2.16 Ensure that PCPs successfully identify and refer members to specialty providers as Medically Necessary.

3.9.1.2.17 For members with special health care needs determined through an assessment by appropriate providers to need a course of treatment or regular care monitoring, have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

3.9.1.2.18 Provide to members and providers clear instructions on how to access Health Care Services, including those that require referral and/or prior authorization.

3.9.1.2.19 The Contractor shall allow each member to choose his or her participating provider to the extent possible and appropriate.

3.9.1.3 The Contractor shall ensure that all participating providers are enrolled with DMAP consistent with the provider disclosure, screening and enrollment requirements of 42 CFR Part 455, subparts B and E as incorporated in 42 CFR 438.608(b) prior to executing a provider participation agreement. Pursuant to 438.602(b)(2), the Contractor may execute a temporary provider participation agreement, pending the outcome of screening and enrollment with DMAP, of up to 120 days but must terminate a participating provider immediately upon notification from the State that the participating provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected members.

3.9.2 **Provider Network Documentation and Assurances**

3.9.2.1 The Contractor shall submit a Provider Network Development and Management Plan that at a minimum, shall include: (i) summary of participating providers, by type and geographic location in the State; (ii) demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services, per the requirements of this Contract; (iii) a summary of participating provider capacity issues by service and county, the Contractor's remediation and QM/QI activities and the targeted and actual completion dates for those activities; (iv) network deficiencies by service and by county and interventions to address the deficiencies; and (v) ongoing activities for provider network development and expansion taking into consideration identified participating provider capacity, network deficiencies, service delivery issues and future needs. The Contractor shall also submit an annual Provider Network Development and Management Evaluation Report that describes outcomes of the plan and lessons learned (see Section 3.21.9 of this Contract).

3.9.2.2 The Contractor shall submit a provider suspension/termination report in accordance with the requirements in Section 3.21.9 of this Contract.

3.9.2.3 The Contractor shall give additional assurances to the State and provide supporting documentation as specified by the State that demonstrates that the Contractor:

3.9.2.3.1 Has the capacity to provide Covered Services to members in accordance with the State's standards for access to care (see Section 3.9.17 of this Contract);

3.9.2.3.2 Offers an appropriate range of preventive, Primary Care, specialty services and behavioral health services that are adequate for the anticipated number of members;

3.9.2.3.3 Offers an appropriate range of LTSS, including institutional services and HCBS, that are adequate for the anticipated number of DSHP Plus LTSS members; and

3.9.2.3.4 Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members.

3.9.2.3.5 The Contractor shall submit this supporting documentation as specified by the State, but no less frequently than the following:

3.9.2.3.5.1 At the time it enters into this Contract; and

3.9.2.3.5.2 At any time there has been a significant change (as defined by the State) in the Contractor's operations that would affect adequate capacity and services, including, but not limited to:

3.9.2.3.5.2.1 Changes in Covered Services or the Contractor's payments; and

3.9.2.3.5.2.2 Enrollment of a new population in the Contractor's MCO.

3.9.3 Mainstreaming and Provider Non-Discrimination

3.9.3.1 The State considers mainstreaming of Medicaid clients into the broader health delivery system to be important. The Contractor, therefore, must ensure that all of its participating providers accept members for treatment. The Contractor must also ensure that participating providers do not intentionally segregate members in any way from other persons receiving services. Examples of prohibited practices include, but are not limited to, the following:

3.9.3.1.1 Denying or not providing to a member any Covered Service or availability of a facility.

3.9.3.1.2 Providing to a member any Covered Service that is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large.

3.9.3.1.3 Subjecting a member to segregation or separate treatment in any manner related to the receipt of any Covered Service.

3.9.3.1.4 The assigning of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, program enrollment, or physical or mental handicap of the members to be served.

3.9.3.1.5 Restricting Medicaid members to a clinic practice when a participating provider has office appointments for a non-Medicaid patient.

3.9.3.1.6 Closing panels to Medicaid members alone. If a provider's panel is closed, it must be closed to all patients. If a provider's plan reopens, the provider must accept patients on a first-come, first-served basis.

3.9.4 Cultural Competency

3.9.4.1 The Contractor shall encourage and foster Cultural Competency among its providers. This includes contracting with providers from different cultures and offering training on how to provide culturally appropriate care to members from different cultural and ethnic backgrounds, disabilities (physical, intellectual, and behavioral), and regardless of gender, sexual orientation or gender identity.

3.9.4.1.1 Training may be provided in-person, online via live or recorded webinar, online self-study, or by other reasonable means. The Contractor shall document training that is provided so that the provider directory requirements can reflect which providers have completed cultural competency training per Section 3.14.1.6.1.7 of this Contract.

3.9.5 Provider – Member Communications

3.9.5.1 In accordance with 42 CFR 438.102, the Contractor shall not prohibit or otherwise restrict a provider, if the provider is acting within the lawful scope of practice, from advising or advocating for a member who is a patient of the provider in the following areas:

3.9.5.1.1 The member's health status, medical care or treatment for the individual's condition of disease including any alternative treatment that may be self-administered, regardless of whether such care or treatment are Covered Services;

3.9.5.1.2 Any information the member needs in order to decide among relevant treatment options;

3.9.5.1.3 The risks, benefits and consequences of treatment or non-treatment; and

3.9.5.1.4 The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.9.5.2 This subsection, however, shall not be construed as requiring the Contractor to provide or reimburse any service if the Contractor:

3.9.5.2.1 Objects to the provision of a counseling or referral service on moral or religious grounds, provided that the Contractor:

3.9.5.2.1.1 Makes available information (consistent with the provisions of 42 CFR 438.10) on its policies and procedures regarding such service to potential members before Enrollment and to members at least 30 calendar days prior to the date the Contractor adopts a change in policy regarding such a counseling or referral service; and

3.9.5.2.1.2 Notifies the State within 10 business days after the effective date of this Contract of its current policies and procedures regarding the Contractor's objection to providing such counseling or referral services based on moral or religious grounds, or within 15 calendar days after Contractor adopts a change in policy regarding such counseling or referral service.

3.9.5.2.2 Can demonstrate that the service in question is not included in the Covered Services.

3.9.5.2.3 Determines that the recommended service is not a Medically Necessary service.

3.9.6 **Provider Services**

3.9.6.1 General

3.9.6.1.1 The Contractor must staff a provider services function that is responsible, at a minimum, for the following:

3.9.6.1.1.1 Assisting providers with questions concerning Covered Services and additional services and member Enrollment;

3.9.6.1.1.2 Assisting providers with prior authorization and referral procedures;

3.9.6.1.1.3 Assisting providers with claims payment procedures;

3.9.6.1.1.4 Handling provider claim disputes; and

3.9.6.1.1.5 Providing/offering/encouraging training to providers, including training to promote sensitivity to the special needs of the Medicaid population.

3.9.6.2 Provider Services Call Center

3.9.6.2.1 The Contractor shall operate a provider services call center with a dedicated toll-free telephone line to respond to provider questions, comments, inquiries and requests for prior authorizations. The provider services call center and its staff must be located in the

United States, and staff must be trained specifically for this Contract.

3.9.6.2.2 The Contractor shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means and compliance with standards.

3.9.6.2.3 The Contractor shall ensure that the provider service line is staffed adequately to respond to providers' questions at a minimum from 8:00 a.m. to 5:00 p.m. eastern time, Monday through Friday except State of Delaware holidays and to respond to UM requests for inpatient hospitalization 24 hours a day, seven days a week.

3.9.6.2.4 The Contractor shall have an automated system available during non-business hours. This automated system shall include, at a minimum, information on how to obtain after hours UM requests for services other than inpatient hospitalization and a voice mailbox for callers to leave messages. The Contractor shall ensure that the automated system has adequate capacity to receive all messages. The Contractor shall return messages on the next business day.

3.9.6.2.5 The provider service line shall be adequately staffed to provide appropriate and timely responses regarding authorization requests as described in Section 3.12 of this Contract. The Contractor may meet this requirement by having a separate UM line. The UM line shall be available as specified in Section 3.9.6.2.3 of this Contract, above.

3.9.6.2.6 The provider services call center staff shall have access to electronic documentation from previous calls made by a provider.

3.9.6.2.7 The Contractor shall adequately staff the provider service line to ensure that the line, including the UM line/queue, meets the following performance standards:

3.9.6.2.7.1 Less than 5% call abandonment rate;

3.9.6.2.7.2 80% of calls are answered by a live voice within 60 seconds (or the prevailing benchmark established by NCQA); and

3.9.6.2.7.3 Average wait time for assistance does not exceed 60 seconds.

3.9.6.3 <u>Provider Manual</u>

3.9.6.3.1 The Contractor shall develop, distribute, and maintain a provider manual that contains specific information for each type of

participating provider, including but not limited to PCPs, specialists, hospitals, behavioral health providers, nursing facilities and HCBS providers.

3.9.6.3.2 The provider manual shall be prior approved by the State.

3.9.6.3.3 The Contractor shall issue bulletins as needed to incorporate any necessary changes to the provider manual and shall review the entire provider manual at least annually.

3.9.6.3.4 The Contractor shall issue a copy or provide on-line access to the provider manual for each provider that submits claims or Encounter Data.

3.9.6.3.5 At a minimum, the provider manual shall include the following information, which shall comply with applicable requirements of this Contract:

3.9.6.3.5.1 A table of contents;

3.9.6.3.5.2 Description of Covered Services and additional services;

3.9.6.3.5.3 Prior authorization, referral and other UM requirements and procedures, including timeframes;

3.9.6.3.5.4 Medically Necessary service standards and clinical practice guidelines;

3.9.6.3.5.5 Appointment availability and office waiting time standards;

3.9.6.3.5.6 How to request and obtain a second opinion for members (see Section 3.4.7 of this Contract);

3.9.6.3.5.7 Emergency Services responsibilities;

3.9.6.3.5.8 The Contractor's case management program for DSHP Plus LTSS members, including the role of case managers;

3.9.6.3.5.9 The Contractor's care coordination program;

3.9.6.3.5.10 The delivery of EPSDT services;

3.9.6.3.5.11 PCP responsibilities;

3.9.6.3.5.12 Pharmacy and PCP lock-in standards and requirements;

3.9.6.3.5.13 Information on the Delaware Prescription Monitoring Program;

3.9.6.3.5.14 The Contractor's Fraud, Waste and Abuse policies and procedures, including how to report suspected Fraud, Waste or Abuse and the State's Fraud, Waste or Abuse hotline telephone number;

3.9.6.3.5.15 Requirements regarding coordination with other providers, Subcontractors and State contractors;

3.9.6.3.5.16 Credentialing and recredentialing requirements;

3.9.6.3.5.17 Requirements regarding background checks;

3.9.6.3.5.18 Information on reporting suspected abuse, neglect and financial exploitation of adults and reporting suspected abuse or neglect of children in accordance with State requirements;

3.9.6.3.5.19 Providers' responsibility to report Critical Incidents and how to report Critical Incidents;

3.9.6.3.5.20 Claims submission protocols and standards, including instructions and all information necessary to submit clean claims;

3.9.6.3.5.21 Protocol for Encounter Data reporting and documentation;

3.9.6.3.5.22 Payment policies;

3.9.6.3.5.23 Requirements for provider record maintenance and retention, including medical and financial records;

3.9.6.3.5.24 Requirements for cooperating with State and Federal agencies and their representatives;

3.9.6.3.5.25 Permitted and prohibited Marketing activities;

3.9.6.3.5.26 Confidentiality and HIPAA requirements;

3.9.6.3.5.27 Member rights and responsibilities;

3.9.6.3.5.28 Information about the DSHP and DSHP Plus Member Advocates, including contact information;

3.9.6.3.5.29 Information on the Grievance and Appeal System, including State Fair Hearings, which shall include but not be limited to the information in 42 CFR 438.10(g)(2)(xi) and Sections 3.15.8.1 and 3.15.8.2 of this Contract;

3.9.6.3.5.30 Policies and procedures of the provider complaint system;

3.9.6.3.5.31 Information on the Contractor's QM/QI program and provider responsibilities regarding QM/QI, including reports and/or clinical information to be submitted by providers to the Contractor;

3.9.6.3.5.32 Requirements for Cultural Competency as well as how the provider can access language interpretation services;

3.9.6.3.5.33 Information on the Contractor's provider website; and

3.9.6.3.5.34 The telephone number for the provider services line and the pharmacy services information line.

3.9.6.3.5.35 Requirement that a public health service entity obtain permission from the State in order to submit claims to the Contractor for drugs purchased through the 340B drug discount program.

3.9.6.4 Provider Website

3.9.6.4.1 The Contractor shall have a provider portal on its website that is accessible to providers. The portal shall include all pertinent information including, but not limited to, the provider manual, sample provider participation agreements, provider bulletins and notifications, and information about the ways to contact the Contractor's provider services and pharmacy service information line.

3.9.6.4.2 The provider portal shall have the functionality to allow providers to make inquiries and receive responses from the Contractor regarding care for members, including real-time eligibility information and electronic prior authorization request and approval.

3.9.6.4.3 The Contractor shall ensure the provider portal is updated regularly and contains accurate information.

3.9.6.5 Provider Education, Training and Technical Assistance

3.9.6.5.1 The Contractor shall submit a provider training and outreach plan to the State annually. The plan shall describe how the Contractor will educate participating providers on Contract requirements and the Contractor's processes and procedures to implement Contract requirements.

3.9.6.5.2 Training shall be offered throughout the State and at different times of the day in order to accommodate participating providers' schedules.

3.9.6.5.3 The provider training and outreach plan shall include, at a minimum:

3.9.6.5.3.1 Initial and ongoing provider training and education regarding Medicaid, the conditions of participation in the Contractor's MCO, billing processes, and the participating provider's responsibilities to the Contractor and its members; and

3.9.6.5.3.2 Initial and ongoing provider education and training to address clinical issues and improve the service delivery system, including, but not limited to, assessments, treatment plans, plans of care, discharge plans, evidence-based practices and models of care such as integrated care and trauma-informed care.

3.9.6.5.4 The education and training conducted under the provider training and outreach plan shall cover, at a minimum, all topics covered in the provider manual (see Section 3.9.6.3 of this Contract, above).

3.9.6.5.5 The Contractor shall provide to the State, upon request, documentation that provider education and training requirements have been met.

3.9.6.5.6 The Contractor shall provide technical assistance to participating providers as determined necessary by the Contractor or the State, including one-on-one meetings with providers. This technical assistance shall be provided in a culturally competent manner.

3.9.6.5.7 The Contractor shall maintain a record of its training and technical assistance activities, which it shall make available to the State upon request.

3.9.6.6 Provider Complaint System

3.9.6.6.1 The Contractor shall establish and maintain a provider complaint system that permits a provider to dispute the Contractor's policies, procedures, or any aspect of the Contractor's administrative functions, including proposed actions, claims, payments, and service authorizations.

3.9.6.6.2 The Contractor shall include its provider complaint system policies and procedures in its provider manual as described above.

3.9.6.6.3 The Contractor shall also distribute the provider complaint system policies and procedures, including claims issues, to non-participating providers with the remittance advice and upon request. The Contractor may distribute a summary of these policies and procedures, if the summary includes information about how

the provider may access the full policies and procedures on the Contractor's website. This summary shall also detail how the provider can request a hard copy from the Contractor at no charge.

3.9.6.6.4 As a part of the provider complaint system, the Contractor shall:

3.9.6.6.4.1 Identify a staff person specifically designated to receive and process provider complaints;

3.9.6.6.4.2 Allow providers 45 calendar days to file a written complaint for issues that are not about claims;

3.9.6.6.4.3 For complaints about claims, allow providers to file a written complaint no later than 12 months from the date of service or 60 calendar days after the payment, denial or recoupment of a timely claim submission, whichever is latest;

3.9.6.6.4.4 Within three business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution;

3.9.6.6.4.5 Ensure that staff who review, investigate and resolve a complaint have the appropriate experience and knowledge for that type of complaint and that Contractor executives with the authority to require corrective action are involved in the provider complaint process;

3.9.6.6.4.6 Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider participation agreement provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures;

3.9.6.6.4.7 Document why a complaint is unresolved after 30 calendar days of receipt and provide written notice of the status to the provider every 30 calendar days thereafter; and

3.9.6.6.4.8 Resolve all complaints within 90 calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three business days of resolution.

3.9.7 **Credentialing and Recredentialing**

3.9.7.1 In accordance with 42 CFR 438.214, the Contractor must have and follow a documented process for credentialing and recredentialing acute, behavioral,

substance use disorders, and LTSS participating providers before they provide services to members.

3.9.7.2 The Contractor's credentialing and recredentialing process or participation criteria shall ensure that all participating providers, including, but not limited to, licensed independent practitioners, licensed organizational providers, and non-licensed independent and organizational providers such as certain HCBS providers and certain behavioral health providers, are qualified to perform their services in accordance with the QMS.

3.9.7.3 The Contractor shall, at a minimum, comply with the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and recredentialing of providers (NCQA credentialing standards).

3.9.7.4 The Contractor shall ensure that all HCBS and behavioral health providers, including those credentialed/recredentialed in accordance with NCQA credentialing standards, meet applicable State requirements.

3.9.7.5 Per the Clinical Laboratory Improvement Act of 1998 (CLIA), the Contractor shall ensure that all participating laboratory testing sites have either a CLIA certification or waiver of certification with a CLIA identification number. The Contractor shall further ensure that laboratories with a certificate of waiver only provide those tests that are CLIA-waived.

3.9.7.6 The Contractor shall have a process that permits providers to apply for credentialing and recredentialing online.

3.9.7.7 The Contractor shall ensure that applicants for credentialing have not been excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Social Security Act.

3.9.7.8 The Contractor shall ensure that all participating providers have completed all required disclosures and shall collect and retain disclosure forms as specified in Section 3.16 of this Contract.

3.9.7.9 The Contractor shall refer any provider who notifies the Contractor of a change in location, licensure, certification, or status to the DMAP provider web portal for updating the provider's enrollment information/status with DMAP if the provider is enrolled with DMAP.

3.9.7.10 The Contractor shall complete the initial credentialing process for a provider in accordance with this Contract before the effective date of the provider's participation agreement for services under this Contract.

3.9.7.11 The Contractor shall completely process credentialing applications from all types of participating providers (physical health, behavioral health and LTSS providers) within 45 calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments. Completely

process shall mean that the Contractor shall review, approve and load approved applicants to its provider files in its claims processing system or deny the application, notify the provider, and ensure that the provider is not used by the Contractor for services under this Contract.

3.9.7.12 The Contractor must have an appeals process providers can use to challenge any denial of credentialing/recredentialing resulting from the Contractor's credentialing/recredentialing process.

3.9.7.13 The Contractor shall notify the State when the Contractor denies a provider credentialing/recredentialing application for program integrity-related reasons or otherwise limits the ability of a provider to participate in the program for program integrity reasons. This notice shall include, but not be limited to the identification of the provider, the reason for the denial and complete documentation to support the reason for the denial. See Section 3.16 of this Contract.

3.9.7.14 The Contractor shall screen all participating providers against the LEIE, SAM, EPLS and SSA DMF as part of initial credentialing and then monthly to ensure providers are not excluded.

3.9.7.15 The Contractor must monitor its providers and take appropriate action against providers who are found to be out-of-compliance with the Contractor's credentialing standards.

3.9.7.16 The Contractor shall recredential all participating providers other than HCBS providers every three years. The Contractor shall recredential or verify participation criteria for HCBS providers annually.

3.9.7.17 The Contractor's recredentialing process shall take into consideration provider performance data including, but not limited to, member Grievances and Appeals, provider audits, and quality of care/quality of service issues.

3.9.7.18 The Contractor's credentialing and recredentialing process for HCBS providers shall include assessment of each provider setting to ensure that all applicable HCB settings requirements are met. The Contractor shall use the process prescribed by DMMA.

3.9.8 **Primary Care Provider (PCP)**

3.9.8.1 <u>PCP Responsibilities</u>

3.9.8.1.1 The Contractor shall ensure that PCPs:

3.9.8.1.1.1 Maintain continuity of each member's health care by serving as the member's PCP;

3.9.8.1.1.2 Provide access 24 hours a day, seven days a week;

3.9.8.1.1.3 Facilitate appropriate member referral to specialty care and other Medically Necessary services not provided by the PCP;

3.9.8.1.1.4 Make an early detection of a child member's problems in development, behavior, social-emotional skills or mental health status, including the use of including the use of a reliable and validated screening tool prior approved by the Contractor, such as PEDS, and make appropriate referrals to address any identified problems;

3.9.8.1.1.5 Make an early identification of behavioral health needs, including the use of a reliable and validated screening tool prior approved by the Contractor, and make appropriate referrals to address behavioral health needs, including referral to PROMISE as appropriate;

3.9.8.1.1.6 Maintain a current medical record for the member, including documentation of all services provided to the member by the PCP as well as any specialty or referral services and report;

3.9.8.1.1.7 Adhere to the State's EPSDT periodicity schedule for members under age 21;

3.9.8.1.1.8 Follow the Contractor's procedures for coordination of in-network and out-of-network services for members; and

3.9.8.1.1.9 Cooperate with all QM/QI initiatives and programs established by the Contractor or the State.

3.9.8.1.2 Although PCPs are responsible for the above activities, the Contractor shall monitor PCPs to ensure they comply with the requirements of this Contract and the Contractor's policies.

3.9.8.1.3 The State encourages the Contractor to promote and support the establishment and use of patient-centered, multi-disciplinary, team-based approaches to care, including but not limited to: patient-centered medical homes (PCMHs); nurse-managed primary care clinics; integrated primary and behavioral health services; use of non-traditional health workers; and accountable care organizations (ACOs).

3.9.8.2 <u>Specialties Permitted to be PCPs</u>

3.9.8.2.1 The Contractor shall limit its PCPs to advanced nurse practitioners, nurse midwives and licensed physicians who are family or general practitioners, geriatricians, pediatricians, OB/GYNs or internists.

3.9.8.2.2 The Contractor shall have a procedure, prior approved by the State, for approving nephrologists as PCPs for members on dialysis. In all other cases, the Contractor shall request prior approval from the State, on a case-by-case basis, to allow a specialist to be a member's PCP.

3.9.8.2.3 The Contractor shall provide pediatric services in a wide range of settings, including community-based clinics, the member's home, child care facilities and schools, based on the needs of the child and the child's family.

3.9.8.3 PCP Teams

3.9.8.3.1 If the Contractor's network includes institutions with teaching programs, PCP teams (comprised of residents and a supervising faculty physician) may serve as a PCP.

3.9.8.3.2 In addition, the Contractor is encouraged to establish PCP teams that include certified nurse midwives, or advanced nurse practitioners who, at the member's discretion, may serve as the point of first contact for the member.

3.9.8.3.3 In both instances, the Contractor must organize its PCP teams so as to ensure continuity of care to members and must identify a "lead physician" within the team for each member. The "lead physician" must be an attending physician and available to provide direct service to the member should the member request it, and services must be provided under the NPI of the "lead physician."

3.9.8.4 PCP Selection or Assignment

3.9.8.4.1 The Contractor must have written policies and procedures for assisting members in the selection of a PCP and encouraging members to establish a relationship with their PCPs.

3.9.8.4.2 The HBM will solicit member's preference of PCPs (based on network information provided by the Contractor). If such a preference is indicated during communications with the HBM, this information will be included with the Enrollment information given to the Contractor. If no PCP selection is made via the HBM, or if the PCP's panel is closed, the Contractor shall assist the member with PCP selection.

3.9.8.4.3 The Contractor must contact a non-dual member within 15 business days of his/her Enrollment date and provide information on options for selecting a PCP or confirmation that the member has been assigned to the PCP of choice. To the extent provider

capacity exists, the Contractor must offer freedom of choice to members in making a selection.

3.9.8.4.4 If a non-dual member does not select a PCP within 30 calendar days of his/her Enrollment date, the Contractor must make an automatic assignment. The PCP auto-assignment shall take into account:

3.9.8.4.4.1 Member's relationship with PCP;

3.9.8.4.4.2 Other family member's current or past relationships with PCP;

3.9.8.4.4.3 Member's age;

3.9.8.4.4.4 Language of member; and

3.9.8.4.4.5 Geographic proximity of PCP.

3.9.8.4.5 The Contractor shall not assign a member to a PCP with a closed panel.

3.9.8.4.6 The Contractor shall assign all members that are reinstated after a temporary loss of eligibility to the PCP who was the member's PCP prior to loss of eligibility unless the member specifically requests another PCP, the PCP is no longer a participating PCP, or the PCP has a closed panel.

3.9.8.4.7 The Contractor must notify the member in writing of his/her PCP's name, location and office telephone number. The Contractor shall also transfer this information to the HBM.

3.9.8.4.8 When a member selects a PCP or is assigned a PCP, the Contractor shall notify the PCP and shall pay the PCP for services provided to the member retroactive to the member's effective date of Enrollment. This could include subcapitation for the Enrollment month or FFS.

3.9.8.5 <u>Changing PCPs</u>

3.9.8.5.1 The Contractor must have written policies and procedures for allowing members to select or be assigned to a new PCP when such a change is mutually agreed to by the Contractor and member, when a PCP is terminated from the Contractor, or when a PCP change is ordered as part of the resolution to a formal Grievance proceeding. The Contractor shall document PCP changes and the reasons given for member requests for PCP changes.

3.9.8.5.2 In cases where a PCP has been terminated, the Contractor shall provide written notice to the member and allow members to select another PCP or make a reassignment within 15 business days of the termination effective date. If the member does not select a new PCP, the Contractor may assign one to the member in accordance with Section 3.9.8.4 of this Contract, above.

3.9.8.5.3 The Contractor may initiate a PCP change for a member under the following circumstances:

3.9.8.5.3.1 The member requires specialized care for an acute or chronic condition and the member and Contractor agree that reassignment to a different PCP is in the member's interest. If the new PCP is a specialist, approval must be granted by the State under 3.9.8.2.2 prior to assignment.

3.9.8.5.3.2 The member's PCP ceases to participate in the Contractor's network.

3.9.8.5.3.3 The member's behavior toward the PCP is disruptive and the PCP has made all reasonable efforts (three attempts within 90 calendar days) to accommodate the member.

3.9.8.5.3.4 The member has taken legal actions against the PCP.

3.9.8.6 PCP Lock-In

3.9.8.6.1 The State shall allow the Contractor to require that a member receive services from a specific PCP when the Contractor has identified continuing utilization of unnecessary services or repeated occurrences of drug seeking behaviors. Prior to placing the member on PCP lock-in, the Contractor shall inform the member of the intent to lock-in, including the reasons for imposing the PCP lock-in. The Contractor's Grievance process shall be made available to any member being designated for PCP lock-in. The member shall be removed from PCP lock-in when the Contractor has determined that the utilization problems have been solved and that recurrence of the problems is judged to be improbable. The Contractor shall document, track and report to the State on lock-ins and lock-in removals (see Section 3.21.9 of this Contract).

3.9.9 **Pharmacies**

3.9.9.1 The Contractor shall comply with the requirements in Section 3.5.7 of this Contract regarding its pharmacy provider network.

3.9.10 **FQHCs**

3.9.10.1 The Contractor shall offer participation agreements to all FQHCs enrolled with DMAP that are located in the State of Delaware, and such participation agreements must include at least the same service array as the State Medicaid FFS contracts with FQHCs.

3.9.11 **School-Based Wellness Centers**

3.9.11.1 The Contractor shall offer participation agreements to all School-Based Wellness Centers (SBWCs) enrolled with DMAP, and such participation agreements must include at least the same service array covered by the State's Medicaid FFS program for the applicable SWBC.

3.9.12 **Mobile Vision**

3.9.12.1 The State anticipates implementing a pilot program for mobile vision that would provide eye exams and eyeglasses to elementary school age children.

3.9.12.2 If the State decides to continue the pilot or implement a mobile vision program during the term of this Contract, the Contractor shall participate in the pilot or program.

3.9.13 **Behavioral Health Providers**

3.9.13.1 Consistent with the requirements of the DOJ Settlement Agreement, the State has developed infrastructure to support a Statewide crisis system including mobile crisis teams, crisis walk-in centers and crisis stabilization services. The Contractor shall have provider participation agreements with mobile and facility-based crisis intervention providers certified by DSAMH.

3.9.14 **LTSS Providers**

3.9.14.1 The Contractor shall offer provider participation agreements to all nursing facilities enrolled with DMAP that are Medicare/Medicaid certified nursing facilities, and such participation agreements must include at least the same service array as the State Medicaid FFS contracts with Medicare/Medicaid certified nursing facilities.

3.9.14.2 <u>Time and Distance Requirements for LTSS</u>

3.9.14.2.1 The Contractor shall contract with sufficient providers such that DSHP Plus LTSS members have a travel distance of no more than 30 miles or 45 minutes between an appropriate facility placement for their individualized needs (such as, a nursing facility, assisted living facility, or adult day program) and the member's residence before entering the placement.

3.9.14.2.2 The Contractor shall contract with sufficient providers to enable DSHP Plus LTSS members to have, at a minimum, a choice between two providers of personal care attendant services

3.9.14.3 The Contractor shall have adequate HCBS provider capacity to meet the needs of DSHP Plus LTSS members and to provide authorized HCBS within the timeframe described in Section 3.7 of this Contract. This includes initiating and continuing HCBS according to the amount, frequency, duration and scope specified in the member's plan of care.

3.9.14.4 LTSS Alternate Service Wait Times

3.9.14.4.1 For the enumerated services, the maximum allowable time between service authorization by the Contractor to service implementation is as follows:

3.9.14.4.1.1 No more than 60 calendar days for minor home modifications;

3.9.14.4.1.2 No more than 10 calendar days for home delivered meals;

3.9.14.4.1.3 No more than 10 calendar days for personal care attendant services for new members; and

3.9.14.4.1.4 Immediately upon authorization for personal care attendant services for members currently placed in a nursing facility and transitioning to the community.

3.9.14.4.2 The Contractor shall provide a report on each of the categories of service authorizations set forth in Section 3.9.14.4.1 every 180 days, together with the geographical access reports set forth in Section 3.21.9.1.

3.9.15 **Family Planning Providers**

3.9.15.1 Per Section 1902(a)(23) of the Social Security Act, the Contractor must allow members freedom of choice of family planning providers, including access without referral or prior authorization, to non-participating family planning providers. While family planning is a benefit for DHCP members, this "freedom of choice" option does not apply to DHCP members.

3.9.16 **Pediatric Specialists**

3.9.16.1 The Contractor must use specialists with pediatric expertise for children where the need for pediatric specialty care is significantly different from the need for

adult specialists (e.g., a pediatric cardiologist for children with congenital health defects).

3.9.16.2 The Contractor must ensure that Children with Special Health Care Needs have access, when needed, to pediatric subspecialty care in a wide range of fields through participation agreements and single case agreements and other provider arrangements and procedures for accessing non-participating pediatric subspecialty providers.

3.9.17 **Access Standards and Requirements**

3.9.17.1 Provider to Member Ratios

3.9.17.1.1 The Contractor shall demonstrate adequate provider capacity, which shall include complying with the following:

3.9.17.1.1.1 The Contractor shall clearly demonstrate that its Primary Care network has sufficient capacity such that there will be at least one full time equivalent PCP for every 2,500 DSHP/DSHP Plus members, accounting for non-DSHP/DSHP Plus patients, unless both physician and member agree that the member can safely be added to the caseload of the physician of his/her choice. The State encourages the Contractor to have higher PCP levels (i.e., lower PCP: member ratios). The Contractor shall require each PCP to provide the Contractor with quarterly reports regarding current caseload, including non-DSHP/DSHP Plus patients.

3.9.17.1.1.2 The number of members assigned to a PCP shall be decreased by the Contractor if necessary to maintain the appointment availability standards or to avoid the PCP from having a caseload or medical practice composed predominately of DSHP/DSHP Plus members.

3.9.17.2 Time and Distance Requirements

3.9.17.2.1 The Contractor shall contract with sufficient providers to enable members to receive Covered Services from the following providers within 30 miles or 45 minutes from the member's primary residence for the following services:

3.9.17.2.1.1 Adult primary care. Adult primary care includes family practitioners, general practitioners, internists, geriatricians and advanced nurse practitioners. The Contractor must make available, to every member who is not a Dual Eligible, a choice of two PCPs who meet the required time and distance standard. Members may, at their discretion, select PCPs located farther from their primary residence.

3.9.17.2.1.2 Pediatric primary care. Pediatric primary care includes family practitioners, general practitioners, pediatricians and advanced nurse practitioners. The Contractor must make available, to every member who is not a Dual Eligible, a choice of two PCPs who meet the required time and distance standard. Members may, at their discretion, select PCPs located farther from their primary residence.

3.9.17.2.1.3 Adult specialty care high volume providers. Adult specialty care high volume providers includes allergy and immunology, cardiology, dermatology, endocrinology, gastroenterology, hematology and oncology, infectious disease, nephrology, neurology, ophthalmology, orthopedic surgery, otolaryngology, podiatry, pulmonology, rheumatology, general surgery, and urology.

3.9.17.2.1.4 Adult specialty care, high volume providers are those specialties that are accessed and used by 1% or more of the Delaware Medicaid managed care population.

3.9.17.2.1.5 Pediatric specialty care high volume providers. Pediatric specialty care high volume providers include neurology, cardiology, otolaryngology, pulmonology, and orthopedic surgery.

3.9.17.2.1.6 Pediatric specialty high volume providers are pediatric specialists who have completed the necessary education and fellowship and have current board certification if available for that specialty. This criteria applies to newly credentialed providers who are board eligible as well as those who have been grandfathered by the Contractor. High volume providers are those specialties that are accessed and used by 1% or more of the Medicaid managed care population.

3.9.17.2.1.7 Obstetrics and gynecology.

3.9.17.2.1.8 Adult and pediatric behavioral health. Adult and pediatric behavioral health care includes licensed prescriber (psychiatrist, nurse practitioner, physician's assistant, psychiatric clinical nurse specialist), psychologist, other licensed behavioral health practitioners (licensed clinical social work, licensed marriage and family therapist, licensed professional counselor), as well as inpatient facilities such as a free standing inpatient psychiatric facility and a hospital-based psychiatric unit.

3.9.17.2.1.9 Adult and pediatric substance use disorder. Adult and pediatric substance use disorder care includes addiction medicine, and substance use disorder treatment programs, including intensive outpatient, inpatient, partial hospitalization, residential, and withdrawal management.

3.9.17.2.1.10 Long term care supports and services. Long term care supports and services include services in licensed nursing facilities, licensed adult day programs, and licensed assisted living facilities. Time and distance requirements for long term care support services are located in Section 3.9.14.2.

3.9.17.2.2 Contractor shall contract with sufficient providers to enable members to receive Covered Services from the following providers within 15 miles or 20 minutes from the member's primary residence for the following services:

3.9.17.2.2.1 Hospitals or emergency departments;

3.9.17.2.2.2 Pharmacy.

3.9.17.3 Appointment Standards

3.9.17.3.1 The Contractor shall, at a minimum, meet the appointment standards in the State's Quality Management Strategy (QMS).

3.9.17.3.2 The Contractor shall disseminate its appointment standards to participating providers and shall educate participating providers about appointment standards.

3.9.17.3.3 The Contractor must assign a specific staff person to monitor and ensure compliance with its appointment standards.

3.9.17.3.4 The Contractor shall require its participating providers to maintain a master history of appointments for a minimum of one year from the date of service to allow for monitoring and investigation of Grievances related to scheduling.

3.9.17.3.5 The Contractor shall monitor member Grievances about appointment standards.

3.9.17.3.6 The Contractor shall require providers to implement a corrective action plan when appointment standards are not met.

3.9.17.3.7 *General Standards*

3.9.17.3.7.1 The Contractor shall meet the general appointment standards in the QMS, including but not limited to the following:

3.9.17.3.7.1.1 Emergency Services are available 24 hours a day, seven days a week.

3.9.17.3.7.1.2 PCP appointments that meet the definition of an "emergency condition" are available the same day. Examples of emergency conditions are: high temperature, persistent vomiting or diarrhea or symptoms which are of sudden or severe onset but which do not require emergency room services.

3.9.17.3.7.1.3 PCP appointments for Urgent Care are available within two calendar days. Examples of Urgent Care include: persistent rash, recurring high-grade temperature, non-specific pain or fever.

3.9.17.3.7.1.4 Routine Care appointments (e.g., well-child exams, routine physical exams) are available within three weeks of member request.

3.9.17.3.8 *Specialty Services*

3.9.17.3.8.1 The Contractor shall meet the appointment standards in the QMS for specialty services, including, but not limited to, the following:

3.9.17.3.8.1.1 Emergency care on an immediate basis, at the nearest facility available, regardless of whether the facility is a participating provider.

3.9.17.3.8.1.2 Urgent Care appointments within 48 hours of member request.

3.9.17.3.8.1.3 Routine appointments within three weeks of member request.

3.9.17.3.9 *Maternity Care*

3.9.17.3.9.1 For maternity care, the Contractor shall provide prenatal care appointments for pregnant members as specified in the QMS, including:

3.9.17.3.9.1.1 First trimester within three weeks of member request.

3.9.17.3.9.1.2 Second trimester within seven calendar days of member request.

3.9.17.3.9.1.3 Third trimester within three calendar days of member request.

3.9.17.3.9.1.4 High-risk pregnancies within three calendar days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.

3.9.17.3.10 *Behavioral Health*

3.9.17.3.10.1 For behavioral health services, the Contractor shall provide appointments as follows:

3.9.17.3.10.1.1 Emergency Services within 24 hours of request.

3.9.17.3.10.1.2 Immediate treatment for a potentially suicidal individual, including mobile team response, within one hour.

3.9.17.3.10.1.3 Routine outpatient services within seven calendar days of request with non-prescribing clinician for:

3.9.17.3.10.1.3.1 Requests for an initial assessment;

3.9.17.3.10.1.3.2 Members being discharged from an inpatient or residential setting to a community placement; and

3.9.17.3.10.1.3.3 Members seen in an emergency room or by a behavioral health crisis provider for a behavioral health condition.

3.9.17.3.10.1.4 Non-emergency outpatient services within three weeks of request for prescribing clinician services.

3.9.17.4 <u>Office Waiting Times</u>

3.9.17.4.1 The Contractor shall ensure that providers do not make members with appointments wait longer than one hour. Office visits can be delayed when a provider "works in" urgent cases, when a serious problem is found, or when a patient had an unknown need that requires more services or education than was described at the time the appointment was made. If a physician or other provider is delayed, patients must be notified as soon as possible so they understand the delay. If the delay will result in a more than a 90 minute wait, then the patient must be offered a new appointment.

3.9.18 **Network Changes**

3.9.18.1 General

3.9.18.1.1 The State must approve all PCP caseloads over 2,500 patients.

3.9.18.1.2 If for any reason the Contractor's network does not meet the access standards in this Contract, the Contractor shall immediately submit a corrective action plan to the State for approval.

3.9.18.1.3 Upon notification from the State that a corrective action plan designed to remedy a network deficiency has not been accepted, the Contractor shall immediately provide written notice to members living in the affected area of a provider shortage in the Contractor's network.

3.9.18.1.4 The Contractor may submit a written request to the State for an exemption from the applicable access standard. The request must specify the provider type, the applicable access standard and the reason for the request and must include written documentation of the Contractor's inability to meet the access standard. The State may grant an exemption, in writing, and establish case-by-case requirements as a condition of granting the exemption. If an exception is granted by the State, the Contractor shall update the annual Provider Network Development and Management Plan with recruiting initiatives that seek to improve network adequacy for the access standard that required an exception. The State will not grant an exemption when the only reason for the request is that an available provider will not sign a participation agreement with the Contractor.

3.9.18.2 Network Change Notification to Members

3.9.18.2.1 *PCP Termination*

3.9.18.2.1.1 If a PCP ceases participation in the Contractor's MCO, the Contractor shall provide written notice of termination of a participating PCP as soon as possible, but no less than 30 calendar days prior to the effective date of the termination and within 15 calendar days after receipt or issuance of the termination notice, to each member who has chosen or been assigned to that provider as his/her PCP, or was seen on a regular basis by the terminated PCP. The requirement to provide notice 30 calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider's death, the provider failing to provide 30 calendar days advance notice to the Contractor, the provider moving

from the service area and failing to notify the Contractor or a provider failing credentialing, and instead shall be made immediately upon the Contractor becoming aware of the circumstances.

3.9.18.2.2 *Termination of Non-PCP Providers Providing Ongoing Treatment, including LTSS Providers*

3.9.18.2.2.1 If a member is in a prior authorized ongoing course of treatment with any non-PCP participating provider who becomes unavailable to continue to provide services to such member and the Contractor is aware of such ongoing course of treatment, the Contractor shall provide written notice to each member as soon as possible but no less than 30 calendar days prior to the effective date of the termination and no more than 15 calendar days after receipt or issuance of the termination notice. The Contractor shall assist members in locating a new non-PCP provider within seven business days to avoid discontinuation or delay of ongoing course of treatment. The requirement to provide notice 30 calendar days prior to the effective date of termination shall be waived in instances where a provider becomes physically unable to care for members due to illness, a provider's death, the provider failing to provide 30 calendar days advance notice to the Contractor, the provider moving from the service area and failing to notify the Contractor or a provider failing credentialing, and instead shall be made immediately upon the Contractor becoming aware of the circumstances.

3.9.18.2.3 *Other Non-PCP Provider Termination*

3.9.18.2.3.1 If a non-PCP provider, including, but not limited to, a specialist or hospital, ceases participation in the Contractor's MCO, the Contractor shall provide written notice to members who have been seen and/or treated by the non-PCP provider within the last six months. Notice shall be issued no less than 30 calendar days prior to the effective date of the termination of the non-PCP provider when possible or immediately upon the Contractor becoming aware of the termination.

3.9.18.3 Network Change Notification to the State

3.9.18.3.1 *Hospital Termination*

3.9.18.3.1.1 Termination of the Contractor's provider participation agreement with any hospital, whether or not the termination is initiated by the hospital or by the Contractor, shall be reported

by the Contractor in writing to the State no less than 30 calendar days prior to the effective date of the termination.

3.9.18.3.2 *Other Provider Terminations*

3.9.18.3.2.1 The Contractor shall notify the State of any provider termination, providing documentation of the provider's name, NPI and the number of members affected within five business days of the provider's termination. The Contractor shall also notify DSAMH, in accordance with DSAMH's processes, if any members affected are participating in PROMISE. The Contractor shall also notify DDDS in accordance with DDDS's processes, if any members affected are enrolled in the DDDS Lifespan Waiver.

3.9.18.3.2.2 If the termination was initiated by the provider, the notice to the State shall include a copy of the provider's notification to the Contractor. The Contractor shall maintain documentation of all information, including a copy of the actual member notice(s), onsite.

3.9.18.3.2.3 Upon request, the Contractor shall provide the State a copy of the following: one or more of the actual member notices mailed, an electronic listing identifying each member to whom a notice was sent, a transition plan for the members affected, and documentation from the Contractor's mail room or outside vendor indicating the quantity and date member notices were mailed as proof of compliance with the member notification requirements.

3.9.18.4 <u>Provider Termination by Contractor</u>

3.9.18.4.1 The Contractor must provide written notice of termination to the provider(s) and such notice shall include:

3.9.18.4.1.1 The reason(s) for the proposed termination;

3.9.18.4.1.2 Notice that the provider has a right to request a hearing or review by the Contractor;

3.9.18.4.1.3 A time limit of not less than 30 calendar days within which the provider may request a hearing or review by the Contractor; and

3.9.18.4.1.4 A time limit for completion of a hearing or review of not more than 60 calendar days after the receipt of the request for a hearing or review.

3.9.18.4.2 In addition to the required notification to the State of provider termination described in Section 3.9.18.3.2.1, if the termination is by the Contractor, the Contractor shall submit to the State documentation of the cause for termination and the results of any hearing or review by the Contractor.

3.9.19 **Telemedicine Requirements**

3.9.19.1 The Contractor shall promote and employ broad-based utilization of Statewide access to HIPAA-compliant Telemedicine service systems including, but not limited to, access to TTYs and 711 Telecommunication Relay Services.

3.9.19.2 The Contractor's Telemedicine program shall align with the State's objectives in recognizing Telemedicine including, but not limited to:

3.9.19.2.1 Improved access to Health Care Services with no loss in quality, safety, or access to existing Health Care Services;

3.9.19.2.2 Improved access to medical subspecialties not widely available in a service area;

3.9.19.2.3 Improved client/member compliance with treatment plans;

3.9.19.2.4 Health care services rendered at an earlier stage of disease;

3.9.19.2.5 Improved health outcomes for patients; and

3.9.19.2.6 Reduced costs for Covered Services such as hospitalizations and transportation.

3.9.19.3 The Contractor shall follow accepted HIPAA and 42 CFR Part 2 regulations that affect Telemedicine transmission, including, but not limited to, staff and provider training, room setup, security of transmission lines, etc. The Contractor shall have and implement policies and procedures that follow all Federal and State security and procedure guidelines.

3.9.19.4 The Contractor shall identify, develop, and implement training for accepted Telemedicine practice.

3.9.19.5 The Contractor shall participate in the needs assessment of the organizational, developmental, and programmatic requirements of Telemedicine programs.

3.9.19.6 The Contractor shall comply with State Telemedicine requirements.

3.9.19.7 The Contractor shall ensure provider compliance with the State Telemedicine requirements, including, but not limited to:

3.9.19.7.1 Obtaining member's written consent;

3.9.19.7.2 Licensure and enrollment requirements;

3.9.19.7.3 Written contingency planning;

3.9.19.7.4 Implementation of confidentiality protocols; and

3.9.19.7.5 Billing practices and requirements.

3.10 PROVIDER PARTICIPATION AGREEMENTS

3.10.1 General

3.10.1.1 The Contractor must execute participation agreements with providers, and such participation agreements shall comply with this Section 3.10 of the Contract.

3.10.1.2 The Contractor shall submit to the State for review templates/sample participation agreements for each type of participating provider. Any changes to templates/sample participation agreements that may materially affect members shall be approved by the State prior to execution by any participating provider.

3.10.1.3 The Contractor shall revise participation agreements as directed by the State.

3.10.1.4 No participation agreement terminates or reduces the legal responsibility of the Contractor to the State to ensure that all activities under the Contract are carried out. It shall be the responsibility of the Contractor to provide all necessary training and information to participating providers to ensure satisfactory performance of all Contractor responsibilities as specified in the Contract.

3.10.1.5 The Contractor shall not include covenant-not-to-compete requirements in its participation agreements. The Contractor shall not execute a participation agreement that requires a participating provider not provide services for any other MCO.

3.10.1.6 The Contractor shall not prohibit a participating provider from entering into a contractual relationship with another MCO, nor include any incentive or disincentive that encourages a participating provider not to enter into a contractual relationship with another MCO.

3.10.1.7 The Contractor shall not execute participation agreements that contain compensation terms that discourage participating providers from serving any specific eligibility category or population covered by the Contract.

3.10.1.8 In accordance with 42 CFR 438.102, no participation agreement shall prohibit or otherwise restrict a participating provider, if the participating provider is acting

within the lawful scope of practice, from advising or advocating for a member who is a patient of the participating provider (see Section 3.9.5 of this Contract).

3.10.1.9 The Contractor shall conduct background checks and credentialing activities as required by State or Federal law and regulation on all participating providers before entering into any participation agreement with such provider.

3.10.1.10 The Contractor may enter into single case agreements with providers performing Covered Services who are not willing to become a part of the Contractor's provider network.

3.10.2 **Minimum Requirements for Participation Agreements**

3.10.2.1 All participation agreements executed by the Contractor, and all participation agreements executed by Subcontractors, shall be in writing and shall comply with the following, as applicable to the provider type:

3.10.2.1.1 Identify, define, and specify the amount, duration, and scope of each service that the participating provider must offer.

3.10.2.1.2 Identify the participating provider's activities or responsibilities related to the provision of Health Care Services.

3.10.2.1.3 Specify that participating providers may not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of the member's diagnosis, type of illness, or condition.

3.10.2.1.4 Require the participating provider to render services in accordance with Medical Necessity as defined in the Contractor's Contract with the State (see Section 3.4.5 of this Contract).

3.10.2.1.5 Include a signature page that contains the Contractor and participating provider names which are typed or legibly written, participating provider company with titles, and dated signatures of all appropriate parties.

3.10.2.1.6 Specify the effective dates of the participation agreement.

3.10.2.1.7 Specify that the participation agreement and its attachments contain all the terms and conditions agreed upon by the parties.

3.10.2.1.8 Require compliance with applicable access requirements, including, but not limited to, appointment and wait times as referenced in Section 3.9.17 of this Contract.

3.10.2.1.9 If the participating provider performs laboratory services, require the provider to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988, including

either a CLIA certification or waiver of certification with a CLIA identification number.

3.10.2.1.10 Require the provider to maintain and share, as appropriate, complete and accurate medical records in accordance with the Contractor's policies and in accordance with professional standards.

3.10.2.1.11 Require that the provider maintain an adequate record system, including, but not limited to, medical and financial records, and that all records be retained for five years from the close of the participation agreement or until all evaluations, audits, reviews or investigations or prosecutions are completed, if longer than five years. (See Section 5.5.3 of this Contract.)

3.10.2.1.12 Include a statement that the participating provider shall give the State or its authorized representative, such as MFCU, any Federal oversight agency, such as DHHS and the DOJ, and any other authorized Federal agency, including authorized representatives of the Federal agency, immediate access to the provider's records upon request, including records requested for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions. Include a statement that HIPAA does not bar disclosure of protected health information (PHI) to the State, authorized Federal agencies, or authorized representatives of the State or Federal agency. (See Section 5.5.1 of this Contract.)

3.10.2.1.13 Include a statement that the participating provider shall give the State and/or its authorized representatives and the Federal government and/or its authorized representatives during normal business hours the right to enter into the premises of the provider, to inspect, monitor, audit, or otherwise evaluate the work being performed. (See Section 5.5.2 of this Contract.)

3.10.2.1.14 Require the participating provider to agree to cooperate with any State or Federal inspection, evaluation, review, audit or investigation.

3.10.2.1.15 Specify the Contractor's responsibilities under the Contract and its agreement with the participating provider, including, but not limited to, provision of a copy of the member handbook and provider manual whether via web site or otherwise and notifying a participating provider of denied authorizations.

3.10.2.1.16 Specify that the participation agreement may be suspended by the Contractor if the provider is suspended by the Delaware Medicaid program (see Section 3.16 of this Contract).

3.10.2.1.17 Include the procedures and specific criteria for terminating the participation agreement including provisions for termination if the provider is terminated from participation in the Delaware Medicaid program, another Medicaid program, or Medicare, for breach of the provider agreement and any violation of applicable State or Federal law. The Contractor shall provide written notice of contract termination to the participating provider(s) in accordance with Section 3.9.18.4 of this Contract.

3.10.2.1.18 Specify that the Contractor shall monitor the quality of services delivered under the participation agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical, behavioral health, or LTSS that is recognized as acceptable professional practice in the respective community in which the participating provider practices and/or the standards established by the State.

3.10.2.1.19 Require the participating provider's participation and cooperation in any QM/QI monitoring, UM, Peer Review and/or Appeal procedures established by the Contractor and/or the State, including any remediation or quality improvement activities.

3.10.2.1.20 Require that the participating provider comply with corrective action plans initiated by or requested by the Contractor.

3.10.2.1.21 Provide that Emergency Services be rendered without the requirement of prior authorization of any kind.

3.10.2.1.22 Require that member information be kept confidential, in accordance with Federal and State law.

3.10.2.1.23 Provide for the timely submission of all reports and clinical information required by the Contractor.

3.10.2.1.24 Require participating provider to comply with the requirements of the Delaware Prescription Monitoring Program (PMP) and to query the PMP to view information about client usage before prescribing Schedule II or III controlled substances.

3.10.2.1.25 Specify that the Contractor shall only pay participating providers for services (i) provided in accordance with the requirements of the Contract, the Contractor's policies and procedures implementing the Contract, and State and Federal law and (ii) provided to the Contractor's member; and specify that the participating provider is

responsible for (i) ensuring that any applicable authorization requirements are met and (ii) verifying that a member is eligible for services on the date of service.

3.10.2.1.26 Require prompt submission of information needed to make payment. Specify that a participating provider shall have 120 calendar days from the date of rendering a Covered Service to file a claim with the Contractor except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a Third Party or if a member is Enrolled in the Contractor's MCO with a retroactive eligibility date. In situations of Third Party benefits, the maximum timeframes for filing a claim shall begin on the date that the Third Party documented resolution of the claim. In situations of Enrollment in the Contractor's MCO with a retroactive eligibility date, the timeframes for filing a claim shall begin on the date that the Contractor receives notification from the State of the member's eligibility/Enrollment.

3.10.2.1.27 Provide for payment to the participating provider upon receipt of a clean claim properly submitted by the provider within the required timeframes as specified in Section 3.18.1 of this Contract.

3.10.2.1.28 Provide for the Contractor to suspend payment to the provider if directed by the State (see Section 3.16 of this Contract).

3.10.2.1.29 Include the reimbursement rates and risk assumption, if applicable.

3.10.2.1.30 Describe, as applicable, any physician incentive plan and any other pay for performance programs the participating provider is subject to.

3.10.2.1.31 Specify the participating provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the member's Third Party payor) plus the amount of any applicable member's cost sharing responsibilities, as payment in full for Covered Services or additional services provided and shall not solicit or accept any payment from the member in excess of the amount of applicable member cost sharing responsibilities.

3.10.2.1.32 For those agreements where the participating provider is compensated via an arrangement other than FFS (e.g., capitation, bundled payment), language that requires:

3.10.2.1.32.1 That if a participating provider becomes aware for any reason that he/she is not entitled to a payment for a particular member (a patient dies, for example), the provider shall immediately

notify both the Contractor and the State by certified mail, return receipt requested; and

3.10.2.1.32.2 The participating provider to promptly submit utilization or Encounter Data as specified by the Contractor so as to ensure the Contractor's ability to submit Encounter Data to the State that meets the same standards of completeness and accuracy as required for proper adjudication of FFS claims.

3.10.2.1.33 Require the participating provider to comply with program integrity requirements described in Section 3.16 of this Contract, including, but not limited to, identification and reporting of suspected Fraud, Waste and Abuse.

3.10.2.1.34 Require that the participating provider comply with Federal and State policy regarding overpayments, including, but not limited to, reporting overpayments and, when it is applicable, returning overpayments to the Contractor within 60 calendar days from the date the overpayment is identified. Overpayments that are not reported and returned within 60 calendar days from the date the overpayment was identified may result in a penalty pursuant to State or Federal law.

3.10.2.1.35 Require participating providers to submit Federal disclosure forms in accordance with Section 3.16.2 of this Contract.

3.10.2.1.36 Specify that any reassignment of payment must be made in accordance with 42 CFR 447.10. All tax-reporting provider entities shall not be permitted to assign State funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly Federal exclusion (LEIE) and debarment (EPLS/SAM) screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

3.10.2.1.37 Require participating providers to screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider must immediately report to the Contractor any exclusion information discovered. The participating provider shall be informed by the Contractor that civil monetary penalties may be imposed against providers who employ or enter

into contracts with excluded individuals or entities to provide items or services to members.

3.10.2.1.38 Include that the participating provider understands and agrees that each claim the participating provider submits to the State or the Contractor constitutes a certification that the participating provider has complied with all applicable Federal and State law (including, but not limited to, the Federal anti-kickback law and the Stark law) and program requirements, in connection with such claims and the services provided therein.

3.10.2.1.39 Require the participating provider to report suspected abuse, neglect and financial exploitation of adults and suspected abuse or neglect of children in accordance with State law.

3.10.2.1.40 Require that, for DSHP Plus LTSS members, the participating provider facilitate notification of the member's case manager by notifying the Contractor, in accordance with the Contractor's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services.

3.10.2.1.41 Require that, for members participating in PROMISE, the participating provider facilitate notification of the member's DSAMH care manager by notifying DSAMH, in accordance with DSAMH's processes, as expeditiously as warranted by the member's circumstances, of any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services.

3.10.2.1.42 Require the participating provider to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the Contractor's members and the Contractor under the participation agreement. The participating provider shall maintain such insurance coverage at all times during the participation agreement and upon execution of the participation agreement furnish the Contractor with written verification of the existence of such coverage.

3.10.2.1.43 Specify the participating provider agrees to abide by all State and Federal law and program requirements applicable to the participating provider. Provide that the agreement incorporates by reference all applicable Federal and State law, and that revisions of applicable Federal and State law shall automatically be incorporated into the participation agreement as they become effective.

3.10.2.1.44 Specify procedures and criteria for any amendment to the participation agreement termination date or for early termination of the agreement. If the agreement does not require amendments to be valid only when reduced to writing, duly signed and attached to the original of the participation agreement, then the agreement shall allow at least 30 calendar days to give notice of rejection and require that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc.).

3.10.2.1.45 Include provisions that allow the Contractor to suspend, deny, refuse to renew or terminate any participation agreement in accordance with the terms of the Contractor's Contract with the State (see Section 5.2 of this Contract) and applicable law and regulation.

3.10.2.1.46 Specify that the State reserves the right to direct the Contractor to terminate or modify the participation agreement when the State determines it to be in the best interest of the State.

3.10.2.1.47 Specify that both parties recognize that in the event of termination of the Contract between the Contractor and the State, the provider shall immediately make available to the State, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the participation agreement. The provision of such records shall be at no expense to the State.

3.10.2.1.48 Include a conflict of interest clause as stated in Section 5.14.2 of this Contract and a lobbying clause as stated in Section 5.2.13 of this Contract between the Contractor and the State.

3.10.2.1.49 Specify that at all times during the term of the Contract, the participating provider shall indemnify and hold the State harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between the State and the Contractor. This indemnification may be accomplished by incorporating Section 5.8 of this Contract between the State and the Contractor in its entirety in the participation agreement or by use of other language developed by the Contractor and prior approved by the State.

3.10.2.1.50 Pursuant to 42 CFR 438.3(g), specify compliance with requirements mandating provider identification of provider-preventable condition (PPCs) as a condition of payment, prohibiting payment of PPCs and reporting all identified PPCs as required by the Contractor or the State. (See Section 3.11.4 of this Contract.)

3.10.2.1.51 Specify any sanctions or reductions in payment that the Contractor may assess on the provider for specific failures to comply with provider participation requirements. This shall include, but may not be limited to, a participating provider's failure or refusal to respond to the Contractor's request for information such as medical records. At the Contractor's discretion or as directed by the State, the Contractor shall impose financial consequences against the participating provider as appropriate.

3.10.2.1.52 Include a provision that states that participating providers are not permitted to encourage or suggest, in any way, that children be placed into State custody in order to receive medical, behavioral, or LTSS benefits covered by the State.

3.10.2.1.53 Require that participating providers offer hours of operation that are no less than the hours of operation offered to commercial patients.

3.10.2.1.54 Include the following nondiscrimination provisions:

3.10.2.1.54.1 Specify that no person on the grounds of handicap, disability, age, race, color, religion, sex, national origin, or any other status protected by Federal or State law, shall be excluded from participation in, or be denied benefits of, or be otherwise subjected to discrimination in the performance of participating provider's obligation under its agreement with the Contractor or in the employment practices of the participating provider.

3.10.2.1.54.2 Specify that the participating provider have written procedures for the provision of language interpretation services for any member who needs such services, including, but not limited to, members with Limited English Proficiency (LEP).

3.10.2.1.55 Specify that the participating provider shall not use the State's name or logos for any materials intended for dissemination to the provider's patients unless said material has been submitted to the State by the Contractor for review and has been approved by the State. This prohibition shall not include references to whether or not the provider accepts Medicaid.

3.10.2.1.56 Specify the participating provider's responsibilities regarding Third Party Liability (TPL), including the provider's obligation to identify TPL coverage, including Medicare and long term care insurance as applicable and, except as otherwise provided in the Contractor's Contract with the State, to seek such TPL payment before submitting claims to the Contractor.

3.10.2.1.57 Require hospitals, including psychiatric hospitals, to cooperate with the Contractor in developing and implementing protocols as part of the Contractor's nursing facility diversion plan, which shall include, at a minimum, the hospital's obligation to promptly notify the Contractor upon admission of an eligible member regardless of payor source for the hospitalization; how the hospital will identify members who may need home health, nursing facility, or HCBS upon discharge, and how the hospital will engage the Contractor and participating providers in the discharge planning process to ensure that members receive the most appropriate and cost-effective Medically Necessary services upon discharge.

3.10.2.1.58 Require hospitals, including psychiatric hospitals, to cooperate with the Contractor in implementing an inpatient behavioral health UM strategy to achieve the utilization reduction targets contained within the DOJ Settlement Agreement. Require hospitals, including psychiatric hospitals, admitting members for acute behavioral health treatment to collaborate with identified outpatient behavioral health providers and, within twenty-four hours of admission, complete a comprehensive assessment including an assessment of anticipated discharge needs.

3.10.2.1.59 Require PCPs to meet the requirements in Section 3.9.8.1 of the Contract.

3.10.2.1.60 Require that if any requirement in the participation agreement is determined by the State to conflict with the Contract between the State and the Contractor, such requirement shall be null and void and all other provisions shall remain in full force and effect.

3.10.2.1.61 Require that a public health service entity obtain permission from the State in order to submit claims to the Contractor for drugs purchased through the 340B drug discount program.

3.10.2.2 No other terms or conditions agreed to by the Contractor and the participating provider shall negate or supersede the requirements listed in Section 3.10.1 or Section 3.10.2 of this Contract, above.

3.10.3 **Requirements for Participation Agreements with Nursing Facilities**

3.10.3.1 The participation agreement with a nursing facility shall meet the minimum requirements specified in both Section 3.10.1 and Section 3.10.2 of this Contract, above, and shall also include, at a minimum, the following requirements:

3.10.3.1.1 Require the nursing facility to promptly notify the Contractor, and/or other entity as directed by the State, of a member's admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when

there is a change in a member's known circumstances and to notify the Contractor, and/or entity as directed by the State, prior to a member's discharge.

3.10.3.1.2 Require the nursing facility to provide written notice to the State and the Contractor in accordance with State and Federal requirements before voluntarily terminating the agreement and to comply with all applicable State and Federal requirements regarding voluntary termination.

3.10.3.1.3 Require the nursing facility to notify the Contractor immediately when considering discharging a member and to consult with the member's case manager to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate.

3.10.3.1.4 Specify that a nursing facility shall not request that a member to leave after his/her Medicare benefit days have been exhausted.

3.10.3.1.5 Require the nursing facility to notify the member and/or the member representative (if applicable) in writing 30 calendar days prior to discharge in accordance with State and Federal requirements (see, e.g., 42 CFR 483.12), and require the Contractor to notify the nursing facility in writing 30 calendar days prior to a member leaving the facility.

3.10.3.1.6 Specify the participating provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the member's Third Party payor) plus the amount of any applicable Patient Liability, as payment in full for services provided and shall not solicit or accept any payment from the member in excess of the amount of applicable Patient Liability responsibilities.

3.10.3.1.7 Specify the nursing facility's responsibilities regarding Patient Liability, which shall include but not be limited to collecting the applicable Patient Liability amounts from members, notifying the member's case manager if there is an issue with collecting a member's Patient Liability, and making good faith efforts to collect payment.

3.10.3.1.8 Require the nursing facility to notify the Contractor of any change in a member's medical or functional condition that could impact the member's level of care for the currently authorized level of nursing facility services.

3.10.3.1.9 Require the nursing facility to comply with State and Federal law applicable to nursing facilities, including, but not limited to, those that govern admission, transfer, and discharge policies.

3.10.3.1.10 Require the nursing facility to comply with Federal Preadmission Screening and Resident Review (PASRR) requirements, including that a level I screening be completed prior to admission, a level II evaluation be completed prior to admission when indicated by the level I screening, and a review be completed based upon a significant physical or mental change in the resident's condition that might impact the member's need for or benefit from Specialized Services.

3.10.3.1.11 Require the nursing facility to cooperate with the Contractor in developing and implementing protocols as part of the Contractor's nursing facility diversion and transition processes (see Sections 3.8.5 and 3.8.6 of this Contract), which shall include, at a minimum, the nursing facility's obligation to promptly notify the Contractor upon admission or request for admission of an eligible member regardless of payor source for the nursing facility stay; how the nursing facility will assist the Contractor in identifying residents who may want to transition from nursing facility services to home and community-based care; the nursing facility's obligation to promptly notify the Contractor regarding all such identified members; and how the nursing facility will work with the Contractor in assessing the member's transition potential and needs, and in developing and implementing a transition plan, as applicable.

3.10.3.1.12 Require the nursing facility to coordinate with the Contractor in complying with the requirements in 42 CFR 483.75(n) regarding written transfer agreements and to use participating providers when transfer is medically appropriate, except as authorized by the Contractor or for Emergency Services.

3.10.3.1.13 Require the nursing facility to immediately notify the Contractor of any change in its license to operate as issued by the State as well as any deficiencies cited during the Federal certification process.

3.10.3.1.14 Provide that if the nursing facility is involuntarily decertified by the State or CMS, the participation agreement will automatically be terminated in accordance with Federal requirements.

3.10.3.1.15 Include language requiring that the participation agreement shall be assignable from the Contractor to the State, or its designee, at the State's discretion upon written notice to the Contractor and the affected nursing facility. Further, the participation agreement shall

include language by which the nursing facility provider agrees to be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of the Contractor.

3.10.4 **Requirements for Participation Agreements with HCBS Providers**

3.10.4.1 The participation agreement with an HCBS provider shall meet the minimum requirements specified in Sections 3.10.1 and 3.10.2 of this Contract, above, as applicable (as determined by the State) and shall also include, at a minimum, the following requirements:

3.10.4.1.1 Require the HCBS provider to provide at least 30 calendar days advance notice to the Contractor when the provider is no longer willing or able to provide services to a member, including the reason for the decision, and to cooperate with the member's case manager to facilitate a seamless transition to alternate providers.

3.10.4.1.2 In the event that an HCBS provider change is initiated for a member, require that, regardless of any other provision in the participation agreement, the transferring HCBS provider continue to provide services to the member in accordance with the member's plan of care until the member has been transitioned to a new provider, as determined by the Contractor, or as otherwise directed by the Contractor, which may exceed 30 calendar days from the date of notice to the Contractor.

3.10.4.1.3 Specify that reimbursement of an HCBS provider shall be contingent upon the provision of services to an eligible member in accordance with applicable Federal and State requirements and the member's plan of care as authorized by the Contractor, and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the member receiving the service, the name of the staff person who delivered the service, the detailed tasks and functions performed as a component of each service, notes for other Caregivers (whether paid or unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who delivered the service.

3.10.4.1.4 Require HCBS providers to immediately report any deviations from a member's service schedule to the member's case manager.

3.10.4.1.5 Require that upon acceptance by the HCBS provider to provide approved services to a member as indicated in the member's plan of care, the provider shall ensure that it has staff sufficient to

provide the service(s) authorized by the Contractor in accordance with the member's plan of care, including the amount, frequency, duration and scope of each service in accordance with the member's service schedule.

3.10.4.1.6 Require HCBS providers to provide back-up for their own staff if they are unable to fulfill their assignment for any reason and ensure that back-up staff meet the qualifications for the authorized service.

3.10.4.1.7 Prohibit HCBS providers from requiring a member to choose the provider as a provider of multiple services as a condition of providing any service to the member.

3.10.4.1.8 Prohibit HCBS providers from soliciting members to receive services from the provider including:

3.10.4.1.8.1 Communicating with existing HCBS members via telephone, face-to-face or written communication for the purpose of petitioning the member to change HCBS providers; or

3.10.4.1.8.2 Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential HCBS members that should instead be referred to the member's MCO as applicable.

3.10.4.1.9 Require HCBS providers to comply with Critical Incident reporting requirements (see Section 3.13.9 of this Contract).

3.10.4.1.10 Require HCBS providers to comply with all applicable Federal requirements for HCB settings requirements (42 CFR 42 441.301(c)(4)).

3.11 PROVIDER PAYMENT

3.11.1 General

3.11.1.1 Unless otherwise specified in the Contract, the Contractor is free to establish reimbursement methodologies with its providers that will result in payments that are sufficient to enlist enough providers so that care and services are available to DSHP and DSHP Plus members at least to the extent that they are available to the general population or to meet access standards that are specified in Section 3.9.17 of this Contract. To the extent possible, payment arrangements should encourage and reward effective management and quality of care (see Section 3.11.6 of this Contract).

3.11.1.2 The Contractor shall require, as a condition of payment, that the provider (participating or non-participating provider) accept the amount paid by the

Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the member's Third Party payor) plus any applicable amount of cost sharing or Patient Liability responsibilities due from the member as payment in full for the service.

3.11.1.3 The Contractor shall ensure that the member is held harmless by the provider for the costs of Medically Necessary Covered Services and additional services except for applicable Copayment amounts (described in Sections 3.4.9.1 and 3.5.4 of this Contract) and Patient Liability amounts (described in Section 3.4.9.2 of this Contract).

3.11.1.4 The Contractor shall not make payment to providers that do not have a DMAP provider number nor to providers that have not completed Federally required disclosures (see Section 3.16.2 of this Contract).

3.11.1.5 The Contractor shall not assign State funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly Federal exclusion (LEIE) and debarment (EPLS/SAM) screening by the assignee if the alternative payee assignment is on-going.

3.11.1.6 In accordance with Section 1902(a)(80) of the Social Security Act and 42 CFR 438.602(i), the Contractor shall not make any payments for Covered Services or additional services to any provider, subcontractor or financial institution located outside of the United States.

3.11.1.7 For any entities to which the Contractor makes payment via electronic transfers, the Contractor shall have a signed EFT form that shall have 42 CFR 455.18 and 42 CFR 455.19 statements immediately preceding the "Signature" section.

3.11.1.8 The Contractor shall not pay 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) 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 under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

3.11.1.9 The Contractor shall not pay 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) furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

3.11.1.10 The Contractor shall not pay 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) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

3.11.1.11 The Contractor shall not pay 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) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

3.11.1.12 The Contractor shall not pay 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) for home health care services provided by an agency or organization, unless the agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.

3.11.2 **Timely Payments**

3.11.2.1 The Contractor shall make timely payments to providers in accordance with the timeliness standards in Section 3.18.1 and Section 3.5.12 of this Contract.

3.11.3 **Special Reimbursement Requirements**

3.11.3.1 FQHCs

3.11.3.1.1 The Contractor's participation agreement with a Delaware FQHC shall include the same service array and the same payment methodology as the State Medicaid FFS contracts with FQHCs. The Medicaid FFS rate is a prospective payment system (PPS) rate paid per FQHC visit.

3.11.3.1.2 The Contractor may pay more than the Medicaid FFS rate for FQHCs but not less.

3.11.3.1.3 The Contractor may include additional services not included in the State's Medicaid FFS contract with the FQHC, but the Contractor must negotiate a separate payment arrangement with the FQHC for those additional services.

3.11.3.2 School-Based Wellness Centers

3.11.3.2.1 If the Contractor has not negotiated a different payment arrangement with a particular SBWC, the Contractor shall pay the SBWC using the Medicaid FFS payment methodology and fee schedule.

3.11.3.3 LTSS

3.11.3.3.1 The Contractor must use the State's Medicaid FFS rate to pay Medicare/Medicaid certified DMAP-enrolled nursing facilities for DSHP Plus LTSS members.

3.11.3.3.2 If the Contractor and a nursing facility, assisted living facility or HCBS provider enrolled with DMAP are not able to reach contractual agreement, the Contractor shall reimburse the non-participating provider for services to DSHP Plus LTSS members at 80% of the applicable Delaware Medicaid FFS rate.

3.11.3.3.3 For DSHP Plus LTSS members residing in a nursing facility or assisted living facility, the Contractor shall delegate collection of Patient Liability to the facility and shall pay the facility net the applicable Patient Liability amount. (See Section 3.4.9.2 of this Contract for additional information regarding Patient Liability.)

3.11.3.4 Pharmacy

3.11.3.4.1 The Contractor shall comply with the requirements in Section 3.5.8 of this Contract regarding payment for pharmacy services.

3.11.3.5 Emergency Services and Post-Stabilization Services

3.11.3.5.1 The Contractor shall not deny a claim from a provider for Emergency Services as defined in this Contract (see Section 1) and shall make payment to a provider for responding to a member's Emergency Medical Condition by performing medical screening examinations and stabilizing treatment, if treatment was performed.

3.11.3.5.2 In accordance with Section 3.4.6.1 of this Contract, the Contractor must make payment to the provider for all medical screening examinations and for subsequent stabilizing treatment provided to members with an Emergency Medical Condition.

3.11.3.5.3 Pursuant to Section 1932(b)(2)(D) of the Social Security Act, the Contractor shall limit payments to non-participating providers of Emergency Services to the amount that would have been paid if the service had been provided under the State's FFS Medicaid program.

3.11.3.5.4 The Contractor shall make payment for post-stabilization services as specified in Section 3.4.6.2 of this Contract.

3.11.3.6 Family Planning Providers

3.11.3.6.1 The Contractor must reimburse non-participating providers for family planning services rendered to members as long as the following conditions are met:

3.11.3.6.1.1 The family planning provider is qualified to provide family planning services based on licensed scope of practice and is a DMAP-enrolled provider;

3.11.3.6.1.2 The family planning provider submits electronic claims using HIPAA standard transactions;

3.11.3.6.1.3 The family planning provider provides medical records sufficient to allow the Contractor to meet its care coordination responsibilities; if a member refuses the release of medical information, the non-participating provider must submit documentation of such refusal; and

3.11.3.6.1.4 The family planning provider obtains informed consent for all contraceptive methods, including sterilization, consistent with requirements of 42 CFR 441.257 and 42 CFR 258.

3.11.3.7 Behavioral Health Crisis Providers

3.11.3.7.1 As specified in Section 3.9.13 of this Contract, the Contractor shall establish provider participation agreements with mobile and facility-based crisis intervention providers certified by DSAMH.

3.11.3.7.2 The Contractor's participation agreement with these providers shall include the same service array and the same payment methodology as the State Medicaid FFS contracts with these providers.

3.11.3.7.3 The Contractor may pay more than the Medicaid FFS rate for behavioral health crisis services but not less.

3.11.3.7.4 The Contractor may include additional services not included in the State's Medicaid FFS contract with behavioral health crisis providers, but the Contractor must negotiate a separate payment arrangement with these providers for those additional services.

3.11.3.8 Payments to Non-Participating Providers

3.11.3.8.1 The Contractor shall make payments to non-participating providers for Medically Necessary Covered Services on the same timeliness standards as referenced in Section 3.18.1 of this Contract when the following criteria are met:

3.11.3.8.1.1 Services were rendered to treat an Emergency Medical Condition;

3.11.3.8.1.2 Services were for family planning services;

3.11.3.8.1.3 Services were prior authorized by the Contractor; or

3.11.3.8.1.4 As otherwise provided in this Contract (e.g., for SBWCs and LTSS providers).

3.11.3.9 Indian Health Care Providers

3.11.3.9.1 *IHCP Network and Coverage Requirements*

3.11.3.9.1.1 Regardless of whether an IHCP is in the Contractor's provider network, all IHCPs must be paid by the Contractor for Covered Services provided to Indian members who are eligible to receive services from IHCPs: (a) at a rate negotiated between the Contractor and the IHCP; or (b) in the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Contractor would make for the services to a participating provider which is not an IHCP.

3.11.3.9.1.2 The Contractor must permit Indian members to obtain services pursuant to this Contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.

3.11.3.9.1.3 The Contractor must permit an out-of-network IHCP to refer an Indian member to a network provider.

3.11.3.9.2 *IHCP Payment Requirements*

3.11.3.9.2.1 When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the Contractor, it must be paid an amount equal to the amount the Contractor would pay a FQHC that is a network provider but is not an IHCP. DMMA shall pay the IHCP a supplemental payment as necessary to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under FFS.

3.11.3.9.2.2 When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the Contractor's provider network, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.

3.11.3.10

3.11.4 **Provider Preventable Conditions (PPCs)**

3.11.4.1 In accordance with 42 CFR 438.3(g), the Contractor shall:

3.11.4.1.1 Comply with the requirements mandating provider identification of PPCs as a condition of payment, as well as the prohibition against payment for PPCs as set forth in 42 CFR 434.6(a)(12) and 42 CFR 447.26; and

3.11.4.1.2 Report all identified PPCs in Encounter Data submitted to the State (see Section 3.18.4 of this Contract).

3.11.4.2 The Contractor shall prevent payment for PPCs, as defined in DMMA's policy manual, unless they fall into one of the two exceptions:

3.11.4.2.1 The Contractor shall not impose a reduction in payment for a PPC on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

3.11.4.2.2 The Contractor may limit reductions in provider payment to the extent that the following apply:

3.11.4.2.2.1 The identified PPC would otherwise result in an increase in payment.

3.11.4.2.2.2 The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.

3.11.4.2.3 The Contractor shall require that all providers agree to comply with the reporting requirements in 42 CFR 447.26(d) as a condition of payment from the Contractor. The Contractor shall require providers to identify PPCs that are associated with claims (see Section 3.18.4 of this Contract).

3.11.5 **Physician Incentive Plans**

3.11.5.1 The Contractor shall not implement a physician incentive plan without the prior approval of the State.

3.11.5.2 As specified in 42 CFR 422.208(c)(1), the Contractor may only operate a physician incentive plan if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

3.11.5.3 As specified in 42 CFR 422.208(c)(2), if the Contractor has a physician incentive plan that places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the Contractor must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection.

3.11.5.4 If the Contractor operates a physician incentive plan, it shall operate the plan in accordance with 42 CFR 438.3(i), 42 CFR 422.208 and 42 CFR 422.210.

3.11.5.5 The Contractor shall provide assurance satisfactory to the State that the requirements of 42 CFR 422.208 are met.

3.11.6 **Payment Reform**

SEE APPENDIX 2

3.12 UTILIZATION MANAGEMENT

3.12.1 **General**

3.12.1.1 The Contractor shall comply with State and Federal requirements for UM including, but not limited to, 42 CFR 438 and 42 CFR 456 as applicable.

3.12.1.2 The Contractor shall develop an internal written UM program that facilitates the delivery of high quality, low cost efficient and effective care and meets the requirements of this Section 3.12.

3.12.1.3 The Contractor's UM program shall be supported by an annual work plan which the Contractor shall evaluate annually and update as necessary. The CMO, Behavioral Health CMO, LTSS CMO, Health Services Director, UM Coordinator and QM/QI Coordinator must be involved in developing the annual work plan and evaluation.

3.12.1.4 The UM program description, associated work plan and evaluation of the previous year's plan shall be submitted to the State annually in March.

3.12.1.5 The UM program, associated work plan and annual evaluation shall be exclusive to DSHP and DSHP Plus and shall not contain documentation from other product lines operated by the Contractor.

3.12.1.6 As part of the UM program, the Contractor shall have distinct written UM policies and procedures regarding services for DSHP and DSHP Plus members including behavioral health and LTSS.

3.12.1.7 The Contractor shall comply with the requirements for UM of pharmacy services in Section 3.5.9 of this Contract.

3.12.1.8 The Contractor shall notify all participating providers of and enforce compliance with all provisions relating to UM procedures.

3.12.1.9 The Contractor shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition.

3.12.1.10 The Contractor shall define service authorization requests in a manner that at least includes a member's request for the provision of services.

3.12.1.11 The Contractor shall assure, consistent with 42 CFR 438.210(e), that 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 Covered Services to any member.

3.12.2 **UM Program Requirements**

3.12.2.1 The written UM program shall at a minimum:

3.12.2.1.1 Have criteria that:

3.12.2.1.1.1 Are based on medical, behavioral health and/or LTSS evidence, to the extent possible;

3.12.2.1.1.2 Are applied based on individual needs;

3.12.2.1.1.3 Are applied based on assessment of the local delivery system; and

3.12.2.1.1.4 Involve appropriate practitioners in developing, adopting and reviewing the criteria.

3.12.2.1.2 Outline the administrative and organizational structures and design of the UM program;

3.12.2.1.3 Ensure that the UM coordinator report to the CMO such that the CMO has ultimate responsibility in all UM activities;

3.12.2.1.4 Include procedures for prospective and concurrent review of inpatient utilization;

3.12.2.1.5 Describe procedures to evaluate Medical Necessity, using the State's criteria, evidence-based nationally recognized Medical Necessity guidelines, information sources, and the process used to review and approve the provision of Covered Services and additional services;

3.12.2.1.6 Describe mechanisms to detect over-, under- and inappropriate utilization of Covered Services and additional services by members;

3.12.2.1.7 Demonstrate that qualified providers make all UM decisions regarding Health Care Services;

3.12.2.1.8 Demonstrate that qualified case managers make all UM decisions regarding non-skilled LTSS for DSHP Plus LTSS members (see Section 3.12.6.3.7 of this Contract, below);

3.12.2.1.9 Describe Appeal mechanisms for providers and members related to utilization decisions;

3.12.2.1.10 Incorporate the UM Committee into the organizational structure and design of the program (see Section 3.12.3 of this Contract, below);

3.12.2.1.11 Ensure that the Contractor maintains sufficient/appropriate staff to perform all UM review activities;

3.12.2.1.12 Describe mechanisms to ensure consistent application of review criteria and uniform decisions;

3.12.2.1.13 Include protocols for denial of services, hospital discharge planning, and retrospective review of claims; and

3.12.2.1.14 Describe methodologies and mechanisms for monitoring and auditing provider performance regarding under-, over- and inappropriate utilization of services, identifying deficiencies, addressing deficiencies with corrective action, monitoring of corrective actions for intended results, and communication of all findings to providers.

3.12.2.2 Internal Staff Requirements

3.12.2.2.1 The Contractor shall submit a staffing plan annually to the State for written State approval that describes the Contractor's UM staffing structure.

3.12.2.2.2 The Contractor must have appropriately qualified staff who are available by telephone, from 8 a.m. to 5 p.m. eastern time Monday

through Friday (except State of Delaware holidays), to render UM decisions for providers and available by telephone 24 hours a day, seven days a week to respond to authorization requests for inpatient hospitalization, or policies and procedures that allow for emergency admissions with authorization the next business day.

3.12.2.2.3 The UM Coordinator must meet the requirements of Section 3.20 of this Contract.

3.12.2.2.4 The UM Coordinator's general responsibilities are included in Section 3.20 of this Contract. The UM Coordinator's specific duties must include but are not limited to the following:

3.12.2.2.4.1 Overseeing the Contractor's UM program; and

3.12.2.2.4.2 Being available to the Contractor's medical staff for consultation on referrals, denials, Grievances and Appeals.

3.12.3 **UM Committee**

3.12.3.1 The Contractor shall develop and maintain a UM committee to review and approve the UM program, plan and annual evaluations as well as any UM policies and procedures.

3.12.3.2 The UM committee shall be chaired by the CMO or his/her designee and include membership by individuals and representative of the organization's participating providers.

3.12.4 **Monitoring of Inpatient Behavioral Health Service Utilization**

3.12.4.1 The Contractor shall work with DSAMH to develop a collaboration protocol that includes strategies and agreements to achieve the inpatient behavioral health utilization reduction targets contained within the DOJ Settlement Agreement. The collaboration agreement, which shall be developed by the Start Date of Operations, shall include at a minimum:

3.12.4.1.1 How the Contractor will monitor adult inpatient behavioral health admissions, readmissions and lengths of stay.

3.12.4.1.2 The process and frequency with which the Contractor will share adult inpatient behavioral health utilization data with DSAMH.

3.12.4.1.3 How the Contractor will collaborate with local emergency rooms and behavioral health providers to appropriately utilize adult inpatient diversion services, such as crisis intervention or other available home and community-based Covered Services or additional services.

3.12.4.1.4 How the Contractor will collaborate with DSAMH in the admission process, utilization review, and discharge planning for adult members participating in PROMISE.

3.12.4.1.5 How the Contractor will provide ongoing utilization review and directly assist with discharge planning for adult members not participating in PROMISE.

3.12.5 **Monitoring of DSHP Plus LTSS Benefit Package Service Utilization**

3.12.5.1 The Contractor shall monitor DSHP Plus LTSS members' utilization of services in the DSHP Plus LTSS benefit package, identify members who have not received such services within a 30 calendar day period of time, and notify the State of these members.

3.12.6 **Service Authorization**

3.12.6.1 The Contractor shall:

3.12.6.1.1 Have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions.

3.12.6.1.2 Authorize LTSS based on a member's current needs assessments and consistent with the member's service plan.

3.12.6.2 The Contractor shall not deny payment for a prior authorized service based on the lack of Medical Necessity, assuming the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances which were described at the time that prior authorization was granted.

3.12.6.3 <u>Requests for Initial and Continuing Service Authorizations</u>

3.12.6.3.1 The Contractor must have in effect mechanisms to ensure consistent application of review criteria.

3.12.6.3.2 The Contractor shall use the Delaware American Society for Addiction Medicine (DE-ASAM) criteria for behavioral health services.

3.12.6.3.3 The Contractor must consult with the requesting provider for health care services when appropriate.

3.12.6.3.4 For PROMISE participants, the Contractor shall notify DSAMH, in accordance with DSAMH's processes, of all adult behavioral

health inpatient authorization decisions within 24 hours of making the decision.

3.12.6.3.5 The Contractor shall not require that non-skilled services in the DSHP Plus LTSS benefit package be ordered by a treating physician, but may consult with the treating physician as appropriate regarding the member's physical, behavioral health, and LTSS needs in order to facilitate communication and coordination.

3.12.6.3.6 Except as otherwise provided for non-skilled services in the DSHP Plus LTSS package, the Contractor shall ensure that any decision to deny a request for a Covered Services that is not administrative or to authorize a Covered Service in an amount, duration, or scope that is less than requested, is made by a provider who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs (see 42 CFR 438.210(b)(3)).

3.12.6.3.7 The Contractor shall ensure that any decision to deny a request for non-skilled service in the DSHP Plus LTSS package that is not administrative, or to authorize a non-skilled service in the DSHP Plus LTSS package in an amount, duration, or scope that is less than requested, is made by the case manager and reviewed and approved by the nurse manager or supervisor and documented in the Contractor's system.

3.12.6.3.8 The Contractor shall comply with requirements in Section 3.5.9 of this Contract regarding prior authorization of pharmacy services.

3.12.6.3.9 The Contractor shall not require prior authorization for the purchase of personal use (non-hospital grade) manual or electric breast pumps when a pump is prescribed by a physician or other licensed practitioner. Before providing a breast pump, the Contractor shall make reasonable efforts to inquire whether the member was provided a breast pump from the State's FFS program or from another MCO within the past 36 months and whether the previously provided breast pump is in working order.

3.12.6.4 Notice of Adverse Benefit Determination

3.12.6.4.1 The Contractor must give written notice to the requesting provider and the member of any decision by the Contractor to deny a service authorization request for a Covered Service, or to authorize a Covered Service in an amount, duration, or scope that is less than requested. Member notices must meet the requirements of 42 CFR 438.404. Provider notices must also comply with 42 CFR 438.404. See Section 3.15.2 of this Contract.

3.12.6.5 Timeframe for Authorization Decisions

3.12.6.5.1 The Contractor shall comply with and shall include in its provider manual the following requirements (see 42 CFR 438.210(d)) as well as the requirements in Section 3.5.9 of this Contract regarding pharmacy services.

3.12.6.5.2 *Service Authorization Decisions*

3.12.6.5.2.1 For standard service authorization decisions, the Contractor shall provide notice as expeditiously as the member's health condition requires and within 10 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if:

3.12.6.5.2.1.1 The member, or the provider, requests extension; or

3.12.6.5.2.1.2 The Contractor justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

3.12.6.5.2.2 If the Contractor extends the timeframe, the Contractor must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a Grievance if he/she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expire.

3.12.6.5.2.3 Expedited authorization decisions

3.12.6.5.2.3.1 For cases in which a provider indicates (in making the request on the member's behalf or supporting the member's request), or the Contractor determines (upon a request from the member), that the standard service authorization decision timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

3.12.6.5.2.4 The Contractor may extend the 72 hour time period by up to 14 calendar days if the member requests an extension, or if the Contractor justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.

3.12.6.5.2.5 If the Contractor extends the timeframe, the Contractor must give the member written notice of the reason for the decision to extend the timeframe, and inform the member of the right to file a Grievance if he/she disagrees with the decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

3.12.6.5.2.6 For all covered outpatient drug authorization decisions, the Contractor shall provide notice as described in section 1927(d)(5)(A) of the Social Security Act.

3.12.6.5.3 Untimely service authorizations constitute a denial and are thus Adverse Benefit Determinations (see Section 3.15 of this Contract). This includes situations in which the Contractor gives notice of its intent to extend the timeframe on the date that the original timeframe expires.

3.12.7 **Referrals**

3.12.7.1 Except as described in this Section of the Contract, the Contractor may require members to seek a referral from their PCP prior to accessing Covered Services.

3.12.7.2 The Contractor may exempt additional Covered Services and additional services from PCP referral.

3.12.7.3 The Contractor shall allow members to access the following services without a PCP referral:

3.12.7.3.1 Emergency care;

3.12.7.3.2 Family planning services, including obstetrics and gynecology services;

3.12.7.3.3 For female members, access to a women's health specialist who is a participating provider for Covered Services necessary to provide women's routine, preventive and prenatal Health Care Services; this is in addition to the member's designated source of Primary Care if that source is not a women's health specialist;

3.12.7.3.4 Behavioral health services provided by a participating provider;

3.12.7.3.5 Eye health services for children, including optometry and ophthalmology, provided by a participating provider;

3.12.7.3.6 Evaluation services from a provider with the Early Childhood Intervention program for children from birth to three years of age with a developmental delay; and

3.12.7.3.7 Generally all specialists (except neuro-psychiatry).

3.12.7.4 As provided in Section 3.4.7 of this Contract, the Contractor shall allow members to access a second opinion from a qualified participating provider or shall arrange for a second opinion from a qualified non-participating provider, at no cost to the member.

3.12.7.5 The Contractor shall provide for the continuation of Medically Necessary Covered Services for new members regardless of referral requirements (see Section 3.8.1 of this Contract).

3.12.8 **PCP Profiling**

3.12.8.1 The Contractor shall profile its PCPs to identify PCPs who appear to be operating outside peer norms and identify utilization, prescribing patterns, and/or quality of care/quality of service issues.

3.12.8.2 The Contractor shall report to the State on PCP profiling trends (see Section 3.21 of this Contract).

3.13 QUALITY

3.13.1 General

3.13.1.1 <u>The State's Quality Management Strategy (QMS)</u>

3.13.1.1.1 The Contractor shall comply with the State's QMS. The QMS includes, among other things, details on the State's expectations and requirements for quality activities.

3.13.1.1.2 The QMS is reviewed annually and may be revised based on such review. If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The Contractor will have an opportunity to review and comment on proposed changes to the QMS through the Contractor's regular participation in the QII Task Force. The Contractor shall comply with any revisions to the QMS.

3.13.1.2 <u>Quality Management/Quality Improvement (QM/QI) Unit</u>

3.13.1.2.1 The Contractor shall establish a QM/QI unit within its organizational structure that is fully dedicated to this Contract and is separate and distinct from any other units or departments in the Contractor's MCO.

3.13.1.2.2 The Contractor shall integrate QM/QI processes in all areas of the Contractor's organization; however, the QM/QI unit shall have ultimate responsibility for all QM/QI activities.

3.13.1.2.3 The QM/QI Coordinator shall lead the QM/QI unit.

3.13.1.3 QM/QI Coordinator

3.13.1.3.1 The QM/QI Coordinator must be accountable to the Contractor's Executive Management.

3.13.1.3.2 The QM/QI Coordinator must meet the requirements in Section 3.20.2 of this Contract.

3.13.1.3.3 The QM/QI Coordinator's general responsibilities are included in Section 3.20.2 of this Contract. The QM/QI Coordinator's specific duties must include but are not limited to:

3.13.1.3.3.1 Being responsible for developing the Contractor's annual written QM/QI program description including areas and objectives, scope, specific activities, and methodologies for continuous tracking, providing review and focus on health outcomes;

3.13.1.3.3.2 Being responsible for the Contractor's QM/QI committee, directing the development and implementation of the Contractor's QM/QI program and monitoring the quality of health care that members receive;

3.13.1.3.3.3 Reviewing all potential quality of care problems and overseeing development and implementation of continuous assessment and improvement of the quality of health care provided to members;

3.13.1.3.3.4 Specifying the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by the State as well as for areas the Contractor selects;

3.13.1.3.3.5 Attending QII Task Force meetings and any other appropriate meetings; and

3.13.1.3.3.6 Attending Grievance and Appeal committee meetings when necessary.

3.13.1.4 QM/QI Committee

3.13.1.4.1 The Contractor must have a QM/QI committee dedicated to this Contract that assists the QM/QI Coordinator in carrying out all quality strategies. The CMO must chair the QM/QI committee.

3.13.1.4.2 The Contractor must have policies and procedures that clearly define the roles, functions, and responsibilities of the QM/QI committee. The QM/QI committee policies and procedures shall include, but not be limited to, the following:

3.13.1.4.2.1 Demonstrate that the QM/QI committee will have oversight responsibility and input on all QM/QI activities;

3.13.1.4.2.2 Demonstrate that the QM/QI committee has accountability to the Contractor's Executive Management;

3.13.1.4.2.3 Ensure membership on the QM/QI committee and active participation by an individual representative of the Contractor's provider community and an individual representative of the member community;

3.13.1.4.2.4 Require regularly scheduled meetings, at least quarterly; and

3.13.1.4.2.5 Maintain appropriate documentation of the QM/QI committee's activities, findings, recommendations, and actions.

3.13.2 **State and Federal Monitoring**

3.13.2.1 The State shall cooperate with any State or Federal monitoring of its performance under this Contract, which may include but is not limited to external quality reviews, operational reviews, performance audits and evaluations.

3.13.2.2 The Contractor must identify, collect and provide any data, medical records or other information requested by the State or its authorized representative or the Federal agency or its authorized representative in the format specified by the State/Federal agency or its authorized representative. The Contractor shall ensure that the requested data, medical records and other information is provided at no charge to the State/Federal agency or its authorized representative.

3.13.2.3 If requested, the Contractor shall provide workspace at the Contractor's local offices for the State/Federal agency or its authorized representative to review requested data, medical records, or other information.

3.13.3 **QM/QI Program**

3.13.3.1 The Contractor shall comply with State and Federal QM/QI standards.

3.13.3.2 The Contractor must employ QM/QI staff that have applicable experience to meet the needs of DSHP and DSHP Plus members.

3.13.3.3 The Contractor must have an ongoing QM/QI program for the services it furnishes to its members.

3.13.3.4 The Contractor's QM/QI program shall include mechanisms to assess the quality and appropriateness of care furnished to DSHP Plus LTSS members, including assessment of care between care settings (such as residential to community (or vice versa), residential to hospital (or vice versa), or hospital to nursing home (or vice versa)) and a comparison of services and supports received with those set forth in the member's plan of care, if applicable.

3.13.3.5 The Contractor's QM/QI program shall include participation in efforts by the state to prevent, detect, and remediate Critical Incidents.

3.13.3.6 The Contractor's QM/QI program shall include QM/QI activities to remediate DCAPs/CAPs and improve health disparities identified through data collection.

3.13.3.7 The Contractor shall submit timely performance measurement data as described in Section 3.13.4 of this Contract, below.

3.13.3.8 The QM/QI Coordinator shall coordinate with the Contractor's other key staff and departments to address issues related to under-, over- and inappropriate utilization of services.

3.13.3.9 The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.

3.13.3.10 Annually the Contractor shall:

3.13.3.10.1 Measure and report to the State its performance, using standard measures required by the State and as described in the QMS including those that incorporate the requirements of this Contract; and

3.13.3.10.2 Submit to the State, data specified by the State, including data if applicable from the Contractor's participating providers and Subcontractors, that enables the State to measure the Contractor's performance.

3.13.3.11 QM/QI Program Review

3.13.3.11.1 The State or its authorized representative will review, at least annually, the impact and effectiveness of the Contractor's QM/QI program. The review will include, but not be limited to:

3.13.3.11.1.1 The Contractor's performance on the standard measures on which it must report; and

3.13.3.11.1.2 The Contractor's results for each Performance Improvement Project (PIP).

3.13.3.11.2 The Contractor shall have a process for its own evaluation of the impact and effectiveness of its QM/QI program.

3.13.4 **Performance Measures**

3.13.4.1 The Contractor shall comply with the requirements in the QMS regarding performance measures for medical, behavioral health and LTSS. The Contractor shall use the methodology established by the State for all performance measures specified in the QMS.

3.13.4.2 At any time, CMS may specify performance measures to be included in this Contract. In addition to complying with the performance measures specified by the State, the Contractor shall comply with any performance measures required by CMS.

3.13.5 **Performance Improvement Projects (PIPs)**

3.13.5.1 The Contractor shall conduct PIPs (including any PIPs required by CMS in accordance with 42 CFR 438.330 (a)(2)) that focus on both clinical and non-clinical areas, designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction.

3.13.5.2 PIPs must incorporate the following:

3.13.5.2.1 Measurement of performance using objective quality indicators;

3.13.5.2.2 Implementation of interventions to achieve improvement in access to and quality of care;

3.13.5.2.3 Evaluation of the effectiveness of the interventions based on the performance measures in 42 CFR 438.330(d)(2)(i); and

3.13.5.2.4 Planning and initiation of activities for increasing or sustaining improvement.

3.13.5.3 The Contractor must report the status and results of each PIP conducted per 42 CFR 438.330(d)(1) to the State as requested but not less than once per year. The Contractor shall conduct PIPs related to medical care, behavioral health and LTSS as described in the QMS.

3.13.5.4 At any time, CMS may specify topics for PIPs to be included in this Contract. In addition to complying with PIPs specified by the State, the Contractor shall comply with any PIPs required by CMS.

3.13.6 **Clinical Practice Guidelines**

3.13.6.1 In accordance with 42 CFR 438.236, the Contractor must adopt health care practice guidelines that:

3.13.6.1.1 Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;

3.13.6.1.2 Consider the needs of the members;

3.13.6.1.3 Are adopted in consultation with participating providers; and

3.13.6.1.4 Are reviewed and updated periodically as appropriate.

3.13.6.2 The Contractor shall disseminate practice guidelines to all affected participating providers and, upon request, to members and potential members (see 42 CFR 438.236).

3.13.6.3 The Contractor shall ensure that decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply are consistent with the guidelines (see 42 CFR 438.236).

3.13.6.4 The Contractor shall comply with the additional requirements regarding clinical practice guidelines included in the QMS.

3.13.7 **Peer Review**

3.13.7.1 The Contractor shall have a Peer Review process that includes:

3.13.7.1.1 Review of a participating provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all Grievances filed against the participating provider relating to medical treatment.

3.13.7.1.2 Evaluation of the appropriateness of care rendered by participating providers.

3.13.7.1.3 Implementation of corrective action(s) when the Contractor deems it necessary to do so.

3.13.7.1.4 Development of policy recommendations to maintain or enhance the quality of care provided to members.

3.13.7.1.5 Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a participating provider's medical/case records, adherence to standards generally accepted by a participating provider's peers and the process and outcome of a participating provider's care.

3.13.7.1.6 Appointment of a Peer Review committee, as a sub-committee to the QM/QI committee, to review participating provider performance when appropriate. The CMO or a designee shall chair the Peer Review committee. Its membership shall be drawn from the provider network and include peers of the participating provider being reviewed.

3.13.7.1.7 Receipt and review of all written and oral allegations of inappropriate or aberrant service by a participating provider.

3.13.7.1.8 Education of members and the Contractor's staff about the Peer Review process, so that members and the Contractor's staff can notify the Peer Review committee of situations or problems relating to participating providers.

3.13.8 **National Committee for Quality Assurance (NCQA) Accreditation**

3.13.8.1 The Contractor and the Contractor's behavioral health subcontractor, if applicable, shall be NCQA accredited in the State of Delaware within two years from the Start Date of Operations. The Contractor shall be NCQA accredited as a Health Plan, and any behavioral health subcontractor shall be NCQA accredited as a Managed Behavioral Health Organization (MBHO).

3.13.8.2 The Contractor shall provide the State information regarding the Contractor's progress in achieving the required NCQA accreditation upon the State's request.

3.13.8.3 Failure to obtain the required NCQA accreditation within two years from the Start Date of Operations or failure to maintain the required accreditation throughout the term of the Contract may result in the imposition of sanctions and/or termination of the Contract as specified in Sections 5.4 and 5.12 of this Contract.

3.13.8.4 The Contractor shall provide the State with evidence of the Contractor's and the Contractor's behavioral health subcontractor's NCQA accreditation, including the results of the Contractor's most recent accreditation review.

3.13.8.5 In addition, the Contractor shall authorize NCQA to provide the State a copy of the most recent accreditation review for the Contractor and the Contractor's behavioral health subcontractor, including:

3.13.8.5.1 Accreditation status, survey type, and level (as applicable);

3.13.8.5.2 Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

3.13.8.5.3 Expiration date of the accreditation.

3.13.9 **Critical Incident Reporting**

3.13.9.1 The Contractor shall operate a Critical Incident management system that complies with State law and policy, including the requirement to report, document, and investigate Critical Incidents that occur with its members.

3.13.9.2 If any member of the Contractor's staff or the staff of a subcontractor that is not a provider has reasonable cause to believe that a member has been abused, mistreated, neglected or financially exploited, or has knowledge of the occurrence of other Critical Incidents, the Contractor shall report such incidents to the State as provided below.

3.13.9.3 As soon as practical, the Contractor shall report to DMMA and the appropriate investigative agency (see Section 3.13.9.4 below) by telephone all current information received or known about a Critical Incident. The Contractor shall follow up the initial telephone report by written report, using the Move IT file transfer system, to DMMA and the appropriate investigative agency within one business day of identifying a Critical Incident. The Contractor shall provide a full written report to DMMA within 30 business days of identifying a Critical Incident that includes, at a minimum, information regarding the Critical Incident, the investigation conducted by the Contractor and/or investigative agency (if applicable), findings by the Contractor and the investigative agency (as applicable), and any corrective actions.

3.13.9.4 The Contractor shall report Critical Incidents to the appropriate investigative agency in accordance with the following:

3.13.9.4.1 Adult Protective Service (APS) for suspected abuse, neglect, disruptive behavior and exploitation. Inadequate self-care cases are handled by the Community Services Program within DSAAPD.

3.13.9.4.2 DHSS Long Term Care Office of the State Ombudsman (OSO) for residents of a long term care facility who have a complaint about their rights.

3.13.9.4.3 Division of Health Care Quality (DHCQ) for members receiving services in a long term care facility and there is an incident of abuse, neglect, or mistreatment, and/or financial exploitation. Reports of suspected abuse, neglect, and exploitation of members who are children residing in pediatric nursing facilities must also be reported to DHCQ.

3.13.9.4.4 Office of Health Facilities Licensing and Certification (OHFLC) is the designated agency to regulate acute and outpatient health care facilities/agencies and receives Critical Incidents occurring in these facilities involving abuse, neglect or harassment; hospital, hospice seclusion and restraint deaths.

3.13.9.4.5 The Division of Family Services (DFS) is the designated agency to receive, investigate, and respond to Critical Incidents of abuse or neglect of children living in the community.

3.13.9.5 The Contractor shall cooperate with DMMA and any investigating agency in documenting, investigating and addressing actual and suspected Critical Incidents.

3.13.9.6 The Contractor shall collect and analyze data regarding Critical Incidents, track and identify trends, identify root causes, and make necessary changes in order to prevent reoccurrence.

3.13.10 **Member Satisfaction Survey(s)**

3.13.10.1 The Contractor shall conduct member satisfaction surveys as required in the QMS. The Contractor shall comply with all Federal and State confidentiality law in conducting member satisfaction survey(s).

3.13.10.2 The Contractor shall make available the results of the member satisfaction surveys to providers, the State, members and families/Caregivers.

3.13.10.3 The Contractor shall incorporate results of the member satisfaction survey(s) in its QM/QI program to improve care for members.

3.13.11 **Provider Satisfaction Survey(s)**

3.13.11.1 The Contractor shall comply with the requirements in the QMS regarding provider satisfaction survey(s).

3.13.11.2 The Contractor shall make a summary of the results of the provider satisfaction survey available to the State.

3.13.11.3 The Contractor shall incorporate results of the provider satisfaction survey(s) in its QM/QI program.

3.13.12 **Medical Records**

3.13.12.1 The Contractor shall ensure the maintenance of complete and accurate medical records for each member. Complete medical records shall include but are not limited to medical charts, hospital records, physician specialists, consultant and other providers' findings, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under this Contract. The content of medical records shall be consistent with the utilization control requirements in 42 CFR Part 456.

3.13.12.2 The Contractor shall ensure that medical records are maintained in a detailed and comprehensive manner that conforms to good professional health care practice, permits effective professional review and audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed, and dated.

3.13.12.3 The Contractor shall ensure that medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

3.13.12.4 The Contractor shall ensure and maintain the confidentiality of all medical records.

3.13.12.5 The Contractor shall ensure the prompt transfer of medical records to both participating and non-participating providers for the medical management of the member.

3.13.12.6 The Contractor shall ensure that when a member changes PCPs, his/her medical records or copies of medical records are forwarded to the new PCP within 10 business days from receipt of request. The State is not required to obtain written approval from a member before requesting the member's record from the PCP or any other participating provider.

3.13.12.7 Medical records shall be produced by the Contractor and shall be available without charge to duly authorized representatives of the State and CMS to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services provided. Except as otherwise provided in this Contract

(see, e.g., Section 3.15 of this Contract), the Contractor shall provide the State or its authorized representative with access to members' medical records, whether electronic or paper, within 30 calendar days of the request for medical records. The Contractor shall be responsible for any reproduction costs for medical records requested by the State or a Federal agency.

3.13.12.8 The Contractor shall upon the written request of the member, furnish a copy of the member's medical records within 10 calendar days of the receipt of the written request. Each member is entitled to one free copy of his/her medical records. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

3.13.12.9 The Contractor shall comply with a member's request that his/her medical records be amended or corrected, as specified in 45 CFR Part 164.

3.13.12.10 The Contractor shall ensure that medical records are preserved and maintained for a minimum of ten years from expiration of this Contract.

3.13.13 **Quality of Care/Quality of Services Issues**

3.13.13.1 The Contractor shall operate a system to collect, address, track and report quality of care and quality of service issues that occur with its members, including quality of care/quality of service Grievances.

3.13.13.2 Quality of care and quality of service issues are any issues impacting the quality of care or services that a member receives, including but not limited to issues affecting safety, access to services, member health care outcomes, or the member experience. Quality of care and quality of service issues can be reported by any individual, including but not limited to an individual in a member's family, a provider, the State, or any member of the Contractor's staff, including case managers and care coordinators.

3.13.13.3 The Contractor shall have a process for individuals to report quality of care and quality of service issues. The Contractor shall make available information and instructions regarding reporting quality of care and quality of service issues, including contact information for where to report an issue.

3.13.13.4 If a Contractor receives a quality of care or quality of service issue from a member, the Contractor shall encourage the member, where appropriate, to file a Grievance according to Section 3.15 of this Contract. If the member does not wish to file a Grievance, the Contractor shall process it as quality of care or

quality of service issue and indicate that the member did not want to file a Grievance and therefore should not be contacted.

3.13.13.5 Upon receipt of a quality of care or quality of service issue, the Contractor shall immediately work with all appropriate parties to resolve the issue. The Contractor shall resolve the issue within 30 calendar days of receiving the issue.

3.13.13.6 The Contractor shall collect and analyze data regarding quality of care and quality of service issues, track and identify trends, identify root causes, and make necessary changes in order to prevent reoccurrence. The Contractor shall use data regarding quality of care and quality of service issues as part of its re-credentialing process (see Section 3.9.7.17) and its PCP profiling process (see Section 3.12.8.1 of this Contract).

3.14 MEMBER SERVICES

3.14.1 Member Materials

3.14.1.1 Prior Approval of Written Materials

3.14.1.1.1 The Contractor shall submit to the State for review and prior approval all member materials that will be distributed to members (referred to as member materials). This includes but is not limited to new member orientation materials, member handbooks, provider directories, identification cards, quarterly member newsletters, member website, Health Education materials and Grievances and Appeals notices.

3.14.1.1.2 The Contractor shall submit to the State in paper and electronic file media, all written member materials in the anticipated format for final distribution to the member. The submitted written materials shall include any graphics that will be included in the final version distributed to members. The materials shall be accompanied by a plan that describes the Contractor's intent and procedure for the distribution and use of the member materials. Electronic files submitted in any other format than those approved by the State will not be processed.

3.14.1.1.3 The State shall review the submitted member materials and either approve or deny them within 45 calendar days from the date of submission.

3.14.1.1.4 Prior to modifying any approved member materials, the Contractor shall submit to the State for prior approval a detailed description of the proposed modifications in accordance with this Section of the Contract.

3.14.1.1.5 The State reserves the right to notify the Contractor to discontinue or modify member materials after approval.

3.14.1.2 Written Member Material Guidelines

3.14.1.2.1 All written member materials must be worded at or below a 6th grade reading level, unless otherwise approved in writing by the State.

3.14.1.2.2 All written materials shall be clearly legible with a minimum font size of 12 point with the exception of the member identification cards and unless otherwise approved in writing by the State.

3.14.1.2.3 All written materials must be printed with the assurance of non-discrimination as provided in Section 3.2.3 of this Contract.

3.14.1.2.4 All written member materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, Grievance and Appeal notices, and denial and termination notices, shall be available in English and shall be translated and available in Spanish and any additional Prevalent Non-English Language in Delaware. The Contractor is responsible for ensuring the translation is accurate and culturally appropriate. Within 90 calendar days of notification from the State, the Contractor shall submit a certification to the State that the translation of the information into the different languages has been reviewed by a qualified individual for accuracy, and that the materials are available in each Prevalent Non-English Language.

3.14.1.2.5 All written member materials shall notify members that oral interpretation is available for any language at no expense to the member and instructions for accessing oral interpretation.

3.14.1.2.6 The Contractor shall make all written member materials available in alternative formats and through the provision of auxiliary aids and services at no expense to the member or potential member. Alternative formats may include, but may not be limited to, Braille, large print, and audio, and shall be based on the needs of the individual member. The Contractor's provision of alternative formats and auxiliary aids and services shall take into consideration the special needs of members or potential members with disabilities or Limited English Proficiency. The Contractor shall notify all members and potential members that information is available in alternative formats and that auxiliary aids and services are available. The Contractor shall have processes in place to ensure that information in alternative formats and auxiliary aids

and services are made available to a member within 45 calendar days of a request.

3.14.1.2.7 The Contractor shall provide written notice to members of any changes to written member materials previously sent to members within 30 calendar days before the effective date of the change.

3.14.1.2.8 The Contractor shall include taglines in the Prevalent Non-English Languages and in a conspicuously visible font size, no smaller than 18 point font, explaining the availability of written translation or oral interpretation to understand the information provided, the toll-free and TTY/TDY telephone number of the Contractor's member services information line, the Contractor's 24/7 nurse triage/nurse advice line, and the Contractor's pharmacy service information line, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

3.14.1.2.9 The Contractor shall provide all information and materials for potential members and members in an easily understood manner and format that is Readily Accessible by potential members and members.

3.14.1.2.10 The Contractor shall use definitions for managed care terminology developed by the State as described in Section 3.14.1.2.12 of this Contract.

3.14.1.2.11 The Contractor shall use model member handbooks and member notices developed by the State.

3.14.1.2.12 The Contractor shall use the following state developed terminology:

3.14.1.2.12.1 Appeal – A request for your plan to review a decision to deny or reduce a benefit.

3.14.1.2.12.2 Benefits – The health care items or services covered under your plan.

3.14.1.2.12.3 Co-payment – A set cost you must pay to receive a covered benefit at the time of service.

3.14.1.2.12.4 Durable Medical Equipment (DME) – Equipment and supplies that your doctor orders as part of your health care.

3.14.1.2.12.5 Emergency Medical Condition – A medical problem so serious that you must seek care right away to avoid severe harm.

3.14.1.2.12.6 Emergency Medical Transportation – The ambulance that takes you to the hospital in an emergency.

3.14.1.2.12.7 Emergency Room Care – The services you get in an emergency room to treat an emergency medical condition.

3.14.1.2.12.8 Emergency Services – Treatment of an emergency medical condition to keep it from getting worse.

3.14.1.2.12.9 Excluded Services – Health care services that your plan may not pay for or cover.

3.14.1.2.12.10 Grievance – A complaint that you make to your plan about how you feel about your health care.

3.14.1.2.12.11 Habilitation Devices – Health care devices that help you keep, learn, or improve skills and functioning for daily living.

3.14.1.2.12.12 Habilitation Services – Health care services that help you keep, learn, or improve skills and functioning for daily living.

3.14.1.2.12.13 Health Insurance – A contract that requires your plan to pay some or all of your health care costs.

3.14.1.2.12.14 Home Health Care – Health care services you receive at home.

3.14.1.2.12.15 Hospice Services – Services to provide comfort and support for people who are terminally ill and their families.

3.14.1.2.12.16 Hospitalization – Care in a hospital where you are admitted and usually stay overnight. An overnight stay for observation could be outpatient care.

3.14.1.2.12.17 Hospital Outpatient Care – Care in a hospital that usually does not require an overnight stay.

3.14.1.2.12.18 Immunization – A shot that protects you from disease.

3.14.1.2.12.19 Long Term Services and Supports (LTSS) – Medical and non-medical care provided to people who are unable to perform basic activities of daily living (ADLs). ADLs include activities such as dressing or bathing. LTSS can be provided at home, in the community, in assisted living or in nursing homes.

3.14.1.2.12.20 Medically Necessary – Health care services or supplies that help to identify or treat an illness, injury, condition, disease or its symptoms and that meet medical standards.

3.14.1.2.12.21 Network – The providers that your plan has contracted with to provide health care services.

3.14.1.2.12.22 Non-Participating Provider – A provider who does not have a contract with your plan to provide services to you.

3.14.1.2.12.23 Physician Services – Health care services a licensed medical doctor provides or plans for you.

3.14.1.2.12.24 Plan – A benefit the State of Delaware provides to you to pay for your health care services. Plan can also be called a Managed Care Organization (MCO) or Accountable Care Organization (ACO).

3.14.1.2.12.25 Preauthorization – An approval from your plan for a health care service.

3.14.1.2.12.26 Participating Provider – A provider who has a contract with your plan to provide health care services to you.

3.14.1.2.12.27 Premium – The amount you pay for your health insurance every month under the Delaware Healthy Children Program.

3.14.1.2.12.28 Prescription Drug Coverage – The part of your plan that helps pay for prescription drugs and medications.

3.14.1.2.12.29 Prescription Drugs – Drugs and medications that, by law, require a prescription.

3.14.1.2.12.30 Primary Care Physician – A doctor who directly provides or plans your health care services.

3.14.1.2.12.31 Primary Care Provider – A doctor, nurse, or physician assistant who provides, plans and/or helps you access health care services.

3.14.1.2.12.32 Provider – A health care professional, facility, or medical business that offers health care services.

3.14.1.2.12.33 Rehabilitation Devices – Health care devices that help you keep, get back, or improve skills and functioning you need for daily living that have been lost or impaired because you were sick, hurt, or disabled.

3.14.1.2.12.34 Rehabilitation Services – Health care services that help you keep, get back, or improve skills and functioning you need for daily living that have been lost or impaired because you were sick, hurt, or disabled.

3.14.1.2.12.35 Skilled Nursing Care – Health care services from licensed nurses in your own home or in a nursing home.

3.14.1.2.12.36 Specialist Care – Health care provided by a doctor who has special training for a specific condition or illness.

3.14.1.2.12.37 Urgent Care – When you need care or medical treatment within 48 hours.

3.14.1.3 Distribution of Member Materials

3.14.1.3.1 The Contractor shall distribute all member materials as required by this Contract. This includes, but is not limited to member handbooks, provider directories, identification cards, new member orientation materials, quarterly member newsletters, member Health Education materials, and Grievances and Appeals notices.

3.14.1.3.2 With prior approval from the State in accordance with Section 3.14.1.1 of this Contract, the Contractor may distribute additional materials and information other than those required by Section 3.14.1 of this Contract to members in order to promote health and/or educate members.

3.14.1.3.3 The Contractor shall not provide member materials electronically unless all of the following are met:

3.14.1.3.3.1 The format is Readily Accessible.

3.14.1.3.3.2 The information is provided in an electronic form that can be electronically retained and printed.

3.14.1.3.3.3 The information is consistent with the content and language requirements in Section 3.14.1.2 of this Contract.

3.14.1.3.3.4 The member is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within five business days.

3.14.1.3.3.5 The Contractor ensures that the member is informed of his or her right to receive information through regular mail instead of electronically.

3.14.1.3.3.6 The Contractor posts materials to the individual's electronic account the same day the information would be mailed.

3.14.1.3.3.7 The Contractor sends a notice by regular mail within three business days of the date of a failed electronic communication if an electronic communication is undeliverable.

3.14.1.3.3.8 The Contractor, at the member's request, provides through regular mail any information posted to the member's electronic account.

3.14.1.4 DSHP and DSHP Plus Member Handbooks

3.14.1.4.1 *General*

3.14.1.4.1.1 The Contractor shall develop a DSHP member handbook and a DSHP Plus member handbook using the State-developed model member handbooks, and update the handbooks at least annually. The Contractor shall maintain documentation verifying that the member handbooks are reviewed and updated as necessary but at least once a year.

3.14.1.4.1.2 The DSHP member handbook shall be distributed to all DSHP members within 10 business days of the member's Enrollment date in the Contractor's MCO. The DSHP Plus member handbook shall be distributed to all DSHP Plus members within 10 business days of the member's Enrollment date. The Contractor may choose to hand-deliver member handbooks to DSHP Plus LTSS members within 10 business days of the member's Enrollment date. Distribution of the member handbooks serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a). The member handbook shall be considered distributed to a member if the Contractor:

3.14.1.4.1.2.1 Mails a printed copy of the member handbook to the member's mailing address;

3.14.1.4.1.2.2 Provides the member handbook by email after obtaining the member's agreement to receive the member handbook by email;

3.14.1.4.1.2.3 Posts the member handbook on the Contractor's web-site and advises the member in paper or electronic form that the member handbook is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access the member handbook online are provided auxiliary aids and services upon request at no cost; or

3.14.1.4.1.2.4 Provides the member handbook by any other method that can reasonably be expected to result in the member receiving the member handbook.

3.14.1.4.1.3 The Contractor shall annually, within 30 calendar days of the end of the Annual Open Enrollment Period, send a letter to members who did not change enrollment during the Annual Open Enrollment Period (for new members see Section 3.14.1.4.1.2 above) notifying them of the availability of an updated DSHP/DSHP Plus member handbook (as applicable to the member) and summarizing any changes to the member handbook. The letter shall provide information on how the member can request a hard copy of the member handbook at no charge, including the telephone number of the DSHP/DSHP Plus member services information line (as applicable to the member) as well as information on how to access the member handbook on line, including a website address that takes the member directly to the online DSHP/DSHP Plus member handbook (as applicable to the member). The Contractor shall provide a member with a hard copy of the member handbook within 10 calendar days of receipt of the request.

3.14.1.4.1.4 When there are program or service site changes, the Contractor must provide notification to the affected members at least 30 calendar days before implementation of the change.

3.14.1.4.1.5 The Contractor shall make an electronic version of the DSHP and DSHP Plus member handbooks available on the Contractor's member website. The Contractor shall update member handbooks on the Contractor's member website daily.

3.14.1.4.1.6 The Contractor shall distribute a DSHP and DSHP Plus member handbook to all participating providers upon initial credentialing, annually thereafter to all participating providers as handbooks are updated, and whenever there are material revisions. For purposes of providing DSHP and DSHP Plus member handbooks to providers, it shall be acceptable to provide handbooks in electronic format, including, but not limited to, CD or access via a web link.

3.14.1.4.1.7 The member handbooks shall comply with all the applicable written material guidelines described in Section 3.14.1.2 of this Contract.

3.14.1.4.1.8 The member handbooks shall include on the front cover the official DHSS logo, which the State will provide to the Contractor.

3.14.1.4.2 *DSHP Member Handbook Contents*

3.14.1.4.2.1 The DSHP member handbook shall include a table of contents and include information that enables the member to understand how to effectively use the managed care program. This information at a minimum must:

3.14.1.4.2.1.1 Comply with all necessary and mandated information in 42 CFR 438.10(g);

3.14.1.4.2.1.2 Include an explanation of how members will be notified of member specific information such as effective date of Enrollment and PCP assignment;

3.14.1.4.2.1.3 Include information about the importance of selecting a PCP and how to choose and change PCPs;

3.14.1.4.2.1.4 Include instructions to the member for notifying the State when family size changes;

3.14.1.4.2.1.5 Include provisions pursuant to 42 CFR 431.304 governing the confidential nature of information about members, including the legal sanctions imposed for improper disclosure and use;

3.14.1.4.2.1.6 Describe appointment procedures and appointment standards, including how to request assistance with making appointments;

3.14.1.4.2.1.7 Include procedures for obtaining referrals to specialists as well as procedures for obtaining referrals to non-participating providers;

3.14.1.4.2.1.8 Describe the DSHP benefit package including amount, duration and scope of services in sufficient detail to ensure that members understand the benefits to which they are entitled;

3.14.1.4.2.1.9 Include instructions on how and whom to contact for questions regarding refilling a prescription;

3.14.1.4.2.1.10 Describe all available State Plan services not provided by the Contractor (see Section 3.4.10 of this Contract), and how to access those services, including any cost sharing and how transportation is provided;

3.14.1.4.2.1.10.1 If the Contractor does not cover a counseling or referral service because of moral or religious objections per Section 3.9.5.2.1 of this Contract, the Contractor shall inform members that the service is not covered by the Contractor. In these cases, the Contractor shall inform members how they can obtain information from the State about how to access these services.

3.14.1.4.2.1.11 Describe limitations or exclusions from coverage;

3.14.1.4.2.1.12 Explain that service authorization is required for some services, list the services that require service authorization, and describe the service authorization process. Notify members that they can call the member services information line with any questions regarding service authorization;

3.14.1.4.2.1.13 Include the Contractor's member services toll-free telephone numbers, including the Contractor's member services information line, the Contractor's 24/7 nurse triage/nurse advice line, and the Contractor's pharmacy service information line with the services and information that may be obtained from each line with a statement that the member may contact the Contractor with questions;

3.14.1.4.2.1.14 Include the number(s) for the DSAMH behavioral health crisis intervention services toll-free hotline(s) with information about when to call that line;

3.14.1.4.2.1.15 Include the Contractor's member website and information that can be obtained on the website, including an updated member handbook and provider directory;

3.14.1.4.2.1.16 Describe the member's right to access a second opinion (see Section 3.4.7 of this Contract) and how to obtain a second opinion from a qualified participating or non-participating providers;

3.14.1.4.2.1.17 Include information on Grievance, Appeal, and State Fair Hearing procedures and timeframes, consistent with 42 CFR Subpart F including but not limited to the information specified in 42 CFR 438.10(g)(2)(xi) and Sections 3.15.8.1 and 3.15.8.2 of this Contract, including but not limited to:

3.14.1.4.2.1.17.1 The right to file Grievances and Appeals.

3.14.1.4.2.1.17.2 The requirements and timeframes for filing a Grievance or an Appeal.

3.14.1.4.2.1.17.3 The availability of assistance in the filing process.

3.14.1.4.2.1.17.4 The right to request a State Fair Hearing after the Contractor has made a determination on a member's Appeal which is adverse to the member.

3.14.1.4.2.1.17.5 When requested by the member, benefits that the Contractor seeks to reduce or terminate will continue if the member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the member may, consistent with state policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the member.

3.14.1.4.2.1.18 Explain how to access after-hours services, Emergency Services and Post Stabilization Services, and also include: (i) what constitutes an emergency medical condition and emergency services ; (ii) clarify that prior authorization is not required for Emergency Services; and (iii) the member has a right to access the nearest emergency room without regard to contracting status with the Contractor;

3.14.1.4.2.1.19 Provide instructions for obtaining all services, including, but not limited to, emergency transportation and non-emergency medical transportation, services, maternity, family planning and sexually transmitted diseases services, behavioral health services, LTSS, Telemedicine, and Urgent Care and after-hours care;

3.14.1.4.2.1.20 Include the name, location and contact information for Urgent Care/after hour care centers and instructions for obtaining care at these facilities;

3.14.1.4.2.1.21 Provide information on Copayment amounts for Covered Services;

3.14.1.4.2.1.22 Provide information on the Contractor's care coordination programs and how to access these programs;

3.14.1.4.2.1.23 Provide instructions to the member for notifying the Contractor in the case of a move of the primary residence out of State;

3.14.1.4.2.1.24 Provide notice to the member that if he/she has a worker's compensation claim, or pending personal injury or medical malpractice law suit, or has been involved in an auto accident to immediately contact the Contractor;

3.14.1.4.2.1.25 Provide notice to the member of contributions that the member can make towards his/her own health, member responsibilities and appropriate and inappropriate behavior;

3.14.1.4.2.1.26 Provide instructions to the member on how to access oral interpretation, written translation services, written materials in alternative formats, and auxiliary aids and services, when needed as well as a statement that interpretation and translation services as well as auxiliary aids and services are free;

3.14.1.4.2.1.27 Provide information regarding Advance Directives, including, but not limited to, how to exercise an Advance Directive as set forth in 42 CFR 438.3(j); policies with respect to the implementation of members' rights including any limitations as a matter of conscience; and information on how members may file complaints regarding non-compliance with Advance Directive requirements with DSAPPD;

3.14.1.4.2.1.28 Provide information regarding the member's rights, including (see 42 CFR 438.100(b):

3.14.1.4.2.1.28.1 The right to be treated with respect and with due consideration for the member's dignity and privacy;

3.14.1.4.2.1.28.2 The right to receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand;

3.14.1.4.2.1.28.3 The right to participate in decisions regarding the member's health care, including the right to refuse treatment;

3.14.1.4.2.1.28.4 The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

3.14.1.4.2.1.28.5 The member's right to request and receive a copy of the member's medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164; and

3.14.1.4.2.1.28.6 The member's right to be furnished health care services in accordance with 42 CFR 438.206 through 42 CFR 438.210.

3.14.1.4.2.1.29 Provide information regarding the member's ability to exercise his/her rights and that the exercise of those rights cannot adversely affect the way the Contractor, its providers or the State treats the member (see 42 CFR 438.100(c));

3.14.1.4.2.1.30 Include information educating members of their rights and necessary steps to amend their data in accordance with HIPAA and State law;

3.14.1.4.2.1.31 Provide information about the role of the DSHP Member Advocate and how to reach the DSHP Member Advocate;

3.14.1.4.2.1.32 Provide information about the Annual Open Enrollment Period, including on the member's right to Transfer to another MCO and instructions for Transfer;

3.14.1.4.2.1.33 Provide information on the reasons for Transfer and Disenrollment according to State and Federal requirements;

3.14.1.4.2.1.34 Describe the extent to which, and how members may obtain benefits, including family planning services and supplies from non-participating providers. This includes an explanation that the Contractor cannot require a member to obtain a referral before choosing a family planning provider;

3.14.1.4.2.1.35 Provide information on how to report suspected Fraud or Abuse;

3.14.1.4.2.1.36 Provide information on State transition of care policies in accordance with 42 CFR 438.62(b)(3) as specified in Section 3.8.1 of this Contract; and

3.14.1.4.2.1.37 Include any other information deemed essential by the Contractor or the State.

3.14.1.4.3 *DSHP Plus Member Handbook Contents*

3.14.1.4.3.1 The DSHP Plus member handbook shall include a table of contents and, at a minimum, shall comply with the following:

3.14.1.4.3.1.1 Include any and all information from the DSHP member handbook that applies to DSHP Plus members;

3.14.1.4.3.1.2 Include a list of services in the DSHP Plus LTSS benefit package services, including any benefit limitations;

3.14.1.4.3.1.3 Describe case management services and the role of the case manager;

3.14.1.4.3.1.4 Provide information on Self-Directed Attendant Care Services, including, but not limited to, the roles and responsibilities of the member and the Contractor and the member's right to participate in or voluntarily withdraw from Self-Directed Attendant Care Services at any time;

3.14.1.4.3.1.5 Provider information regarding the Contractor's nursing facility transition process;

3.14.1.4.3.1.6 Provide information regarding services available to qualifying individuals transitioning from nursing facilities to the community;

3.14.1.4.3.1.7 Provide information about the DSHP Plus Member Advocate, including, but not limited to, the role of the DSHP Plus Member Advocate and how to contact the DSHP Plus Member Advocate for assistance;

3.14.1.4.3.1.8 Provide information about the member's right to choose between nursing facility care and HCBS if the member qualifies for nursing facility care and if the member's needs can be safely and effectively met in the community;

3.14.1.4.3.1.9 Provide information about Patient Liability responsibilities, including the potential consequences of failure to comply with Patient Liability requirements, including loss of the member's nursing facility or assisted living facility provider.

3.14.1.5 Identification Cards

3.14.1.5.1 The Contractor shall provide each member an identification (ID) card within 30 calendar days of the member's Enrollment date.

3.14.1.5.2 The Contractor shall re-issue a member ID card within 10 calendar days of notice if a member reports a lost card or if information on the member ID card needs to be changed.

3.14.1.5.3 The member ID cards shall not be overtly different in design from the ID card the Contractor issues to its non-Medicaid members.

3.14.1.5.4 The ID cards shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), comply with all State and Federal requirements and, at a minimum, include:

3.14.1.5.4.1 The Contractor's name;

3.14.1.5.4.2 Phone numbers for the Contractor's toll free member services information line, nurse advice/nurse triage line, pharmacy services call center, and any other key numbers;

3.14.1.5.4.3 Descriptions of procedures to be followed for Emergency Services;

3.14.1.5.4.4 The member's identification number;

3.14.1.5.4.5 The member's name (first and last name and middle initial);

3.14.1.5.4.6 The member's date of birth;

3.14.1.5.4.7 The member's Copayment information for Covered Services;

3.14.1.5.4.8 For DSHP members and DSHP Plus members who are not Dual Eligibles, the member's PCP; and

3.14.1.5.4.9 For DSHP Plus LTSS members, the letters "LTSS" on the front and back of the card.

3.14.1.6 DSHP and DSHP Plus Provider Directories

3.14.1.6.1 The Contractor shall develop and maintain DSHP and DSHP Plus provider directories, which shall be made available to all members in electronic form, and in paper form upon request. The provider directories must include the following for all participating providers, including physicians and specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers in the Contractor's DSHP and DSHP Plus networks:

3.14.1.6.1.1 The provider's name, as well as any group affiliation;

3.14.1.6.1.2 All locations, including street address(es);

3.14.1.6.1.3 Telephone number(s);

3.14.1.6.1.4 Website URL, as applicable;

3.14.1.6.1.5 Specialties, as applicable;

3.14.1.6.1.6 Whether the provider will accept new patients;

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

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

3.14.1.6.2 The provider directories shall be submitted to the State annually for prior approval in accordance with Section 3.14.1.1 of this Contract. The text of the directories shall be in the format approved by the State. The provider information used to populate the provider directories shall be submitted as a TXT file or such format as otherwise approved in writing by the State and be produced using the same extract process as the actual provider directories.

3.14.1.6.3 Within 30 calendar days of a member's Enrollment date, the Contractor shall notify the member of the availability of the online DSHP/DSHP Plus provider directory (as applicable to the member) and how to access the online DSHP/DSHP Plus provider directory, including a website address that takes the member directly to the online DSHP/DSHP Plus provider directory. The notice shall also notify the member of his/her right to request a hard copy of the DSHP/DSHP Plus provider directory and instructions for doing so, including the telephone number of the DSHP/DSHP Plus member services information line. Annually thereafter, the Contractor shall notify members of their right to request a hard copy of the provider directories and instructions for doing so. The Contractor shall provide the member with a hard copy of the DSHP/DSHP Plus provider directory within 10 calendar days of receipt of request.

3.14.1.6.4 The Contractor shall post the DSHP and DSHP Plus provider directories on the Contractor's website in a machine readable file and format as specified by the Secretary of HHS. The online

version of the provider directories shall be searchable by provider type, distance from member's address, zip code and/or whether the provider is accepting new patients. The online version of the provider directories shall be updated on a daily basis and shall contain a disclaimer that the online provider directories are updated more frequently than the printed directory. Members receiving a hard copy of the provider directories shall be advised that the Contractor's network may have changed since the directories were printed, and how to access current information regarding the Contractor's participating providers. The hard copy of the provider directories shall be updated at least monthly. The Contractor shall submit to the State for prior approval its policy for processing monthly updates to the hard copy of the provider directories.

3.14.1.6.5 Upon request, the Contractor shall provide information on the participation status of any provider and the means for obtaining more information about providers who participate in the Contractor's provider network, including open and closed panel status.

3.14.1.6.6 The Contractor shall ensure the accuracy and completeness of the information in its provider directory, including the data elements listed in Section 3.14.1.6.1. On a quarterly basis the Contractor shall review and validate the data for each provider type represented in the directory (i.e., physicians and specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers). In addition to the quarterly review, the Contractor shall review the accuracy of these data elements during re-credentialing.

3.14.1.7 Member Website

3.14.1.7.1 The Contractor shall have a member website that is available to all members, containing accurate, up-to-date information about the Contractor's MCO, services provided, the Contractors' PDL, the provider directory, frequently asked questions, and contact phone numbers including the DSAMH behavioral health crisis intervention toll-free hotline(s), and e-mail addresses. Members shall have access to the member handbook and provider directory via the website without having to log in.

3.14.1.7.2 The Contractor's member website shall contain information related to pharmacy benefits specified in Section 3.5.10.3 of this Contract.

3.14.1.7.3 Member services information line staff shall have access to the website and provide assistance to members with navigating the site and locating information.

3.14.1.7.4 The member website shall comply with the Marketing policies and procedures and requirements for written materials described in this Contract as well as all applicable State and Federal law.

3.14.1.8 Quarterly Member Newsletter

3.14.1.8.1 The Contractor shall, at a minimum, distribute on a quarterly basis a newsletter to all members which is intended to educate the member to the managed care system, proper utilization of services, etc., and encourage utilization of preventive care services. The State may require the Contractor to address a specific topic in the quarterly newsletter. The Contractor shall submit the quarterly newsletter to the State for approval 45 calendar days prior to the date on which it proposes to use or distribute the newsletter.

3.14.1.9 Member Health Education

3.14.1.9.1 The Contractor shall develop a Health Education Plan and submit it to the State for prior review and approval.

3.14.1.9.2 The Health Education Plan shall include a member education program that uses classes, individual or group sessions, videotapes, written material, media campaigns, and modern technologies (e.g., mobile applications and tools, social media, etc.). All instructional material shall be provided in a manner and format that is easily understood and in keeping with requirements for written member materials as prescribed in this Contract.

3.14.1.9.3 The Contractor shall submit an annual evaluation of its Health Education Plan that describes the Contractor's Health Education activities for the previous year and an evaluation of their effectiveness and any lessons learned.

3.14.1.9.4 The Contractor shall make Health Education materials available to the State upon request.

3.14.1.9.5 The Contractor shall notify members of the schedule of educational events and shall post such information on its website.

3.14.1.10 Additional Information Available Upon Request

3.14.1.10.1 The Contractor shall provide to members upon request all other information required by CMS, including, but not limited to, the following information:

3.14.1.10.1.1 Information regarding the structure and operation of the Contractor's MCO; and

3.14.1.10.1.2 Any physician incentive plans in place as set forth in 42 CFR 438.3(i); and

3.14.1.10.1.3 As specified in 42 CFR 438.915(b), the Contractor shall make available to the member the reason for any denial by the Contractor of reimbursement or payment for behavioral health services to the member.

3.14.1.11 Formulary

3.14.1.11.1 The Contractor shall make available in electronic or paper form, the following information about its formulary:

3.14.1.11.1.1 Which medications are covered (both generic and name brand).

3.14.1.11.1.2 What tier each medication is on.

3.14.1.11.2 Formulary drug lists must be made available on the Contractor's website in a machine readable file and format as specified by the Secretary of HHS.

3.14.2 **Member Services**

3.14.2.1 New DSHP Member Orientation

3.14.2.1.1 The Contractor must have written policies and procedures for orienting new DSHP members. The new DSHP member orientation must at a minimum provide information on:

3.14.2.1.1.1 The DSHP benefit package;

3.14.2.1.1.2 Coordination of benefits, including for members with Medicare and Medicaid;

3.14.2.1.1.3 The role of the PCP and selecting a PCP;

3.14.2.1.1.4 How to make appointments and utilize services;

3.14.2.1.1.5 Medicaid benefits provided by the State (see Section 3.4.10 of this Contract);

3.14.2.1.1.6 The Contractor's member service information line and nurse triage/nurse advice line;

3.14.2.1.1.7 What to do in an emergency or urgent medical situation, or behavioral health;

3.14.2.1.1.8 How to register a Grievance or file an Appeal, including the State Fair Hearing process;

3.14.2.1.1.9 Information about the DSHP Member Advocate, including, but not limited to, the role of the DSHP Member Advocate and how to contact the DSHP Member Advocate for assistance; and

3.14.2.1.1.10 Members' rights and responsibilities.

3.14.2.1.2 All written orientation materials distributed to new members must comply with the requirements listed in Section 3.14.1 of this Contract.

3.14.2.1.3 As part of its new member orientation process, the Contractor shall provide members with a welcome call within 30 calendar days of the member's Enrollment date. The purpose of the welcome call shall be to provide the member with information regarding the Contractor's MCO, which shall include the information listed in Section 3.14.2.1.1 of this Contract not otherwise provided as part of new member orientation, and to complete a health risk assessment (HRA) as described in Section 3.6.2 of this Contract.

3.14.2.2 New DSHP Plus Member Orientation

3.14.2.2.1 The Contractor must have written policies and procedures for orienting new DSHP Plus members, and the orientation at a minimum must include the information specified for DSHP member orientation (see Section 3.14.2.1 of this Contract) as applied to DSHP Plus members.

3.14.2.2.2 All written orientation materials distributed to new DSHP Plus members must comply with the requirements listed in Section 3.14.1 of this Contract.

3.14.2.2.3 As part of its new orientation process for DSHP Plus members, the Contractor shall provide DSHP Plus members with a welcome call within five business days of the member's Enrollment date. The welcome call shall provide the member with information regarding the Contractor's MCO, including relevant member orientation information provided to DSHP members (see Section 3.14.2.1 of this Contract, above), completing an HRA for DSHP Plus members who are not DSHP Plus LTSS members, and assistance in arranging a face-to-face meeting with a case manager for DSHP Plus LTSS members. As specified in Section 3.7.2.2 of this Contract, the case manager shall provide information about DSHP Plus LTSS to new DSHP Plus LTSS members during the initial visit.

3.14.2.3 DSHP and DSHP Plus Toll-Free Member Services Telephone Lines

3.14.2.3.1 The Contractor shall operate a call center with separate toll-free telephone lines for DSHP and DSHP Plus members to respond to member questions, concerns, inquiries, and complaints from the member, the member's family or the member's provider.

3.14.2.3.2 The Contractor shall maintain member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including referrals from all sources, monitoring of calls via recording or other means, translation/interpretation and compliance with standards.

3.14.2.3.3 The Contractor's information lines shall have the capacity for the State or its authorized representative to monitor calls remotely.

3.14.2.3.4 The member services information lines shall be equipped to handle calls from LEP callers as well as calls from members who are hearing impaired.

3.14.2.3.5 The Contractor shall have bilingual Spanish representatives as well as bilingual representatives in any other Prevalent Non-English Language.

3.14.2.3.6 Members who call the member services information lines must first be given the option of choosing their preferred language. Upon selecting the preferred language, the member shall have the option of having his/her call transferred immediately to a call center representative without requiring the caller to make additional selections in the information line's automated system.

3.14.2.3.7 The Contractor shall ensure that the member services information lines are staffed adequately to respond to members' questions, at a minimum, from 8 a.m. to 7 p.m. eastern time, Monday through Friday, except State of Delaware holidays.

3.14.2.3.8 The member services information line staff must be trained to respond to member questions on DSHP and DSHP Plus and the Contractor' MCO, including, but not limited to, Covered Services, additional services, the provider network, and member Enrollment issues. Member services information line staff must also receive training on identifying, handling, documenting, processing, and referring calls where the member expresses a Grievance or requests to file an Appeal. Staff answering calls on the DSHP Plus information line shall receive specialized training regarding the DSHP Plus LTSS program, including the LTSS benefit package,

case management, LTSS providers, coordination with Medicare and the potential needs of DSHP Plus LTSS members.

3.14.2.3.9 The member services information line staff shall receive ongoing training, at least quarterly, through instructor-led trainings and staff meetings. The member services information line staff must receive training immediately following changes to service delivery and Covered Services.

3.14.2.3.10 The Contractor shall implement protocols, with prior approval from the State, to ensure that calls to the member services information lines that should be transferred/referred to other Contractor staff, including, but not limited to, a nurse, member services supervisor or a case manager, or to an external entity, are transferred/referred appropriately.

3.14.2.3.11 The Contractor shall have the capability to Warm Transfer calls from the member services information lines to the nurse triage/nurse advice line, to the DSAMH behavioral health crisis intervention services toll-free hotline(s), to the Contractor's member call center for pharmacy services/pharmacy service information line (see Section 3.5.10.1 of this Contract), and to the Contractor's appointment assistance and linkage to services staff (see Section 3.6.3.2.1 of this Contract).

3.14.2.3.12 The Contractor shall measure and monitor the accuracy of responses and take corrective action as necessary to ensure the accuracy of responses by staff.

3.14.2.3.13 The Contractor shall have an automated system available during non-business hours, including weekends and State of Delaware holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency, the option to speak directly to a nurse, and shall include, at a minimum, a voice mailbox for callers to leave messages. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages. The Contractor shall return all messages by close of business on the next business day.

3.14.2.3.14 The member services information line staff shall have access to electronic documentation from previous calls made by or on behalf of the member to the member services information line, nurse triage/nurse advice line, pharmacy service information line, care coordination and case management.

3.14.2.4 Performance Standards for Member Services Information Lines

3.14.2.4.1 The Contractor shall adequately staff the member services information lines to ensure that the lines meet the following performance standards: less than 5% call abandonment rate; 80% of calls are answered by a live voice within 30 seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed 30 seconds.

3.14.2.4.2 The Contractor's member services information line systems shall have the capability to track the metrics identified above. Metrics shall be reported separately for the member services information line for DSHP and for DSHP Plus.

3.14.2.5 Toll-Free Nurse Triage/Nurse Advice Telephone Line

3.14.2.5.1 The Contractor shall operate a DSHP/DSHP Plus nurse triage/nurse advice line that is available 24 hours a day, seven days a week. The nurse triage/nurse advice line shall be staffed with qualified nurses to triage Urgent Care and emergency calls from members and to facilitate transfer of calls to a case manager from or on behalf of members.

3.14.2.5.2 The Contractor shall ensure that all calls to the nurse triage/nurse advice line that require immediate attention by a case manager are immediately addressed or transferred to a case manager. During normal business hours, the transfer shall be a Warm Transfer. After normal business hours, if the Contractor cannot transfer the call as a Warm Transfer, the Contractor shall ensure that a case manager is notified and returns the member's call within 30 minutes and that the case manager has access to the necessary information (e.g., the member's plan of care) to resolve member issues. The Contractor shall implement protocols, with prior approval from the State, that describe how calls to the nurse advice/nurse triage line from members will be handled.

3.14.2.5.3 The Contractor shall have the capability to Warm Transfer callers from the nurse triage/nurse advice line to the DSAMH behavioral health crisis intervention services toll-free hotline(s).

3.14.2.6 Performance Standards for the Nurse Triage/Nurse Advice Telephone Line

3.14.2.6.1 The Contractor shall adequately staff the nurse triage/nurse advice line to ensure that the line meets the following performance standards: less than five % call abandonment rate; 80% of calls are answered by a live voice within 30 seconds (or the prevailing benchmark established by NCQA); and average wait time for assistance does not exceed 30 seconds.

3.14.2.6.2 The Contractor's nurse triage/nurse advice line shall have the capability to track the metrics identified above.

3.14.2.7 Advance Directives

3.14.2.7.1 The Contractor shall comply with the following with respect to Advance Directives:

3.14.2.7.1.1 Ensure compliance with State and Federal law, including but not limited to 42 CFR 438.3((j), 42 CFR 422.128 and 42 CFR Part 489, Subpart I;

3.14.2.7.1.2 Maintain written policies and procedures regarding Advance Directives in accordance with 42 CFR 422.128 as if such regulation applied directly to the Contractor;

3.14.2.7.1.3 Provide written information to all adult members concerning their rights under State law to accept or refuse medical or surgical treatment and to formulate Advance Directives and update such information as a result of changes to State law as soon as possible but no later than 90 calendar days of after the effective date of any change;

3.14.2.7.1.4 The written information provided to adult members concerning their rights must include the Contractor's policies implementing those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

3.14.2.7.1.5 Document in the member's medical record and plan of care whether or not the member has executed an Advance Directive;

3.14.2.7.1.6 Prohibit making the execution of an Advance Directive a condition of the provision of care or otherwise discriminating against a member based on whether the member has executed an Advance Directive;

3.14.2.7.1.7 Inform members that complaints regarding non-compliance with the Advance Directive requirements may be filed with the DSAAPD; and

3.14.2.7.1.8 Provide education for participating providers and staff on issues concerning Advance Directives.

3.14.2.8 Family Planning Education

3.14.2.8.1 The Contractor must provide its members with sufficient information to allow them to make an informed choice regarding

the types of family planning services available, their right to access these services in a timely and confidential manner, and the freedom of members (other than DHCP members) to choose a qualified family planning provider both within and outside the Contractor's provider network.

3.14.2.9 Interpreter and Translation Services

3.14.2.9.1 As required by 42 CFR 438.10(d), the State has established a method for identifying the Prevalent Non-English Languages used by members and potential members and will notify the Contractor of the applicable Prevalent Non-English Languages.

3.14.2.9.2 For information provided by the Contractor, in accordance with 42 CFR 438.10(d), the Contractor shall:

3.14.2.9.2.1 Provide oral interpreter services in all non-English languages, not just those identified by the State as Prevalent Non-English Languages, including the use of auxiliary aids such as TTY/TDY and American Sign Language. The Contractor shall provide those services free of charge to members and potential members.

3.14.2.9.2.2 Provide, free of charge, written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, Grievance and Appeal notices, and denial and termination notices in all Prevalent Non-English Languages to all members and potential members.

3.14.2.9.2.3 Notify members and potential members that oral interpreter services and auxiliary aids are available for any non-English language and written information is available in any Prevalent Non-English Language free of charge, and how to access these services and written information.

3.14.2.9.3 The Contractor shall document the offer of an interpreter, including a sign language interpreter, and whether the individual declined or accepted the interpreter service.

3.14.2.9.4 The Contractor shall not require or suggest that members with LEP or members using sign language provide their own interpreters or utilize friends or family members to provide interpretation.

3.14.2.10 Member Advocacy

3.14.2.10.1 The Contractor shall fulfill the following member advocacy responsibilities:

3.14.2.10.1.1 Investigate and resolve access and cultural sensitivity issues identified by Contractor staff, State staff, providers, advocate organizations or members;

3.14.2.10.1.2 Monitor Grievances with Grievance personnel to look at trends or major areas of concern;

3.14.2.10.1.3 Coordinate with schools, community agencies and State agencies providing services to members;

3.14.2.10.1.4 Recommend policy and procedural changes to Contractor management including those needed to ensure/improve member access to care and quality of care (changes can be recommended for both internal administrative policies and provider requirements);

3.14.2.10.1.5 Identify a staff person to function as a primary contact for member advocacy groups and work with these groups to identify and correct member access barriers;

3.14.2.10.1.6 Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of members;

3.14.2.10.1.7 Analyze systems functions through meetings with staff;

3.14.2.10.1.8 Organize and provide training and educational materials for Contractor staff and providers to enhance their understanding of the values and practices of all cultures with which the Contractors interact;

3.14.2.10.1.9 Provide input to Contractor management on how provider changes will affect member access and quality/continuity of care and develop/coordinate plans to minimize any potential problems;

3.14.2.10.1.10 Review all informational material to be distributed to members; and

3.14.2.10.1.11 Assist members and member representatives in obtaining medical records.

3.14.2.10.2 *DSHP and DSHP Plus Member Advocates*

3.14.2.10.2.1 The Contractor shall employ a full-time DSHP Member Advocate and a full-time DSHP Plus Member Advocate dedicated to this Contract.

3.14.2.10.2.2 The DSHP and DSHP Plus Member Advocates shall be responsible for working with members, providers and the member's case managers as needed to:

3.14.2.10.2.2.1 Assist the member in obtaining care, including scheduling appointments; and

3.14.2.10.2.2.2 Assist the member with the Contractor's Grievance and Appeals process.

3.14.2.10.2.3 Members shall be referred to the Contractor's DSHP or DSHP Plus Member Advocate through at a minimum the following means:

3.14.2.10.2.3.1 Request from the State;

3.14.2.10.2.3.2 For DSHP Plus LTSS members, request from the member's case manager;

3.14.2.10.2.3.3 Member request;

3.14.2.10.2.3.4 Provider request; and

3.14.2.10.2.3.5 Referral from the Contractor's member services information lines.

3.14.2.10.2.4 The DSHP and DSHP Plus Member Advocates shall be responsible for maintaining full and complete records of all activities performed by the Member Advocate on behalf of a member.

3.14.2.10.2.5 The Contractor shall provide the DSHP and DSHP Plus Member Advocates with the resources necessary to assist members for whom English is not their primary language or who communicate non-verbally.

3.14.2.10.2.6 The Contractor shall provide the State with the name and contact information of the Contractor's DSHP and DSHP Plus Member Advocates as of the effective date of this Contract.

3.14.2.10.3 *Member Advisory Committee*

3.14.2.10.3.1 The Contractor shall maintain a member advisory committee as required in the State's Quality Management Strategy. The member advisory committee shall maintain a reasonable representation of DSHP Plus LTSS members (including members residing in nursing facilities and members residing in

the community) or other individuals representing DSHP Plus LTSS members.

3.14.2.11 Cultural Competency

3.14.2.11.1 As required by 42 CFR 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity.

3.14.2.11.2 The Contractor shall encourage and foster Cultural Competency among its employees and providers.

3.15 GRIEVANCE AND APPEAL SYSTEM

3.15.1 General

3.15.1.1 In accordance with 42 CFR Part 438, Subpart F, the Contractor shall establish a Grievance and Appeal System.

3.15.1.2 The Contractor shall have only one level of Appeal for members.

3.15.1.3 The Contractor shall provide information on Grievance and Appeal System procedures and timeframes to all members (see Section 3.14.1.4 of this Contract) and to all participating providers and Subcontractors (see Section 3.15.6 of this Contract).

3.15.1.4 The Contractor shall allow a member to file a Grievance and request an Appeal, and a member may request a State Fair Hearing after receiving notice that the Adverse Benefit Determination is upheld (see Section 3.15.8 of this Contract, below).

3.15.1.4.1 In the case that the Contractor fails to adhere to the notice and timing requirements in Section 3.15.4 of this Contract, the member is deemed to have exhausted the Contractor's Appeals process, and the member may initiate a State Fair Hearing.

3.15.1.5 With the written consent of the member, the Contractor shall allow a provider or representative to file a Grievance, request an Appeal, request an expedited Appeal, or request a State Fair Hearing on behalf of a member. When the term member is used throughout Section 3.15 of the Contract it includes providers and representatives consistent with this subsection except that providers cannot

request continuation of benefits in accordance with Section 3.15.9 of this Contract.

3.15.1.6 The timeframe for filing an Appeal shall not exceed 60 calendar days from the date on the Contractor's Notice of Adverse Benefit Determination. Within that timeframe, the member may file an Appeal.

3.15.1.7 The member may file a Grievance with the Contractor at any time either orally or in writing.

3.15.1.8 A member may request an Appeal orally or in writing.

3.15.1.9 The Contractor shall ensure that punitive action is not taken against a provider who requests a Grievance, Appeal or State Fair Hearing or supports a member's Grievance, Appeal or State Fair Hearing.

3.15.1.10 The Contractor shall provide members with a choice to receive Notices of Adverse Benefit Determinations, notices of disposition or resolution and other information related to Grievances or Appeals in electronic format or by regular mail and allow members to change such election. If a member elects to receive communication electronically, the Contractor shall comply with Section 3.14.1.3.3 of this Contract.

3.15.2 **Notice of Adverse Benefit Determination**

3.15.2.1 Pursuant to 42 CFR 438.210, the Contractor shall provide written notice to the requesting provider and the member of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Contractor's notices shall meet the requirements of 42 CFR 438.404.

3.15.2.2 The Contractor's written Notice of Adverse Benefit Determination to members must meet the language and format requirements in Section 3.14.1.2 of this Contract regarding written member materials.

3.15.2.3 The Notice of Adverse Benefit Determination must explain the following:

3.15.2.3.1 The Adverse Benefit Determination the Contractor has made or intends to make;

3.15.2.3.2 The reasons for the Adverse Benefit Determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

3.15.2.3.3 The member's right to request an Appeal of the Contractor's Adverse Benefit Determination, including information on exhausting the Contractor's one level of Appeal;

3.15.2.3.4 The member's right to request a State Fair Hearing consistent with Section 3.15.8 of this Contract and 42 CFR 438.402(c);

3.15.2.3.5 The procedures for exercising the right to request an Appeal or a State Fair Hearing;

3.15.2.3.6 The circumstances under which an Appeal process can be expedited and how to request it; and

3.15.2.3.7 The member's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services.

3.15.2.4 The Contractor must send the Notice of Adverse Benefit Determination within the following timeframes:

3.15.2.4.1 For termination, suspension, or reduction of previously authorized Covered Services, within 10 calendar days of the date of Adverse Benefit Determination; except:

3.15.2.4.1.1 The Contractor may shorten the period of advanced notice to five calendar days before the date of Adverse Benefit Determination if probable member Fraud has been verified (see 42 CFR 431.214);

3.15.2.4.1.2 The Contractor may send a notice by the date of the Adverse Benefit Determination if (see 42 CFR 431.213):

3.15.2.4.1.2.1 The Contractor has factual information confirming the death of the member;

3.15.2.4.1.2.2 The Contractor receives a clear written statement signed by the member that he/she no longer wishes the service or gives information requiring termination or reduction of services and indicates he/she understands that this must be the result of supplying that information;

3.15.2.4.1.2.3 The member has been admitted to an institution where he/she is ineligible for further services;

3.15.2.4.1.2.4 The member's whereabouts are unknown and mail directed to him or her is returned with no forwarding

address and the Contractor has sent information to the State for research to determine a more current address;

3.15.2.4.1.2.5 The member has been accepted for Medicaid services by another state's Medicaid program;

3.15.2.4.1.2.6 The member's physician prescribes the change in the level of medical care; or

3.15.2.4.1.2.7 The date of Adverse Benefit Determination will occur in less than 10 calendar days, in accordance with 42 CFR 483.15(c)(4)(ii)which provides exceptions to the 30 calendar day notice requirement for transfer or discharge of nursing facility residents if the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 calendar days.

3.15.2.4.2 For denial of payment, at the time of any Adverse Benefit Determination affecting the claim;

3.15.2.4.3 For standard service authorization decisions that deny or limit services, within the timeframe specified in Section 3.12.6 of this Contract;

3.15.2.4.4 If the Contractor meets the criteria for extending the timeframe for standard service authorization decisions in accordance with Section 3.12.6 of this Contract, it must:

3.15.2.4.4.1 Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a Grievance if he/she disagrees with that decision; and

3.15.2.4.4.2 Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

3.15.2.4.5 For service authorization decisions not reached within the timeframes specified in Section 3.12.6 of this Contract (which constitutes a denial and is thus an Adverse Benefit Determination), on the date that the timeframes expire; and

3.15.2.4.6 For expedited service authorization decisions, within the timeframe specified in Section 3.12.6 of this Contract.

3.15.3 **Handling of Grievances and Appeals**

3.15.3.1 In handling Grievances and Appeals, the Contractor must:

3.15.3.1.1 Give members any reasonable assistance in completing forms and taking other procedural steps related to a Grievance or Appeal. This includes, but is 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.

3.15.3.1.2 Acknowledge receipt of each Grievance and Appeal in writing to the member within five business days of receipt.

3.15.3.1.3 Ensure that the individuals who make decisions on Grievances and Appeals are individuals:

3.15.3.1.3.1 Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;

3.15.3.1.3.2 Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:

3.15.3.1.3.2.1 An Appeal of a denial that is based on lack of Medical Necessity.

3.15.3.1.3.2.2 A Grievance regarding denial of expedited resolution of an Appeal.

3.15.3.1.3.2.3 A Grievance or Appeal that involves clinical issues.

3.15.3.1.3.3 Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

3.15.3.2 The Contractor's process for Appeals must:

3.15.3.2.1 Provide that oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals, unless the member or the provider requests expedited resolution.

3.15.3.2.2 Provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the

resolution timeframe for Appeals as specified in Section 3.15.4.3 of this Contract.)

3.15.3.2.3 Provide the member and member representative the member'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. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals.

3.15.3.2.4 Provide to the State a copy of the member's case file, including medical records, within five business days of the State's request.

3.15.3.2.5 Include, as parties to the Appeal:

3.15.3.2.5.1 The member and member representative; or

3.15.3.2.5.2 The legal representative of a deceased member's estate.

3.15.3.2.6 Provide the member and member representative the opportunity to participate in the Appeal meeting in person or telephonically.

3.15.3.2.7 Ensure the Contractor's DSHP Member Advocate (for DSHP members) or DSHP Plus Member Advocate (for DSHP Plus members) (see Section 3.20.2 of this Contract) participate in the Appeal process and support the member and member representative during the Appeal. If the member or member representative attends the Appeal meeting in person, the applicable member advocate shall attend the Appeal meeting in person.

3.15.3.2.8 Operate an Appeal committee that includes individuals who meet the requirements of Section 3.15.3.1.3 of this Contract, above. At a minimum the Appeal committee shall include as voting members one State staff person designated by the State, a physician employed by the Contractor, and the Contractor's QM/QI Coordinator or designee.

3.15.3.2.8.1 For expedited Appeals, pursuant to Section 3.15.5, Contractor shall make reasonable efforts to schedule consideration of expedited Appeals during business days. If Contractor is unable to schedule a meeting of the Appeal committee during a business day for the consideration of an expedited Appeal, and after reasonable efforts is unable to contact the State designee, the Contractor may use a staff Registered Nurse in place of the State designee for consideration of such expedited Appeal. The Contractor shall document and have available for DMMA review all efforts to contact the State designee.

3.15.4 **Resolution and Notification: Grievance and Appeals**

3.15.4.1 The Contractor must resolve each Grievance and Appeal, and provide notice, as expeditiously as the member's health condition requires, within timeframes that may not exceed the timeframes specified in this Section of the Contract.

3.15.4.2 For standard resolution of Grievance and notice to the affected parties, the timeframe shall not exceed 30 calendar days from the day the Contractor receives the Grievance. This timeframe may be extended under Section 3.15.4.5 of this Contract, below.

3.15.4.3 For standard resolution of an Appeal and notice to the affected parties, the timeframe shall not exceed 30 calendar days from the day the Contractor receives the Appeal. This timeframe may be extended under Section 3.15.4.5 of this Contract, below.

3.15.4.4 For expedited resolution of an Appeal, the Contractor shall resolve the Appeal and notice the affected parties as expeditiously as the member's health condition requires, but no longer than 72 hours after the Contractor receives the Appeal. This timeframe may be extended under Section 3.15.4.5 of this Contract, below.

3.15.4.5 The Contractor may extend the timeframes for Sections 3.15.4.2, 3.15.4.3, and 3.15.4.4 of this Contract, above, by up to 14 calendar days if:

3.15.4.5.1 The member requests the extension; or

3.15.4.5.2 The Contractor shows (to the satisfaction of the State that there is need for additional information and how the delay is in the member's interest.

3.15.4.6 If the Contractor extends the timeframes not at the request of the member, it must complete all of the following:

3.15.4.6.1 Make reasonable efforts to give the member prompt oral notice of the delay.

3.15.4.6.2 Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a Grievance if the member disagrees with that decision.

3.15.4.6.3 Resolve the Appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

3.15.4.7 For all Grievances the Contractor shall provide written notice to the member of the resolution of the Grievance within two business days of the resolution and

ensure that such notification methods meet, at a minimum, the standards described in Section 3.14.1.2 of this Contract.

3.15.4.8 For all Appeals (standard or expedited), the Contractor must provide written notice of resolution to the member in a format and language that, at a minimum, meets the standards described in Section 3.14.1.2 of this Contract and a copy to the State within two business days of the resolution. For notice of resolution of an expedited resolution of an Appeal, the Contractor must also make reasonable efforts to provide oral notice to the member by the close of business on the day of the resolution.

3.15.4.9 The written notice of the disposition or resolution must include the following:

3.15.4.9.1 The results of the Grievance/Appeals process and the date it was completed.

3.15.4.9.2 For Appeals not resolved wholly in favor of the member:

3.15.4.9.2.1 The right to request a State Fair Hearing, and how to do so;

3.15.4.9.2.2 The right to request and receive Covered Services while the State Fair Hearing is pending, and how to make the request; and

3.15.4.9.2.3 That the member may, consistent with State policy, be held liable for the cost of those Covered Services if the State Fair Hearing decision upholds the Contractor's Adverse Benefit Determination.

3.15.5 **Expedited Resolution of Appeals**

3.15.5.1 The Contractor must establish and maintain an expedited review process for Appeals, when the Contractor determines (upon a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

3.15.5.2 If the Contractor denies a request for expedited resolution of an Appeal, it must:

3.15.5.2.1 Transfer the Appeal to the timeframe for standard resolution in accordance with Section 3.15.4.3 of this Contract, above (30 calendar days from the day the Contractor receives the Appeal with a possible 14 calendar day extension in accordance with Section 3.15.4.5 of this Contract, above).

3.15.5.2.2 Make reasonable efforts to give the member prompt oral notice of the denial, and within two calendar days give the member written notice.

3.15.5.3 The Contractor shall ensure that expedited Appeals follow all standard Appeal requirements except where differences are specifically noted in 42 CFR 438.410 for expedited resolution.

3.15.6 **Information about the Grievance and Appeal System to Providers and Subcontractors**

3.15.6.1 The Contractor must provide information about the procedures and timeframes for the Grievance and Appeal System to all participating providers as part of the participation agreement, provider manual, and provider training (see Sections 3.10 and 3.9 of this Contract) and to all Subcontractors at the time they enter into a contract.

3.15.6.2 This information shall include but is not limited to the information listed in 42 CFR 438.10(g)(2)(xi) and in Sections 3.15.8.1 and 3.15.8.2 of this Contract.

3.15.7 **Recordkeeping**

3.15.7.1 The Contractor shall maintain records of Grievances and Appeals.

3.15.7.1.1 The record of each Grievance or Appeal shall include, but not be limited to: a general description of the reason for the Grievance or Appeal, the date received, the date of each review/review meeting, the resolution at each level, the date of resolution at each level, the name of the member for whom the Grievance or Appeal was filed, a call tracking record, the Notice of Adverse Benefit Determination (for Appeals), the member's Grievance or Appeal request, the Contractor's acknowledgement letter, documentation of the investigation, and the Contractor's notice of disposition or resolution.

3.15.7.1.2 The Contractor shall maintain the records accurately and in an electronic manner accessible to the State and available upon request to CMS.

3.15.7.1.3 The Contractor shall maintain records for a period of no less than ten years in accordance with 42 CFR 438.3(u).

3.15.7.2 The Contractor shall track, trend, and review Grievance and Appeals as part of its quality assessment and performance improvement program.

3.15.8 **State Fair Hearing**

3.15.8.1 Members may request a State Fair Hearing only after receiving notice that the Contractor is upholding the Adverse Benefit Determination. Members may request a State Fair Hearing within 90 calendar days from the date on the Contractor's notice of resolution upholding the Adverse Benefit Determination.

3.15.8.1.1 If the Contractor fails to adhere to the notice and timing requirements in Section 3.15.4 of the Contract, the member is deemed to have exhausted the Contractor's Appeals process, and the member may request a State Fair Hearing.

3.15.8.2 The parties to the State Fair Hearing include the Contractor and the member and member representative or the representative of a deceased member's estate.

3.15.8.3 The Contractor shall provide the State Fair Hearings Office and the Division of Medicaid & Medical Assistance with a hearing summary that provides the factual and legal reason(s) for the Adverse Benefit Determination under Appeal.

3.15.8.4 The Contractor shall provide any additional information requested by the State as part of the State Fair Hearing process.

3.15.8.5 The Contractor shall notify DMMA of any pending State Fair Hearing, including the date, time, and place of the hearing, within two business days of receiving notification from the State Fair Hearings Office.

3.15.8.6 Before the hearing, the member and the member representative can ask to look at and copy the documents and records the Contractor will use at the hearing or that the member may otherwise need to prepare his/her case for the hearing. The Contractor shall provide such documents and records at no charge.

3.15.8.7 The Contractor shall appear with appropriate clinical personnel at all scheduled State Fair Hearings concerning its clinical determinations to present evidence as justification for its determination regarding the disputed benefits.

3.15.8.8 The Contractor shall have its legal counsel appear at all scheduled State Fair Hearings for which the Contractor has received notification that the member has legal counsel and when the State provides it with not less than seven calendar days' notice that legal representation will be required.

3.15.8.9 The Contractor shall comply with all determinations rendered as a result of State Fair Hearings. Nothing in this Section shall limit the remedies available to State or the Federal government relating to any non-compliance by the Contractor with

a State Fair Hearing determination or by the Contractor's refusal to provide disputed services.

3.15.8.10 Within five business days of being notified of a decision of the State Fair Hearing Officer, the Contractor shall notify DMMA of the decision and, if the decision is adverse to the Contractor, how the Contractor will implement the decision, including timeframes.

3.15.9 **Continuation of Benefits While Appeal or State Fair Hearing is Pending**

3.15.9.1 The Contractor shall provide continuation of Covered Services in accordance with 42 CFR 438.420 and this Section of the Contract.

3.15.9.2 As used in this section, timely files means files for continuation of benefits on or before the later of the following:

3.15.9.2.1 Within 10 calendar days of the Contractor sending the Notice of Adverse Benefit Determination; or

3.15.9.2.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination.

3.15.9.3 The Contractor shall continue the member's Covered Services if all of the following occur:

3.15.9.3.1 The member files the request for an Appeal timely;

3.15.9.3.2 The Appeal involves the termination, suspension, or reduction of a previously authorized service;

3.15.9.3.3 The services were ordered by an authorized provider;

3.15.9.3.4 The period covered by the original authorization has not expired; and

3.15.9.3.5 The member timely files for continuation of the benefits.

3.15.9.4 If, at the member's request, the Contractor continues or reinstates the member's Covered Services while the Appeal or State Fair Hearing is pending, the Covered Services must be continued until one of following occurs:

3.15.9.4.1 The member withdraws the Appeal or request for a State Fair Hearing.

3.15.9.4.2 The member fails to request a State Fair Hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution..

3.15.9.4.3 A State Fair Hearing officer issues a hearing decision adverse to the member.

3.15.9.5 If the final resolution of the Appeal or State Fair Hearing is adverse to the member, that is, upholds the Contractor's Adverse Benefit Determination, the Contractor may recover the cost of the Covered Services furnished to the member while the Appeal or State Fair Hearing was pending, to the extent that the Covered Services were furnished solely because of the requirements of this Section of the Contract.

3.15.10 **Effectuation of Reversed Appeal Resolutions**

3.15.10.1 If the Contractor or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

3.15.10.2 If the Contractor, or the State Fair Hearing officer, reverses a decision to deny authorization of services, and the member received the disputed services while the Appeal was pending, the Contractor must pay for those services.

3.15.11 Should the member petition federal or state court regarding an Adverse Benefit Determination made by the Contractor, the Contractor shall be solely responsible for defending the Adverse Benefit Determination at issue.

3.16 PROGRAM INTEGRITY

3.16.1 General

3.16.1.1 The Contactor shall have and implement a comprehensive internal Fraud, Waste and Abuse program to prevent, detect, report, investigate, correct and resolve potential or confirmed Fraud, Waste and Abuse in the administration and delivery of services under this Contract.

3.16.1.2 The Contractor shall comply with all Federal and State law regarding Fraud, Waste and Abuse, including, but not limited to, Sections 1128, 1128J(d), 1156, 1902(a)(39), 1902(a)(68), 1866(j)(5), 1903 and 1932(d)(1) of the Social Security Act and 42 CFR Parts 431, 433, 434, 435, 438, 441, 447, 455 and 1001.

3.16.1.3 The Contractor shall have surveillance and utilization control programs and procedures (see 42 CFR 456.3, 42 CFR 456.4, 42 CFR 456.23, 42 CFR 438.608) to safeguard against underutilization, unnecessary or inappropriate use of Covered Services and against excess payments for Covered Services.

3.16.1.4 The Contractor shall have adequate staffing and resources to identify and investigate potential Fraud, Waste and Abuse and to develop and implement corrective action plans to assist the Contractor in preventing and detecting

potential Fraud, Waste and Abuse. The Contractor's staff shall include at a minimum the following staff dedicated to this Contract:

3.16.1.4.1 A Compliance Officer (see Section 3.20 of this Contract).

3.16.1.4.2 An investigator who is responsible for Fraud, Waste and Abuse investigations related to this Contract.

3.16.1.4.3 An auditor who is responsible for identifying potential Fraud, Waste and Abuse through analysis of claims and related information for this Contract.

3.16.1.4.4 An analyst who is responsible for reviewing and researching evidence of potential Fraud, Waste and Abuse under this Contract.

3.16.1.5 The Contractor shall meet quarterly with the State to provide updates on the Contractor's Fraud, Waste and Abuse detection efforts and results, including ongoing and completed investigations.

3.16.1.6 The Contractor shall cooperate fully in any activity performed by duly authorized State or Federal agencies or representatives, including, but not limited to, DMMA, MFCU, the Delaware Department of Justice, the Medicaid Recovery Audit Contractor (RAC), HHS, a Payment Error Rate Measurement (PERM) contractor, or a Medicaid Integrity Contractor (MIC), including making available any and all administrative, financial and medical records relating to this Contract during normal business hours at its place of business.

3.16.1.7 The Contractor shall notify the State of any proposed recoveries within five business days of identification, and must report to the State all recoveries collected by the Contractor at least annually and as otherwise directed by the State.

3.16.1.7.1 If the Contractor identified the potential Fraud, Waste or Abuse that led to the recovery, and reported the potential Fraud, Waste or Abuse in accordance with Section 3.16.4 of this Contract, the Contractor may retain the entire amount of the recovery.

3.16.1.7.2 If the State or Federal government identified the potential Fraud, Waste or Abuse that led to the recovery, and the Contractor did not previously report the potential Fraud, Waste or Abuse in accordance with Section 3.16.4 of this Contract, the Contractor shall return the entire amount of the recovery to the State within 30 calendar days of the State's notification that the recovery is subject to this Section.

3.16.1.7.3 If the Contractor has not initiated recovery within 60 calendar days after the completion of the Contractor's or State's investigation confirming the recovery or fails to complete the recovery within

six months of the completion of the investigation, the State shall have the sole right of recovery and may retain the entire amount of any recovery.

3.16.1.8 The Contractor shall notify the State within five business days when it receives information about changes in a member's circumstances that may affect the member's eligibility including:

3.16.1.8.1.1 Changes in the member's residence; or

3.16.1.8.1.2 The death of a member.

3.16.1.9 The Contractor shall notify the State within five business days when it receives information about a change in a participating provider's circumstances that may affect the participating provider's eligibility to participate in DSHP or DSHP Plus, including the termination of the provider participation agreement with the Contractor.

3.16.1.10 The Contractor shall establish processes for the suspension of payments to a participating provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23 and Section 3.11.1.9 of this Contract.

3.16.2 **Disclosure Requirements**

3.16.2.1 In accordance with Section 1932(d)(1) of the Social Security Act and 42 CFR 438.610, the Contractor shall not knowingly have a relationship of the type described in 42 CFR 438.610(c) with an individual or an entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 or with an individual or an entity that is an Affiliate, as defined in the FAR at 48 CFR 2.101, of such an individual. The Contractor shall not have a relationship as defined in 42 CFR 438.610(c) with an individual or an entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act. If the Contractor becomes aware of such a relationship, the

Contractor shall notify the State within 20 business days after becoming aware of such a relationship.

3.16.2.2 The Contractor shall submit to the State a completed DMMA provider disclosure form annually.

3.16.2.3 The Contractor shall immediately disclose to the State any and all criminal convictions, in any jurisdiction, of its managing employees (see 42 CFR 455.106).

3.16.2.4 Regarding provider disclosures, the Contractor shall:

3.16.2.4.1 Not make payment to a provider unless the provider has submitted completed disclosures required by Federal law either to the State or the Contractor. This includes but is not limited to disclosure regarding ownership and control, business transactions, and criminal convictions (see 42 CFR Part 455, Subpart B). In accordance with 42 CFR 438.608(c), the Contractor shall provide written disclosures of any prohibited affiliation under 42 CFR 455.104.

3.16.2.4.2 Track information received from the State identifying providers from whom the State has received completed disclosures.

3.16.2.4.3 For participating providers for whom the State has not received completed disclosures, as reported to the Contractor, collect and retain completed provider disclosures as part of initial credentialing and then annually, using a disclosure form prior approved by the State in writing.

3.16.2.4.4 In accordance with 42 CFR 455.106, immediately report any criminal conviction disclosures to the State and explain what action it will take (e.g., terminate the provider).

3.16.2.4.5 In accordance with Section 1866(j)(5) of the Social Security Act and implementing regulations, as part of credentialing and re-credentialing, collect disclosures from providers that are not DMAP-enrolled providers regarding any current or previous affiliations with a provider or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in Section 1128B(f)), has been excluded from participation under Medicare, Medicaid, CHIP, or has had its billing privileges denied or revoked. The Contractor shall notify the State if the Contractor determines that such affiliation poses an undue risk of Fraud, Waste or Abuse and denies the application.

3.16.2.5 Regarding Contractor's staff, the Contractor shall:

3.16.2.5.1 Require applicants for positions that will have direct (in-person) contact with members to disclose if they have been arrested for, charged with or convicted of a crime of dishonesty or breach of trust.

3.16.2.5.2 Require employees who have direct (in-person) contact with members to immediately notify the Contractor if the employee is arrested for or charged with a crime of dishonesty or breach of trust.

3.16.2.6 Recordkeeping Requirements

3.16.2.6.1 The Contractor shall meet the recordkeeping provisions in 42 CFR 438.3(u), to maintain the data, information, and documentation specified in Section 3.16.2 of this Contract for a period of no less than ten years.

3.16.3 **Service Verification with Members**

3.16.3.1 In accordance with 42 CFR 438.608(a)(5), the Contractor shall implement a process for verifying with members whether services billed by providers were received.

3.16.3.2 The Contractor must employ a methodology and sampling process prior approved by the State to verify with its members on a monthly basis whether services billed to the Contractor by providers were actually received. The methodology and sampling process must include criteria for identifying "high-risk" services and provider types.

3.16.4 **Reporting and Investigating Suspected Fraud, Waste and Abuse**

3.16.4.1 The Contractor shall cooperate with all duly authorized State and Federal agencies and representatives in reporting, investigating and prosecuting Fraud, Waste and Abuse.

3.16.4.2 The Contractor shall have methods for identifying, investigating and referring suspected Fraud, Waste and Abuse pursuant to 42 CFR 455.1, 42 CFR 455.13, 42 CFR 455.14, 42 CFR 455.21, and 42 CFR 438.608(a)(7).

3.16.4.3 The Contractor shall notify concurrently DMMA's Program Integrity Unit and MFCU of any and all cases of suspected Fraud, Waste or Abuse by its providers, members, employees or Subcontractors using the State-approved notification form within two business days after discovering suspect incidents. For each case

of provider Fraud, Waste or Abuse, the report shall include the information provided in 42 CFR 455.17.

3.16.4.4 After notifying DMMA's Program Integrity Unit and MFCU, the Contractor shall promptly perform a preliminary investigation of the reported suspected Fraud, Waste or Abuse to determine whether there is sufficient basis to warrant a full investigation.

3.16.4.5 Unless prior written approval is obtained from the State, after notifying DMMA's Program Integrity Unit and MFCU of suspected Fraud, Waste or Abuse, the Contractor shall not take any of the following actions:

3.16.4.5.1 Contact the subject of the investigation about any matter related to the investigation;

3.16.4.5.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

3.16.4.5.3 Accept any monetary or other type of consideration offered by the subject of the investigation in connection with the incident.

3.16.4.6 The Contractor shall conclude its preliminary investigation within 10 business days of identifying the potential Fraud, Waste or Abuse and shall provide the findings of its preliminary investigations in writing to both DMMA's Program Integrity Unit and MFCU within two business days of completing the preliminary investigation.

3.16.4.7 If directed by the State, the Contractor shall conduct a full investigation. The Contractor shall provide the results of its full investigations in writing to both DMMA's Program Integrity Unit and MFCU within two business days of completing the investigation. This report shall include any referrals made and actions taken by the Contractor or external entity.

3.16.4.8 The Contractor shall cooperate fully and promptly in any investigations or prosecutions by any duly authorized State or Federal agency or representative, whether administrative, civil, or criminal. Such cooperation shall include actively participating in meeting; providing requested information and access to requested records; providing access to interview Contractor employees and consultants, including, but not limited to, those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation or prosecution. Such cooperation shall also include providing

personnel to testify at any hearings, trials or other legal proceedings on an as-needed basis.

3.16.4.9 Upon notification by the State, the Contractor shall suspend payments to identified providers.

3.16.4.10 If a provider is suspended or terminated from participation in the Delaware Medicaid program by the State, the Contractor shall also suspend or terminate the provider.

3.16.4.11 If a provider is terminated from Medicare, another Federal health care program, or another state's Medicaid or CHIP program, the Contractor shall terminate its provider participation agreement with that provider.

3.16.4.12 The Contractor shall notify the State within two business days of taking any action against a provider for program integrity reasons, including, but not limited to, denial of a provider credentialing/re-credentialing application, corrective action or limiting the ability of a provider to participate in the program (e.g., suspending or terminating a provider). The notification shall include but not be limited to identification of the provider and a description of the action, the reason for the action, and documentation to support the reason. The Contractor shall provide additional information upon the State's request.

3.16.4.13 The Contractor shall submit a risk assessment on an "as needed" basis and immediately after a program integrity related action against a provider. The Contractor shall inform the State of such action and provide details of such financial action.

3.16.5 **Fraud, Waste and Abuse Compliance Plan**

3.16.5.1 The Contractor shall have a written Fraud, Waste and Abuse compliance plan and policies and procedures to implement the compliance plan. The Contractor shall provide the plan to the State for review and prior approval on an annual basis. The Contractor shall make any requested updates or modifications as requested by the State.

3.16.5.2 The Contractor's Fraud, Waste and Abuse compliance plan shall:

3.16.5.2.1 In accordance with 42 CFR 438.608, include:

3.16.5.2.1.1 Written policies, procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards.

3.16.5.2.1.2 The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements

of this Contract and who reports directly to the Contractor's Executive Management and the Board of Directors.

3.16.5.2.1.3 The establishment of a Regulatory Compliance Committee on the Board of Directors and at the Contractor's Executive Management level charged with overseeing the Contractor's compliance program and its compliance with the requirements of this Contract.

3.16.5.2.1.4 A system for effective training and education for the Compliance Officer, the Contractor's Executive Management and the Contractor's employees for the Federal and State standards and requirements under this Contract.

3.16.5.2.1.5 Effective lines of communication between the Compliance Officer and the Contractor's employees to ensure that employees understand and comply with the Contractor's Fraud, Waste and Abuse program.

3.16.5.2.1.6 Enforcement of standards through well-publicized disciplinary guidelines.

3.16.5.2.1.7 Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements of this Contract.

3.16.5.2.2 Include a risk assessment of the Contractor's various Fraud, Waste and Abuse processes. The risk assessment shall include a listing of the Contractor's top three vulnerable areas and outline action plans to mitigate risks.

3.16.5.2.3 Describe the Contractor's staff responsible for the investigation and reporting of potential Fraud, Waste or Abuse including an organizational chart and roles and responsibilities.

3.16.5.2.4 Describe the Contractor's procedures for preventing, detecting and investigating potential Fraud, Waste or Abuse.

3.16.5.2.5 Describe unique policies and procedures and specific measures designed to prevent and detect potential Fraud, Waste and Abuse related to services in the DSHP Plus LTSS benefit package.

3.16.5.2.6 Include provisions regarding reporting and investigating Fraud, Waste and Abuse as required in Section 3.16.4 of this Contract, above.

3.16.5.2.7 Include provisions regarding conducting checks of its provider files, including atypical providers, against both the System for Award Management (SAM), the HHS-OIG List of Excluded Individual Entities (LEIE), EPLS and SSA DMF as part of credentialing and re-credentialing and at least monthly on an ongoing basis.

3.16.5.2.8 Include provisions regarding performing monthly checks for exclusions of the Contractor's owners, agents and managing employees.

3.16.5.2.9 Include provisions regarding prompt terminations of inactive providers due to inactivity in the past 12 months.

3.16.5.2.10 Include a description of the specific controls in place for prevention and detection of potential Fraud, Waste and Abuse, including, but not limited to:

3.16.5.2.10.1 Information on the Contractor's Fraud, Waste and Abuse detection system (if applicable);

3.16.5.2.10.2 A list of automated pre-payment claims edits;

3.16.5.2.10.3 A list of automated post-payment claims edits;

3.16.5.2.10.4 Frequency and type of desk audits on post-processing review of claims;

3.16.5.2.10.5 Frequency and type of routine exception reports;

3.16.5.2.10.6 A list of trending analyses;

3.16.5.2.10.7 Description of reports of provider profiling and credentialing used to aid program and payment integrity reviews;

3.16.5.2.10.8 Description of surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of Covered Services;

3.16.5.2.10.9 A list of provisions in Subcontract and provider participation agreements that ensure the integrity of provider credentials; and

3.16.5.2.10.10 A list of references in provider and member material regarding Fraud, Waste and Abuse referrals.

3.16.5.2.11 Specify the Contractor's methodology and sampling process for verifying that services were actually provided to members (see Section 3.16.3 of this Contract, above);

3.16.5.2.12 Include procedures for the confidential reporting of potential Fraud, Waste and Abuse, including potential Contractor violations;

3.16.5.2.13 Include procedures to ensure that there is no retaliation against an individual who reports Contractor violations or other potential Fraud, Waste or Abuse to the Contractor or an external entity;

3.16.5.2.14 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting and reporting Fraud, Waste and Abuse;

3.16.5.2.15 Describe how the Contractor complies with Section 1902(a)(68) of the Social Security Act, including establishing written policies with information about the Federal False Claims Act, the Delaware False Claims and Reporting Act, and whistleblower protections under such acts and the Contractor's policies and procedures for preventing and detecting Fraud, Waste and Abuse and including required information in an employee handbook; and

3.16.5.2.16 Include work plans for conducting both announced and unannounced site visits and field audits to providers defined as high risk (e.g., providers with cycle/auto billing activities, providers offering DME, home health or behavioral health) to ensure services are rendered and billed correctly.

3.17 FINANCIAL MANAGEMENT

3.17.1 Contractor's DOI Licensure or DHSS Certification

3.17.1.1 The Contractor shall be licensed by DOI as an HMO or a Health Service Corporation or certified by DHSS and shall continue to be meet licensure or certification requirements (as applicable) throughout the Contract term.

3.17.1.2 If, at any time during the term of this Contract, the Contractor incurs loss of its DOI licensure, DHSS certification, and/or qualifications as an HMO, the Contractor shall report such loss to the State. Such loss may be grounds for termination of this Contract.

3.17.2 **Reserving Funds for IBNR and Received But Unpaid Claims**

3.17.2.1 As part of its accounting and budgeting function, the Contractor must establish an actuarially sound process for estimating and tracking IBNR. The Contractor shall reserve funds for each major category of service (e.g., hospital inpatient, physician, nursing facility) to cover both incurred but not reported and reported but unpaid claims. The Contractor must conduct reviews, at least annually, to assess its reserving methodology and make adjustments as necessary to the methodology.

3.17.2.2 The Contractor shall submit financial reports as specified in Section 3.21.15 of this Contract.

3.17.3 **Inspection and Audit of Financial Records**

3.17.3.1 The Contractor shall meet all Federal and State requirements with respect to inspection and auditing of financial records or documents and access to facilities. The Contractor shall cooperate with the State, HHS, the HHS-OIG, the Comptroller General, or any of their authorized representatives, which at any time may inspect and audit the Contractor's financial records or documents or inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit exists for ten years from the final date of the Contract period or from the date of completion of any audit, whichever is greater.

3.17.4 **Financial Stability**

3.17.4.1 The Contractor shall be responsible for sound financial management of its MCO in accordance with applicable professional standards.

3.17.4.2 Throughout the term of this Contract, the Contractor shall:

3.17.4.2.1 Comply with and be subject to all applicable State and Federal law including those regarding solvency and risk standards.

3.17.4.2.2 Present to the State any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to the State, at no cost to the State, in a reasonable time from the date of the request or as specified therein.

3.17.4.2.3 In accordance with 42 CFR 438.604(a)(4), submit data on adequate provisions made against the risk of insolvency as required under 42 CFR 438.116.

3.17.4.2.4 Immediately notify the State when the Contractor has reason to consider insolvency or otherwise has reason to believe it or any Subcontractor is other than financially sound and stable, or when

financial difficulties are significant enough for the Chief Executive Officer or Chief Financial Officer to notify the Contractor's governing body of the potential for insolvency.

3.17.4.3 The Contractor shall maintain a performance bond in the amount of 100% of the first month of Capitation Payment for each of the first 12 months after the Start Date of Operations.

3.17.4.3.1 The performance bond must be restricted to this Contract.

3.17.4.3.2 If the performance bond falls below 90% of the first month's capitation in any month, the Contractor has 30 calendar days to comply with the requirements of this Section of the Contract and provide proof of the increased bond amount.

3.17.4.4 The Contractor shall maintain a uniform accounting system that adheres to generally accepted accounting principles for charging and allocating to all funding resources the Contractor's costs incurred hereunder including, but not limited to, the American Institute of Certified Public Accountants Statement of Position 89-5 "Financial Accounting and Reporting by Providers of Prepaid Health Care Services."

3.17.4.5 The Contractor shall contract with an independent licensed certified public accountant to conduct an annual financial audit of the Contractor, including but not limited to the financial transactions made under this Contract.

3.17.4.6 The Contractor must notify the State within 10 calendar days if its contract with an independent auditor or actuary has changed or been terminated. The notification must include the date of and reason for the change or termination. If the change or termination occurred as a result of a disagreement or dispute, the notification shall include the nature of the disagreement or dispute. In addition, the notification shall include the name of the replacement auditor or actuary, if any.

3.17.5 **Insurance**

3.17.5.1 Before delivering services under this Contract, the Contractor shall obtain, from an insurance company duly authorized to do business in Delaware, the minimum coverage levels described below:

3.17.5.1.1 *Professional Liability Insurance*

3.17.5.1.1.1 The Contractor shall obtain and maintain, for the duration of this Contract, professional liability insurance in the amount of at least one million dollars ($1,000,000) for each occurrence. The Contractor shall obtain, pay for, and keep in force for the duration of this Contract errors and omissions insurance in the amount of one million dollars ($1,000,000).

3.17.5.1.2 *Workers' Compensation*

3.17.5.1.2.1 The Contractor shall obtain and maintain, for the duration of this Contract, workers' compensation insurance for all of its employees employed in Delaware. In the event any work is Subcontracted, the Contractor shall require the Subcontractor similarly to provide workers' compensation insurance for all the Subcontractor's employees employed at any site in Delaware, unless such Subcontractor employees are covered by the workers' compensation protection afforded by the Contractor. Any Subcontract executed with a firm not having the requisite workers' compensation coverage will be considered void by the State.

3.17.5.1.3 *Other Insurance*

3.17.5.1.3.1 The Contractor shall obtain, pay for, and keep in force during the duration of this Contract general liability insurance (including automobile and broad form contractual coverage) against bodily injury or death of any person in the amount of one million dollars ($1,000,000) for any one occurrence; insurance against liability for property damages, as well as first-party fire insurance, including contents coverage for all records maintained pursuant to this Contract, in the amount of five hundred thousand dollars ($500,000) for each occurrence; and such insurance coverage that will protect the State against liability from other types of damages, for up to five hundred thousand dollars ($500,000) for each occurrence.

3.17.5.1.4 The Contractor's certificates of insurance shall constitute an attachment to this Contract. Each certificate will state the policy, the insured, and the insurance period. Each Contractor insurance policy shall contain a clause that requires the State be notified at least 10 calendar days prior to cancellation.

3.17.5.1.5 The Contractor shall be in compliance with all applicable State and Federal insurance law.

3.17.5.1.6 The Contractor shall also require that each of its Subcontractors maintain insurance coverage as specified above or provide coverage for each Subcontractor's liability and employees. The provisions of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its Subcontractors.

3.17.6 **Reinsurance**

3.17.6.1 The Contractor shall obtain adequate reinsurance for financial risks accepted as part of this Contract, or propose an alternative method of financial protection prior to the Start Date of Operations. Any arrangement selected by the Contractor is subject to approval by the State. In the absence of an accepted alternative proposal, the Contractor must provide the State with a copy of the reinsurance policy specifying the costs and coverages of the reinsurance.

3.17.6.2 The State reserves the right to revisit reinsurance annually and modify the reinsurance threshold amount, to be determined by the State, if, upon review of financial and Encounter Data, or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by the State.

3.17.7 **Medical Loss Ratio (MLR)**

3.17.7.1 The Contractor shall meet a minimum MLR, as specified in Section 3.17.7.2, for the MLR reporting year that aligns with the calendar year rating period under this Contract. The State reserves the right to reduce or increase the minimum MLR over the term of this Contract, provided that any such change applies prospectively, excludes any retroactive increase to allowable direct medical services, and complies with State and Federal law.

3.17.7.2 The minimum MLR shall be:

3.17.7.2.1 Eighty-five percent (85%) for the combined population excluding the portion of the CHIP population referenced in 3.17.7.2.2 for which a separate MLR calculation will apply

3.17.7.2.2 Eighty-five percent (85%) for the CHIP rate cell (excluding the Medicaid-CHIP (MCHIP) population, which is included in Section 3.17.7.2.1).

3.17.7.2.3 The MLR for all rate cells as measured under 3.17.7.2.1 and 3.17.7.2.2 shall include any adjustment (if applicable) from risk corridors, risk shares, or other similar mechanisms contained in the Contract and any applicable health care quality or other adjustments as provided for in 42 CFR 438.8.

3.17.7.3 The Contractor's MLR calculation and reporting shall be consistent with 42 CFR 438.8. The Contractor shall use the following key components in its MLR calculation:

3.17.7.3.1 Numerator: Sum of the Contractor's incurred claims, activities that improve health care quality, and fraud prevention activities..

3.17.7.3.2 Denominator: The adjusted premium revenue, which is premium revenue less the Contractor's Federal, State, and local taxes and licensing and regulatory fees.

3.17.7.3.3 Aggregation method: The Contractor shall separately calculate the MLR for the MLR reporting year for the CHIP (as defined in 3.17.7.2.2), and all other rate cells (combined).

3.17.7.3.4 The Contractor may apply a credibility adjustment factor to the MLR if the MLR experience is deemed to be partially credible as specified in the credibility adjustment factors issued by CMS for the MLR reporting year. In the event that CMS has not issued Medicaid credibility adjustment factors and standards for the applicable MLR reporting year, the Contractor shall apply the credibility adjustment factors issued by CMS for the private market.

3.17.7.4 The Contractor shall calculate and report the MLR to the State using the MLR instructions and report developed by the State as part of the Financial Management Reports (see Section 3.21.15 of this Contract).

3.17.7.5 The Contractor shall pay a remittance to the State per each aggregated population for a MLR reporting year for which the minimum MLR standard in Section 3.17.7.2 of this Contract is not met. The amount of the remittance is the amount that would bring the MLR experience per each aggregated population for the MLR reporting year to the required minimum MLR. The remittance is due within 30 days of notification from the State that a remittance is owed. The requirement to pay the remittance survives the termination of this Contract.

3.18 CLAIMS MANAGEMENT

3.18.1 General

3.18.1.1 The Contractor and any of its Subcontractors or participating providers paying their own claims shall maintain claims processing capabilities to include, but not be limited to:

3.18.1.1.1 Accepting NPI and HIPAA-compliant formats for electronic claims submission.

3.18.1.1.2 Assigning unique identifiers for all claims received from all providers.

3.18.1.1.3 Standardizing protocols for the transfer of claims information between the Contractor and its participating providers/Subcontractors, audit trail activities, and the communication of data transfer totals and dates.

3.18.1.1.4 Recording the date of receipt of all claims.

3.18.1.1.5 Running a payment cycle to include all adjudicated claims to date at least weekly.

3.18.1.1.6 Paying clean claims in a timely manner as follows:

3.18.1.1.6.1 90% of all clean claims must be adjudicated within 30 calendar days of receipt, and 99% of all clean claims must be adjudicated within 90 calendar days of receipt.

3.18.1.1.7 Complying with requirements in Section 3.5.12 of this Contract regarding claims management for pharmacy services.

3.18.1.1.8 Meeting both State and Federal standards for processing claims.

3.18.1.1.9 Suspending payments to providers upon notification from the State.

3.18.1.1.10 Generating remittance advice and/or electronic response files to all providers for all claims submissions.

3.18.1.1.11 Accepting only national HIPAA-compliant standard codes and editing to ensure that the standard measure of units is billed and paid for, unless otherwise specified by the State.

3.18.1.1.11.1 Editing claims to ensure that claims being paid are for services furnished by providers licensed to render these services, that services are appropriate in scope and amount, that members are eligible to receive the services, and that services are billed in a manner consistent with State defined criteria and national coding standards.

3.18.1.1.11.2 Developing and maintaining electronic billing systems for all providers submitting bills directly to the Contractor and requiring all Subcontractors to meet the same standards.

3.18.1.1.12 Maintaining adequate data to the same standards of completeness and accuracy as required for proper adjudication of FFS Medicaid claims for all services, regardless of the method of payment for those services, to meet the Encounter Data requirements in Section 3.18.4 of this Contract, including, but not limited to:

3.18.1.1.12.1 Services provided by any Subcontractor;

3.18.1.1.12.2 Services provided under subcapitation payment arrangements; and

3.18.1.1.12.3 Services provided as part of a bundled rate.

3.18.1.1.13 Adhering to Federal and State timely filing requirements.

3.18.1.2 DMMA is enrolled with CMS as a Trading Partner under a Coordination of Benefits Agreement (COBA). The Contractor shall:

3.18.1.2.1 Work with DMMA to complete an Attachment packet to the COBA to establish a new COBA ID for management of the Contractor's cross-over claims;

3.18.1.2.2 Provide single individual points of contact by name for technical and administrative issues related to COBA processing;

3.18.1.2.3 Generate an eligibility file to the Coordination of Benefits Contractor (COBC), using the COBA Eligibility format required by COBA. For those members listed on the eligibility file, the COBC will transfer claims to trading partners in the HIPAA American National Standard Institute (ANSI) Accredited Standard Committee (ASC)-X12 837 COB (versions 5010A1 and 5010A2) and NCPDP version D.0 batch standard 1.2 formats;

3.18.1.2.4 Adhere to the enrollment, testing, and implementation requirements and timelines identified in the most current COBA Implementation User Guide;

3.18.1.2.5 Notify DMMA of the need for signatures and coordinate the completion and delivery of the required documents to the Coordination of Benefits Contractor.

3.18.1.3 The Contractor shall participate on a committee or committees with the State to discuss and resolve systems and data related issues, as required by the State.

3.18.1.4 For audit and verification purposes, the Contractor shall maintain all claims data for a minimum of 10 years, in a manner that allows viewing and analysis compatible with current standards.

3.18.2 **Claims Payment Accuracy – Minimum Audit Procedures**

3.18.2.1 The Contractor shall conduct and submit to the State a monthly audit of claims accuracy. The audit shall be conducted by an entity or Contractor staff independent of claims management.

3.18.2.2 The audit shall utilize a statistically valid, random sample of all processed or paid claims upon initial submission in each month. Additionally, each monthly sample shall contain a statistically valid sample of claims associated with nursing facility

services provided to members and a statistically valid sample of claims associated with HCBS provided to members.

3.18.2.3 The minimum attributes to be tested for each claim selected shall include:

3.18.2.3.1 Claim data correctly entered into the claims processing system.

3.18.2.3.2 Claim is associated to the correct provider.

3.18.2.3.3 Service obtained the proper authorization.

3.18.2.3.4 Member eligibility at processing date correctly applied.

3.18.2.3.5 Allowed payment amount agrees with contracted rate and the terms of the provider participation agreement.

3.18.2.3.6 Duplicate payment of the same claim has not occurred.

3.18.2.3.7 Denial reason applied appropriately.

3.18.2.3.8 Copayment considered and applied.

3.18.2.3.9 Patient Liability correctly identified and applied.

3.18.2.3.10 Effect of modifier codes correctly applied.

3.18.2.3.11 Other insurance, including long-term care insurance, properly considered and applied.

3.18.2.3.12 Application of benefit limits.

3.18.2.4 The results of testing at a minimum must be documented to include:

3.18.2.4.1 Results for each attribute tested for each claim selected.

3.18.2.4.2 Amount of overpayment or underpayment for claims processed or paid in error.

3.18.2.4.3 Explanation of the erroneous processing for each claim processed or paid in error.

3.18.2.4.4 Determination of the source of the error.

3.18.2.4.5 Claims processed or paid in error have been corrected.

3.18.2.5 If the Contractor Subcontracts for the provision of any Health Care Services and the Subcontractor is responsible for processing claims, then the Contractor shall

submit a claims payment accuracy percentage report for the claims processed by the Subcontractor.

3.18.3 **Third Party Liability (TPL)**

3.18.3.1 The State has delegated the pursuit of Third Party payment for Covered Services to the Contractor. To that end, the Contractor shall require its providers to utilize or pursue, when available, other Third Party coverage from such sources as private commercial insurance and Medicare. This responsibility includes identification and pursuit of Third Party payment for Covered Services provided by the Contractor that may be related to an accidental injury, medical malpractice or any other cause for legal action including claims identified from the Contractor's review of claims with diagnosis codes indicative of trauma, injury, poisoning, and other consequences of external causes. This includes seeking payment from vehicle and homeowners insurance for accident and trauma cases that occur while an individual is Enrolled in the Contractor's MCO. The Contractor may retain all funds collected as part of TPL activities.

3.18.3.2 The State will provide the Contractor with available TPL data on members Enrolled in the Contractor's MCO each month in an electronic file. Additionally, real time TPL data is available to the Contractor via the DMAP website. The Contractor shall submit TPL coverage and policy information obtained independently by the Contractor to the State via electronic format on a monthly basis. Encounter Data submitted by the Contractor shall indicate when other Third Party payments have paid for all or a portion of a claim that would otherwise be payable by the Contractor.

3.18.3.3 Recovery of TPL by the Contractor must be initiated within 60 calendar days of the date the Third Party coverage becomes known to the Contractor. The Contractor shall conduct follow-up at 60-day intervals after the original reimbursement claim was sent to the Third Party insurance, and until the claim is resolved. If the Contractor does not initiate original recovery within 60 calendar days of the date of discovery, the State reserves the right to initiate recovery action. Collections made pursuant to such State action will be retained by the State and subtracted from MCO payment amounts used to calculate capitation rates.

3.18.3.4 The Contractor may not withhold payment for services provided to a member if TPL or the amount of liability cannot be determined, or if payment shall not be

available within a reasonable time, beyond 60 calendar days from the date of receipt of a clean claim.

3.18.3.5 If the probable existence of TPL has been established at the time the claim is received, the Contractor must reject the claim and return it to the provider for a determination of the amount of any TPL.

3.18.3.6 The Contractor may not withhold payment for Health Care Services provided to a member or withhold prior authorization for Health Care Services to be provided to a member if the Contractor has documentation that the member's third party payor does not cover the service. The Contractor shall accept the following documentation as evidence that a member's third party payor does not cover a particular service: explanation of benefits, explanation of payment, remittance advice, or correspondence on company letterhead from the member's third party payor that the service is not covered. The Contractor shall accept and apply this documentation on a one-time calendar year basis (i.e., the Contractor shall accept a single documentation for the entire year for the member, rather than requesting documentation each time a claim or prior authorization for the service is submitted).

3.18.3.7 The Contractor shall pay claims for EPSDT and prenatal care at the time they are presented for payment by the provider, and the Contractor shall bill the responsible Third Party.

3.18.3.8 The Contractor shall deny payment on a claim that has been denied by a Third Party payor when the reason for denial is the participating provider's or member's failure to follow prescribed procedures, including, but not limited to, failure to obtain required prior authorization, timely filing, non-participating provider, etc.

3.18.3.9 The Contractor shall treat funds recovered from Third Parties as reductions to claims payments. The Contractor shall report all TPL collection amounts to the State in accordance with Federal guidelines and submit Encounter Data adjustments including pharmacy claims as described in Section 3.5.12 of this Contract to reflect the adjusted claim payment amount if the collected amount is associated with an identifiable claim.

3.18.3.10 The Contractor shall be required to seek subrogation amounts regardless of the amount believed to be available as required by Federal Medicaid guidelines. The amount of any subrogation recoveries collected by the Contractor

outside of the claims processing system shall be treated by the Contractor as offsets to medical expenses for the purposes of reporting.

3.18.3.11 Cost sharing and Patient Liability responsibilities shall not be considered TPL.

3.18.3.12 The Contractor shall provide TPL data to any participating provider having a claim denied by the Contractor based upon TPL.

3.18.3.13 If the Contractor operates or administers any non-Medicaid HMO, health plan or other health insurance-related line of business, the Contractor shall assist the State with the identification of members with access to other insurance.

3.18.3.14 Upon request, the Contractor shall demonstrate to the State that reasonable effort has been made to seek, collect and/or report Third Party recoveries. The State shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. This determination shall take into account reasonable industry standards and practices.

3.18.3.15 The Contractor is encouraged to develop innovative, cost-effective procedures to identify, collect and/or cost avoid Third Party payments.

3.18.4 **Encounter Data Reporting**

3.18.4.1 The accurate and timely reporting of Encounter Data is important to evaluating the success of DSHP/DSHP Plus. The State uses Encounter Data to set capitation rates, evaluate utilization of appropriate care and evaluate quality of care.

3.18.4.2 The Contractor shall submit Encounter Data as described in 42 CFR 438.242 and in the format specified by the State.

3.18.4.3 The Contractor shall submit Encounter Data electronically in a HIPAA-compliant standard transaction format for all services administered by the Contractor, including any Subcontractor.

3.18.4.4 The Contractor shall comply with requirements in Section 3.5.12 of this Contract regarding Encounter Data for pharmacy services.

3.18.4.5 <u>Timeliness of Encounter Data Submission</u>

3.18.4.5.1 The Contractor shall submit Encounter Data as described in Section 3.18.4 to the State's Fiscal Agent no less frequently than weekly.

3.18.4.5.2 The Contractor shall meet the State Encounter Data timeliness requirements by submitting to the State at least 90% of its claims, originals and adjustments, within 30 calendar days of the date of adjudication, and 99% within 60 calendar days of the date of

adjudication in accord with the specifications included in the HIPAA Technical Review Guides, regardless of whether the Encounter Data is from a Subcontractor or subcapitated arrangement. The Contractor may not withhold submission of required Encounter Data without State approval.

3.18.4.5.3 The Contractor shall have written contractual requirements of Subcontractors or providers that pay their own claims to submit Encounter Data to the Contractor on a timely basis, which ensures that the Contractor can meet its timeliness requirements for Encounter Data submission.

3.18.4.5.4 The Contractor shall systematically edit Encounter Data prior to submission to prevent or decrease submission of duplicate encounters and other types of Encounter Data errors. The State will share the edits it uses in Encounter Data adjudication for use by the Contractor to perform its own edits to ensure optimum accuracy and completeness of Encounter Data.

3.18.4.5.5 Where the Contractor has entered into subcapitated or other non-FFS reimbursement arrangements with providers, the Contractor shall require submission of all utilization or Encounter Data to the same standards of completeness and accuracy as required for proper adjudication of FFS Medicaid claims, as a condition of the Capitation Payment and shall make every effort to enforce this provision to ensure timely receipt of complete and accurate Encounter Data.

3.18.4.6 Quality of Encounter Data Submission

3.18.4.6.1 The State maintains oversight responsibility for evaluating and monitoring the volume, completeness, timeliness, and quality of Encounter Data submitted by the Contractor. If the Contractor elects to contract with a Subcontractor, the Contractor must ensure that the Subcontractor complies with all claims and Encounter Data requirements. The Contractor must submit all Encounter Data for all services administered by the Contractor. The Contractor is responsible for the quality, accuracy, and timeliness of all Encounter Data submitted to the State. The State will communicate directly with the Contractor any requirements and/or deficiencies regarding completeness, quality, accuracy and timeliness of Encounter Data, and not with any third party contractor. Failure to submit accurate and complete Encounter Data will result in monetary sanctions described in Section 5.4 of this Contract. The State may also choose to auto-assign members who do not initially choose an MCO to only those MCOs that are providing complete and accurate Encounter Data.

3.18.4.6.2 The Contractor shall meet Encounter Data accuracy requirements by submitting Contractor paid encounters with no more than a 3% error rate, calculated for a month's worth of Encounter Data submissions. The Contractor shall achieve an DMES acceptance rate of 98% within 90 days of adjudication for all submittable encounters.

3.18.4.6.3 *Encounter Data Reporting of PPCs*

3.18.4.6.3.1 Pursuant to Section 2702 of the ACA and implementing regulations (see 42 CFR 434.6(a)(12) and 42 CFR 447.26), the Contractor shall not make payment for PPCs (see Section 3.11.4 of this Contract). Participating providers must self-report the occurrence of PPCs through existing claims systems for any PPCs that are associated with claims for Medicaid payment. Participating providers who are paid by the Contractor are subject to this reporting requirement for claims submitted to the Contractor, and the Contractor must submit these encounters in its submission to the State. The Contractor shall include claims that indicate a PPC in Encounter Data submissions even if no payment is made by the Contractor.

3.19 INFORMATION SYSTEMS

3.19.1 General System Hardware, Software and Information Systems Requirements

3.19.1.1 The Contractor shall maintain system hardware, software, and Information Systems resources sufficient to provide the capability to:

3.19.1.1.1 Accept, transmit, process, maintain and report specific information necessary to the administration of the State's Medicaid program, including, but not limited to, data pertaining to providers, members, claims, Encounter Data, Grievance and Appeals, Disenrollment/Transfer for reasons other than loss of Medicaid eligibility and HEDIS and other quality measures.

3.19.1.1.2 Comply with the most current Federal and State standards for encryption of any data that is transmitted via the internet by the Contractor or its Subcontractors.

3.19.1.1.3 Conduct automated claims processing with current NPI for health care providers and OEID/State assigned ID for atypical providers in HIPAA-compliant formats.

3.19.1.1.4 Monitor and transmit electronic Encounter Data to the State according to the State's Encounter Data submission standards.

3.19.1.1.5 Maintain a website for disseminating information to participating providers and members, and be able to receive comments electronically and respond when appropriate, including responding to provider transactions for eligibility and formulary information.

3.19.1.1.6 Receive data elements associated with identifying members who are receiving ongoing services from another MCO and using, where possible, the formats that the State uses to transmit similar information to an MCO.

3.19.1.1.7 If a member is Transferring to another MCO, transmit to the State or the new MCO data elements associated with members who have been receiving ongoing services from the Contractor.

3.19.1.1.8 Comply with the requirements in Section 3.5.12 of this Contract related to pharmacy information.

3.19.1.1.8.1 The system must be able to identify pharmacy claims filled by 340B enrolled providers for members to ensure the State correctly excludes 340B utilization from CMS rebate invoices to manufacturers.

3.19.1.1.9 Comply with the section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.

3.19.1.1.10 Comply with the requirements in 42 CFR 438.242 regarding application programming interfaces (APIs).

3.19.1.1.11 Comply with DMMA's electronic visit verification (EVV) requirements including sending member authorization data for services subject to EVV to the State's EVV system, receiving and paying claims submitted by the State's or third party EVV system on behalf of providers, and integrating and using data from the State's EVV system for care coordination, case management, service monitoring, pre-payment claims review, and post-payment claims review.

3.19.1.2 The Contractor shall transmit to and receive from the State all transactions and code sets in the appropriate standard formats as specified under HIPAA and other applicable State or Federal law and as directed by the State, so long as the State direction does not conflict with State or Federal law.

3.19.1.3 The Contractor's systems shall conform to future Federal and/or State specific standards for data exchange within the timeframe stipulated by Federal

authorities or the State. The Contractor shall partner with the State in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other Federal effort. Furthermore, the Contractor shall conform to these standards as stipulated in the plan to implement such standards.

3.19.1.4 The Contractor shall participate in and, as may be directed, implement any HIE or EHR initiatives undertaken by the State or other entities, including but not limited to:

3.19.1.4.1 Validating patient volume for its providers through documentation of Encounter Data by NPI and Medicaid Identification Number (MIN);

3.19.1.4.2 The Contractor recognizes that DMMA is a mandatory reporting entity pursuant to the Delaware Health Care Claims Database. On DMMA's behalf, the Contractor shall provide directly to the DHIN all required claims data, as set forth in 16 *Del. C.* Ch. 103, necessary for DMMA to meet its reporting obligations pursuant to the Health Care Claims Database.

3.19.1.4.3 Collaborating with the DHIN to implement any future changes required to expand HIE functionality;

3.19.1.4.4 *EHR Incentive Payment Program*

3.19.1.4.4.1 Supporting provider education on the EHR Incentive Payment Program including encouraging the use of EHR and attestation for incentive payments by participating providers; and

3.19.1.4.4.2 At the State's request, providing claims verification data for the EHR Incentive Payment Program in support of attestations from Medicaid providers in the Contractor's network. This requirement shall survive the conclusion of this Contract.

3.19.1.4.5 Participating in provider education or surveys through the provider incentive payment (PIP) team; and

3.19.1.4.6 Supporting reporting of clinical quality measures (CQMs) and eventually electronic or eCQMs from the EHR to the DHIN and Delaware Medicaid to allow for population health analysis of members.

3.19.1.5 The Contractor shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its

information management processes and Information Systems and shall provide these documents to the State upon request.

3.19.1.6 The Contractor shall implement proprietary file exchanges and interfaces as required to transfer data to and from the State's Fiscal Agent DMES, and modify these as necessary to meet future changes to those requirements. Information about these interfaces is available from the State.

3.19.1.7 In addition to the requirements in this Contract, the Contractor's Information Systems shall meet all State technical requirements and standards for Information Systems. Information about these standards and links to the current versions of other State technical requirements documentation were included in the RFQ and/or is available upon request from the State.

3.19.2 **Member Information Requirements**

3.19.2.1 The Contractor's member information requirements shall include, but not be limited to, accepting, maintaining and transmitting all required member information.

3.19.2.2 The Contractor shall receive, process and update Enrollment Files sent daily by the State.

3.19.2.3 The Contractor shall update its eligibility/Enrollment databases within 24 hours of receipt of Enrollment Files from the State.

3.19.2.4 The Contractor shall be capable of uniquely identifying a distinct member across multiple populations and systems within its span of control.

3.19.2.5 The Contractor shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by the State, resolve the duplication such that the Enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

3.19.2.6 The Contractor shall:

3.19.2.6.1 Provide a means for providers and Subcontractors to verify member eligibility and Enrollment status 24 hours a day, seven days a week.

3.19.2.6.2 Ensure that current and updated eligibility information received from the State is available to all providers via the Contractor's eligibility verification system and all Subcontractors' eligibility verification systems within 24 hours of receipt of any and all Enrollment Files from the State.

3.19.2.6.3 Meet CMS, HIPAA, and other applicable Federal and State standards for release of member information (applies to Subcontractors as well).

3.19.3 **System and Information Security and Access Management Requirements**

3.19.3.1 The Contractor's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

3.19.3.1.1 Restrict access to information on a "least privilege" basis (e.g., users permitted inquiry privileges only will not be permitted to modify information); and

3.19.3.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified appropriate staff.

3.19.3.2 The Contractor shall make system information, including all collected data, available to duly authorized representatives of the State and Federal government to evaluate, through inspections, audits, or other means, the quality, appropriateness and timeliness of services performed.

3.19.3.3 The Contractor's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The Contractor shall test these controls in periodic and spot audits and make the results of these tests available to the State upon request.

3.19.3.4 The Contractor shall provide a Privacy/Security Incident Report as specified in Section 3.21.17 of this Contract.

3.19.3.5 Audit trails shall be incorporated into all systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

3.19.3.5.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action.

3.19.3.5.2 Have the date and identification "stamp" displayed on any online inquiry.

3.19.3.5.3 Have the ability to trace data from the final place of recording back to its source data file and/or document.

3.19.3.5.4 Be supported by listings, transaction reports, update reports, transaction logs or error logs.

3.19.3.5.5 Facilitate auditing of individual records as well as batch audits.

3.19.3.5.6 Be maintained online for no less than two years; additional history shall be retained for no less than seven years and shall be retrievable within 48 hours.

3.19.3.6 The Contractor's systems shall have inherent functionality that prevents the alteration of finalized records.

3.19.3.7 The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide the State with access to data facilities upon request.

3.19.3.8 The Contractor shall restrict perimeter access to equipment sites, processing areas and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

3.19.3.9 The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

3.19.3.10 The Contractor shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network within the Contractor's span of control. This includes but is not limited to: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.

3.19.3.11 The Contractor shall ensure that remote access users of its systems can only access said systems through two-factor user authentication and via methods such as Virtual Private Network.

3.19.3.12 The Contractor shall comply with recognized industry standards governing security of State and Federal automated data processing systems and information processing. At a minimum, the Contractor shall conduct a security risk assessment and communicate the results in an information security plan provided to the State prior to the Start Date of Operations. The risk assessment shall also be made available to appropriate State and Federal agencies upon request.

3.19.4 **Systems Availability, Performance and Problem Management Requirement**

3.19.4.1 The Contractor's data center shall at a minimum meet Tier 3 Standards, as defined by the Telecommunications Industry Association.

3.19.4.2 The Contractor shall ensure that critical member and provider Internet and/or telephone-based functions and information, including but not limited to member eligibility and Enrollment systems, are available to the applicable system users 24

hours a day, seven days a week, except during periods of scheduled system unavailability agreed upon by the State and the Contractor.

3.19.4.3 The Contractor shall ensure that at a minimum all other system functions and information are available to the applicable system users between the hours of 8 a.m. and 5 p.m. eastern time, Monday through Friday, except State of Delaware holidays.

3.19.4.4 In the event of a declared major failure or disaster, the Contractor's core eligibility/Enrollment and claims processing systems shall have functionality restored within 72 hours of the failure's or disaster's occurrence.

3.19.4.5 In the event of a problem with system availability that exceeds four hours, the Contractor shall notify the State immediately, and provide the State, within five business days, with full written documentation that includes a Corrective Action Plan describing how the Contractor will prevent the problem from occurring again.

3.19.5 **Business Continuity and Disaster Recovery (BC-DR) Plan**

3.19.5.1 Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a BC-DR plan that has been reviewed and prior approved by the State.

3.19.5.2 At a minimum the Contractor's BC-DR plan shall address the following scenarios:

3.19.5.2.1 The central computer installation and resident software are destroyed or damaged.

3.19.5.2.2 System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage.

3.19.5.2.3 System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system.

3.19.5.2.4 System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system (i.e., causes unscheduled system unavailability).

3.19.5.3 The Contractor's BC-DR plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

3.19.5.4 The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures and provide the results of this testing to the State upon request.

3.20 STAFFING

3.20.1 General

3.20.1.1 The Contractor shall have sufficient, qualified staff to fulfill all the requirements of this Contract.

3.20.1.2 The Contractor shall submit to the State the names, resumes and contact information of the key personnel identified below.

3.20.1.3 The Contractor must notify the State within seven calendar days of any change in key personnel.

3.20.1.4 Key personnel, once assigned by the Contractor to this Contract, shall not be reassigned by the Contractor to another project without prior written consent of the State.

3.20.1.5 Key personnel positions must be filled within 90 calendar days of a vacancy, and proposed candidates are subject to State approval. During the recruitment process, the Contractor shall provide the State with written updates every two weeks on the Contractor's efforts to fill the vacancy. Upon demonstration of good faith efforts by the Contractor to fill the position, as determined by the State, the State may grant the Contractor an extension beyond the 90 calendar days to fill a vacant position in key personnel without imposing a monetary sanction pursuant to Section 5.4.7.2 of this Contract. In addition, the Contractor shall not employ a person as key personnel without prior approval by the State.

3.20.1.6 The Contractor is not required to report to the State the names of staff not identified as key personnel in Section 3.20.2 of this Contract. However, the Contractor shall provide its staffing plan to the State upon request.

3.20.1.7 The Contractor must designate key management and technical personnel assigned to this Contract, including, at a minimum, the key personnel listed in Section 3.20.2 of this Contract, below.

3.20.1.8 If a full-time staff person is required, that means that one person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a

full-time staff person is not specified, the position does not require a full-time staff person.

3.20.1.9 Except as otherwise provided in Addendum3, Special Provisions for Current Contract Year, all key personnel shall be located in the State of Delaware and shall be fully dedicated to this Contract.

3.20.1.10 If the Contractor will not have the majority of key personnel, as determined by the State, hired at least 90 calendar days before the scheduled Start Date of Operations, the Contractor shall provide, for prior approval by the State, and implement a transition plan to ensure the effective transition from implementation to operational activities. This plan shall include having the project manager of the implementation or another full-time senior executive who had a significant role in the implementation, as prior approved by the State, continue to provide full-time, onsite support for six months after the Start Date of Operations.

3.20.2 **Minimum Key Personnel Positions**

3.20.2.1 The Contractor shall, at a minimum, employ the following key personnel:

3.20.2.1.1 A full-time Chief Executive Officer (CEO) who must hold a senior executive or management position in the Contractor's organization. The CEO must be authorized and empowered to represent the Contractor regarding all matters pertaining to this Contract.

3.20.2.1.2 A full-time Chief Operations Officer (COO) who shall be authorized and empowered to represent the Contractor regarding all matters pertaining to this Contract, and who shall serve as the Contract Manager.

3.20.2.1.3 A full-time Chief Medical Officer/Medical Director (CMO) who is a Delaware licensed physician (Medical Doctor or Doctor of Osteopathic Medicine.).

3.20.2.1.4 A full-time Behavioral Health Medical Officer/Medical Director (BH CMO) who is a board certified Psychiatric Mental Health Nurse Practitioner or Clinical Nurse Specialist with an Advanced Practice Nursing (APN) license in the State of Delaware and has at least five years of combined experience in mental health and substance use services. This person shall oversee and be responsible for all behavioral health activities, including oversight of coordination activities with DSAMH.

3.20.2.1.5 A full-time Long Term Services and Supports Medical Officer/Medical Director (LTSS CMO) who is a board certified physician with experience in LTSS. This person shall oversee and be responsible for all LTSS.

3.20.2.1.6 A full-time senior level pharmacist who is a Delaware licensed pharmacist. This person shall oversee and be responsible for all pharmacy activities related to this Contract.

3.20.2.1.7 A full time Health Services Director who is a licensed nurse in the State of Delaware who shall oversee and be responsible for the Contractor's case management services for all DSHP and DSHP Plus members.

3.20.2.1.8 A full-time Chief Financial Officer (CFO) who shall be responsible for accounting and finance operations, including all audit activities.

3.20.2.1.9 A full-time Chief Data Analytics Coordinator who shall oversee and be responsible for the Contractor's data analytics functions supporting this Contract.

3.20.2.1.10 A full-time staff person responsible for DSHP provider services and provider relations, including all network development staff and management issues, provider payment issues, and provider education.

3.20.2.1.11 A full-time staff person dedicated to this Contract who is responsible for DSHP Plus and DSHP Plus LTSS provider services and provider relations, including all network development staff and management issues, provider payment issues and provider education.

3.20.2.1.12 A full-time UM Coordinator who directly reports to the CMO. This person shall be responsible for the development and implementation of the Contractor's UM program, including directing the Contractor's UM Committee (see Section 3.12 of this Contract).

3.20.2.1.13 A full-time staff member who shall be responsible for member services, including, among others, (i) the member services call center, and (ii) the Contractor's health literacy and Health Education efforts.

3.20.2.1.14 A full-time DSHP Member Advocate who shall have at least two years of experience in health care, including behavioral health experience, preferably working with low-income populations, and have demonstrated expertise in topics related to Cultural Competency. The DSHP Member Advocate shall fulfill the responsibilities specified in Section 3.14.2.10.2 of this Contract.

3.20.2.1.15 A full-time DSHP Plus Member Advocate who shall have at least two years of experience in health care, preferably working with low-income populations, and have demonstrated expertise in topics

related to LTSS and Cultural Competency. The DSHP Plus Member Advocate shall fulfill the responsibilities specified in 3.14.2.10.2 of this Contract.

3.20.2.1.16 A staff person responsible for managing member Grievances and Appeals including requests for State fair hearings.

3.20.2.1.17 A staff person responsible for managing provider complaints.

3.20.2.1.18 A full-time staff person responsible for all claims management activities, including any claims management activities that may be Subcontracted.

3.20.2.1.19 A full-time Compliance Officer who will be responsible for overall Contract compliance, and who will oversee Fraud, Waste and Abuse monitoring and investigations. The Compliance Officer will also lead a compliance committee that is accountable to the Contractor's Executive Management in accordance with Section 3.16.5.2.1.2 of this Contract.

3.20.2.1.20 A full-time QM/QI Coordinator who directly reports to the CMO. This individual is responsible for the development and implementation of the Contractor's quality strategy. The coordinator must have adequate and appropriate experience in successful quality strategies. This person will also be responsible for assuring the interface and support of the EQRO and State quality strategy as necessary.

3.20.3 **Staff Training and Education**

3.20.3.1 The Contractor shall provide an initial orientation and training as well as ongoing training, including training targeted to different types of staff, to ensure that all staff can fulfill the requirements of the positions they hold and to ensure compliance with this Contract. The Contractor shall use the most appropriate training methods, which may include instructor-led and web-based trainings.

3.20.3.2 The Contractor shall ensure that all training provided to ensure compliance with this Contract (including but not limited to the topics identified in Section 3.20.3.6), regardless of training method, incorporates adult learner principles and is designed to maximize engagement and knowledge retention. All the Contractor's training activities shall incorporate a training evaluation process to assess training effectiveness, and results of the assessment shall be used to improve the overall quality of the applicable training.

3.20.3.3 The Contractor shall submit a comprehensive annual staff training and education plan that encompasses all training activities, for all business units responsible for providing services under this Contract, for State approval. The staff training and education plan shall detail the Contractor's staff training and education activities,

including the frequency of training and topics included in training. In addition, the Contractor shall report on the status of the staff training and education plan at monthly MCO internal meetings with State staff.

3.20.3.4 The Contractor shall have a Staff Training Coordinator who is responsible for developing, overseeing and evaluating the Contractor's staff training and education plan.

3.20.3.5 Staff training may include any topic that the Contractor deems relevant, but must at a minimum include: (i) Advance Directives, (ii) Cultural Competency, (iii) early identification of DSHP and DSHP Plus members who may be candidates for nursing facility diversion, (iv) compliance, (v) topics related to the pharmacy benefit, (vi) Critical Incidents, (vii) behavioral health topics, including the PROMISE program and co-occurring disorders, (viii) the Pathways program, (ix) transition of members from DSHP to DSHP Plus, (x) the role of the DSHP and DSHP Plus LTSS Member Advocates, (xi) the identification and reporting of Fraud, Waste and Abuse, (xii) the DDDS Lifespan Waiver, and (xiii) any additional training topics as determined by the State.

3.20.3.6 The Contractor shall verify and document that it has met the training requirements in Section 3.20.3 of this Contract. The Contractor must make this documentation available for the State's review upon request.

3.20.3.7 The Contractor shall develop and implement a process to evaluate the effectiveness and outcomes of the training provided and document that it has met this requirement.

3.21 REPORTING

3.21.1 General

3.21.1.1 The Contractor shall comply with all the reporting requirements established by the State.

3.21.1.2 The Contractor shall adhere to State defined standards, templates, formats and submission requirements for all reports and reporting requirements. The State shall provide the Contractor with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required by the State.

3.21.1.3 If the State requests any revisions to the reports already submitted, the Contractor shall make the changes and re-submit the reports, according to the time period and format required by the State.

3.21.1.4 The State reserves the right to request reports more frequently during the Implementation Period.

3.21.1.5 The State's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of this Contract.

The Contractor shall comply with all changes specified in writing by the State after the State has discussed such changes with the Contractor. Except as otherwise required by Federal or State law the State will notify the Contractor, in writing, of changes to required report content, format or schedule at least 30 calendar days prior to implementing the change and will notify the Contractor, in writing, of new reports at least 60 calendar days prior to implementing the new report.

3.21.1.6 The Contractor shall submit reports timely and in proper format. The submission of late, inaccurate or otherwise incomplete reports constitutes failure to report. "Timely submission" shall mean that the report was submitted on or before the date it was due. "Accuracy" shall mean the report was substantially prepared according to the specific written guidance, including report template, provided by the State to the Contractor. If the report is late, inaccurate or otherwise incomplete, the report is deemed in "error" and the Contractor may be subject to monetary sanctions in accordance with Section 5.4 of this Contract. The State will not impose a monetary sanction for an error if the error in a submitted report is identified by the Contractor and reported to the State prior to the State's identification of the error. Corrected reports in this type of situation must be submitted to the State in a timeframe determined by the State after consulting with the Contractor.

3.21.1.7 All reports listed in Section 3.21 of this Contract require Contractor certification. The Contractor shall ensure that an Authorized Certifier reviews the narrative, analysis, and data in each report prior to submitting the report to the State. The Contractor shall submit a certification signed by an Authorized Certifier each time a report is submitted. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of the report. The State will deem incomplete any report that does not include a certification.

3.21.1.8 The Contractor shall submit all reports to the State, unless otherwise requested by the State, according to the schedule below:

Deliverable	**Due Date**
Daily Reports	Within two business days
Weekly Reports	Wednesday of the following week
Monthly Reports	Day 18 of the following month
Quarterly Reports	Day 18 of the following month
Semi-Annual Reports	January 31 and July 31
Annual Reports	30 calendar days after the end of the calendar year
On Request Reports	Within three business days from the date of the request unless otherwise specified by the State

Deliverable	Due Date
Ad Hoc Reports	Within 10 business days from the date of the request unless otherwise specified by the State

3.21.1.9 If a report due date falls on a weekend or a State of Delaware holiday, receipt of the report the next business day is acceptable.

3.21.1.10 Extensions to report submission dates will be considered by the State after the Contractor has contacted the State via email at least three business days in advance of the report due date. Extension for submission of reports should be under rare and unusual circumstances. If the State grants an extension, and the report is submitted before the extended deadline, the report(s) will be considered timely and not subject to sanction. Not requesting an extension within at least three business days of the report due date is considered failure to report timely.

3.21.1.11 Except as otherwise provided in this Contract, the Contractor shall submit all reports to DMMA.

3.21.1.12 The Contractor shall review, as part of its continuous improvement activities, the timeliness and accuracy of reports submitted to the State to identify instances and patterns of non-compliance. The Contractor shall perform an analysis identifying any patterns or issues of non-compliance and shall implement quality improvement activities to improve overall performance and compliance.

3.21.2 **DSHP QCMMR and DSHP PLUS-QCMMR**

3.21.2.1 The Contractor shall submit QCMMR data on a monthly, quarterly and annual basis and in accordance with technical specifications provided by the State. The data elements that comprise the QCMMR at a minimum include: (i) health risk assessments; (ii) case management; (iii) access—timely appointments; (iv) network availability; (v) customer service; (vi) Grievances; (vii) Appeals; (viii) quality of care and quality of services issues; (ix) provider disputes; (x) inpatient services; (xi) outpatient services and physician visits; (xii) outreach and education; and (xiii) behavioral health.

3.21.2.2 The Contractor shall submit PLUS-QCMMR data on a monthly, quarterly and annual basis and in accordance with the technical specifications provided by the State. The data elements that comprise the QCMMR at a minimum include: (i) health risk assessments; (ii) choice and community tenure; (iii) access and availability of HCBS; (iv) behavioral health services; (v) case management; (vi) customer service; (vii) Grievances; (viii) Appeals; (ix) quality of care and quality of services issues; (x) provider disputes; (xi) inpatient services; (xii) outpatient services and physician visits; and (xiii) safety and welfare.

3.21.3 **Marketing Reports**

3.21.3.1 The Contractor shall submit a Weekly *Events Calendar* as specified in Section 3.3.1.6 of this Contract.

3.21.3.2 The Contractor shall submit an annual *Marketing Plan* as specified in Section 3.3.1.7 of this Contract.

3.21.4 **Covered Services Reports**

3.21.4.1 The Contractor shall submit a quarterly *School-Based Wellness Center Report* that provides information on all of the procedure codes being billed by each approved SBWC. The report shall include the number of submitted, paid, denied, resubmitted, adjudicated, open and reversed claims. At a minimum, the report will include: (i) SBWC provider name; (ii) total claims submitted, paid, denied, resubmitted, adjudicated, open and reversed; (iii) year to date services by service code; (iv) year to date claims total; (v) year to date claims status; and (vi) claims denied and resubmitted.

3.21.4.2 To the extent the Contractor provides extra services in accordance with Section 3.4.8 of this Contract, the Contractor shall submit a quarterly *Extra Services Report.* Such report shall include but not be limited to the following information by service: (i) the name of the service; (ii) the procedure code(s) for the service; (iii) the number of members who received the service; (iv) the unit of service and utilization of each service; (v) the number of denied requests; and (vi) payments for each service. In addition, the report shall include an unduplicated count of members who received an extra service.

3.21.4.3 The Contractor shall submit a quarterly *Specialized Services* report as specified by the State.

3.21.5 **Pharmacy Reports**

3.21.5.1 The Contractor shall submit a quarterly report detailing prior authorization requests that include:

3.21.5.1.1 The percent of total drugs approved that are within the PDL categories, and the ten most approved drugs with non-preferred status;

3.21.5.1.2 For the top 50 drugs and device total requests, based on clinical criteria. Such report shall include but not be limited to the following information (i) total requests, (ii) overall approval total, (iii) rate of approval of requests; (iv) overall percentage of approvals, and (v) denials (name of drug or device, number of requests, number of denials);

3.21.5.2 The Contractor shall submit a quarterly report on the top 100 drugs and devices and the top 50 drug and device categories listed both by expenditures and claim count;

3.21.5.3 The Contractor shall submit a quarterly report to describe the Contractor's pharmacy activities, which must include the following:

3.21.5.3.1 Prospective DUR statistics and programs;

3.21.5.3.2 Retrospective DUR interventions and programs;

3.21.5.3.3 The nature and scope of the MTM;

3.21.5.3.4 A summary of the interventions on quality of care; and

3.21.5.3.5 An estimate of the cost savings generated as a result of such program.

3.21.5.3.6 DUR reporting as required in Section 1004 of the SUPPORT for Patients and Communities Act.

3.21.5.4 The Contractor shall submit a quarterly report comparing the Contractor's MAC for generic products to the National Average Drug Acquisition Cost (NADAC) price;

3.21.5.5 The Contractor shall submit a quarterly usage report that provides: (i) the number of prescriptions dispensed by public retail pharmacies, mail order pharmacies and specialty pharmacies; (ii) total expenditures; (iii) total claims; (iv) participating members; (v) utilizing members; (vi) average cost per claim; (vii) average cost per month per participating member; and (viii) average cost per month per utilizing member;

3.21.5.6 The Contractor shall submit an annual report on cost-containment initiatives including but not limited to: quantity limits, prior authorization, step therapy, dose optimization, MAC, etc.;

3.21.5.7 The Contractor shall submit a quarterly report on pharmacy call center performance and pharmacy services prior authorization request turnaround time; and

3.21.5.8 The Contractor shall submit a quarterly report on Grievance and Appeals related to pharmacy services.

3.21.5.9 No later than 30 calendar days after the end of each quarterly rebate period, the Contractor shall report drug utilization data necessary for the State to bill manufacturers for rebates in accordance with Section 1927(b)(1)(A) of the Social Security Act and 42 CFR 438.3(s)(2). The Contractor shall include information such as the total number of units of each dosage form, strength, and package size

by National Drug Code of each covered outpatient drug dispensed, as provided in the Encounter Data. If the Contractor's encounter submissions include all necessary and required information, then the encounter submission satisfies this requirement and a separate report is not required.

3.21.5.10 The Contractor shall provide a detailed description of its DUR program activities to the State on an annual basis, and partner with DMMA to obtain all information needed to complete the CMS DUR Annual Report.

3.21.5.11 The Contractor shall provide an annual report with monthly metrics on e-Prescribing providing statistics. The annual report shall include the following: number of providers using an e-prescribing system; number and percentage of providers who had at least one drug claim per month; total eligibility transactions processed successfully; total medication history transactions processed successfully; for New and Total prescriptions: provide total drug claims; total drug claims with electronic origin code; percentage of total claim volume with electronic origin code. The State will supply a reporting template to the Contractor.

3.21.6 **Care Coordination Reports**

3.21.6.1 The Contractor shall submit a quarterly *Care Coordination Program Report* which at a minimum shall include the following elements based on the previous quarter's experience:

3.21.6.1.1 For the All-Member Level:

3.21.6.1.1.1 A narrative summary of the Contractor's care coordination activities in the previous quarter for all members as specified in Section 3.6.2 of this Contract, as well as any barriers identified and the Contractor's efforts to overcome these barriers.

3.21.6.1.1.2 Number of members referred from the member services information line to the Contractor's appointment and linkage to services program, and the primary reason for the referral;

3.21.6.1.1.3 Number of members who were provided appointment assistance by the Contractor's appointment and linkage to services program staff;

3.21.6.1.1.4 Number of members who were provided linkage to services by the Contractor's appointment and linkage to services program staff;

3.21.6.1.1.5 Number of members who the Contractor referred to a wellness program in the community, the number of members referred who began a wellness program and the number who completed a program; and

3.21.6.1.1.6 A narrative summary of the Contractor's efforts to train providers to implement wellness programs with their patients, including the number of providers trained, the content of the training, and the outcome of the training (i.e. whether the provider took steps to begin a wellness program with their patients) and the number of new programs identified or started.

3.21.6.1.2 For Level 1 members:

3.21.6.1.2.1 The number of members identified as Level 1 during the quarter and any members previously identified as Level 1 who the Contractor identified as meeting Level 2 criteria;

3.21.6.1.2.2 The number of Level 1 members who received assistance from the Contractor's resource coordination staff with discharge planning following a physical health inpatient stay and/or following a behavioral health inpatient stay;

3.21.6.1.2.3 The number of Level 1 members who received discharge planning assistance following a physical health or behavioral health inpatient visit who were seen by a PCP within 14 calendar days of the MCO being notified of their discharge from the inpatient facility; and

3.21.6.1.2.4 The number of Level 1 members who received discharge planning assistance following a physical health or behavioral health inpatient visit but were readmitted to an inpatient facility within 30 calendar days.

3.21.6.1.3 For Level 2 members:

3.21.6.1.3.1 The total number of members identified as Level 2, including members newly identified to Level 2 during the quarter;

3.21.6.1.3.2 The number of members identified as Level 2 who received outreach by the Contractor's clinical care coordination staff and the outreach methods used;

3.21.6.1.3.3 The number and percentage of Level 2 members who the Contractor's clinical care coordination staff were unable to contact;

3.21.6.1.3.4 The number of newly identified Level 2 members who declined participation in clinical care coordination and reasons for declining participation;

3.21.6.1.3.5 The number of face-to-face interactions the Contractor's clinical care coordination staff had with Level 2 members in the community, member homes and in provider locations;

3.21.6.1.3.6 The number of Level 2 members who were reassessed as eligible to move to a lower level of care coordination (i.e. Level 1 or All Member level); and

3.21.6.1.3.7 A list of the Contractor's clinical care coordinators and their monthly caseloads.

3.21.6.2 The Contractor shall submit an annual *Care Coordination Program Summary Report* which shall aggregate the measures on the quarterly *Care Coordination Program Report.*

3.21.6.3 The Contractor shall submit a semi-annual *Wellness Program Training and Registry Report* which at a minimum shall include:

3.21.6.3.1 The number of providers the Contractor outreached to provide wellness program training;

3.21.6.3.2 The number of providers the Contractor provided wellness program training; and

3.21.6.3.3 The number of new wellness programs available to the Contractor's members that the Contractor added to its wellness program registry.

3.21.7 **Case Management for DSHP Plus LTSS Members Reports**

3.21.7.1 The Contractor shall submit an annual *Case Management Plan* to the State as specified in Section 3.7.1.11.1 of this Contract.

3.21.7.2 The Contractor shall submit a quarterly *Case Management Monitoring Report* as specified in Section 3.7.1.11.2.1 of this Contract.

3.21.7.3 The Contractor shall submit an annual *Case Management Training Plan* that describes initial and ongoing training, including, at a minimum, the training topics, the training mode and venue, who will provide the training (Contractor staff or vendor) and the length of the training.

3.21.7.4 The Contractor shall submit a monthly *Unable to Contact Report* regarding DSHP Plus LTSS members that the Contractor is unable to locate for case management. This report shall include at a minimum: (i) member name and contact information; (ii) numbers of attempts; (iii) type of attempt (phone, post-

card, visit to residence); and (iv) efforts to obtain current contact information such as contacting the member's relatives, neighbors and providers.

3.21.7.5 The Contractor shall submit a quarterly *Late and Missed Visits* report. This report shall be a narrative report that provides a summary of the Contractor's findings regarding late and missed visits for DSHP Plus LTSS members during the reporting quarter, and a summary of the Contractor's corrective actions taken to address late and missed visits.

3.21.7.6 The Contractor shall submit a monthly *Caseload and Staffing Ratio Report*. The report shall reflect the case manager-to-member staffing ratios and case manager caseloads using the weighted ratio formula described in 3.7.1.5 on the last business day of the month prior to the report submission (e.g., the report submitted in April 2017 will reflect the caseloads and staffing ratios as they appeared on March 31, 2017). The report shall include at a minimum: (i) the average case manager-to-member staffing ratio, by member type (NF, HCBS, Self-Directed Attendant Care Services); (ii) the caseload of member assignments to each individual case manager; and (iii) an analysis of any changes to the Contractor's case management staff that impact case manager caseload, and the Contractor's efforts to resolve these issues.

3.21.8 **Service Coordination Reports**

3.21.8.1 The Contractor shall submit a quarterly *Nursing Facility to Community Transition Report.* The report shall include information, by month, on specified measures, which shall include but not be limited to the following:

3.21.8.1.1 Number of DSHP Plus LTSS members identified as potential candidates for transition from a nursing facility;

3.21.8.1.2 Of members identified as potential candidates for transition, the number and percent of members who were identified:

3.21.8.1.2.1 By referral (by type of referral, including but not limited to referral by treating physician, nursing facility, community-based organization, family, self, and other).

3.21.8.1.2.2 Via case management.

3.21.8.1.2.3 By other source.

3.21.8.1.3 Number of DSHP Plus LTSS members transitioned from a nursing facility;

3.21.8.1.4 Of members who transitioned from a nursing facility, the number and percent of members who transitioned to:

3.21.8.1.4.1 An assisted living facility.

3.21.8.1.4.2 A residential setting where the member will be living independently.

3.21.8.1.4.3 A residential setting where the member will be living with a relative or other Caregiver.

3.21.8.1.5 Of members who transitioned from a nursing facility, the number and percent of members who:

3.21.8.1.5.1 Are still in the community.

3.21.8.1.5.2 Returned to a nursing facility within 90 calendar days after transition.

3.21.8.1.5.3 Returned to a nursing facility more than 90 days after transition.

3.21.8.2 The Contractor shall submit a monthly *Transition Report* that at a minimum shall include: (i) member demographic information including housing situation; (ii) tracking of key dates in each member's transition (e.g., referral date, planning meeting date, discharge date); (iii) tracking of any re-institutionalization; and (iv) home visit tracking (e.g., dates of home visits).

3.21.8.3 The Contractor shall submit a quarterly *Self-Directed Attendant Care Services Report*. The report shall include current information, by month, on specified measures, which shall include but not be limited to the following:

3.21.8.3.1 Total number of DSHP Plus LTSS members;

3.21.8.3.2 The number and percent of DSHP Plus LTSS members receiving Self-Directed Attendant Care Services;

3.21.8.3.3 Number and percent of members receiving Self-Directed Attendant Care Services who have an Employer Representative; and

3.21.8.3.4 Number and percent of members receiving Self-Directed Attendant Care Services who disenrolled voluntarily or involuntarily from Self-Directed Attendant Care Services (for each month in the reporting period).

3.21.9 **Provider Network Reports**

3.21.9.1 The Contractor shall submit a semi-annual Geo-Access Report as specified in the QMS. The report shall include but not be limited to (i) an accessibility summary; (ii) city and county detail information; (iii) therma maps demonstrating access issues; (iv) provider location maps; and (v) city access standard detail reports.

The report shall at a minimum include overall access to the care types set forth in Section 3.9.17.2.

3.21.9.2 The Contractor shall submit a monthly *Member Lock-In Report* that at a minimum shall include the names of members who are under PCP or pharmacy lock-in, the PCP or pharmacy to which they are locked in, the span of the lock-ins, the reason for the lock-in, and lock-in removals.

3.21.9.3 The Contractor shall submit a monthly *Delivery Reform Report* that at a minimum shall include the number and percentage of PCPs in the Contractor's provider network participating in patient-centered, multi-disciplinary, team-based models by type of model (e.g., PCMH, ACO), the criteria for enrollment in each model/provider, the number of members per model/provider, and each model/provider's performance on quality and cost measures, including measures specified by the State.

3.21.9.4 The Contractor shall submit a quarterly *Telemedicine Report* describing its progress in improving access and availability of Covered Services to members through the use of Telemedicine technology. The report shall include, but is not limited to: (i) Telemedicine member demographics and Telemedicine services received; (ii) number of unduplicated members utilizing Telemedicine services; and (iii) name and location of contracted Telemedicine distant sites (remote provider).

3.21.9.5 The Contractor shall submit an annual *Provider Network Development and Management Plan* as specified in Section 3.9.2.1 of this Contract.

3.21.9.6 The Contractor shall submit a quarterly *Provider Suspensions and Terminations Report* that lists by name all participating provider suspensions or terminations. This report shall include information on all participating providers. At a minimum, the report shall include: (i) each participating provider's name; (ii) the participating provider's specialty; (iii) the participating provider's SSN, as appropriate; (iv) the participating provider's NPI; (v) the participating provider's primary city; (vi) reason(s) for the action taken; and (vii) the effective date of the suspension or termination. If the Contractor has taken no action against providers during the quarter, the Contractor must document this in the *Provider Suspensions and Terminations Report*.

3.21.10 **Provider Payment Reports**

3.21.10.1 The Contractor shall submit a quarterly Payment Reform Report that includes information on the Contractor's payment reform initiatives. At a minimum, the report shall include: (i) a brief description of the Contractor's payment models that reward value, including P4V and total cost of care models; (ii) a description of how the Contractor supports provider transition to payment models that reward value the number and types of provider per model; (iii) the

share of total provider payments per model; and (iv) performance on quality measures, including measures specified by the State.

3.21.11 **UM Reports**

3.21.11.1 The Contractor shall annually submit a *UM Program Description and an associated UM Program Work Plan and Evaluation*. The annual evaluation shall, at a minimum, include an analysis of findings and actions taken as well as any UM committee reports and minutes. See Section 3.12.1 of this Contract for additional requirements regarding the UM program description, work plan, and evaluation.

3.21.11.2 The Contractor shall submit a quarterly *Over-and-Under Utilization of Services Report* that shall at a minimum include information regarding the most utilized services by code and by provider. The report shall also include an analysis tab where the Contractor shall provide details regarding important trends in service utilization (e.g., in prescription drug and emergency room utilization).

3.21.11.3 The Contractor shall submit a quarterly *Denied/Deferred Prior Authorization Requests Report* that includes prior authorization information by service and by population. The report shall, at a minimum, include the following data: (i) date of request; (ii) name of the requesting provider; (iii) member's name and ID number; (iv) date of birth; (v) the Covered Service for which authorization was requested; (vi) justification given by the provider for the member's need for the service/medication; (vii) justification of the Contractor's denial or the reason(s) for deferral of the request; (viii) the date and method of notification of the provider and the member of the Contractor's determination; and (ix) whether the denial was for a PROMISE, Pathways, or DDDS Lifespan Waiver participant.

3.21.12 **QM/QI Reports**

3.21.12.1 The Contractor shall submit an annual *QM/QI Work Plan and Evaluation* as specified in the QMS.

3.21.12.2 The Contractor shall submit its annual performance measure data as specified in the QMS. The Contractor shall also submit quarterly status reports on each performance measure, as specified in the QMS.

3.21.12.3 The Contractor shall submit the results of its annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as specified in the QMS.

3.21.12.4 The Contractor shall submit quarterly status reports on each PIP, as specified in the QMS.

3.21.12.5 The Contractor shall submit its *NCQA Accreditation Report* (the final bound copy from NCQA) immediately upon receipt, but not to exceed 10 calendar days from receipt from NCQA.

3.21.12.6 The Contractor shall submit its annual reevaluation of NCQA accreditation status based on HEDIS scores immediately upon receipt from NCQA, but not to exceed 10 calendar days from receipt from NCQA.

3.21.13**Member and Provider Services Reports**

3.21.13.1 The Contractor shall submit an annual *Health Education Plan* describing the Contractor's plans regarding Health Education services for members as specified in Section 3.14.1.9 of this Contract and a *Health Education Plan Evaluation* to evaluate the initiatives in the plan and present findings of lessons learned.

3.21.13.2 The Contractor shall submit an annual *Provider Training and Outreach Plan* describing the Contractor's plans to educate providers and a *Provider Training and Outreach Evaluation Report* to evaluate the initiatives in the plan and present findings of lessons learned. Both reports shall be submitted in narrative format. The *Provider Training and Outreach Evaluation Report* is due annually and shall at a minimum specify: (i) target audiences; (ii) location of training/event; (iii) date of training/event; (iv) topics; (v) funds expended; and (vi) number and types of attendees.

3.21.14**Program Integrity Reports**

3.21.14.1 The Contractor shall submit an annual *Fraud, Waste and Abuse Compliance Plan* that complies with Section 3.16.5 of this Contract.

3.21.14.2 The Contractor shall submit a quarterly *Fraud, Waste and Abuse Report*. This report shall summarize the results of the Contractor's Fraud, Waste and Abuse compliance plan (see Section 3.16.5 of this Contract) and any other Fraud, Waste and Abuse prevention, detection, reporting and investigation measures. The report shall be cumulative, meaning that an individual investigation will continue to appear on the report until it is resolved. At a minimum the report shall include, with respect to individual investigations of Fraud, Waste and Abuse:

1) Member Name and ID Number;
2) Provider Name and NPI;
3) Type of Provider;
4) All communications between the Contractor and the provider regarding the complaint;
5) Nature of complaint, including alleged persons or entities involved, category of services, factual explanation of the allegation and the dates of conduct;
6) Date of the complaint;

7) Source or referral of complaint;
8) Investigative reasons of the complaint;
9) Approximate dollars involved or amount paid regarding the complaint;
10) The result of a preliminary investigation of the complaint;
11) Any referrals;
12) The result of any full investigations of the complaint;
13) Disciplinary measures or actions taken by the Contractor, if any;
14) The amount of any recovery;
15) Contact information for a Contractor staff person involved with relevant knowledge of the complaint; and
16) The legal or administrative disposition of the case.

3.21.14.3 The Contractor shall submit the results of a preliminary investigation (see Section 3.16 of this Contract) within two business days of completing the preliminary investigation. At a minimum the results of the preliminary investigation must include:

3.21.14.3.1 Information pertaining to the results of the initial assessment of the preliminary investigation and a description of the type of Fraud, Waste or Abuse under investigation;

3.21.14.3.2 A review of the quality and credibility of the referrals related to the investigation;

3.21.14.3.3 Information on any corrective action plans and timelines developed as part of the investigation process;

3.21.14.3.4 An assessment of the severity of the referral that clearly identifies any potential financial or member impact; and

3.21.14.3.5 Identification of Contractor staff responsible for the investigation.

3.21.14.4 The Contractor shall submit the results of a full investigation (see Section 3.16 of this Contract) to the State within two business days of completing the investigation. This shall be a narrative report and shall at a minimum include: (i) the result of the preliminary and full investigation, including any referrals; (ii) any disciplinary measures or actions taken by the Contractor; (iii) the amount of any recovery; (iv) contact information for a Contractor staff person involved with relevant knowledge of the complaint; and (v) the legal or administrative disposition of the case.

3.21.14.5 The Contractor shall submit a quarterly *Disclosure Submission Rate Report* that provides the percentage of participating providers for which the Contractor has obtained and/or verified complete and current disclosures in accordance with Section 3.16.2 of this Contract. If the percentage is not 100%,

the report shall include the Contractor's attestation that the Contractor is not making/will not make payment to any participating provider for which the Contractor has not obtained and/or verified a complete disclosure and describe the actions the Contractor is taking to obtain the missing disclosures.

3.21.14.6 The Contractor shall submit a monthly *Program Integrity Exception List Report* that summarizes the Contractor's monthly check of employees, Subcontractors, providers not enrolled with DMAP and other disclosing entities against the LEIE, EPLS, SSA DMF and the SAM, including the results and any corrective actions.

3.21.14.7 The Contractor shall provide written notice to the State within two business days of taking any action against a provider for program integrity reasons, including but not limited to denial of a provider credentialing/re-credentialing application, corrective action or limiting the ability of a provider to participate in the program (e.g., suspending or terminating a provider). The notification shall include but not be limited to identification of the provider and a description of the action, the reason for the action, and documentation to support the reason.

3.21.14.8 The Contractor must submit a quarterly *Member Service Verification Report* that details the results of the Contractor's verification process, including at a minimum findings and any proposed corrective actions.

3.21.15 **Financial Management Reports**

3.21.15.1 The Contractor shall submit financial reports as described in the Financial Reporting guide. At a minimum, these reports shall include the following:

3.21.15.1.1 Quarterly:

3.21.15.1.1.1 Balance sheet;

3.21.15.1.1.2 Income sheet;

3.21.15.1.1.3 Financial statement footnotes (quarterly and annual);

3.21.15.1.1.4 Profitability statements;

3.21.15.1.1.5 Investments;

3.21.15.1.1.6 Risk pools;

3.21.15.1.1.7 Other assets;

3.21.15.1.1.8 Other liabilities;

3.21.15.1.1.9 Long term debt;

3.21.15.1.1.10 Medical liability summary;

3.21.15.1.1.11 Received but unpaid claims;

3.21.15.1.1.12 Lag reports;

3.21.15.1.1.13 Utilization;

3.21.15.1.1.14 Subcapitated expenses;

3.21.15.1.1.15 FQHC and public health clinic report;

3.21.15.1.1.16 MFP grant expenditure report; and

3.21.15.1.1.17 LTSS placement/setting of care census report.

3.21.15.1.2 Annual:

3.21.15.1.2.1 Audited financial statements specific to this Contract and developed in accordance with generally accepted accounting principles and generally accepted auditing standards;

3.21.15.1.2.2 Audited balance sheet reconciliation;

3.21.15.1.2.3 Audited income statement reconciliation;

3.21.15.1.2.4 Audited entry adjustments;

3.21.15.1.2.5 Non-State Plan direct client services expenditures;

3.21.15.1.2.6 Maternity expenditures and

3.21.15.1.2.7 Financial disclosure statement.

3.21.15.2 The Contractor shall submit an MLR report (see Section 3.17.7 of this Contract). The Contractor shall submit its MLR calculation report by the last business day in December following the MLR reporting year. The State reserves the right to request additional information to validate the report as necessary. The State will notify the Contractor if it disputes the information and the Contractor shall work timely and collaboratively to resolve the matter.

3.21.15.3 Reporting Transactions with Parties in Interest

3.21.15.3.1 Within 30 days of any transaction between the Contractor and a party in interest, as defined at 42 U.S.C. § 300e-17, the Contractor must report to DMMA, and upon request, to the Secretary of HHS, HHS-OIG, and the Comptroller General, a description of the transaction, including the following transactions:

3.21.15.3.1.1 Any sale or exchange, or leasing of any property between the Contractor and the party in interest;

3.21.15.3.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and the party in interest. This provision excludes salaries paid to employees for services provided in the normal course of their employment; and

3.21.15.3.1.3 Any lending of money or other extension of credit between the Contractor and the party in interest.

3.21.15.3.2 The Contractor shall make all reports created and provided to DMMA, the Secretary of HHS, HHS-OIG, and the Comptroller General pursuant to Section 3.21.15.3.1 available to its members upon reasonable request.

3.21.16**Claims Management Reports**

3.21.16.1 The Contractor shall submit *Encounter Data* in a standardized format and meeting the timeliness requirements as specified by the State (see Section 3.18.4 of this Contract) electronically to the State.

3.21.16.2 The Contractor shall submit a quarterly *Encounter Data to Financials Reconciliation Report*, and provide any information and/or data requested in a format to be specified by the State as required to support the validation, testing or auditing of the completeness and accuracy of Encounter Data submitted by the Contractor.

3.21.16.3 The Contractor shall submit claims management reports as described in the Claims Reporting Guide. At a minimum, these reports shall include the following:

3.21.16.3.1 Claims Accuracy: Results of the Contractor's internal audits;

3.21.16.3.2 Claims Activity: Claims received, rejected, adjudicated, paid, denied, in process, and timeliness of payment;

3.21.16.3.3 Encounter Data Processing: Encounters submitted, denied, and timeliness of submission;

3.21.16.3.4 Denial detail: Detail of claims denied by reason, type, and procedure code;

3.21.16.3.5 Utilization detail: Detail of claims paid by cohort, type, and category; and

3.21.16.3.6 Subcontractor detail: Details of services provided under Subcontracts, included subcapitated Subcontracts.

3.21.16.4 The Contractor shall submit a monthly, quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for Third Party resources as well as funds for services for which the Contractor does not pay a claim or a portion of a claim due to TPL coverage, including Medicare. The Contractor shall calculate cost savings in categories identified by the State.

3.21.16.5 Per 42 CFR 457.1201(o) and CFR 457.1201(n)(2), the Contractor shall include an attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.

3.21.17 **Information Systems Reports**

3.21.17.1 In accordance with HIPAA requirements and the Contractor's Business Associate Agreement ("BAA") with the State, the Contractor shall immediately notify the State by phone or email of any breach, regardless of the number of members it effects. Within five business days of the initial notification, the Contractor shall submit a written report that shall include but not be limited to a thorough description of the breach and the Contractor's corrective action plan. To the extent there is any conflict in the reporting requirements set forth here and the Contractor's BAA with the State, this provision shall take precedence.

3.21.17.2 The Contractor shall submit a quarterly *Privacy/Security Incident Report*. The report shall include, at a minimum, the nature and scope of the incident, the Contractor's response to the incident, and the mitigating measures taken by the Contractor to prevent similar incidents in the future. "Port scans" or other unsuccessful queries to the Contractor's Information System shall not be considered a privacy/security incident for purposes of this report.

3.21.17.3 The Contractor shall submit a *BC-DR Plan* for review and prior approval as specified by the State in accordance with Section 3.21.17 of this Contract. The Contractor shall communicate proposed modifications to the BC-DR plan at least 45 calendar days prior to their proposed incorporation. Such modifications shall be subject to review and prior approval by the State.

3.21.17.4 The Contractor shall submit a monthly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the Contractor's confirmation of Contractor's Enrollment and electronic claims management functions, as measured within the Contractor's span of control. The report shall meet the requirements of Section 3.21.17 of this Contract.

3.21.18 **Staffing Reports**

3.21.18.1 The Contractor shall submit an *Annual Staff Training and Education Plan* and an *Annual Staff Training Evaluation* in accordance with Section 3.20.3 of this Contract.

3.21.19 **Payments to the Contractor Reports**

3.21.19.1 The Contractor shall submit a *Monthly Enrollment/Capitation Payment Reconciliation Report* that serves as a record that the Contractor has reconciled member eligibility data with Capitation Payments for each rate cell, and verified that the Contractor has an Enrollment record for all members for whom the Contractor has received a Capitation Payment. The report shall include an item for each discrepancy in the event that it has members for whom a Capitation Payment has not been made or an incorrect payment has been made. This report shall be submitted with a one-month lag time and is due to the State by the end of the second month following the reporting period. These reports shall include all un-reconciled items until such time that the State notifies the Contractor otherwise; no item may be removed without State approval.

SECTION 4 PAYMENTS TO THE CONTRACTOR

4.1 GENERAL

4.1.1 The obligation of the State to make payments to the Contractor shall be limited to monthly capitation rates, maternity care payments and any other payment explicitly provided for in this Contract. The Contractor shall accept these payments from the State as payment in full of the State's obligation to the Contractor.

4.1.2 The State will pay the Contractor for each Medicaid/CHIP-eligible member based on a set of capitated rates that includes all benefit package services, including the DSHP benefit package and the DSHP Plus LTSS benefit package (see Section 3.4 of this Contract). The Contractor shall only retain Capitation Payments for Medicaid-eligible members. The State will make Capitation Payments to the Contractor on a monthly basis via electronic funds transfer (EFT).

4.1.3 The State will make payments based on capitation rates that are actuarially sound as defined by 42 CFR 438.4(a) and meet the applicable provisions in 42 CFR 438.5 and 42 CFR 438.6(c). Rates will be developed in accordance with standards specified in 42 CFR 438.5 and generally accepted actuarial principles and practices. Rates will be certified as meeting the foregoing requirements by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

4.1.4 The State will make a separate Capitation Payment to the Contractor for the month in which a member (i.e., pregnant female) delivery takes place. This payment, called a maternity care payment, represents all allowable service costs three months prior to delivery and all the delivery costs related to the pregnant female/mother only. A regular Capitation Payment will initially be made for the month of delivery, which will be replaced by the maternity care payment after the delivery of a live newborn becomes known to DMMA. In the case of the delivery of multiple newborns (e.g., twins, triplets) from a single pregnancy, the State will make a single maternity care payment. If the services covered or the maternity care payment mechanism changes, the Contractor will be notified regarding this change and will be provided with updated rates that are consistent with the change. The Contractor shall provide the State any requested information that may be required by the State to support the correct payment of the maternity care payment. The Contractor will be eligible for a maternity care payment based on submission of required data needed by DMMA to confirm the birth event and identification of the newborn, which can be provided up to 12 months from the date of birth. The maternity care payment is not applicable to individuals who are assigned to the NF/HCBS Dual, NF/HCBS Non-Dual or Community Well rate tiers. The contractor is not eligible to receive the maternity care payment for individuals on these identified rate tiers.

4.1.5 Capitation rates will reflect an amount that is net of applicable TPL/COB, copayments or other cost/expenditure offsets. Capitation rates paid by the State to the Contractor for DSHP Plus LTSS members will also be net of the member-specific Patient Liability amount as determined by the State.

4.1.6 The Contractor is at risk of incurring losses if its expenses for, and related to, providing the benefit package exceed its Capitation Payment. The State shall not provide a retroactive payment adjustment to the Contractor to reflect the cost of services actually furnished by the Contractor. The State makes no guarantee that Capitation Payments will exceed the Contractor's expenses for medical costs and administration.

4.1.7 In order to support the State's appropriate claiming of Federal funds in accordance with 42 CFR 438.6(e), the Contractor shall submit a quarterly report identifying stays in an IMD for treatment of a mental health conditions that exceed 15 calendar days during the month.

4.1.8 Any incentive-based payment(s) or other risk-sharing payment(s) will conform with Federal requirements applicable to such payments, including 42 CFR 438.6(b)(2), and will be remitted by the State to the Contractor based on the specified terms and conditions for the respective payment. The methodology for determining payments to Contractor for an incentive-based or other risk-sharing payment will be provided to the Contractor.

4.1.8.1 Any incentive arrangement shall be for a fixed period of time.

4.1.8.2 Performance for any incentive arrangement shall be measured during the rating period under the contract in which the incentive arrangement is applied.

4.1.8.3 Any incentive arrangement shall not be renewed automatically.

4.1.8.4 Any incentive arrangement shall be made to both public and private contractors under the same terms of performance.

4.1.8.5 Any incentive arrangement shall not condition Contractor participation in the incentive arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements.

4.1.8.6 Any incentive arrangement shall be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's Quality Management Strategy.

4.1.9 By executing this Contract, the Contractor affirms that it has reviewed the rates provided by the State and accepts the rates for the relevant contract period as actuarially sound as defined in 42 CFR 438.4.

4.1.10 As applicable, the State will make direct payments to providers for disproportionate share hospital (DSH).Therefore, DSH amounts will not be included in the payments made by the State to the Contractor. Graduate medical education (GME) amounts will be included in capitation payments to the Contractor.

4.1.11 Any and all discrepancies in Capitation Payments shall be communicated to the State in the Monthly Enrollment/Capitation Payment Reconciliation Report described in Section 3.21.19 of this Contract.

4.1.12 In accordance with 42 CFR 438.604(a)(2), the Contractor shall submit to the State data on the basis of which actuarial soundness of capitation rates is certified, including base data described in 42 CFR 438.5(c).

4.2 RISK ADJUSTMENT PROCESS FOR DSHP RATES

4.2.1 The Contractor's base capitation rates are based on the health status and utilization of the entire managed care population within each rate tier and not only on the portion of the population that is Enrolled in the Contractor's MCO. In order to attempt to mitigate adverse client/member selection between the MCOs, the State intends to risk adjust the Contractor's base rates in two six month intervals. The July 1 through December 31 period would be referred to as CYb. The January 1 through June 30 period would be referred to as CYa. The State intends to use the CDPS+Rx model developed by the University of California at San Diego to measure the relative health risk of each MCO's membership on a budget neutral basis. However, the State may choose another risk adjustment model if it determines that another model will more appropriately serve the State's interests. Rate tiers specific to children under age 1 and maternity care payments will not be risk adjusted. The methodology used to produce the risk scores and ultimately the risk adjusted rates will be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices and will be shared with the Contractor for every semi-annual process.

4.2.2 In the event that the risk adjustment process for CYb is not completed in time that the newly developed factors can be applied to the original payment of the July capitation, the State shall continue to pay the risk adjusted rates in effect for June until such time as the CYb risk adjusted rates become available. The CYb rates shall be paid prospectively and shall be also be applied retroactively to any Capitation Payments for the applicable CYb period originally paid at the prior year contract rates. The same process will be followed for the CYa risk adjustment period. If a retroactive adjustment due to late receipt of risk adjusted capitation rates results in funds being owed by the Contractor to the State, the full amount of the funds owed will be withheld by the State from the next monthly Capitation Payment due to the Contractor. Notwithstanding any provision of this Contract to the contrary, the Contractor hereby agrees to accept the resulting final risk adjusted rates including any retroactive adjustments without further Contract negotiations or Contract amendments.

4.3 RISK ADJUSTMENT PROCESS FOR DSHP PLUS RATES

4.3.1 DSHP Plus members will not be subject to risk adjustment using the CDPS+Rx model. The Contractor's base capitation rates for DSHP Plus members that are in the nursing facility/HCBS rate tiers may be periodically subject to risk adjustment that takes into consideration population mix (e.g., percentage of nursing facility members) and/or acuity levels as determined by the State. Any risk adjustment applied to these rate tiers will be developed to be budget neutral to the State consistent with generally accepted actuarial principles and practices, and the Contractor shall accept the resulting final risk-adjusted rates, including any retroactive adjustments, without further Contract negotiations or adjustments. The State's methodology for adjusting the DSHP Plus rates will be shared with the Contractor. In the event that the risk adjustment process relevant to the DSHP Plus rate tiers is not completed in time that the newly developed adjustment factors can be applied to the original Capitation Payment, the State shall continue to pay the rates in effect and agreed to prior to the risk adjustment.

4.4 RELATIONSHIP OF ELIGIBILITY AND ENROLLMENT DATES TO CONTRACTOR PAYMENT

4.4.1 The State shall make a full monthly payment to the Contractor for the month in which the member's Enrollment in the Contractor's MCO is terminated. The Contractor shall be responsible for Covered Services provided to the member in any month for which the State paid the Contractor for the member's care under the terms of this Contract.

4.4.2 The State shall have the discretion to recoup payments made by the State for payments found to be in error by withholding the amount of money due from the next Capitation Payment or successive Capitation Payments to the Contractor, or to request direct repayment from the Contractor, at the State's discretion.

4.4.3 The State acknowledges and agrees that, in the event of any recoupment pursuant to this Section of the Contract, the Contractor shall have the right to recoup from providers or other persons to whom Contractor has made payment during this period of time.

4.4.4 The Contractor shall be responsible for payments for Covered Services rendered starting on the effective date of Enrollment, including a retroactive date of Enrollment, until the date the member is Transferred or Disenrolled.

4.4.5 Except as provided below or in Section 3.2.4 of this Contract, the effective date of a member's Enrollment shall not be retroactive.

4.4.5.1 The effective date of Enrollment for newborns shall be retroactive to the date of birth.

4.4.5.2 The effective date of Enrollment for DSHP Plus LTSS members residing in a nursing facility may be retroactive up to 90 calendar days prior to the member's date of application for Medicaid.

4.4.6 Administrative processing times may result in Contractor Capitation Payments being made retroactive to the date of Enrollment.

4.5 COMPENSATION AND PROGRAMMATIC CHANGES

4.5.1 Amendments, revisions, or additions to the Medicaid State Plan or to State or Federal law or policies shall, insofar as they affect the scope or nature of benefits available to clients, amend the Contractor's obligations as specified herein, unless the State notifies the Contractor otherwise. The State will inform the Contractor of any amendments to the Medicaid State Plan or changes in DMMA's regulations, guidelines, or policies in a timely manner.

4.5.2 If the scope of members or services, inclusive of limitations on those services, that are the responsibility of the Contractor is changed, the State will determine whether the change is sufficient that an actuarial analysis might conclude that a rate change is appropriate. If so, the State will arrange for the actuarial analysis, and the State will determine whether a rate change is appropriate. The State will take into account the actuarial analysis, and the State will consider input from the Contractor, when making this determination. At a minimum, the State will adjust the rates as necessary to maintain actuarial soundness of the rates. If the State makes a change, the State will provide the Contractor information on the impact of the rate adjustment.

4.6 ADJUSTMENT TO THE CAPITATION RATES FOR THE HEALTH INSURANCE PROVIDERS FEE UNDER SECTION 9010 OF THE ACA

4.6.1 If the Contractor is a covered entity or a member of a controlled group under Section 9010 of the Affordable Care Act that is required to file IRS Form 8963, Report of Health Insurance Provider Information (Form 8963), the Contractor shall comply with the requirements of this Section 4.6. This Section 4.6 does not apply if the Contractor is exempt from the Health Insurance Providers Fee (HIPF).

4.6.2 The Contractor shall provide the State a copy of its final Form 8963 within five business days of submitting the final Form 8963 to the United States Internal Revenue Service (IRS). The Contractor shall provide the State with any corrected Form 8963 within five business days of submitting the corrected Form 8963 to the IRS.

4.6.2.1 With the Form 8963 the Contractor shall submit a methodological description of how its Delaware-specific Medicaid/CHIP premium revenue (payments to the

Contractor pursuant to this Contract) was determined, including how the long-term care (LTC) exclusion was determined by the Contractor.

4.6.2.2 If the Contractor's Delaware-specific Medicaid/CHIP premium revenue is not delineated on its Form 8963, the Contractor shall submit with its Form 8963 a supplemental delineation of Delaware-specific Medicaid/CHIP premium revenue that was listed on the Contractor's Form 8963. The Contractor shall also submit a certification regarding the supplemental delineation consistent with 42 CFR 438.604 and 42 CFR 438.606 and Section 5.3.4 of this Contract.

4.6.3 The State will check the reasonableness of the Contractor's Delaware-specific Medicaid/CHIP premium revenue included on the Contractor's Form 8963/supplemental delineation. This reasonableness check will include, but may not be limited to, comparing the Contractor's reported Delaware-specific Medicaid/CHIP premium revenue to the State's capitation payment records.

4.6.4 The Contractor shall provide the State a copy of its notice of preliminary fee calculation and its notification of final fee calculation within five business days of receiving such notice/notification from the IRS.

4.6.5 The Contractor shall provide its corporate income tax rates (Federal and State) for the last three years with the copy of its notification of final fee calculation and shall include a certification regarding the corporate income tax rates consistent with 42 CFR 438.604 and 42 CFR 438.606 and Section 5.3.4 of this Contract.

4.6.6 The State will calculate the HIPF percentage based on the Contractor's notification of final fee calculation (i.e., HIPF liability) and all premiums for the Contractor subject to Section 9010, as reported on the Contractor's Form 8963.

4.6.7 The State will determine the Contract-specific prorated share of the Contractor's HIPF liability based on the HIPF percentage and the Contractor's Delaware-specific Medicaid/CHIP premium revenue.

4.6.8 The State will determine the capitation revenue in the fee year (the calendar year in which the fee must be paid to the government) that was paid to the Contractor through the most recent month for which the member months (i.e., number of capitation payments) are known, for populations that were included in the data year (the calendar year immediately before the fee year).

4.6.9 The State will determine what percentage the Contract-specific prorated HIPF liability amount (see Section 4.6.7 above) is of the fee year capitation revenue to be adjusted.

4.6.10 The State will adjust the HIPF capitation rate increase percentage calculated in Section 4.6.9 above to account for the Contractor's applicable Federal and State corporate income tax impacts (including deductibility of State income tax when computing Federal tax) on the additional revenue intended to cover the HIPF liability.

4.6.11 The State will adjust the applicable fee year capitation rates for the Contractor by the percentage determined in Section 4.6.10 above and, using the known member months from Section 4.6.8 above, determine the change in capitation revenue. The State will compute the change in capitation revenue that is due to the higher capitation rates by multiplying the adjusted capitation rates by the known member months to determine the total supplemental HIPF payment amount for the Contractor. The State will then make this supplemental payment to the Contractor with a goal to complete this transaction by December 31 of each fee year.

4.7 CAPITATION RATES

4.7.1 The Contractor's capitation rates are provided in Addendum 2.

SECTION 5 TERMS AND CONDITIONS

5.1 CONTRACTOR RESPONSIBILITIES

5.1.1 The Contractor

5.1.1.1 The Contractor shall be the sole point of contact in all contractual matters, and shall be wholly responsible for performance of the entire Contract. Any Subcontract that the prime Contractor enters into with respect to performance under this Contract (see Section 5.1.2 of this Contract, below) shall not relieve the prime Contractor in any way of responsibility for performance of its duties under this Contract. The State will only make payment to the Contractor.

5.1.1.2 The Contractor shall be responsible for the professional quality, technical accuracy, timely completion, and coordination of all services furnished by the Contractor, its Subcontractors and its and their principals, officers, employees and agents under this Contract. In performing the specified services, the Contractor shall follow practices consistent with generally accepted professional and technical standards.

5.1.1.3 The Contractor shall be responsible for ensuring that all services, products and deliverables furnished pursuant to this Contract comply with the standards promulgated by the Department of Technology and Information (DTI) published at http://dti.delaware.gov/, and as modified from time to time by DTI during the term of this Contract. If any service, product or deliverable furnished pursuant to this Contract does not conform with DTI standards, the Contractor shall, at its expense and option either (i) replace it with a conforming equivalent or (ii) modify it to conform with DTI standards. The Contractor shall be and remain liable in accordance with the terms of this Contract and applicable law for all damages to the State caused by the Contractor's failure to ensure compliance with DTI standards.

5.1.1.4 Permitted or required approval by the State of any products, deliverables or services furnished by the Contractor shall not in any way relieve the Contractor of responsibility for the professional and technical accuracy and adequacy of its work. The State's review, approval, acceptance, or payment for any of the Contractor's services herein shall not be construed to operate as a waiver of any rights under this Contract or of any cause of action arising out of the performance of this Contract, and the Contractor shall be and remain liable in accordance with the terms of this Contract and applicable law for all damages to the State caused by the Contractor's performance or failure to perform under this Contract.

5.1.2 Subcontractors

5.1.2.1 General

5.1.2.1.1 In carrying out the terms of this Contract, the Contractor, if prior approved by the State, may enter into written Subcontract(s) with

other entities for the provision of administrative services or a combination of Health Care Services and administrative services.

5.1.2.1.2 Except as provided in Section 3.7.1.5.4 of this Contract regarding contracting with agencies to provide case management to DSHP LTSS members with HIV/AIDS, the Contractor shall not Subcontract with non-Affiliates for case managers who will meet face-to-face with members, unless otherwise approved by DMMA.

5.1.2.1.3 If the Contractor Subcontracts with a PBM, it shall also comply with the requirements in Section 3.5.16 of this Contract.

5.1.2.1.4 The Contractor shall assume sole responsibility for all functions performed by a Subcontractor(s), as well as any payments to a Subcontractor(s) for services related to this Contract. In the event that a Subcontractor is incapable of performing the service contracted for by the Contractor, the Contractor shall assume responsibility for providing the services that the Subcontractor is incapable of performing.

5.1.2.1.5 If the Contractor becomes aware of a Subcontractor's failure to comply with this Contract, the Contractor shall correct the failure within 30 calendar days of becoming aware of the failure.

5.1.2.1.6 All Subcontracts and revisions thereto shall be prior approved by the State. The approval requirements of this Section of the Contract do not extend to the purchase of articles, supplies, equipment, rentals, leases and other day-to-day operational expenses in support of staff or facilities providing the services covered by this Contract. The Contractor shall submit Subcontracts to the State at least 90 calendar days prior to the anticipated implementation date of the Subcontract. The Contractor shall revise Subcontracts as directed by the State and resubmit the Subcontract for approval. Once a Subcontract has been approved by the State and executed by all of the participating parties, the Contractor shall provide a copy of the fully executed Subcontract to the State within 30 calendar days of execution.

5.1.2.1.7 The Contractor shall not Subcontract with a person or entity that is debarred or suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) at 48 CFR 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or a person or entity that is an Affiliate, as defined in FAR, of a such a person or entity (see 42 CFR 438.610). The Contractor shall not subcontract with an individual or an entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Social Security Act.

5.1.2.1.8 The State shall have the right to review all financial transactions between the Contractor and a Subcontractor upon request.

5.1.2.1.9 The Contractor shall give the State immediate notice in writing, by certified mail, of any action or suit filed and of any claim made against the Contractor by the Subcontractor or against a Subcontractor(s) that, in the opinion of the Contractor, may result in litigation related in any way to this Contract.

5.1.2.1.10 In keeping with Executive Orders 14 and 29, the Contractor must maximize supplier diversity in its provision of services under this Contract. This includes maximizing the use of qualified minority, woman and veteran owned business enterprises as Subcontractors in the provision of services under this Contract.

5.1.2.1.11 When a Subcontract related to the provision of Covered Services or that includes claims processing services is being terminated other than for cause, the Contractor shall give at least 120 calendar days prior written notice of the termination to the State. If the termination is for cause, the Contractor shall immediately notify the State.

5.1.2.2 <u>Federal Requirements regarding Subcontractual Relationship and Delegation</u>

5.1.2.2.1 If the Contractor delegates responsibilities to a Subcontractor, the Contractor shall ensure that the Subcontracting relationship and Subcontract comply with Federal requirements, including, but not limited to, compliance with the applicable provisions of 42 CFR 438.230 and 42 CFR 434.6 as described below:

5.1.2.2.1.1 Before any delegation, the Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated. Notwithstanding any relationship that the Contractor may have with any Subcontractor, the Contractor

maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract;

5.1.2.2.1.2 All contracts or written arrangements between the Contractor and any Subcontractor shall:

5.1.2.2.1.2.1 Specify the delegated activities or obligations, and related reporting responsibilities.

5.1.2.2.1.2.2 Specify that the Subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's obligations under this Contract.

5.1.2.2.1.2.3 Provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the Contractor determines that the Subcontractor has not performed satisfactorily.

5.1.2.2.1.2.4 Specify that the Subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and the provisions of this Contract.

5.1.2.2.1.2.5 Specify that the Subcontractor agrees that:

5.1.2.2.1.2.5.1 The State, CMS, the HHS-OIG, the Comptroller General, or their designees have the right 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, or determination of amounts payable under the Contractor's agreement with the State.

5.1.2.2.1.2.5.2 Its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members will be made available for purposes of an audit, evaluation, or inspection under 42 CFR 438.230(c)(3)(i).

5.1.2.2.1.2.5.3 The right to audit under 42 CFR 438.230(c)(3)(i) will exist through 10 years from the final date of the Subcontractor's contract with the Contractor or from the date of completion of any audit, whichever is later.

5.1.2.2.1.2.5.4 If the State, CMS, or the HHS-OIG determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS-OIG may inspect, evaluate, and audit the Subcontractor at any time.

5.1.2.3 Additional Requirements regarding Subcontractual Relationship and Delegation

5.1.2.3.1 All of the requirements in this Contract shall apply to Subcontractors and, to the extent relevant, to the duties they are performing.

5.1.2.3.2 Nothing in the Subcontract shall create any contractual relationship between any Subcontractor and the State.

5.1.2.3.3 If the Subcontract is for purposes of providing or securing the provision of Health Care Services to members, the Contractor shall ensure that all requirements described in Section 3.10 of this Contract are included in the Subcontract and/or a separate provider participation agreement is executed by the appropriate parties. If the Subcontract is for behavioral health services, the Subcontractor shall be NCQA accredited in accordance with Section 3.13.8 of this Contract.

5.1.2.3.4 The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards and prior approved by the State. If the Contractor identifies deficiencies or areas for improvement, the Contractor shall require the Subcontractor to take corrective action.

5.1.2.3.5 The Contractor's Subcontracts shall include, at a minimum, the following:

5.1.2.3.5.1 The relationship between the Contractor and the Subcontractor including if the Subcontractor is a subsidiary of the Contractor or within the Contractor's corporate organization;

5.1.2.3.5.2 The responsibilities of the Contractor and the Subcontractor;

5.1.2.3.5.3 The reimbursement methodology and amount;

5.1.2.3.5.4 Incorporation of the applicable requirements of this Contract;

5.1.2.3.5.5 The Subcontractor shall not enter into any subsequent agreements or Subcontracts for any of the work contemplated under the Subcontract for purposes of this Contract without prior written approval of the Contractor and the State;

5.1.2.3.5.6 Incorporation of the requirements found in Section 5.14.12 of this Contract;

5.1.2.3.5.7 The frequency of reporting by the Subcontractor to the Contractor;

5.1.2.3.5.8 Incorporation of the specific requirements found in Section 5.5 of this Contract;

5.1.2.3.5.9 The process by which the Contractor evaluates the Subcontractor;

5.1.2.3.5.10 Incorporation of the specific requirements found in Section 5.14.2 of this Contract;

5.1.2.3.5.11 Lobbying certification language as described in Section 5.2.13 of this Contract;

5.1.2.3.5.12 Requirement to maintain insurance coverage as specified in Section 3.17.3 of this Contract;

5.1.2.3.5.13 Subcontracts in excess of one hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and EPA regulations (see 40 CFR Part 15);

5.1.2.3.5.14 The remedies, including termination, available to the Contractor if the Subcontractor does not fulfill its obligations; and

5.1.2.3.5.15 Termination provisions, including that the Subcontract may be terminated by the Contractor for convenience upon a specified number of calendar days written notice. See also Section 5.1.2.1.11 of this Contract regarding 120 calendar day notice of termination to State for certain Subcontracts.

5.2 GENERAL PROVISIONS

5.2.1 Contract Composition

5.2.1.1 The component parts of the Contract between the State of Delaware and the Contractor shall include:

5.2.1.1.1 This Contract, inclusive of appendices, addenda and amendments;

5.2.1.1.2 The State's RFQ and its associated amendments and addenda; and

5.2.1.1.3 The Contractor's proposal submitted in response to the RFQ, including any clarifications or representations incorporated as part of the procurement or negotiation process.

5.2.1.2 The order of precedence among the Contract components shall be: first, the Contract; second, the State's RFQ; and third, the Contractor's proposal. In the event of a contradiction, conflict or difference in language among the provisions of the documents comprising the Contract, the conflicts or difference shall be resolved according to the order of precedence.

5.2.1.3 The State reserves the right to clarify any contractual requirement in writing, and such clarifications shall govern in case of conflict with the requirements of this Contract. If an issue is addressed in the Contractor's proposal that is not addressed in the RFQ or Contract, no conflict in language shall be deemed to have occurred.

5.2.2 Conformance with State and Federal Law

5.2.2.1 The Contractor shall comply with all State and Federal law and policy, as they exist or as amended, that are or may be applicable to this Contract, including those not specifically mentioned. This includes, but is not limited to: Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; and section 1557 of the Patient Protection and Affordable Care Act. In the event that the Contractor may, from time to time, request the State to make policy determinations or to issue operating guidelines required for proper performance of this Contract, the State shall do so in a timely manner, and the Contractor shall be entitled to rely upon and act in accordance with such policy

determinations and operating guidelines and shall incur no liability in doing so unless the Contractor acts negligently, maliciously, fraudulently, or in bad faith.

5.2.2.2 Provision of such information by the State does not relieve the Contractor of its obligation to keep itself informed of applicable State and Federal law and policies to conform therewith.

5.2.2.3 The Contractor and all Subcontractors represent that they are properly licensed and authorized to transact business in the State of Delaware as provided in 30 *Del. C.* § 2502.

5.2.2.4 The Contractor warrants that no person or selling agency has been employed or retained to solicit or secure this Contract upon an agreement or understanding for a commission, or a percentage, brokerage or contingent fee. For breach or violation of this warranty, the State shall have the right to annul this Contract without liability or at its discretion deduct from the Contract price or otherwise recover the full amount of such commission, percentage, brokerage or contingent fee.

5.2.2.5 This Contract was drafted with the joint participation of both parties and shall be construed neither against nor in favor of either, but rather in accordance with the fair meaning thereof.

5.2.3 **Integration**

5.2.3.1 The Contract (see Section 5.2.1.1 of this Contract, above), shall represent the entire agreement between the State and the Contractor, and will supersede all prior negotiations, representations, or agreements, either written or oral, between the parties relating to the subject matter hereof. The Contract between the parties shall be independent of, and have no effect upon, any other contracts of either party.

5.2.4 **Effective Date and Term**

5.2.4.1 The Contract is subject to prior approval from CMS (see Section 5.2.12.1 of this Contract, below). The Contract shall be effective from January 1, 2018 through December 31, 2019 for an initial Contract period of two years from the Start Date of Operations unless terminated prior to that date in accordance with provisions of this Contract.

5.2.5 **Conditions Precedent**

5.2.5.1 The State shall have no obligation to Enroll any clients into the Contractor's MCO or make any payments to the Contractor until such time as the State has determined that the Contractor has the ability to meet the requirements of this

Contract and begin operations. See Section 2.3 of this Contract regarding readiness reviews.

5.2.6 Extensions and Re-negotiations

5.2.6.1 Contract extensions, if any, will be made in accordance with any applicable State of Delaware procurement law or other required competitive process. This Contract may be extended one or more periods of all or part of one year, with the aggregate time period (including the initial Contract period) not to exceed five years from the Start date of Operations. In the event that the public exigency requires, this Contract may be extended beyond the period noted above.

5.2.6.2 Nothing in this paragraph or Contract shall preclude renegotiation of the Contract, in accordance with any applicable State of Delaware procurement law or other required competitive process.

5.2.7 Contract Administration

5.2.7.1 The Contract shall be administered for the State by DMMA. The State has appointed a Program Manager to be responsible for all matters related to the Contract. This Program Manager shall be the Contractor's primary liaison in working with other State staff.

5.2.7.2 In no instance shall the Contractor refer any matter to another DMMA or State official unless initial contact, both verbal and in writing, regarding the matter has been presented to the Program Manager or designee.

5.2.7.3 Whenever the State is required by the terms of the Contract to provide written notice to the Contractor, such notice shall be signed by the Program Manager or Division Director of DMMA (the Medicaid Director). All notices regarding the failure to meet performance requirements and any assessments of sanctions under the provisions set forth herein shall be issued by the Program Manager or the Medicaid Director.

5.2.8 Contract Manager

5.2.8.1 The Contractor shall designate a Contract Manager. Such designation may be changed during the period of this Contract only by written notice to the State as provided in Section 3.20.1 of this Contract. The Contractor's Contract Manager

shall be authorized and empowered to represent the Contractor regarding all matters pertaining to this Contract.

5.2.8.2 The Contract Manager shall receive all inquiries regarding the Contract and all required reports.

5.2.9 **Notification of Administrative Changes**

5.2.9.1 The Contractor shall notify the State of any and all changes materially affecting the delivery of Health Care Services or the administration of this Contract.

5.2.10 **Notices**

5.2.10.1 Whenever notice is required to be given to the other party, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if a signed receipt is obtained when delivered by hand or certified mail, return receipt requested or by other means as long as proof of delivery and receipt is given. Notices to the State shall be addressed as indicated below. Notices to the Contractor will be addressed as indicated below.

5.2.10.2 Said notices shall become effective on the date of receipt or the date specified within the notice, whichever comes later. Either party may change its address for notification purposes by email of mailing a notice stating the change and setting forth the new address.

5.2.11 **Authority**

5.2.11.1 Each party has full power and authority to enter into and perform the Contract, and by signing this Contract, each party certifies that the person signing on its behalf has been properly authorized and empowered to enter into this Contract. Each party will further acknowledge by its signature that it has read the Contract, understands it, and agrees to be bound by it.

5.2.12 **Federal Approval of Contract**

5.2.12.1 Pursuant to Federal law, CMS must approve this Contract. If CMS does not approve this Contract, the Contract will be considered null and void.

5.2.13 **Uniform Administrative Requirements for Awards of Federal Grant Funds**

5.2.13.1 The Contractor certifies that by signing this Contract, it agrees to be bound by the following Federal requirements:

5.2.13.1.1 *Equal Employment Opportunity (EEO)*

5.2.13.1.1.1 The Contractor shall comply with EEO provisions.

5.2.13.1.2 *Rights to Inventions*

5.2.13.1.2.1 For the performance of experimental, developmental, or research work the Contractor shall provide for the rights of the Federal Government and the State in any resulting invention.

5.2.13.1.3 *Clean Air Act and Federal Water Pollution Control Act*

5.2.13.1.3.1 The Contractor shall comply with all applicable standards, orders or regulations.

5.2.13.1.4 *Byrd Anti-Lobbying Amendment*

5.2.13.1.4.1 By signing this Contract, the Contractor certifies, to the best of its knowledge and belief, that Federal funds have not been used for lobbying as prohibited by 31 USC 1352 and 45 CFR Part 93. The Contractor shall disclose any lobbying activities using non-Federal funds in accordance with 45 CFR Part 93.

5.2.13.1.5 *Debarment and Suspension*

5.2.13.1.5.1 The Contractor shall submit to the State a completed DMMA provider disclosure form annually and comply with the additional disclosure requirements in Section 3.16.2 of this Contract.

5.3 GUARANTEES, WARRANTIES AND CERTIFICATIONS

5.3.1 **Warranty**

5.3.1.1 The Contractor warrants that its services will be performed in a good and workmanlike manner. The Contractor agrees to re-perform any work not in compliance with this warranty brought to its attention within a reasonable time after that work is performed.

5.3.1.2 Third party products within the scope of this Contract are warranted solely under the terms and conditions of the licenses or other agreements by which such products are governed. With respect to all third party products and services purchased by the Contractor for the State in connection with the provision of services under this Contract, the Contractor shall pass through or assign to the State the rights the Contractor obtains from the manufacturers and/or vendors of

such products and services (including warranty and indemnification rights), all to the extent that such rights are assignable.

5.3.2 **Cost**

5.3.2.1 Per 42 CFR 457.1201(p), the Contractor must guarantee that it will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.

5.3.3 **Certification of Legality**

5.3.3.1 The Contractor shall represent, to the best of its knowledge, that it has complied with and shall comply with all applicable Federal, State, and local law relating to its property and conduct of operations, and there are no violations of any law existing or threatened.

5.3.4 **Certification of Accurate, Complete and Truthful Submission**

5.3.4.1 The Contractor must certify data, documentation and information specified in this Section and as otherwise directed by the State, including but not limited to:

5.3.4.1.1 Encounter Data in the form and manner described in Section 3.18.4 of this Contract.

5.3.4.1.2 Data on the basis of which actuarial soundness of capitation rates is certified, including base data described in 42 CFR 438.5(c).

5.3.4.1.3 Data on the basis of which the State determines the Contractor's compliance with the MLR requirement described in Section 3.17.7 of this Contract.

5.3.4.1.4 Data on the basis of which the State determines that the Contractor has made adequate provision against the risk of insolvency pursuant to 42 CFR 438.116.

5.3.4.1.5 Documentation described in 42 CFR 438.207(b) and Section 3.9.2 of this Contract on which the State bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network.

5.3.4.1.6 Information on ownership and control described in 42 CFR 455.104 from the Contractor and any Subcontractors.

5.3.4.1.7 The annual report of overpayment recoveries as required in Section 3.16.1.7.

5.3.4.2 The certification must attest, based on best information, knowledge, and belief, that the data, documentation, and information is accurate, complete and truthful.

5.3.4.3 The certification must be signed by an Authorized Certifier.

5.3.4.4 The Contractor must submit the certification concurrently with the submission of the certified data, documentation or information.

5.3.5 **Contractor's Retention of Data, Documentation and Information**

5.3.5.1 In accordance with 42 CFR 438.3(u), the Contractor shall retain the data, documentation and information specified in Section 5.3.4.1 of this Contract for no less than ten years.

5.3.6 **Contractor's DOI License or DHSS Certification**

5.3.6.1 As provided in Section 2.2 of this Contract, the Contractor shall be licensed by DOI as an HMO or HSC or certified by DHSS.

5.3.6.2 The Contractor shall comply with the financial requirements specified in Section 3.17 of this Contract.

5.3.7 **Insurance**

5.3.7.1 Before delivering services under this Contract, the Contractor shall obtain, from an insurance company duly authorized to do business in Delaware, the minimum coverage levels specified in Section 3.17 of this Contract.

5.4 FAILURE TO MEET PERFORMANCE STANDARDS

5.4.1 **General**

5.4.1.1 The performance standards for this Contract shall be defined as absolute and total compliance with the requirements specified in this Contract. The Contractor shall meet these performance standards in full or be subject to sanctions by the State, including, but not limited to, monetary and non-monetary sanctions.

5.4.1.2 In the event that the Contractor, including an Affiliate of the Contractor, the Contractor's parent, the Contractor's agent or a Subcontractor, fails to meet the

performance standards for this Contract, the State may impose, at the State's discretion, the monetary and non-monetary sanctions described in this Contract.

5.4.1.3 The State retains the right to apply progressively strict sanctions against the Contractor for failure to perform.

5.4.1.4 If the State imposes a sanction, it will provide a written Notice of Deficiency to the Contractor explaining the basis and nature of the sanction.

5.4.1.5 Unless the State specifies the duration of a sanction, the sanction shall remain in effect until the State is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

5.4.1.6 The use of discretion by the State to not impose a sanction does not waive the Contractor's non-compliance.

5.4.1.7 If the State imposes monetary sanctions, the Contractor must pay the monetary sanctions to the State within 30 calendar days from receipt of the Notice of Deficiency.

5.4.1.8 Amounts due to the State as a monetary sanction may be deducted by the State from any money payable to the Contractor pursuant to this Contract. The State will notify the Contractor in writing of any claim for sanction at least 15 calendar days prior to the date the State deducts such sums from money payable to the Contractor.

5.4.1.9 No sanction, including the withholding of Capitation Payments, is just cause for the Contractor to interrupt the provision of Covered Services to members.

5.4.1.10 The State may impose any other administrative, contractual or legal remedies available under Federal or State law for the Contractor's non-compliance under this Contract.

5.4.1.11 The rights and remedies of the State provided for in this Contract are in addition to any other rights and remedies provided by law.

5.4.2 Corrective Action Plans

5.4.2.1 If the State determines that the Contractor is not in compliance with one or more requirements in this Contract, the State may issue a Notice of Deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements either in the form of a Corrective Action Plan (CAP) developed by the Contractor or a Directed Corrective Action Plan (DCAP) developed by the State. A Notice of Deficiency from the State requiring a CAP or DCAP will also serve as a notice

for sanctions in the event the State determines that sanctions are also necessary (see Section 5.4.1 of this Contract, above).

5.4.2.2 The Contractor shall provide CAPs to the State within 14 calendar days of receipt of a Notice of Deficiency from the State. CAPs are subject to review and approval by the State. If the State disapproves the Contractor's CAP, the Contractor shall submit a new CAP within 10 business days, or an expedited timeframe if required by the State, that addresses the concerns identified by the State.

5.4.2.3 If the State imposes a DCAP on the Contractor, the Contractor will have 14 calendar days to respond to the State.

5.4.3 **Intermediate Sanctions**

5.4.3.1 The State may impose any or all of the intermediate sanctions described in this Section of the Contract if the State determines that the Contractor has violated any of the provisions enumerated below. The State may impose any or all of the sanctions as described in this Section 5.4 of the Contract to the extent authorized by Federal and State law.

5.4.3.2 The State may impose intermediate sanctions on the Contractor simultaneously with the development and implementation of a CAP or DCAP if the deficiencies are severe and/or numerous.

5.4.3.3 In accordance with 42 CFR 438.700, the State may impose intermediate sanctions if it determines that the Contractor acted or failed to act as follows:

5.4.3.3.1 Fails substantially to provide Medically Necessary services that the Contractor is required to provide, under law or under this Contract, to a member covered under the Contract.

5.4.3.3.2 Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

5.4.3.3.3 Acts to discriminate among members on the basis of their health status or need for Health Care Services. This includes Contractor-initiated Transfers or refusal to re-Enroll a client, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment by clients whose medical condition or history indicates probable need for substantial future Health Care Services.

5.4.3.3.4 Misrepresents or falsifies information that it furnishes to CMS or to the State.

5.4.3.3.5 Misrepresents or falsifies information that it furnishes to a member, potential member, or health care provider.

5.4.3.3.6 Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 42 CFR 422.210, or Medicaid as set forth in section 3.11.6 .

5.4.3.3.7 Distributes directly or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information.

5.4.3.3.8 Violates any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations.

5.4.3.3.9 Violates any of the requirements of this Contract.

5.4.3.4 In accordance with 42 CFR 438.702 and 42 438.704, for any of the violations specified in Section 5.4.3.3 of this Contract, above, the State may impose the following intermediate sanctions:

5.4.3.4.1 Civil money penalties in the maximum amounts specified herein:

5.4.3.4.1.1 Up to $25,000 for each determination for violations under Sections 5.4.3.3.1, 5.4.3.3.5, 5.4.3.3.6, or 5.4.3.3.7 of this Contract, above;

5.4.3.4.1.2 Up to $100,000 for each determination for violations under Sections 5.4.3.3.3 or 5.4.3.3.4 of this Contract, above;

5.4.3.4.1.3 Up to $15,000 per each client or member for the violation in Section 5.4.3.3.3 of this Contract above subject to an overall limit of $100,000; and

5.4.3.4.1.4 Up to $25,000 or double the amount of the excess charges, whichever is greater, for violation of Section 5.4.3.3.3 of this Contract, above.

5.4.3.4.1.5 For premiums or charges in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty is $25,000 or double the amount of the excess charges, whichever is greater. The State must deduct from the penalty the amount of overcharge and return it to the affected members.

5.4.3.4.2 Appointment of temporary management for the Contractor (see Section 5.4.3.6 of this Contract, below).

5.4.3.4.3 Granting members the right to Transfer without cause and notifying the affected members of their right to Transfer.

5.4.3.4.4 Suspension of all new Enrollment, including default Enrollment, after the date the Secretary or the State notifies the Contractor of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

5.4.3.4.5 Suspension of payment for members Enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

5.4.3.4.6 Actual damages incurred by the State and/or members resulting from the Contractor's non-compliance.

5.4.3.4.7 Damages in an amount equal to the costs of obtaining alternative benefits for a member in the event of the Contractor's non-compliance in providing Covered Services. The sanctions shall include the difference in the capitated rates paid to the non-compliant Contractor and the rates paid to the replacement Contractor, if the non-compliance results in Transfer of members to another Contractor.

5.4.3.4.8 Additional sanctions permitted under Federal or State law.

5.4.3.5 Suspension of New Enrollment

5.4.3.5.1 Whenever the State determines that the Contractor is failing to meet performance standards, it may suspend Enrollment in the Contractor's MCO. The State, when exercising this option, shall notify the Contractor in writing of its intent to suspend new Enrollment. The suspension period may be for any length of time specified by the State, or may be indefinite. The State also may notify the Contractor's members of Contractor non-performance and permit the Contractor's members to Transfer to another MCO immediately without cause.

5.4.3.6 Temporary Management

5.4.3.6.1 As specified in 42 CFR 438.706(a), the State may impose temporary management only if it finds that:

5.4.3.6.1.1 There is continued egregious behavior by the Contractor, including but not limited to behavior that is described in 42 CFR 438.700 (see Section 5.4.3.3 of this Contract), or that is contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act;

5.4.3.6.1.2 There is substantial risk to members' health; or

5.4.3.6.1.3 The sanction is necessary to ensure the health of the Contractor's members (i) while improvements are made to remedy violations under 42 CFR 438.700; or (ii) until there is an orderly termination or reorganization of the Contractor.

5.4.3.6.2 In accordance with 42 CFR 438.706(b), the State must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a Contractor has repeatedly failed to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act, or of 42 CFR 438.706. The State must also grant members the right to terminate Enrollment without cause, as described in 42 CFR 438.702(a)(3), and must notify the affected members of their right to terminate Enrollment.

5.4.3.6.3 As specified in 42 438.706(c), the State may not delay imposition of temporary management to provide a hearing before imposing this sanction.

5.4.3.6.4 In accordance with 42 CFR 438.706(d), the State may not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not recur.

5.4.3.7 Termination of the Contract

5.4.3.7.1 In addition to the termination provisions in Section 5.12 of this Contract, in accordance with 42 CFR 438.708, the State may terminate this Contract and enroll the Contractor's members in other MCOs or provide their Medicaid benefits through other options included in the State Plan, if the State determines that the Contractor has failed to carry out the substantive terms of the Contract or failed to meet the applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social Security Act.

5.4.4 Notice of Intermediate Sanction

5.4.4.1 Except for the sanction described in Section 5.4.3.6 of this Contract, above (temporary management), before imposing any of the intermediate sanctions enumerated in Section 5.4.3 of this Contract, above, the State must give the Contractor timely written notice that explains the basis and nature of the sanction.

5.4.5 Pre-Termination Hearing

5.4.5.1 In accordance with 42 CFR 438.710(b), before terminating this Contract for failure to carry out the substantive terms of the Contract or failure to meet the applicable requirements in Sections 1932, 1903(m) or 1905(t) of the Social

Security Act (see Section 5.4.3.7 of the Contract, above), the State must provide the Contractor a pre-termination hearing. The State must do the following:

5.4.5.1.1 Give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;

5.4.5.1.2 After the hearing, give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination; and

5.4.5.1.3 For an affirming decision, give the Contractor's members notice of the termination and information on their options for receiving Medicaid/DHCP services following the effective date of termination.

5.4.5.2 After the State notifies the Contractor that it intends to terminate the Contract, the State may give the Contractor's members written notice of the State's intent to terminate the Contract and allow the Contractor's members to Transfer to another MCO immediately without cause.

5.4.6 **Sanction by CMS**

5.4.6.1 Payments provided for under this Contract will be denied for new members, when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

5.4.7 **Additional Monetary Sanctions**

5.4.7.1 In addition to other monetary and non-monetary sanctions and remedies to the State, the State may, in its discretion, impose monetary sanctions in accordance with the "Monetary Sanctions Chart" below (Section 5.4.7.2 of this Contract).

5.4.7.2 Monetary Sanctions Chart

	Deficiency	**Monetary Sanction**
1.	Failure to comply with timely claims processing as described in Section 3.18.1 of this Contract	• $25,000 for the first month that the State determines that the Contractor is not in compliance with the timely claims processing requirements of Section 3.18.1 of this Contract • $50,000 per month for each month after the first month that the State determines that the Contractor is not in compliance with the timely claims processing requirements of Section 3.18.1 of this Contract

	Deficiency	Monetary Sanction
2.	Failure to comply with Encounter Data submission requirements in Section 3.18.4 of this Contract, including, but not limited to, timeliness and quality	• $50,000 per month, for each month that the State determines that the Contractor is not in compliance with any of the requirements of Section 3.18.4 of this Contract
3.	Failure to comply with the timeframes for developing and approving a plan of care for DSHP Plus LTSS members (see Section 3.7)	• $25,000 per month that the Contractor's performance is 80-94% • $50,000 per month that the Contractor's performance is less than 80%
4.	Failure to complete or comply with a CAP/DCAP	• $1,000 per calendar day for each day the CAP is late or deficient or the Contractor fails to comply with an approved CAP or a DCAP
5.	Failure to comply with the timeframe for resolving Grievances and Appeals required in Section 3.15 of this Contract	• $10,000 per month that the Contractor's performance is 75-94% • $25,000 per month that the Contractor's performance is less than 75%
6.	Failure to submit reports timely in accordance with Section 3.21 of this Contract	• Except as otherwise provided in Section 3.21.1 of this Contract regarding extensions, $500 per report, per calendar day
7.	Failure to submit accurate reports and/or properly formatted reports in accordance with Section 3.21 of this Contract	• Except as otherwise provided in Section 3.21.1 of this Contract (Contractor-identified errors), $1,000 per report
8.	Failure to fill key personnel vacancies within the timeframe specified in Section 3.20.1 of this Contract	• $1,000 per calendar day
9.	Failure to correct a Subcontractor's deficiency within the timeframe specified in Section 5.1.2 of this Contract.	• $1,000 per calendar day until the Subcontract is in compliance

	Deficiency	Monetary Sanction
10.	Failure to ensure that all data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH, such that it is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of member PHI (see Section 5.9.1.5 of this Contract and the Business Associate Agreement between the parties)	• $500 per member per occurrence, not to exceed $1.5 million per year for violations of an identical provision AND if the State deems credit monitoring and/or identity theft safeguards are needed to protect those members whose PHI was placed at risk by the 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
11.	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 Section 5.9.1.5 of this Contract and the Business Associate Agreement between the parties)	• $500 per member per occurrence, not to exceed $1.5 million for the same violation
12.	Failure to achieve NCQA accreditation within the specified timeframe or failure to maintain NCQA accreditation during the term of this Contract (see Section 3.13.8 of this Contract)	• $100,000
13.	Failure to meet the following standard on a quarterly basis: 95% of all dispensed outpatient drugs and devices are PDL drugs and devices	• $25,000 per quarter
14.	Failure to submit pharmacy Encounter Data for outpatient drugs and devices and physician-administered drugs that when invoiced to manufacturers for rebate at least 90% are collectable within 90 calendar days of manufacturer invoicing by the State and are not disputed by the manufacturer	• $25,000 per quarter
15.	Failure to report a deficiency that is later identified by the State	• Except as otherwise provided in Section 3.21.1 of this Contract, twice the amount otherwise applicable

	Deficiency	Monetary Sanction
16.	Failure to successfully conduct health risk assessments for at least 50% of the Contractor's members in accordance with Section 3.6.2.1.	• $10,000 per month that the Contractor's performance is 30-49% • $20,000 per month that the Contractor's performance is less than 30%

5.5 INSPECTION OF WORK PERFORMED

5.5.1 Access to Information

5.5.1.1 The State and/or its authorized representatives, and the Federal government and/or its authorized representatives, shall have access to the Contractor's medical information, quality of service information (including Grievance and Appeal Information) financial information, and other information related to performance of this Contract, including information from its Subcontractors and participating providers, in order to evaluate through inspection or other means, the quality, appropriateness, timeliness and cost of services performed under the Contract (see 42 CFR 434.6(a)(5)).

5.5.1.2 The State and/or representatives, and the Federal government (including but not limited to HHS and the U.S. Comptroller General) and/or its authorized representatives shall have access to any books, documents, papers, and records of the Contractor that are pertinent to this Contract for the purpose of making audits, examinations, excerpts, and transcriptions.

5.5.1.3 The State and/or representatives, and the Federal government (including but not limited to HHS and the U.S. Comptroller General) and/or its authorized representatives) have the right of timely and unrestricted access to any books, documents, papers, or other records of the Contractor that are pertinent to the Contract award, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to the Contractor's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

5.5.1.4 The Contractor agrees to maintain or to make available at a location within the State of Delaware, such records as are necessary or deemed necessary by the State to fully disclose and substantiate the nature and extent of items and services rendered to members or the Contractor's performance of other Contract requirements. All records shall be made available at once to authorized Federal or State representatives, including but not limited to MFCU, for the purpose of conducting audits to substantiate claims, costs, etc. or determining compliance with the Contract or Federal or State law. Further, all records shall be made available for inspection and reproduction.

5.5.2 Inspection of Premises

5.5.2.1 The State and/or its authorized representatives and the Federal government and/or its authorized representatives shall, during normal business hours, have the right to enter into the premises of the Contractor, including its Subcontractors and providers, or such other places where duties under the Contract are being performed, to inspect, monitor, audit, or otherwise evaluate the work being performed.

5.5.2.2 All inspections and evaluations shall be performed in such a manner as to not unduly delay the Contractor's performance of its duties.

5.5.3 Records Retention

5.5.3.1 The Contractor shall maintain such records as are necessary to disclose fully the extent of services provided under this Contract. This includes but is not limited to financial records, supporting documents and statistical records.

5.5.3.2 The Contractor must keep these records for ten years after the State makes final payment and all other pending matters (e.g., evaluations, audits, reviews, investigations, litigation or prosecutions) are closed. The Contractor shall retain records involving litigation for one year following the termination of such litigation.

5.5.3.3 The Contractor must have written policies and procedures for storing this information so that it can be easily retrieved if necessary as per the terms of this Contract.

5.6 DISPUTES

5.6.1 Waivers

5.6.1.1 No covenant, condition, duty, obligation, or undertaking contained in or made a part of the Contract shall be waived except by the written agreement of the parties. Forbearance or indulgence in any form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, conditions, duties, obligations, and undertakings to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other party shall have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings.

5.6.1.2 Waiver of any breach of any term or condition in the Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of the Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties thereto.

5.6.2 Severability

5.6.2.1 If any provision of the Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, invalid or void, then both the State and the Contractor shall be relieved of all obligations arising under such provision. However, if the remainder of the Contract is capable of being performed, it shall not be affected by such declaration or finding and those duties and tasks shall be fully performed. To this end, the provisions of the Contract are declared to be severable.

5.6.3 Legal Considerations

5.6.3.1 The Contract shall be governed and construed in accordance with the law of the State of Delaware.

5.6.3.2 The Contractor, by signing the Contract, agrees to submit to the jurisdiction of the courts of the State of Delaware and agree that venue for any legal proceeding against the State regarding the Contract shall be filed in a court of competent jurisdiction within the State of Delaware.

5.6.3.3 In the event that the State prevails when either party deems it necessary to take legal action to enforce any provision of the Contract, the Contractor shall pay all expenses of the litigation, including attorney fees and costs as assessed by the court. Any action against the State, including, but not limited to, actions either for breach of Contract or for enforcement of its provisions, or both, shall be commenced within three years from the date of completion specified in the Contract and shall be tried by a court sitting without a jury. All defenses in law or equity, except the defense of governmental immunity, shall be preserved to the State. Any further Appeal of the court's decision may be taken to the court of competent jurisdiction within the State of Delaware.

5.7 CONTRACT AMENDMENTS AND MODIFICATIONS

5.7.1 General

5.7.1.1 An approved Contract amendment is required whenever a change affects the general requirements, scope of work, payments to the Contractor, the terms and conditions or the term of the Contract. Formal Contract amendments will be negotiated by the State with the Contractor whenever necessary to effect changes to the general requirements, scope of work, payment to the MCO, terms and conditions, or the term of the Contract. An approved Contract amendment means one signed by the State and the Contractor and approved by all other applicable State and Federal agencies prior to the effective date of the amendment.

5.7.2 Changes in Law or Appropriation(s)

5.7.2.1 If Federal or State law or policy is adopted, promulgated, judicially interpreted or changes, or changes in Federal or State appropriation(s) or other circumstances require a change in the way the State manages its Medicaid program, this Contract shall be subject to modification by amendment. Such election shall be

effected by the State sending written notice to the Contractor. The State's decision as to the requirement for change in the scope of the Medicaid program shall be final and binding.

5.7.2.2 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., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), 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 Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If the state paid 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 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 Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

5.7.3 Modification Process

5.7.3.1 If the State seeks modification to the Contract, it shall provide notice to the Contractor that specifies those modifications, which may changes to general requirements, scope of work, payments to the Contractor, the terms and conditions or the term of the Contract.

5.7.3.2 The Contractor must respond to the State's notice of proposed modification within 10 business days of receipt unless otherwise provided by the State. If the Contractor fails to respond, the State shall consider the proposed modification(s) acceptable to the Contractor and shall implement the proposed modification(s) as soon as practicable. Upon receipt of the Contractor's response to the proposed modifications, the State may enter into negotiations with the Contractor to arrive at mutually agreeable amendments. In the event that the State determines that the Parties will be unable to reach agreement on mutually satisfactory modifications, then the State will provide written notice to the Contractor of its intent to terminate this Contract, or not to extend the Contract beyond the current term.

5.7.4 Option to Reduce Scope of Work

5.7.4.1 The State shall have the option at its sole discretion to consider the Contract, or any task or sub-task thereof, completed before all of said task or sub-tasks have been performed, whenever in the judgment of the Program Manager, based upon results of work already performed, the goals of the Contract have been

successfully achieved, or can be successfully achieved through a reduced scope of work. In such event, the State may reduce the scope of work for any task, sub-tasks or portions thereof by written notice to the Contractor.

5.7.4.2 Upon receipt of such notification, the Contractor will submit to the Program Manager within five business days an itemization of the work already completed (by task, or sub-task) and the work which will be required (by task or sub-task) to complete the affected tasks or sub-tasks in accordance with said notification. Upon approval of the proposed work effort by the State, the Contractor shall complete the Contract in accordance with said approval. The Contractor shall be compensated in accordance with the applicable portions ofAddendum 2, Capitation Rates.

5.7.5 **Suspension of Work**

5.7.5.1 The Program Manager may at any time for valid reason direct the Contractor to suspend work under the Contract for a specific period of time. Such order shall be given by at least 10 business days' notice in writing, and shall specify the period during which work shall be stopped. The Contractor shall be paid up until the stop order, but subsequent payments shall be held in abeyance until final decisions regarding the Contract are made. Any permanent Contract termination shall be in accordance with Section 5.12 of this Contract.

5.7.5.2 The Contractor (unless the Contract is terminated) shall resume work upon the date specified in the stop work order or upon such other date as the Program Manager may thereafter specify in writing. The period during which work shall have been stopped shall be deemed added to any applicable approved schedule of contract performance. Stoppage of work under this Section of the Contract shall not, however, be construed as extending the term of the Contract, and shall not give rise to any claim against the State.

5.7.5.3 All prices negotiated during the RFQ process for this Contract must remain firm during the entire term of the Contract, including any extensions, notwithstanding the level of effort dictated by the State or the level of available funding.

5.8 INDEMNIFICATION

5.8.1 The Contractor shall indemnify, defend, protect, and hold harmless the State of Delaware and any of its officers, agents, and employees, and DSHP and DSHP Plus members and their eligible dependents from:

5.8.1.1 Any claims, damages or losses arising from services rendered by the Contractor, any Subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract;

5.8.1.2 Any claims, damages or losses to any person or firm and/or property injured or damaged by erroneous, negligent or willful acts, including disregard of State or

Federal law, by the Contractor, its officers, agents, employees, or Subcontractors in the performance of the Contract;

5.8.1.3 Any claims, damages or liability resulting to any person or firm injured or damaged by the Contractor, its officers, agents, employees, participating providers or Subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Contract in a manner not authorized by the Contract or by Federal or State law;

5.8.1.4 Any failure of the Contractor, its officers, employees, participating providers or Subcontractors to observe Federal or State law, including, but not limited to, labor law and minimum wage law;

5.8.1.5 Any claims, damages, or liability resulting from Contractor insolvency, inability or failure to pay its officers, agents, employees, providers or Subcontractors, or any other person or firm furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract;

5.8.1.6 Any claims, damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of the State in connection with the defense of claims for such injuries, losses, claims, or damages specified above.

5.8.2 Before delivering services under this Contract, the Contractor shall provide adequate demonstration to the State that insurance protections necessary to address each of the above risk areas are in place. Except as otherwise provided in this Contract (see Section 3.17) the Contractor may elect to self-insure any portion of the risk assumed under the provision of this Contract based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse financial actions, including withholding of payment or imposition of monetary sanctions by the State.

5.8.3 The Contractor shall ensure that no member is held liable for any the following:

5.8.3.1 The Contractor's debts, in the event of the Contractor's insolvency.

5.8.3.2 Covered Services provided to the member, for which the State does not pay the Contractor.

5.8.3.3 Covered Services or additional services, set forth in 3.4.8 provided to the member, for which the State or the Contractor does not pay the provider that furnished the services.

5.8.3.4 For any payment in excess of cost sharing or patient liability responsibilities specified in this Contract.

5.8.3.5 For payments for Covered Services to the extent that those payments are in excess of the amount that the member would owe if the Contractor covered the services directly.

5.9 CONFIDENTIALITY, PRIVACY, AND SECURITY

5.9.1 Access to Confidential Information

5.9.1.1 The State and the Contractor shall sign documents, including, but not limited to, business associate agreements, as required by HIPAA and HITECH. The Contractor shall comply with the requirements of those signed documents as well as all applicable requirements of HIPAA and HITECH.

5.9.1.2 The Contractor shall protect all information, records, and data collected in connection with the Contract from unauthorized disclosures. In addition, the Contractor shall agree to guard the confidentiality of client/member information. Access to all individually identifiable information relating to Medicaid members that is obtained by the Contractor shall be limited by the Contractor to persons or agencies that require the information in order to perform their duties in accordance with this Contract, and to such others as may be authorized by the State in accordance with applicable law.

5.9.1.3 Any other party shall be granted access to confidential information only after complying with the requirements of State and Federal law pertaining to such access. The State shall have absolute authority to determine if and when any other party has properly obtained the right to have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify particular individuals. The Contractor shall retain the right to use information for its QM/QI and UM and research purposes subject to the data ownership and publicity requirements defined within the Contract.

5.9.1.4 The Contractor must have written policies and procedures for maintaining the security and confidentiality of data, including medical records/member information and adolescent/sexually transmitted disease appointment records. All member information, medical records, data and data elements collected, maintained, or used in the administration of this Contract shall be protected by the Contractor from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E. The Contractor must provide safeguards that restrict the use or disclosure of protected health information (PHI) concerning members to purposes directly connected with the administration of this Contract.

5.9.1.5 The Contractor must comply with HIPAA notification requirements, including those set forth in HITECH. The Contractor must notify the State of all breaches or potential breaches of unspecified PHI, as defined by HITECH, without unreasonable delay and in no event later than 30 calendar days after discovery of

the breach or potential breach. If, in the State's determination, the Contractor has not provided notice in the manner or format prescribed by HITECH, then the State may require the Contractor to provide such notice.

5.9.2 **Assurance to Confidentiality**

5.9.2.1 The Contractor shall take reasonable steps to ensure the physical security of data under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data; limited terminal access; limited access to input documents and output documents; and design provisions to limit use of member or client names.

5.9.2.2 The Contractor shall inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the State and Federal law relating to confidentiality.

5.9.3 **Return of Confidential Data**

5.9.3.1 The Contractor shall return all personal data furnished pursuant to this Contract promptly at the request of the State in whatever form it is maintained by the Contractor. Upon the termination or completion of the Contract, the Contractor may not use any such data or any material derived from the data for any purpose not permitted by State or Federal law or regulation and where so instructed by the State must destroy such data or material if permitted by State or Federal law or regulation.

5.9.4 **State Assurance of Confidentiality**

5.9.4.1 The State agrees to comply with Federal and State law regarding confidentiality to protect member and provider information, to the extent permissible under the Delaware Freedom of Information Act, 29 *Del. C.* § 10001 et seq.

5.9.5 **Publicizing Safeguarding Requirements**

5.9.5.1 The Contractor shall comply with 42 CFR 431.304. The Contractor agrees to publicize provisions governing the confidential nature of information about clients and members, including the legal sanctions imposed for improper disclosure and use. The Contractor must include these provisions in the member handbook and provide copies of these provisions to clients and members and to other persons and agencies to which information is disclosed.

5.10 EMPLOYMENT PRACTICES

5.10.1 Designation of persons for each key staff position is subject to review and approval by the State. If a staff person can no longer perform services under this Contract for what are now unforeseeable circumstances, the Contractor will notify the State immediately and work out a transition plan that is acceptable to both parties, as well as agree to an acceptable replacement plan to fill or complete the work assigned to this staff position. Replacement staff persons are subject to review and approval by the State. If the Contractor fails to make a required replacement as specified in Section 3.20.1 of this Contract, the State may terminate this Contract for default. Upon receipt of written notice from the State that an employee of the Contractor is unsuitable to the State for good cause, the Contractor shall remove such employee from the performance of services under this Contract and substitute in his/her place a suitable employee.

5.10.2 The Contractor shall furnish to the State's Program Manager copies of all correspondence to regulatory agencies for review prior to mailing such correspondence.

5.10.3 The Contractor agrees that its officers and employees will cooperate with the State in the performance of services under this Contract and will be available for consultation with the State at such reasonable times with advance notice as to not conflict with their other responsibilities.

5.10.4 The Contractor has or will retain such employees as it may need to perform the services required by this Contract. Such employees shall not be employed by the State or any other political subdivision of the State.

5.10.5 Except as the other party expressly authorizes in writing in advance, neither party shall solicit, offer work to, employ, or contract with, whether as a partner, employee or independent contractor, directly or indirectly, any of the other party's personnel during their participation in the services or during the 12 months thereafter. For purposes of this Section of the Contract, personnel includes any individual or company a party employs as a partner, employee or independent contractor and with which a party comes into direct contact in the course of the services.

5.10.6 Possession of a Security Clearance, as issued by the Delaware Department of Public Safety, may be required of any employee of the Contractor who will be assigned to this Contract.

5.10.7 All of the Contractor staff working on this Contract will be subject to a Criminal Background Check (CBC). The Contractor shall be solely responsible for the cost of the CBC. The State will review the CBC results. The State at its sole discretion may request that a Contractor staff member be replaced if his/her CBC result is unsatisfactory.

5.10.8 As specified by the State, Contractor staff working on this Contract shall fill out DTI's Acceptable Use Policy, Biggs Data Center User Authorization Form, and the Biggs Data Center Non-Disclosure Agreement for necessary authorizations before starting work. Staff working at a secured State site will be issued a security access card by the State as per the State Standard.

5.10.9 The Contractor will not use the State's name, either express or implied, in any of its advertising or sales materials without the State's express written consent. The Contractor will not use the State Seal in violation of 29 *Del. C.* § 2306.

5.10.10 **Compliance with Existing Employment Law**

5.10.10.1 The Contractor shall comply with Federal and State requirements relating to fair employment practices, to the extent applicable and agrees further to include a similar provision in any and all provider participation agreements and Subcontracts. The Contractor shall agree to comply with all existing Federal employment law, including, but not limited to:

5.10.10.1.1 Title VI and VII of the Civil Rights Act of 1964, as amended (42 USC 2000d and 42 USC 2000e) and regulations issued pursuant thereto;

5.10.10.1.2 The Civil Rights Act of 1991, as amended (42 USC 1981 et seq.), and regulations issued pursuant thereto;

5.10.10.1.3 Executive Order 11246, entitled "Equal Employment Opportunity", as amended, and regulations issued pursuant thereto;

5.10.10.1.4 Sections 503 and 504 of the Rehabilitation Act of 1973 (29 USC 793 and 29 USC 794), and regulations issued pursuant thereto;

5.10.10.1.5 Title IX of the Education Amendments of 1973, as amended (20 USC 1681 et seq.), and regulations issued pursuant thereto;

5.10.10.1.6 The Age Discrimination Act of 1975, as amended (42 USC 6101 et seq.), and regulations issued pursuant thereto;

5.10.10.1.7 The Vietnam Era Veterans Readjustment Assistance Act, as amended (43 USC 4301 et seq.), and regulations issued pursuant thereto;

5.10.10.1.8 The Hatch Political Activity Act (53 Stat 1147), and regulations issued pursuant thereto;

5.10.10.1.9 The Drug-Free Workplace Act of 1988 (PL 100-690 (41 USC 701 et seq.), and regulations issued pursuant thereto;

5.10.10.1.10 The Americans with Disabilities Act of 1990 (PL 101-336), as amended, and any regulations issued pursuant thereto; and

5.10.10.1.11 Any and all State and Federal non-discrimination laws.

5.10.11 **Employment of State Personnel**

5.10.11.1 The Contractor shall not knowingly engage on a full-time, part-time, or other basis, during the period of the Contract, any professional or technical personnel who are, or have been at any time during the period of this Contract, State employees, except those regularly retired individuals, without prior written approval from the State.

5.10.12 **Independent Nature of Contractor Personnel**

5.10.12.1 The Contractor shall act in an independent capacity and not as an agent, officer, employee, partner, or associate of the State of Delaware. The Contractor's staff will not hold themselves out as nor claim to be officers or employees of the State of Delaware. This provision applies to all Subcontractors as well. 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 State.

5.11 NONDISCRIMINATION

5.11.1 The Contractor shall not, on the grounds of race, ethnicity, color, sex, religion, national origin, creed, marital status, age, Vietnam era or disabled veteran status, income level, gender identity or the presence of any sensory, mental or physical handicap, or any other status protected by Federal or State law:

5.11.1.1 Deny any individual any Covered Services or other benefits provided under the Contract.

5.11.1.2 Provide any Covered Services or other benefits to an individual that are different, or are provided in a different manner from those provided to others under the Contract.

5.11.1.3 Subject an individual to unlawful segregation, separate treatment, or discriminatory treatment in any manner related to the receipt of any Covered Service or other benefits provided under the Contract.

5.11.1.4 Deny any individual an opportunity to participate in any program provided by the Contract through the provision of Covered Services or otherwise, or afford an opportunity to do so that is different from that afforded others under the Contract.

5.12 TERMINATION

5.12.1 The Contract may be terminated for the following reasons:

5.12.1.1 Default

5.12.1.1.1 The State may terminate the Contract, in whole or in part, whenever it determines that the Contractor, including any Subcontractor, has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable or unwilling to cure such failure within 60 calendar days (or a period of time as specified in writing by the Program Manager), taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

5.12.1.1.2 Upon determination by the State that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, return receipt requested, of the failure and of the time period that has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the State will notify the Contractor that the Contract, in full or in part, has been terminated for default.

5.12.1.1.3 If, after notice of termination for default, it is determined by the State or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of, and without error or negligence on the part of, the Contractor, the notice of termination shall be deemed to have been issued as a termination for the convenience of the State, and the rights and obligations of the parties shall be governed accordingly.

5.12.1.1.4 In the event that the State elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail either 30 calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of termination. Termination shall be effective as of the close of business on the date specified in the notice.

5.12.1.1.5 In the event of termination for default, in full or in part as provided under this clause, the State may cover, upon such terms and in such manner as is deemed appropriate by the State, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies or services and all other damages allowed by law. In addition, the Contractor shall be liable to the State for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. Payment for such costs may be assessed against the Contractor's performance bond or substitute security approved by the State.

5.12.1.1.6 In the event of a termination for default, the Contractor shall be paid for any outstanding monies due less any assessed sanctions in accordance with Section 5.4 of this Contract. If sanctions exceed monies due from invoices, collection can be made from the Contractor's performance bond or substitute security approved by the State.

5.12.1.1.7 The rights and remedies of the State provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

5.12.1.2 Unavailability of Funds

5.12.1.2.1 In the event that funding from State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of the Contract and prior to the anticipated Contract expiration date, the State may terminate the Contract under the termination for convenience clause.

5.12.1.2.2 In the event that the State elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail, either 30 calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of termination. Termination shall be effective as of the close of business on the date specified in the notice.

5.12.1.2.3 In the event of a termination for unavailability of funds, the Contractor shall be paid any outstanding monies due less any assessed sanctions in accordance with Section 5.4 of this Contract.

5.12.1.3 Financial Instability

5.12.1.3.1 In the event that the Contractor becomes financially unstable to the point of threatening the ability of the State to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this Contract effective the close of business on the date specified.

5.12.1.3.2 In the event that the State elects to terminate the Contract under this provision, the Contractor shall be notified in writing by either certified or registered mail either 30 calendar days prior to or such other reasonable period of time prior to the effective date, of the basis and extent of termination. Termination shall be effective as of the close of business on the date specified in the notice. In the event of the filing of a petition in bankruptcy by or against a principal Subcontractor, the Contractor shall immediately so advise the Program Manager. The Contractor shall ensure that all tasks related to the Subcontract are performed in accordance with the terms of this Contract.

5.12.1.3.3 In the event of a termination for financial instability, the Contractor shall be paid for any outstanding monies due less any assessed sanctions in accordance with Section 5.4 of this Contract.

5.12.1.4 Convenience

5.12.1.4.1 The State may terminate, upon 60 calendar days advance written notice, performance of work under this Contract in whole or in part, whenever, for any reason, the State determines that such termination is in its best interest.

5.12.1.4.2 Termination for convenience includes termination as a result of the expiration of this Contract, including expiration resulting from the State not electing to extend the term of this Contract pursuant to Section 5.2.6 of this Contract.

5.12.1.4.3 In the event that the State terminates this Contract for convenience, other than for expiration of this Contract, the Contractor shall have the right to assert a claim for the Contractor's direct termination costs in accordance with Section 5.12.5 of this Contract. Such claim must be delivered to the State and asserted within three months of the date of termination for convenience, or, in the event the termination was originally issued under the provisions for termination for default, three months from the date the notice of termination was deemed to have been issued. The three month period may be extended if the Contractor makes a written request to the Program Manager, and the Program Manager or the Medicaid Director deems the grounds for the request to be reasonable. The State will notify the Contractor of the decision within 60 calendar days of the receipt of the claim.

5.12.1.4.4 Upon receipt of notice of termination of convenience, the Contractor shall be paid as provided by Section 5.12.1.1 of this Contract.

5.12.1.5 Mutual Agreement

5.12.1.5.1 Under mutual agreement, the State and the Contractor may terminate this Contract for any reason if it is in the best interest of both parties. Both parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination, and the extent to which performance of work under this Contract is terminated.

5.12.1.5.2 In the event of a termination by mutual agreement, the Contractor shall be paid for any outstanding monies due less any assessed sanctions in accordance with Section 5.4 of this Contract.

5.12.2 **Notification of Members**

5.12.2.1 In the event that the Contract is terminated for any of the reasons outlined above, or in the event that the Contract is not renewed for any reason, the State will be responsible for notifying all members covered under the Contract of the date of termination and the process by which those members will continue to receive Medicaid/DHCP benefits/services.

5.12.3 **Refunds of Advance Payments**

5.12.3.1 The Contractor shall return within 30 calendar days of receipt any funds advanced for coverage of members for periods after the date of termination.

5.12.4 **Liability for Medical Claims**

5.12.4.1 The Contractor shall be liable for all claims for Covered Services and additional services,set forth in section 3.4.8, incurred up to the date of termination of this Contract. This shall include all charges for hospital inpatient claims incurred for members hospitalized at the time of termination up to and including the date of discharge.

5.12.5 **Termination Procedures**

5.12.5.1 The State shall render written notice of termination to the Contractor by certified mail, return receipt requested; registered mail, return receipt requested; or in person with proof of receipt. The notice of termination shall specify the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective.

5.12.5.2 Upon termination or expiration, the State shall pay the Contractor all amounts due for service from the Start Date of Operations through the effective date of such termination. The State may deduct from amounts otherwise payable to the Contractor monies due to the State from the Contractor. Any amounts in dispute at the time of termination shall be placed by the State in an interest-bearing

escrow account with an escrow agent mutually agreed to by the State and the Contractor.

5.12.5.3 Upon receipt of notice of termination, and subject to the provisions of this Section of the Contract, on the date and to the extent specified in the notice of termination, the Contractor shall:

5.12.5.3.1 Not incur additional financial obligations for materials, services or facilities under this Contract, without prior written approval of the State;

5.12.5.3.2 Terminate all purchase orders or procurements and Subcontracts and stop all work to the extent specified in the notice of termination, except as the State may direct for orderly completion and transition or as required to prevent the Contractor from being in breach of its existing contractual obligations;

5.12.5.3.3 At the point of termination, assign to the State in the manner and extent directed by the State all the rights, title and interest of the Contractor in the Subcontracts, in which case the State shall have the right, in its discretion, to settle or pay any of the claims arising out of the termination of such agreements and Subcontracts;

5.12.5.3.4 Complete the performance of such part of the Contract that shall have not been terminated under the notice of termination;

5.12.5.3.5 Take such action as may be necessary, or as the State may direct, for the protection of property related to this Contract that is in possession of the Contractor and in which the State has or may acquire an interest;

5.12.5.3.6 In the event the Contract is terminated by the State, continue to serve or arrange for provision of services to the members in the Contractor's MCO for up to 45 calendar days from the Contract termination date or until the members can be Transferred to another MCO, whichever is longer. During this transition period, the State shall continue to make payments as specified in Section 5.12.5.2 of this Contract;

5.12.5.3.7 Promptly make available to the State, or its designated entity, any and all records, whether medical, behavioral, related to long term services and supports or financial, related to the Contractor's activities undertaken pursuant to this Contract. Such records shall be in a usable form and shall be provided at no expense to the State or its designated entity;

5.12.5.3.8 Promptly supply all information necessary to the State or its designated entity for reimbursement of any outstanding claims at the time of termination;

5.12.5.3.9 Submit a termination plan to the State for review, which is subject to the State's written approval. This plan shall, at a minimum, contain the provisions in Sections 5.12.5.3.10 through 5.12.5.3.15 of this Contract, below. The Contractor shall agree to make revisions to the plan as necessary in order to obtain approval by the State. Failure to submit a termination plan and obtain written approval of the termination plan by the State shall result in the withhold of 10% of the Contractor's monthly Capitation Payment;

5.12.5.3.10 Agree to maintain claims processing functions as necessary for a minimum of 12 months in order to complete adjudication of all claims;

5.12.5.3.11 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Contract, including, but not limited to, the Grievance and Appeal process as described in Section 3.15 of this Contract;

5.12.5.3.12 File all reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;

5.12.5.3.13 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of members from coverage under this Contract to coverage under any new arrangement developed by the State;

5.12.5.3.14 In order to ensure that the Contractor fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in Section 3.17 of this Contract as of the Contractor's date of termination notice), until the State provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled; and

5.12.5.3.15 Upon expiration or termination of this Contract, submit reports to the State every 30 calendar days detailing the Contractor's progress in completing its continuing obligations under this Contract. The Contractor, upon completion of these continuing obligations, shall submit a final report to the State describing how the Contractor has completed its continuing obligations. The State shall within 20 calendar days of receipt of this report advise in writing whether the State agrees that the Contractor has fulfilled its continuing obligations. If the State finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, then the

State shall require the Contractor to submit a revised final report. The State shall in writing notify the Contractor once the Contractor has submitted a revised final report evidencing to the satisfaction of the State that the Contractor has fulfilled its continuing obligations.

5.12.5.3.16 Notwithstanding any other provision of this Contract, upon termination for any reason, the State will pay the Contractor that portion of the compensation that has been earned as of the effective date of termination but:

5.12.5.3.16.1 No amount shall be allowed for anticipated profit on unperformed services, and

5.12.5.3.16.2 Any payment due to the Contractor at the time of termination may be adjusted to the extent of any additional costs occasioned to the State by reason of the Contractor's default.

5.12.5.3.17 Upon termination for default, the State may take over the work and prosecute the same to completion by agreement with another party or otherwise. In the event the Contractor shall cease conducting business, the State shall have the right to make an unsolicited offer of employment to any employees of the Contractor assigned to the performance of the Contract, notwithstanding the provisions of Section 5.10 of this Contract.

5.13 MERGER/ACQUISITION REQUIREMENTS

5.13.1 General

5.13.1.1 In addition to any other information otherwise required by the State, the Contractor that intends to merge with or be acquired by another entity (and therefore becomes the "non-surviving contractor") shall provide the following information and documents to the State 120 calendar days prior to the effective date of the merger/acquisition:

5.13.1.1.1 The basic details of the sale, including the name of the acquiring legal entity, the date of the sale and a list of all owners with 5% or more ownership.

5.13.1.1.2 The source of funds for the purchase.

5.13.1.1.3 A Certificate of Authority modification, if applicable.

5.13.1.1.4 Any changes in the provider network, including, but not limited to, a comparison of hospitals that no longer will be available under the new network, and comparison of PCPs and specialists participating and not participating in the network. This shall also include an analysis of the impact on members.

5.13.1.1.5 A draft of the asset purchase agreement to the State for approval prior to the execution of the document.

5.13.1.1.6 The closing date for the merger/acquisition, which shall occur prior to the required notification to members.

5.13.1.1.7 All information, including all financials, sent to/required by the State.

5.13.1.1.8 Plan to meet and complete all outstanding issues, reporting requirements (including, but not limited to, Encounter Data reporting, QM/QI studies, financial reports, etc.).

5.13.2 **Member Notification**

5.13.2.1 By no later than 75 calendar days, the non-surviving contractor shall prepare and submit, in English and Spanish, to the State, letters and other materials which shall be mailed to its members no later than 60 calendar days prior to the effective date of Transfer in order to assist them in making an informed decision about their health and needs. Such letters shall not be mailed until the State has provided written approval that the provider network information meets all State requirements. The letter must contain the following, at a minimum:

5.13.2.1.1 From the non-surviving contractor:

5.13.2.1.1.1 The basic details of the sale, including the name of the acquiring legal entity, and the date of the sale.

5.13.2.1.1.2 Any major changes in the provider network, including at minimum a comparison of hospitals that no longer will be available under the network, if that is the case.

5.13.2.1.1.3 For each member, a representation whether that individual's PCP under the non-surviving contractor's MCO will be available under the acquiring contractor's MCO. When the PCP is no longer available under the acquiring contractor's MCO, the member shall be advised to call the HBM to see what other MCO the PCP participates in.

5.13.2.1.1.4 Information on members in treatment plans and the status of any continuing Covered Services being rendered under the non-surviving contractor's MCO, how that treatment will

continue, and timeframes for transition from the non-surviving contractor's MCO to the acquiring contractor's MCO.

5.13.2.1.1.5 Any changes in the benefits or procedures between the non-surviving contractor's MCO and the acquiring contractor's MCO, including for example, additional services and referral procedures, etc.

5.13.2.1.1.6 Toll free telephone numbers for the HBM and the acquiring entity where members' questions can be answered.

5.13.2.1.1.7 A timeframe of not less than 14 calendar days for the member to make a decision about staying in the acquiring contractor's MCO, or switching to another MCO. The timeframe must incorporate the monthly cut-off dates established by the State for the timely and accurate production of identification cards.

5.13.2.1.2 From the acquiring contractor:

5.13.2.1.2.1 If the acquiring contractor wishes to send welcome letters, it shall submit for prior approval to the State, all welcome letters and information it will send to the new members no later than 30 calendar days prior to the effective date of Transfer.

5.13.2.1.2.2 The acquiring contractor may not, either directly or indirectly, contact the members of the non-surviving contractor prior to the members' conversion.

5.13.2.1.2.2.1 The Contractor shall re-send any returned mail two additional times. If the mail to a member is returned three times, the Contractor shall submit the name, the Medicaid identification number and last known address to the State for research to determine a more current address.

5.13.2.1.3 *Provider Notification*

5.13.2.1.3.1 By no later than 90 calendar days prior to the effective date of Transfer, the non-surviving contractor shall notify its providers of the pending sale or merger, and of hospitals, specialists and laboratories that will no longer be participating as a result of the merger/acquisition.

5.13.2.2 Marketing/Outreach

5.13.2.2.1 The acquiring contractor may not make any unsolicited home visits or telephone calls to members of the non-surviving contractor before the effective date of coverage under the acquiring Contractor's MCO.

5.13.2.2.2 Coincident with the date that member notification letters are sent to those members affected by the merger/acquisition, the non-surviving contractor shall no longer be offered as an option to either new members or to those seeking to Transfer from other MCOs. The State shall approve all member notification letters, and they shall be mailed by the non-surviving contractor.

5.13.3 **Provider Network**

5.13.3.1 The acquiring contractor shall supply letters to go out to members 60 calendar days prior to Transfer to the State and an updated provider network 90 calendar days prior to the effective date of Transfer and monthly thereafter. Additionally, the acquiring contractor shall furnish to the State individual provider capacity analyses and how the provider/member ratio limits will be maintained in the new entity. This network information shall be furnished before the member notification letters are to be sent. Such letters shall not be mailed until there is a clear written notification by the State that the provider network information meets all of the State requirements. The network submission shall include all required provider types covered by this Contract and shall include a list of all providers who decline participation with the acquiring contractor and new providers who will participate with the acquiring contractor. The acquiring contractor shall submit weekly updates through the 90 day period following the effective date of Transfer.

5.13.4 **Administrative**

5.13.4.1 The non-surviving contractor shall inform the State of the corporate structure it will assume once all members are transitioned to the acquiring contractor. Additionally, an indication of the timeframe that this entity will continue to exist shall be provided.

5.13.4.2 The contract of the non-surviving contractor is not terminated until the transaction (acquisition or merger) is approved, members are placed, and all outstanding issues with the State are resolved. Some infrastructure shall exist for up to one year beyond the last date of services to members in order to fulfill contractual requirements.

5.13.4.3 The acquiring contractor and the non-surviving contractor shall each maintain its own separate administrative structure and stuff until the effective date of Transfer.

5.14 OTHER CONTRACT TERMS AND CONDITIONS

5.14.1 **Independent Contractor**

5.14.1.1 The Contractor recognizes that it is operating as an independent Contractor and that it is liable for any and all losses, penalties, damages, sanctions, expenses, attorney's fees, judgments, and/or settlements incurred by reason of injury to or

death of any and all persons, or injury to any and all property, of any nature, arising out of the Contractor's negligent performance under this Contract, and particularly without limiting the foregoing, caused by, resulting from, or arising out of any act of omission on the part of the Contractor in its negligent performance under this Contract.

5.14.1.2 The Contractor acknowledges that the Contractor and any Subcontractors, agents or employees employed by the Contractor shall not, under any circumstances, be considered employees of the State, and that they shall not be entitled to any of the benefits or rights afforded employees of the State, including, but not limited to, sick leave, vacation leave, holiday pay, Public Employees Retirement System benefits, or health, life, dental, long term disability or worker's compensation insurance benefits. The State will not provide or pay for any liability or medical insurance, retirement contributions or any other benefits for or on behalf of the State or any of its officers, employees or other agents.

5.14.1.3 The Contractor shall be responsible for providing liability insurance for its personnel.

5.14.1.4 As an independent contractor, the Contractor has no authority to bind or commit the State. Nothing herein shall be deemed or construed to create a joint venture, partnership, fiduciary or agency relationship between the parties for any purpose.

5.14.2 **Conflict of Interest**

5.14.2.1 No official or employee of the State of Delaware or the Federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the Contract or the enrollment processes specified in 42 CFR 438.54(b) shall voluntarily acquire any personal interest, direct or indirect, in the Contract. All State employees shall be subject to the provisions governing conflicts of interest.

5.14.2.2 The Contractor shall represent and covenant 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 under the Contract. The Contractor further covenants that, in the performance of the Contract, no person having any such known interests shall be employed.

5.14.2.3 In accordance with 42 CFR 438.604(a)(6), the Contractor shall disclose information on individuals, entities, or corporations with an ownership or control interest in the MCO (as described in 42 CFR 455.104) and any Subcontractors to the State at the following times:

(i) When the MCO submits a proposal in accordance with the state's procurement process
(ii) When the MCO executes a contract with the state,
(iii) When the state renews or extends the MCO contract, and
(iv) Within 36 days after any change in ownership of the MCO.

5.14.2.4 This contract may be terminated by the State if it is determined that the Contractor, its officers, agents, employees, or Subcontractors offered or gave wages, compensation, gratuities or gifts of any kind to any officials or employees of the State of Delaware. The Contractor certifies that no member of or delegate to Congress, or employee of any Federal agency has or will benefit financially or materially from this Contract.

5.14.2.5 In the event that the Contract is terminated under this Section of the Contract, the State shall be entitled to pursue the same remedies against the Contractor as it could pursue in the event of a breach of the Contract by the Contractor. The rights and remedies provided for in this Section of the Contract are in addition to any rights and remedies provided under law.

5.14.2.6 The Contractor shall include the substance of this clause in all Subcontracts.

5.14.3 **Publicity**

5.14.3.1 Any publicity given to the program or services provided herein, including, but not limited to, notices, information pamphlets, press releases, research, reports signs, and similar public notices prepared by or for the Contractor, shall identify the State of Delaware as the sponsor and shall not be released without prior written approval from the State.

5.14.4 **Patent or Copyright Infringement**

5.14.4.1 The Contractor shall represent that, to the best of its knowledge, none of the intellectual property to be used, developed, or provided pursuant to this Contract violates or infringes upon any patent, copyright, or any other right of a third party. If any claim or suit is brought against the State for the infringement of such patents or copyrights arising from the Contractor's or the State's use of any equipment, materials, computer software and products, or information prepared for, or developed in connection with performance of, this Contract, then the Contractor shall, at its expense, defend such use. The Contractor shall satisfy any final award for such infringement, whether it is resolved by settlement or judgment involving such a claim or suit.

5.14.5 **Antitrust Claims**

5.14.5.1 As consideration for the award and execution of this Contract by the State, the Contractor hereby grants, conveys, sells, assigns, and transfers to the State all of its right, title and interest in and to all known or unknown causes of action it presently has or may now or hereafter acquire under the antitrust law of the United States and the State of Delaware, relating to the particular goods or services purchased or acquired by the State pursuant to this Contract.

5.14.6 **Work Product**

5.14.6.1 All materials, information, documents, and reports, whether finished, unfinished, or draft, developed, prepared, completed, or acquired by the Contractor for the State relating to the services to be performed hereunder shall become the property of the State and shall be delivered to the State's Program Manager upon completion or termination of this Contract, whichever comes first. The Contractor shall not be liable for damages, claims, and losses arising out of any reuse of any work products on any other project conducted by the State. The State shall have the right to reproduce all documentation supplied pursuant to this Contract.

5.14.6.2 The Contractor retains all title and interest to the data it furnished and/or generated pursuant to this Contract. Retention of such title and interest does not conflict with the State's rights to the materials, information and documents developed in performing the project. Upon final payment, the State shall have a perpetual, nontransferable, non-exclusive paid-up right and license to use, copy, modify and prepare derivative works of all materials in which the Contractor retains title, whether individually by the Contractor or jointly with the State. Any and all source code developed in connection with the services provided will be provided to the State, and the aforementioned right and license shall apply to source code. The parties will cooperate with each other and execute such other documents as may be reasonably deemed necessary to achieve the objectives of this Section of the Contract.

5.14.6.3 In no event shall the Contractor be precluded from developing for itself, or for others, materials that are competitive with the work products, irrespective of their similarity to the Deliverables. In addition, the Contractor shall be free to use its general knowledge, skills and experience, and any ideas, concepts, know-how, and techniques within the scope of its practice that are used in the course of providing the services.

5.14.6.4 Notwithstanding anything to the contrary contained herein or in any attachment hereto, any and all intellectual property or other proprietary data owned by the Contractor prior to the effective date of this Contract ("Preexisting Information") shall remain the exclusive property of the Contractor even if such Preexisting Information is embedded or otherwise incorporated into materials or products first produced as a result of this Contract or used to develop such materials or products. The State's rights under this Section of the Contract shall not apply to any Preexisting Information or any component thereof regardless of form or media.

5.14.7 **Sovereign State**

5.14.7.1 The State is a sovereign entity, and shall not be liable for the payment of Federal, State and local sales, use and excise taxes, including any interest and penalties

from any related deficiency, which may become due and payable as a consequence of this Contract.

5.14.8 **Notification of Legal Action Against the Contractor**

5.14.8.1 The Contractor shall notify the State in writing, by certified mail, return receipt requested, within five business days of the Contractor being served with any administrative or legal action or complaint filed regarding any claim in law or equity made against the Contractor or an Affiliate of the Contractor (including, but not limited to, a parent company), that would materially impact either such Affiliate's ability to operate its business or the Contractor's performance of duties under this Contract. It is the intent of this provision that the Contractor notify the State of any and all actions described herein that may affect the Contractor's financial viability and/or program operations.

5.14.9 **Emergency Management Plan**

5.14.9.1 The Contractor shall develop, and implement as needed, an emergency management plan to ensure the ongoing provision of Covered Services in an emergency, including but not limited to a localized or Statewide epidemic, natural disaster or emergency or man-made disaster or emergency such as technological and/or terrorist attack-related emergencies.

5.14.9.2 The Contractor's emergency management plan shall be prior approved by the State.

5.14.9.3 At a minimum, the Contractor's emergency management plan shall include the following:

5.14.9.3.1 Educating members and providers regarding disaster preparedness and evacuation planning;

5.14.9.3.2 Providing a resource list for members and providers to access information about where Covered Services may be accessed;

5.14.9.3.3 Identifying members who require evacuation assistance and informing local officials of those identified;

5.14.9.3.4 MOUs with providers (especially hospitals, dialysis providers and nursing facilities) for provision of Covered Services to evacuated members;

5.14.9.3.5 MOUs with provider facilities that allow evacuated providers to render services within their facilities;

5.14.9.3.6 Registry of providers (physicians, nurses, social workers, etc.) who are willing to volunteer in state operated shelters for individuals with health care needs; and

5.14.9.3.7 Emergency contracting with out-of-state providers to provide Covered Services to evacuated members.

5.14.10 **Environmental Compliance**

5.14.10.1 The Contractor shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC 7606), Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (see 40 CFR Part 15). These provisions prohibit the use under nonexempt Federal contracts, grants, or loans, of facilities included on the EPA List of Violating Facilities. The Contractor shall report violations to the State, CMS, and the US EPA Assistant Administrator for Enforcement.

5.14.11 **Energy Conservation**

5.14.11.1 The Contractor shall comply with any applicable mandatory standards and policies relating to energy efficiency that are contained in the State energy conservation plan as used in compliance with the Energy Policy and Conservation Act of 1975 (PL 94-165) and any amendment thereto.

5.14.12 **Related Contracts**

5.14.12.1 The State may undertake other contracts for work related to the Contract. Examples of other such contracts include, but are not limited to, contracts with other MCOs to provide Medicaid managed care services and contracts with management firms to assist in administration of DSHP or DSHP Plus. The Contractor shall be bound to cooperate fully as directed by the State. All Subcontractors will be required to abide by this provision as a condition of the Contract between the Subcontractor and the prime Contractor.

5.14.13 **Other Contracts**

5.14.13.1 Nothing contained in the Contract shall be construed to prevent a Contractor from operating other comprehensive health care plans or providing Health Care Services to persons other than those covered under this Contract.

5.14.13.2 Nothing in the Contract shall be construed to prevent the State from contracting with other MCOs for the same Enrollment area. The State shall not

disclose any proprietary information pursuant to the Contract except as required by law.

5.14.14**Counterparts**

5.14.14.1 The Contract may be executed simultaneously in two or more counterparts each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.14.15**Force Majeure**

5.14.15.1 Neither the Contractor nor the State shall be liable for any damages or excess costs for failure to perform its Contract responsibilities if such failure arises from causes beyond the reasonable control and without fault or negligence by the responsible party. Such causes may include, but are not restricted to, fires, earthquakes, tornadoes, floods, unusually severe weather, or other catastrophic natural events or acts of God; quarantine restrictions; explosions; subsequent legislation by the State of Delaware or the Federal government; strikes by other than the Contractor's employees; and freight embargoes. In all cases, the failure to perform must be beyond the reasonable control of, and without fault or negligence of the responsible party, and the responsible party shall timely notify the other party of the likelihood or actual occurrence of such cause.

5.14.15.2 If these conditions are met, such non-performance shall not be a ground for termination for default. Immediately upon occurrence of any such cause, the responsible party shall commence to use its best efforts to provide alternate and, to the extent practical, comparable performance.

5.14.16**Titles Not Controlling**

5.14.16.1 Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and shall not be construed to infer a contractual construction of language.

APPENDIX 1: CONTRACTOR RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES TO MEMBERS UNDER AGE 18

Contractor Responsibility within the 30 Units of Outpatient Behavioral Health Services for Members under Age 18

1. As specified in Section 3.4 of this Contract, the Contractor shall provide 30 outpatient units of behavioral health services per year for any member under age 18. Each unit is defined as one hour of service.

2. As part of the 30 outpatient units of behavioral health services, the Contractor shall provide the following five periodic outpatient services:

    a. Assessment – This service evaluates the child's behavioral health problem, establishes a valid DSM diagnosis and a treatment plan. In addition to assessments needed for treatment planning purposes, the Contractor must provide the required assessments to refer appropriate children to DSCYF for moderate or intensive services.

    b. Individual, Family and Group Therapy – Psychological counseling for the child, child's family, or significant others shall be appropriate and culturally responsive to the diverse needs of the individuals served.

    c. Crisis Intervention – If a family or clinician defines the member's behavioral health problem as an emergency requiring immediate response, the Contractor must be capable of seeing the child and family immediately in the family's home or other appropriate setting. This service must be available 24 hours a day, seven days a week.

    d. Intensive Outpatient – Some children in acute situations may avoid placement out of home if intensive treatment and supervision is provided for a brief period. This service also involves psychotherapeutic intervention in the family's home or other relevant environments.

    e. Rehabilitation Services – Services provided on an individual, family or group basis to enable children to remain in the home and to improve the family's capacity for self-sufficiency (i.e., functioning without DSCYF statutory intervention). Key functions include but are not limited to training and assistance in developing or maintaining skills such as conflict resolution, home management, stress management, healthy lifestyles, and education, training, and the family's role in management of the illness.

Contractor Responsibility Outside the 30 Units of Outpatient Behavioral Health Services for Members under Age 18

Certain behavioral health-related services and services to members under age 18 with behavioral health needs are Covered Services outside of the 30 units of outpatient behavioral health services. The Contractor shall provide these services as Medically Necessary and shall not count these services against the 30 units of outpatient behavioral health services. These services include, but are not limited to the following:

1. EPSDT screening, including specific behavioral health screening components.

2. All non-psychiatric treatment services provided in inpatient hospitals, regardless of the child's behavioral health diagnosis, for example, an anorexic adolescent with life-threatening weight loss.

3. All prescribed medications, including psychotropic, anti-depressant or other drugs used in behavioral health treatment.

4. Medication management, inpatient or outpatient, for all prescribed medications, including psychotropic, anti-depressant or other drugs used in behavioral health treatment.

5. Outpatient physician or pediatrician visits, including emergency room visits for medical and behavioral health reasons.

6. Medical detox services to adequately evaluate for appropriate triage and follow-up services.

7. Care coordination provided to link children and their families to needed medically-related services, and coordination with relevant agencies that provide those services; consultation with the child, family members, and family social network in the development of the child's integrated health and behavioral health treatment plan.

8. Coordination activities to ensure adequate continuity of care for a child between Contractor and DSCYF services, and coordination activities to ensure adequate and necessary primary health care provision for children in custody of DSCYF.

9. In general, both a diagnosis of behavioral health and an acceptable (agreed to by the State) procedure (or revenue) code must be provided to be considered part of the 30 units of outpatient behavioral health services for members under age 18.

APPENDIX 2: VALUE-BASED PURCHASING CARE INITIATIVE

SECTION 1 PURPOSE

a. The Department's value-based purchasing (VBP) care initiative applies to all Contractors. The purpose of this initiative is to accelerate the implementation of reforms/innovation within Delaware's health care delivery system to migrate the system away from traditional fee-for-service (FFS)/volume-based care to a system that focuses on rewarding and incentivizing improved outcomes, value, quality improvement and reduced expenditures. Delaware seeks to align the incentives of the Contractor, providers and members through innovative VBP strategies.

   This Appendix, see Section 6, also describes the requirements on the Contractors to enter into accountable care organization (ACO) Contracts with at least two DMMA-authorized Medicaid/CHIP ACOs.

SECTION 2 TWO-PART STRATEGY

a. To effectuate these changes, Delaware will hold the Contractor financially accountable to make meaningful progress on the Purpose through a two part strategy:

   i. **Quality Performance Measures (QPM)**: The Department will select measures that relate to any of the following domains: quality, access, utilization, long-term services and supports, provider participation, spending and/or member/provider satisfaction and assess a financial penalty for each measure if Contractor does not achieve performance levels defined in this Appendix.

   ii. **Value-Based Purchasing Strategies (VBPS)**: The Contractor will be required to implement provider payment/contracting strategies that promote value over volume and reach minimum payment threshold levels in each year of operation. The Department will impose a financial penalty for any year in which the minimum threshold level for VBPS, as defined in this Appendix, is not achieved for that year.

b. Contractor agrees to comply with all applicable federal and state laws and regulations in the course of carrying out these strategies.

SECTION 3 QUALITY PERFORMANCE MEASURES (QPM)

a. QPM Performance/Measurement Year: For purposes of this Appendix, the Contractor's performance/measurement on each QPM will be evaluated on a calendar year basis unless a different performance/measurement period is otherwise required by the selected QPM.

b. For the calendar year (CY) 2022 performance/measurement year, the Department selected the following seven (7) QPM:

   i. QPM #1: Comprehensive Diabetes Care (HbA1c control <8%) (*HEDIS CDC*)
   ii. QPM #2: Asthma Medication Ratio (ages 5 – 11, 12 – 18) (HEDIS AMR)

iii. QPM #3: Cervical Cancer Screening (*HEDIS CCS*)
iv. QPM #4: Breast Cancer Screening (*HEDIS BCS*)
v. QPM #5: Controlling High Blood Pressure (HEDIS CBP)
vi. QPM #6: Prenatal and Postpartum Care (Timeliness of Prenatal Care) *(HEDIS PPC)*
vii. QPM #7: 30-day Hospital Readmission Rate (*Delaware Measure*)

c. The Department reserves the right to modify (e.g., add, delete, change) the number and type of QPM for each year of the Agreement. The Contractor will be given at least 90 calendar day notice of any changes to the QPM. Additionally:

   i. The Department will also offer assistance to the Contractor as it relates to the understanding of the QPM (e.g., technical assistance provided by the Department's external quality review organization).
   ii. The Department reserves the right to develop a standardized report form based on the selected measures to be submitted by the Contractor.

d. QPM Penalty: For each applicable QPM performance/measurement year, the Contractor will be assessed a financial penalty if Contractor does not achieve the respective Satisfactory Performance Level specified in this Appendix.

   i. For the CY 2022 QPM performance/measurement year and any subsequent performance/measurement year unless otherwise changed,, the penalty that can be assessed against the Contractor is a maximum of up to one percent (1.0%) of the Contractor's total net revenue received from the Department for <u>all</u> populations covered under this Agreement. If a penalty is applicable to the Contractor the Department may assess/collect the penalty either through a deduction in future payments to the Contractor or through a remittance paid by the Contractor to the Department.

   ii. To avoid a penalty, the Contractor must achieve at least a Satisfactory Performance Level on each QPM as specified in the Evaluating Performance Level section of this Appendix.

e. QPM Performance Weighting Factor: Each QPM will have a performance weighting factor as determined by the Department. This factor determines the proportion of the maximum penalty attributable to each QPM. The performance weighting factors for each QPM are shown below:

   i. For the CY 2022 performance/measurement year:

      1. QPM #1: A maximum of 1/7 of the total QPM penalty.

      2. QPM #2: A maximum of 1/7 of the total QPM penalty.

3. QPM #3: A maximum of 1/7 of the total QPM penalty.

4. QPM #4: A maximum of 1/7 of the total QPM penalty.

5. QPM #5: A maximum of 1/7 of the total QPM penalty.

6. QPM #6: A maximum of 1/7 of the total QPM penalty.

7. QPM #7: A maximum of 1/7 of the total QPM penalty.

- For example, if the Contractor achieves a satisfactory performance level on QPM #1, QPM #4 and QPM #5, but does not achieve a satisfactory performance level on QPM #2, QPM #3, QPM #6 and QPM #7, the Contractor may be assessed a penalty of 1/7 of 1.0% for QPM #2, QPM #3, QPM #6 and QPM #7 each, respectively. The result will be a total QPM penalty of up to 0.57% of the Contractor's total net revenue received from the Department for <u>all</u> populations covered under this Agreement.

ii. The Department reserves the right to modify (e.g., increase or decrease) the penalty for each subsequent performance/measurement year, including the performance weighting factors and criteria for defining a satisfactory performance level. The Contractor will be given at least 90 calendar day notice of any changes to the penalty.

f. Satisfactory Performance Level: For purposes of evaluating the Contractor's performance on the QPM and for purposes of assessing, if any, penalty, the Contractor's performance in the CY 2022 performance/measurement period will be measured as follows:

i. QPM #1: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure and performance/measurement period. Contractor must be at or above the 50th percentile and/or show improvement compared to the previous year's final result to achieve a satisfactory performance level on this QPM.

ii. QPM #2: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure and performance/measurement period. Contractor must be at or above the 33rd percentile and/or show improvement compared to the previous year's final result to achieve a satisfactory performance level on this QPM.

iii. QPM #3: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure and performance/measurement period. Contractor must be at or above the 50th percentile and/or show improvement compared to the previous year's final result to achieve a satisfactory performance level on this QPM.

iv. QPM #4: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure and performance/measurement period. Contractor must be at or above the 50th

percentile and/or show improvement compared to the previous year's final result to achieve a satisfactory performance level on this QPM.

v. QPM #5: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure and performance/measurement period. Contractor must be at or above the 33rd percentile and/or show improvement compared to the previous year's final result to achieve a satisfactory performance level on this QPM.

vi. QPM #6: Contractor's results will be compared against national HEDIS results for all Medicaid or Medicaid/CHIP managed care plans for the same measure and performance/measurement period. Contractor must be at or above the 66.67th percentile and/or show improvement compared to the previous year's final result to achieve a satisfactory performance level on this QPM.

vii. QPM #7: Contractor's results will be compared to the Contractor's CY 2018 benchmark level and/or show improvement compared to the previous year's final result and if the Contractor's rate is higher than the benchmark year, the Department may assess the penalty applicable to this QPM.

g. The Department reserves the right and intends to modify how a Satisfactory Performance Level is evaluated in future years of this Agreement to incorporate any or all of the following elements:

i. Progressively raise the performance level of each QPM as measured against national standard(s). For example, the Department may define a Satisfactory Performance Level of a specified QPM to be at or above the 75th percentile for the applicable performance/measurement year.

ii. Measuring the Contractor's individual performance improvement level by comparing the Contractor's current performance/measurement year's QPM result to the Contractor's prior performance/measurement year's QPM result for the same QPM. For example, if the Contractor goes from a rate of 55% to a rate of 62%, that would be a 7 percentage point positive improvement, which may be factored into a future year penalty assessment process.

iii. Changes to how the Satisfactory Performance Level is evaluated may also be paired with changes to the performance weighting factors to allow the Contractor to achieve success through a combination of comparisons to national standards and/or year-over-year individual performance improvement.

h. The Department will inform the Contractor of the amount of the penalty, if any, assessed against the Contractor.

i. The Department reserves the right to grant a full or partial suspension of the QPM penalty.

SECTION 4 VALUE-BASED PURCHASING STRATEGIES (VBPS)

a. VBPS Performance/Measurement Year: For purposes of this Appendix, the Contractor's performance/measurement on VBPS will be evaluated on a calendar year basis unless a different performance/measurement period is otherwise specified by the Department.

b. The Contractor is required to enter into payment arrangements/models with providers that align payment more directly to the quality and efficiency of care provided, by rewarding providers for their performance across different dimensions of quality and/or transferring the financial risk for member care to providers. The goal is to transition away from traditional FFS-based volume of care payment systems.

   i. The Contractor may choose, and the Department encourages the Contractor, to implement concurrent delivery system reforms/innovations with its providers such as implementing, developing or contracting with patient-centered medical homes, accountable care organizations or other forms of delivery system changes. However, for purposes of evaluating the Contractor's performance with regard to VBPS, the underlying delivery system will not be measured/evaluated.

      1. For example, if the Contractor contracts with a patient-centered medical home with Provider X, but Provider X continues to be paid using traditional FFS methods with no adoption of any of the acceptable VBPS listed in Section 4.c, the Contractor's payments to Provider X will not receive any credit toward meeting the threshold levels listed in Section 4.e.

c. For purpose of the VBPS, acceptable arrangements/models between the Contractor and providers are described as follows. While some of these arrangements/models may still use a traditional FFS payment method for the payment of services, the Department seeks VBPS that progressively diminish the use of traditional FFS in Delaware's health care delivery system.

   i. **Shared Savings**: A purchasing strategy that provides a basis for providers or provider entities to reduce unnecessary health spending and concurrently improve quality/outcomes of care for a defined population of patients/members by offering providers a percentage of any realized net savings (i.e., upside risk only). "Savings" could be measured as the difference between expected and actual costs in the given measurement year that also involves obtaining specified quality/outcome goals.

      1. Under this VBPS, the payments to provider(s) that qualify toward meeting the annual threshold levels in Section 4.e are: 1) the amount of actual "savings" payments made to the respective provider(s), 2) the amount of direct medical/service expenditures paid directly to the specific provider(s) for members covered by the respective VBPS and 3) the amount of total medical/services expenditures paid by the Contractor that are included in the shared savings calculations/arrangement.

         - For example, if the Contractor develops a shared savings arrangement with Provider X for children that includes all services except prescription drug spending in the shared savings arrangement, the Contractor can count toward its threshold levels any shared savings payment to Provider X, all medical/service

expenditures for children paid directly to Provider X and all other non-prescription drug expenditures for children to any provider as prescribed consistent with the conditions of the shared savings arrangement.

ii. **Bundled/Episodic Payments**: A purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically-defined episodes that may involve several provider types, several settings of care or several procedures/services over a defined period of time. The provider receives a lump sum, prospectively or retrospectively, for all health services delivered for a single episode of care.

1. Under this VBPS, the payments to provider(s) that qualify toward meeting the annual threshold levels in Section 4.e are the amount of bundled/episodic payments to the respective provider(s).

iii. **Risk/Capitation/Total Cost of Care**: A purchasing strategy in which the Contractor and the provider(s) share the financial risk of the cost, utilization and quality of care/outcomes of a defined population of patients/members (i.e., upside and downside risk). Provider may be paid a periodic, fixed amount to assume responsibility for the quality, cost and outcomes of a specific population or otherwise include the potential for financial loss. Payment arrangements may include partial risk (e.g., limited scope of services/responsibilities, but including at least all professional services or hospital-based services) or full risk (e.g., total cost of care).

1. Under this VBPS, the payments to provider(s) that qualify toward meeting the annual threshold levels in Section 4.e are the amount of all medical/service expenditures associated with the members covered by and medical/services attributable to the risk/capitation/total cost of care payment arrangement/model. In some cases, this will be the amount of the risk payments for applicable members.

iv. **Other Innovative Payment Arrangements**: As described in Section 4.d.ii, the Contractor may propose other innovative VBPS that are not specifically delineated herein, but otherwise consistent with the overall strategy of paying for value not volume and moving providers to accept risk for the cost/utilization of services.

1. The Contractor must disclose to the Department, in either the Annual Planning Report and/or the Quarterly Progress Report required in Section 5, other innovative payment arrangement(s) if the Contractor is seeking to count related expenditures towards the applicable threshold level(s) in Section 4.e. The Contractor will provide the Department information necessary for the Department to assess the Contractor's proposal.

2. The Department will make a final determination and inform the Contractor in writing on whether the other innovative payment arrangement(s) will be allowed to be counted towards the applicable threshold level in Section 4.e.

and specifically what expenditures related to the payment arrangement will be counted towards which threshold requirement.

- For example, if for CY 2022 the Contractor proposes an innovative provider payment arrangement, the State may choose to: 1) disallow the payment arrangement entirely for purposes of Section 4.e, 2) allow some expenditure to count towards the total VBPS expenditure goal in Section 4.e or 3) allow some portion of the related expenditure to count towards the portion of the Section 4.e goal associated with the more advanced arrangements.

d. The Department reserves the right to modify (e.g., add, delete, change) the number and type of VBPS for each year of the Contract. The Contractor will be given at least 90 calendar day notice of any changes to the VBPS. Additionally:

   i. The Department will also offer assistance to the Contractor as it relates to the understanding of the VBPS (e.g., technical assistance provided by the Department's external quality review organization and/or actuarial/financial consultant).

   ii. The Contractor may propose certain VBPS that align with the aforementioned list of acceptable arrangements/models, but may on the surface/name/terminology, not appear to fit into one of the acceptable arrangements/models. The Contractor will be expected to provide the Department sufficient details, including provider contracts and payment terms, for the Department to make a determination if the Contractor's proposed VBPS meets the criteria for one of the acceptable VBPS arrangements/models. If the Contractor refuses to provide the Department requested information, the Contractor may forfeit receiving credit for payments made to providers under these non-accepted VBPS payment arrangements/models.

e. VBPS Threshold Level: The Contractor is expected to achieve an annual threshold level for VBPS that will be measured as the portion of total medical/service expenditure to all providers for all members enrolled with the Contractor during the respective performance/measurement year that are associated with one or more of the acceptable VBPS arrangements/models. The same VBPS-related medical/service expenditures cannot be counted more than once for purposes of measuring against the respective threshold levels. The Department intends that the minimum threshold level will grow each year according to the following schedule:

   i. Calendar Year 2018: A minimum of 20% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the expenditure threshold as approved/specified by the Department.

1. For a Contractor that newly enters the program on January 1, 2018, the minimum threshold will be 10%, but all other requirements remain the same.

ii. Calendar Year 2019: A minimum of 30% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the expenditure threshold as approved/specified by the Department.

1. For a Contractor that newly enters the program on January 1, 2018, the minimum threshold will be 20%, but all other requirements remain the same.

iii. Calendar Year 2020: A minimum of 40% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 1/3 of the 40% (i.e., 13%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department.

iv. Calendar Year 2021: A minimum of 50% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 1/2 of the 50% (i.e., 25%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department.

v. Calendar Year 2022: A minimum of 60% of all medical/service expenditures for all populations must be expended through the VBPS listed in Section 4.c. However, at least 3/4 of the 60% (i.e., 45%) must be from a combination of only the VBPS listed in Section 4.c.ii through 4.c.iii. Only other payment arrangement(s) under Section 4.c.iv that are approved by the Department in writing to the Contractor may be counted towards the respective/applicable expenditure threshold as approved/specified by the Department.

f. VBPS Penalty: For each performance/measurement year, the Contractor will be assessed a financial penalty if Contractor does not achieve performance levels specified in Section 4.e of this Appendix.

g. For the CY 2021 VBPS performance/measurement year and any subsequent performance/measurement year unless otherwise changed,, the penalty that can be assessed against the Contractor is a maximum of up to one percent (1.0%) of the Contractor's total net revenue received from the Department for <u>all</u> populations covered under this Agreement. If a

penalty is applicable to the Contractor, the Department may assess/collect the penalty either through a deduction in future payments to the Contractor or through a remittance paid by the Contractor to the Department.

i. The Department reserves the right to grant a full or partial suspension of the penalty if the Contractor can demonstrate that through no material fault of its own that the Contractor was unable to obtain the VBPS threshold level, but can otherwise demonstrate to the Department's satisfaction that a good-faith effort was put forth and at least 50% of the applicable threshold level for the particular performance/measurement year was met and the Contractor submits to the Department a performance improvement plan that is acceptable to the Department for obtaining the VBPS threshold level(s) in the next performance/measurement year.

ii. The Department will inform the Contractor of the applicable penalty, if any, that will assessed against the Contractor.

SECTION 5 DATA SHARING AND REPORTING

a. **From the Contractor to Providers:** The Contractor must provide timely and actionable data to its providers participating in VBP arrangements. This data should include, but is not limited to, the following:

i. Identification of high risk patients;
ii. Comprehensive care gaps inclusive of gaps related to quality metrics used in the VBP arrangement; and
iii. Service utilization and claims data across clinical areas such as primary care, inpatient admissions, non-inpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

b. **From the Contractor to the Department**: In support of this Appendix, the Contractor will be required to provide to the Department the following reports:

i. **Annual Planning Report**: By October 1 of each year, the Contractor will provide the Department a report that describes the Contractor's goals for the following calendar year regarding QPM and VBPS, types of provider VBPS (including other innovative VBPS noted in Section 4.c.iv), expected challenges/obstacles and plan to overcome, rational/reasoning for selecting certain strategies and other information that the Contractor seeks to provide the Department regarding the Contractor's plans to address the two-part strategy of this Appendix. The Contractor must separately address the QPM and the VBPS within this report in a manner that will be understandable by the reader and not be overly technical or exceedingly long. This Annual Planning Report should clearly highlight new endeavors/actions the Contractors intend to take in the forthcoming performance/measurement year, including any strategies intended to correct or ameliorate prior year challenges or

shortcomings in obtaining satisfactory performance levels or payment threshold levels.

1. The Department will use this report to assess the Contractor's plans and advise the Contractor on what will be allowable activities/expenditures toward the performance levels specified in this Appendix.

ii. **Quarterly Progress Report**: The Contractor will provide the Department a concise progress report on the Contractor's efforts related to QPM and VBPS, respectively.

1. For the fourth (4th) calendar year quarter, the Quarterly Progress Report will be replaced by the Year End Accomplishments Report.

2. Each quarterly progress report will have a run-out period of one quarter and will be due 18 days after the run-out period. For example, the 1Q quarterly report will be due July 18 (or next business day), the 2Q quarterly report will be due October 18 (or next business day) and so on.

3. Each quarterly report will be based/reported on a cumulative year-to-date performance.

4. If required, the Contractor will use a reporting template provided by the Department.

5. Contractor must disclose and describe any new VBPS that were not included in the Annual Planning Report that the Contractor seeks to receive credit towards the expenditures threshold levels in Section 4.e.

iii. **Year End Accomplishments Report**: Within 180 calendar days of the end of each performance/measurement year, the Contractor will provide the Department a comprehensive yet concise report on the activities related to QPM and VBPS completed in the respective performance/measurement year. This report will contain both written (i.e., Word document) and numerical (i.e., Excel exhibits) findings, observations and comments. The Year End Accomplishments Report will be the source of the Contractor's final reported QPM results and VBPS figures for purposes of assessing any applicable financial penalty. At a minimum the Year End Accomplishments Report must include at least:

1. A final Excel-based data reporting template, in the same manner and structure as the previous quarters.

2. A cataloging of the Contractor's efforts to achieve a satisfactory performance level on each of the QPM applicable to the respective performance/measurement year that includes, but is not limited to:

i. Description of Contractor's efforts related to each QPM.
ii. Expected results of each effort.
iii. Challenges/obstacles encountered during the year.
iv. Other information Contractors want to share with the Department regarding the QPM.
v. Other reasonable and appropriate information at the request of the Department.

3. A cataloging of the Contractor's VBPS activities implemented during the respective performance/measurement year to obtain the VBPS threshold level that must include at least:

i. Description of each VBPS, including effective/start date and intended purpose/goal.
ii. List of providers included/covered by each respective VBPS.
iii. Number of members covered by each respective VBPS. If a member is covered by more than one VBPS, the Contractor should count the member once in the VBPS that is associated with a preponderance of the member's medical/services expenditures in the given year.
iv. For each provider with a VBPS arrangement/model, the total net amount of medical/services expenditures the Contractor believes qualify toward the annual VBPS threshold level delineated by type of payment (e.g., bonus/incentives, direct service expenditures, shared savings payments, risk/capitation payments, etc.). Note: The same VBPS-related medical/service expenditures cannot be counted more than once.
v. For each provider with a VBPS arrangement/model, the total net amount of all medical/service expenditures paid for all members.
vi. The total net amount of all medical/service expenditures paid to all providers for all members.
vii. Challenges/obstacles encountered during the year in implementing, developing or effectuating VBPS.
viii. Other information Contractors want to share with the Department regarding the QPM.
ix. Other reasonable and appropriate information at the request of the Department.

SECTION 6 CONTRACTING REQUIREMENTS WITH DMMA-AUTHORIZED ACOS

a. DMMA's Medicaid/CHIP ACO initiative is contained in Section 80000 of Title 16 of the Delaware Administrative Code. In this context, Section 80000 contained the following definitions:

i. An "ACO Contract" means a contract formed between an ACO and [the Contractor] that includes payment via a value-based purchasing arrangement as defined by DHSS.

ii. "Value-Based Purchasing" or "VBP" means a model for provider reimbursement that promotes value over volume, such as a shared savings or risk-based arrangement.

b. To further Delaware's migration away from traditional FFS/volume-based care to a system that focuses on rewarding and incentivizing improved outcomes, value, quality improvement and reduced expenditures, the Contractor will be required to enter into ACO Contracts with at least two (2) DMMA-authorized Medicaid/CHIP ACOs.
   i. If there are not at least two authorized Medicaid/CHIP ACOs, the Contractor will be required to enter into an ACO Contract with the number of DMMA-authorized Medicaid/CHIP ACOs, which could be one or zero.

c. DMMA will publicly announce the list of DMMA-authorized Medicaid/CHIP ACOs. The number of and specific entities or organizations that obtain DMMA ACO authorization status may change over time.

d. DMMA-authorized Medicaid/CHIP ACOs will commence operations as of July 1, 2021, which is also the start date for ACO Contracts referenced in this Section.

e. The minimum design parameters for the DMMA-authorized Medicaid/CHIP ACO program are available in the "ACO Application" document available on DMMA's website or by request submitted to DMMA.

   i. The Contractor's ACO Contracts must adhere to the minimum design parameters in the "ACO Application" in order for the Contractor to comply with the requirements in this Section.
   ii. If the ACO Contract does not satisfy the minimum design parameters in DMMA's "ACO Application", the Contractor will be deemed non-compliant with this Section and be subject to a sanction described in Section 6.f.

f. If the Contractor does not enter into an ACO Contract with the minimum number of DMMA-authorized ACOs as indicated in this Section or if the ACO Contract does not satisfy DMMA's minimum design parameters, the Contractor is subject to a sanction in accordance with the terms and conditions of the Managed Care Master Services Agreement.

g. The Contractor is required to have ACO Contracts that use a calendar year period as the ACO contracting period. Due to the July 1, 2021 ACO approval start date, the Contractor has the option to enter into ACO Contracts that either:

   i. Have an initial six-month period applicable to July through December 2021 then be on a calendar year basis thereafter.
   ii. Have an initial 18-month period applicable to July 2021 through December 2022 then be on a calendar year basis thereafter.

h. DMMA reserves the right to request and review all ACO Contracts including any payment provisions, quality measures or other contract arrangements between the Contractor and a DMMA-authorized ACO.

i. If Contractor does not provide a copy of the complete ACO Contract, DMMA will consider this a sanctionable offense subject to the sanction in Section 6.f.

APPENDIX 3: ADULT DENTAL SERVICES

January 1, 2022 – December 31, 2022

From January 1, 2022 through December 31, 2022 (also known as Arrangement Time Period), the following terms shall apply:

A. General

This appendix includes requirements specific to dental services. In the event of a conflict between requirements in this appendix and another Section of the Contract, the requirements in this appendix of the Contract shall apply.

B. General Coverage Provisions

The Contractor shall provide access to dental services for members age 21 and older as described in the State's Medicaid State Plan, the Division of Medicaid and Medical Assistance's (DMMA's) adult dental fee-for-service (FFS) fee schedule hereafter known as the FFS fee schedule, and this Contract. Members eligible for dental services may be referenced as the Covered Population for purposes of this appendix. For purposes of this appendix, eligible dental services represented on the FFS fee schedule may be known as Covered Services.

The Contractor shall cover up to $1,000 in dental services per member per calendar year unless an additional amount of up to $1,500 per member per calendar year is authorized by the Contractor on an emergency basis.

Per procedure code, service limitations for adult dental services are described in the FFS fee schedule. The Contractor shall apply all service limitations contained within the FFS fee schedule.

Dental services do not include the removal of bony impacted wisdom teeth. The Contractor shall cover the removal of bony impacted wisdom teeth as a surgery that is included in this Contract for all members.

C. Additional Emergency Dental Benefit

The Contractor, on an emergency basis, must provide members age 21 and older up to an additional $1,500 per year beyond the $1,000 annual benefit limit for dental care treatment. The Contractor must ensure that if a member requires dental services on an emergency basis, the member has exhausted the $1,000 annual benefit prior to authorizing access to the additional $1,500 in funds.

For purposes of this Appendix "Emergency basis" is defined as:

(i) An unforeseen or sudden occurrence demanding immediate remedy or action, without which a reasonable licensed dental professional would predict a serious health risk or rapid decline in oral health for the member; or

(ii) When a member's dental care needs exceed the $1,000 per year dental benefit limit, and postponement of treatment until the next calendar year would result in tooth loss or exacerbation of an existing medical condition.

To access the additional emergency dental benefit on the basis of an emergency as defined in subsection C(ii) of this appendix, the member's participating dental provider must submit a request to the Contractor for prior authorization. The request for prior authorization must include a comprehensive treatment plan that anticipates the preventive, therapeutic and restorative needs for the member, along with the following supporting documentation as appropriate:

- Complete record of existing restorations, conditions and diagnoses
- Comprehensive periodontal assessment record
- Diagnostic full mouth series of x-rays
- Intra- and extra-oral images that support the diagnosis and treatment plan

In the case of an emergency as defined in subsection C(i) of this appendix, a prior authorization is not required; however, the dental provider must submit to the Contractor diagnostic-quality pre- and post-operative radiographs and images of the affected area along with a detailed narrative supporting the provider's rationale for providing immediate services.

The Contractor shall only cover procedures and/or services that meet standard clinical practice guidelines and that are included in the FFS fee schedule.

D. Adult Dental Cost Sharing

The Contractor shall impose Copayments on adult dental services as directed by the State in accordance with 42 CFR 447.50 through 42 CFR 447.82.

The Contractor shall require members age 21 or older, other than those specifically excluded by federal regulations, to pay a $3.00 Copayment for each dental visit as specified in 31 Del. C. § 503 and State's Medicaid State Plan.

The Contractor shall ensure that participating providers do not refuse to provide dental services when a member advises a participating provider of an inability to pay the applicable Copayment amount at the time of service (see 42 CFR 447.52(e)).

Members remain liable for any unpaid Copayment amount and are responsible for paying the provider when financially able. The provider is permitted to pursue reimbursement of the Copayment amount from the member and any amounts that exceed the benefit limit and/or are otherwise not covered by the adult dental benefit. The provider is required to follow the DMMA policy on adult member billing.

E. Transition of New Members

The Contractor's continuity of care transition plan (see Section 3.8.1 of this Contract) shall include procedures for continuity of care of prior authorized dental services for new members.

F. Provider Network

The Contractor must contract on an equal basis with any dental provider qualified to participate in the Delaware Medical Assistance Program dental program and that is willing to comply with the Contractor's payment rates and terms and to adhere to quality standards established by the Contractor.

G. Access Standards

Time and Distance Requirements

The Contractor shall contract with sufficient general dental providers and dental specialists to enable members to receive Covered Services within 30 miles or 45 minutes from the member's primary residence.

Appointment Standards

The Contractor shall ensure that appointments with general dentists meet the appointment standards for PCP appointments as described in Section 3.9.17.3.7.1.1 through 3.9.17.3.7.1.4 of this Contract.

The Contractor shall ensure that appointments with dental specialists (oral surgeons, prosthodontists, and periodontists) meet the appointment standards for other specialists as described in Section 3.9.17.3.8.1 of this Contract.

Office Waiting Times

The Contractor shall ensure that the office waiting times for dental appointments meet the waiting time standards described in Section 3.9.17.4.1 of this Contract.

H. Network Change

Network Change Notification to Members

The Contractor shall comply with the requirements described in Section 3.9.18.2.2.1 and Section 3.9.18.2.31 of this Contract for notification to members regarding the termination of dental providers.

Network Change Notification to the State

The Contractor shall comply with the requirements described in Section 3.19.18.3.2 of this Contract for notification to the State of the termination of a dental provider.

Provider Termination by Contractor

The Contractor shall comply with the requirements described within Section 3.19.18.4 of this Contract for the termination of a provider contract with a dental provider, when the Contractor is terminating its contract with the provider.

I. Provider Payment

The Contractor shall pay participating dental providers in accordance with the FFS fee schedule.

J. Timely Payments

The Contractor shall make timely payments to providers in accordance with the timeliness standards in Section 3.18.1 of this Contract.

K. Utilization Management

Prior Authorization

The Contractor shall require prior authorization as a condition of coverage or payment for certain adult dental services as described in the FFS fee schedule.

The Contractor shall require prior authorization as a condition of coverage or payment of the emergency dental benefit except in an emergency as defined in Section C(i) of this appendix.

The Contractor shall comply with the requirements described in Section 3.12.6.5 of this Contract regarding the timeframes for authorization decisions.

L. Member ID Cards

The Contractor shall integrate relevant dental information into the member's ID card. The Contractor shall not issue a separate ID card for dental services.

M. Member Materials

The Contractor may have a separate member handbook for dental services, which shall comply with the requirements described in Sections 3.14.1.2, 3.14.1.3 and 3.14.1.4 of this Contract.

N. Member and Provider Services

Toll-Free Member Services Telephone Lines

The Contractor shall not operate a separate toll-free member services telephone line for dental services. The Contractor may operate a separate call center for dental services as long as it can be accessed through IVR technology or a transfer directly from the Contractor's toll-free member services telephone line, without requiring the member to call back to another number.

If the Contractor has a separate dental call center, the call center shall comply with all requirements described in Section 3.14.2.3 of this Contract.

Provider Services Call Center

The Contractor may operate a separate provider call center for dental providers. If the Contractor has separate call center for dental providers, the call center shall comply with all requirements described in Section 3.14.2.3 of this Contract.

O. Financial Management

Third Party Liability (TPL)

The Contractor must comply with the TPL procedures described in Section 3.18.3 of this Contract.

Coordination of Benefits Agreement

The Contractor must comply with the coordination of benefits agreement described in Section 3.18.1 of this Contract.

P. Encounter Submission

The Contractor shall submit a claim level detail file of dental Encounter Data to the State within five calendar days of a payment cycle. The file must include individual claim level detail information on each dental service provided to a Diamond State Health Plan (DSHP) or DSHP Plus member, including all required data fields as identified by the State. The MCO shall report the amount paid to the providers on the encounter. The Contractor shall run payment cycles weekly.

Q. Staffing

The Contractor shall designate a dental services liaison who will serve as the main point of contact for DMMA regarding dental services.

R. Reporting

The Contractor shall submit a quarterly dental services report, with data broken down for each month of the quarter that includes:

- The number of members who received a dental service.
- The number of members who received a comprehensive oral exam.
- The number of members with diabetes who received a comprehensive oral exam.
- The number of members who received caries treatment.
- The number of members who received a prior authorization for a dental service, broken down by service.
- The number of members whose prior authorization of dental services was denied, broken down by service.
- The number of members for whom a prior authorization was requested in order to access the emergency benefit.
- The number of prior authorizations received and approved by the Contractor in order for a member to access the emergency benefit.
- The number of members who accessed the emergency benefit for whom a prior authorization was not required.

S. Subcontracting

The Contractor may Subcontract with a dental benefit manager (DBM) for the provision of dental services and to process dental claims only if the DBM subcontract has received advance written approval by the State and meets the requirements for Subcontracting as specified in Section 5.1.2 of this Contract.

T. Non-Risk Invoicing Process

Dental providers will render Covered Services to the Covered Population and submit claims to the Contractor for payment.

The Contractor must submit to DMMA an invoice that contains the total paid amount for Covered Services provided to members for the reporting quarter. Along with the invoice, the Contractor is required to submit details on all claims paid. The format of the invoice and detailed claims reporting will be determined by DMMA.

The Contractor agrees to provide all data, files or information requested by DMMA related to the operationalization and administration of this Arrangement. Failure to provide requested information may result in a financial penalty being applied to the Contractor consistent with the terms and conditions of this Contract.

All Covered Services paid for by the Contractor for which the Contractor is requesting reimbursement must be submitted in the quarterly invoice submission. Submission of claims associated with this Arrangement Time Period will not be accepted after this Arrangement Time Period invoice submission.

If the Contractor deems additional run-out time is needed to accurately include all Covered Services for the Arrangement Time Period within the final invoice submission, the Contractor may request an extension. DMMA may elect to provide the Contractor with additional run-out time to complete the submission, as necessary.

DMMA will review the invoice and requested supporting documentation and notify the Contractor of any identified errors or concerns within 30 calendar days after receipt of the required reporting package. If no concerns are identified, DMMA will proceed with payment within 30 calendar days after the review is complete. If DMMA does identify issues with the Contractor submission, the clock will be paused for a reasonable amount of time necessary to resolve all reporting issues/errors/concerns. Once any issues are adequately addressed, DMMA will proceed with payment within 30 calendar days of adequate resolution. DMMA has the sole authority to decide when reporting issues are adequately resolved.

The Contractor is required to submit encounter data for all Covered Services in accordance with the terms and conditions of the contract.

<u>Administrative Payment</u>

DMMA will also pay a separate administrative fee to the Contractor for assuming the administration of the adult dental benefit. If the Contractor is requesting reimbursement for administrative services, for the Arrangement Time Period, the Contractor must submit to DMMA an invoice (separate from the claims invoice described above) that contains the total

amount paid to their dental benefits administrator for purposes of administering Covered Services provided to members for the reporting quarter. Along with the invoice, the Contractor is required to submit supporting documentation of the administrative payments made. The format of the invoice and supporting documentation will be determined by DMMA.

DMMA will review the invoice and requested supporting documentation and notify the Contractor of any identified errors or concerns within 30 calendar days after receipt. If no concerns are identified, DMMA will proceed with payment within 30 calendar days after the review is complete. If DMMA does identify issues with the Contractor submission, the clock will be paused for a reasonable amount of time necessary to resolve all reporting issues/errors/concerns. Once any issues are adequately addressed, DMMA will proceed with payment within 30 calendar days of adequate resolution. DMMA has the sole authority to decide when reporting issues are adequately resolved.

Encounter Data Validation

As noted, the Contractor is required to submit encounter data for all Covered Services in accordance with the terms and conditions of this Contract. DMMA retains the right to complete an encounter data validation at the end of the Arrangement Time Period. After receipt and review of all submitted Covered Services through the process outlined in Section T of this appendix, corresponding encounter data for the Covered Services will be pulled and compared to what is reported on the Contractor submissions. Material discrepancies, as determined by DMMA, will need to be resolved and DMMA will work with the Contractor on reconciling material discrepancies. DMMA retains the right to recoup payments, consistent with any discrepancies, if encounter data submissions for Covered Services do not adequately support all quarterly invoiced amounts. DMMA has the sole authority to decide when any reporting discrepancies are adequately resolved.

Centers for Medicare & Medicaid Services (CMS) Requirements

The non-risk invoicing process shall comply with all applicable CMS requirements and regulations pertaining to this process, and is subject to the CMS regulations for payments under non-risk managed care contracts at 42 CFR 447.362. Payments to the Contractor are contingent upon CMS approval and participation of federal matching funds. The Contractor agrees to provide DMMA any supporting information or data that may be required to respond to CMS questions about this process. The Contractor agrees to perform under the terms of Section T of this appendix beginning on the Effective Date of this appendix pending CMS approval. In the event that CMS rejects the language contained within Section T of this appendix, the parties shall work in good faith to propose an alternate process to CMS within twenty (20) business days of notification of rejection by CMS. In the event that the parties fail to negotiate an acceptable proposed alternative within the 20-day period specified herein, or in the event that CMS does not accept the alternative jointly submitted by the Parties pursuant to this paragraph, all obligations under this appendix are immediately terminated with the exception that the DMMA shall reimburse the Contractor for all claims that have been incurred to date.

APPENDIX 4: COVID VACCINE ADMINISTRATION

January 1, 2021 – December 31, 2022

From January 1, 2021 through December 31, 2022, the following terms shall apply:

1. The Contractor shall cover COVID-19 vaccine administration in accordance with DMMA's policy, including the "Medicaid Provider Information and FAQs" regularly posted to DMMA's website.

2. The State will reimburse the Contractor for COVID-19 vaccine administration on a non-risk basis, in accordance with the 42 CFR 447.362.

3. The Contractor shall report COVID-19 vaccine administration utilization as specified by DMMA.