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CONTRACT #415-12208

NORTH DAKOTA MEDICAID EXPANSION

MANAGED CARE ORGANIZATION CONTRACT

BETWEEN

The State of North Dakota, acting through its North Dakota Department of Human Services, Medical Services Division (STATE)

AND

Blue Cross Blue Shield of North Dakota (MCO)

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ARTICLE 1: ARTICLE 1: DEFINITION OF TERMS

1.1 Definition of Terms

Abuse means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Advance Directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated.

Adverse Benefit Determination (or Adverse Determination) means any of the following:

- The denial or limited authorization of a requested service, including, but not limited to determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a Clean Claim is not an adverse benefit determination.
- The failure to provide services in a timely manner, as defined by STATE.
- The failure of an MCO to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
- The denial of an Enrollee's request to dispute a financial liability, including cost-sharing, co-payments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Affordable Care Act (ACA) means the Patient Protection and Affordable Care Act which was signed into law on March 23, 2010.

Alternative Benefit Plan (ABP) means Benchmark or Benchmark-equivalent coverage as defined in 42 C.F.R. §440.305(a). For purposes of this Contract, references to ABP and Benchmark are synonymous.

Alternative Payment Methodology (APM) means a health care payment methodology between MCO and Provider that is an alternative to fee-for-service and which uses financial incentives to promote or leverage greater value - including higher quality care and cost efficiency. APMs are identified in Health Care Payment Learning & Action Network (LAN) APM Framework Categories 2-4.

Appeal means a request for a review of an Adverse Benefit Determination, as defined pursuant to 42 C.F.R. §438.400(b).

Balance Bill means the practice of billing patients for charges that exceed the amount reimbursed by an insurer for a particular service. Providers are prohibited from balance billing for Medicaid beneficiaries.

Behavioral Health is an umbrella term referring to the diagnosis and treatment of mental health and substance use disorders.

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Capitation means the reimbursement arrangement in which a fixed rate of payment per Enrollee per month is made to MCO for the performance of all of MCO's duties and obligations pursuant to this Contract.

Capitation Payment means payment, fixed in advance, that STATE makes to MCO for each Enrollee covered under the Contract for provision of Covered Services. This payment is made regardless of whether the Enrollee receives any Covered Services during the period covered by the payment.

Capitation Rate means the fixed per member per month amount for a defined set of Covered Services that MCO is prepaid by STATE for each Enrollee according to one of the Medicaid Expansion Rating Categories. For each applicable period, the Capitation Rate(s) will meet the requirements in 42 C.F.R. §438.4(b) and be actuarially sound.

Care Coordination is the deliberate organization of patient care activities by a person or entity, including MCO that is formally designated as primarily responsible for coordinating services furnished by Providers involved in the Enrollee's care, to facilitate the appropriate delivery of Health Care Services. Care coordination activities may include but are not limited to the coordination of specialty referrals, assistance with ancillary services, and referrals to and coordination with community services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of the Enrollee's care.

Care Management means an overall approach to managing Enrollees' care needs and encompasses a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage health conditions.

Care Needs Screening is a tool utilized by the MCO to conduct an assessment of an individual's physical health, Behavioral Health, and social service needs.

Case Management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual Enrollee's health-related needs through communication and available resources to promote quality and cost-effective outcomes. Case management implicitly enhances care coordination through the designation of a Case Manager whose specific responsibility is to oversee and coordinate access and care delivery targeted to high-risk patients with diverse combinations of health, functional, and social needs.

Case Manager is a licensed registered nurse, licensed mental health practitioner, or other trained individual who is employed or contracted by MCO or an Enrollee's PCP. The Case Manager is accountable for providing intensive monitoring, follow-up, clinical management of high risk Enrollees, and care coordination activities, which include development of the MCO plan of care; ensuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the PCP; supporting the Enrollee in addressing social determinants of health; and supporting safe transitions in care for Enrollees moving between institutional and community care settings. The Case Manager may serve on one or more multi-disciplinary

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care teams and is responsible for coordinating and facilitating meetings and other activities of those care teams.

Centers for Medicare & Medicaid Services (CMS) means the federal agency (and its designated agents) within the United States Department of Health and Human Services responsible for federal oversight of the Medicaid, Medicare, and Children's Health Insurance Programs.

Claim means: (1) a bill for services; (2) a line item of services; or (3) all services for one Enrollee within a bill.

Clean Claim means a Claim that can be processed without obtaining any additional information from the Provider of the service or from a third party. It includes a Claim with errors originating from MCO's Claims system. It does not include a Claim from a Provider who is under investigation for Fraud or Abuse, or a Claim under review for Medical Necessity.

Cold-Call Marketing means any unsolicited personal contact with a Potential Enrollee by MCO, its staff, its volunteers, or its vendors/Subcontractors for the purpose of influencing the Potential Enrollee to enroll in MCO or to not enroll in or disenroll from another MCO.

Comprehensive Risk Contract means a Risk Contract between STATE and MCO that covers comprehensive services, that is, inpatient hospital services, and any of the following services, or any of three (3) or more of the following services:

- Outpatient hospital services
- Rural Health Clinic services
- Federally Qualified Health Center (FQHC) services
- Other laboratory and X-ray services
- Nursing facility (NF) services
- Family planning services
- Physician services
- Home health services.

Contract means the written agreement between STATE and MCO regarding requirements for operation and administration of the Medicaid Managed Care Program for North Dakota.

Contracted Provider means a Practitioner and/or Provider who is directly contracted with MCO. Payment rates for all Practitioners and/or Providers are contractual with MCO.

Coordinated Services Program means the program that limits an Enrollee to certain prescribers and pharmacies; also referred to as a lock-in program.

Co-payment refers to any cost-sharing payment for which the Enrollee is responsible, in accordance with 42 C.F.R. §447.50 and Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) for Native American members.

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Cost Proposal means the portion of the Offeror's proposal in response to STATE's procurement that includes the Offeror's proposed rates to provide services under this Contract.

Covered Service means a service within the ABP, including the Essential Health Benefits, as well as services necessary to comply with Medicaid requirements and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, that is required to be provided by MCO; it does not include any services noted as Non-Covered within or attached to this Contract.

Durable Medical Equipment (DME) is inclusive of equipment which: (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) generally is not useful to a person in the absence of illness or injury; and (4) is appropriate for use in the home.

Emergency Medical Condition means medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of a woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Services means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations and Title XIX of the Social Security Act; and needed to screen, evaluate or stabilize an Emergency Medical Condition as defined under 42 C.F.R. §438.114.

Encounter means an individual service or procedure provided to an Enrollee that would result in a Claim if the service or procedure were to be reimbursed Fee-for-Service under the North Dakota Medicaid Program.

Enrollee means a Medicaid Expansion recipient who is currently enrolled by STATE with MCO. A Medicaid beneficiary shall be considered an Enrollee beginning on the effective date of Enrollment with MCO. The Enrollee may be entitled to retroactive coverage.

Enrollee with Special Health Care Needs (ESHCN) means individual who has, or is at increased risk for, chronic physical, developmental, behavioral, or emotional conditions who also requires health and related services of a type or amount beyond that required by an Enrollee generally.

Essential Health Benefits (EHB) are a set of 10 categories of services Health Insurance plans must cover under the ACA. They include:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Behavioral Health care services, including mental health and substance use disorder treatment services;

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- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Excluded Provider means a specific Provider who has defrauded or abused the Medicaid program and will not be reimbursed under Medicaid.

External Quality Review means the analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness, and access to the Health Care Services that MCO or its Subcontractors furnish to Medicaid Expansion Enrollees.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 C.F.R. §438.354, and performs External Quality Review, other EQR-related activities as set forth in 42 C.F.R. §438.358, or both.

Federally Qualified Health Center (FQHC) means an entity as defined in Section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. §1396d(l)(2)(B)).

Fee-for-Service (FFS) means the Fee-for-Service North Dakota Medicaid Program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes Fraud under applicable federal or state law. Under North Dakota Administrative Code (N.D.A.C.) §75-02-05-03, Fraud means deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or another and includes an act that constitutes Fraud under applicable federal or state law.

Full Credibility (or Fully Credible) means a standard for which the experience of an MCO is determined to be sufficient for the calculation of a Medical Loss Ratio with a minimal chance that the difference between the actual and target Medical Loss Ratio is not statistically significant. An MCO that is assigned Full Credibility (or is Fully Credible) will not receive a credibility adjustment to its MLR

Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination, as defined pursuant to 42 C.F.R. §438.400(b).

Grievance Process means MCO's process for handling Grievances that complies with the requirements including, but not limited to, the procedural steps for an Enrollee to file a Grievance, the process for disposition of a Grievance, and the timing and manner of required notifications.

Health Care Services means all Medicaid Expansion services provided by MCO under contract with State Medicaid agency in any setting, including but not limited to medical care and Behavioral Health care.

Healthcare Effectiveness Data and Information Set (HEDIS) means set of Performance Measures developed by the National Committee for Quality Assurance (NCQA). The measures are designed to help

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health care purchasers understand the value of health care purchases and measure plan (e.g., MCO) performance. HEDIS is a registered trademark of NCQA.

Health Insurance is a type of insurance coverage that pays for medical and surgical expenses incurred by the insured. Health Insurance can reimburse the insured for expenses incurred from illness or injury or pay the care Provider directly.

Home Health Care or Services refers to patient care services provided in the patient's residential setting or any setting in which normal life activities take place under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury including one or more of the following services: (1) skilled nursing; (2) physical therapy; (3) speech-language therapy; (4) occupational therapy; (5) home health aide services; or (6) medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place.

Hospice Services are an alternative treatment approach that is based on a recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and supporting family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of Hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

Hospitalization means the admission to a hospital for treatment.

Hospital Outpatient Care means care in a hospital that usually does not require an overnight stay.

Indian Health Care Provider (IHCP) is 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 I/T/U) as those terms are defined in §4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

In Lieu of Service (ILOS) means a medically-appropriate service outside of Covered Services or settings (or beyond service limits established by STATE for Covered Services) that are provided to Enrollees, at their option, by MCO as a cost-effective alternative to a Covered Service or setting. In lieu of services requested to be covered by the MCO and approved by the STATE are included in Appendix F.

Licensed Mental Health Professional (LMHP) is an individual who is licensed in the state of North Dakota to diagnose and treat mental illness or substance use disorder acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently as:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Licensed Mental Health Technician
- Advanced Practice Registered Nurses (APRN) that are nurse practitioner Specialists in Adult

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Psychiatric & Mental Health and Family Psychiatric & Mental Health or Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and may practice to the extent that services are within the APRN's scope of practice.

North Dakota also has Human Services Centers (HSCs) which act as Community Mental Health Centers.

Liquidated Damages means damages that may be assessed whenever an MCO, its Providers, and/or its Subcontractors fail to achieve certain performance standards and other items defined in the terms and conditions of the Contract.

Managed Care Organization (MCO) means an entity that meets the mandatory business requirements of the RFP and contracts with the state of North Dakota to provide Covered Services to North Dakota Medicaid Managed Care Program Enrollees in exchange for a monthly prepaid capitated amount per Enrollee.

Managed Care Program means North Dakota's Medicaid Expansion program providing Medicaid Covered Services to eligible Enrollees through select MCO(s) with the goal of effectively utilizing resources to promote the health and well-being of North Dakotans.

Material Subcontract means any contract or agreement by which MCO procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of any program area or function that relates to the delivery or payment of Covered Services including, but not limited to, Behavioral Health, Claims processing, Care Management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy Providers.

Material Subcontractor means an entity that has a contract with MCO for the provision of all, or part, of any program area or function that relates to the delivery or payment of Covered Services including, but not limited to, Behavioral Health, Claims processing, Care Management, utilization management, transportation, or pharmacy benefits, including specialty pharmacy Providers.

MCO Service Area means the geographic area including all counties within North Dakota plus one contiguous county into the bordering states of Minnesota, South Dakota, and Montana wherein MCO is authorized to act as an HMO or maintains a Network of Providers.

Medicaid Expansion means the group of individuals covered under Medicaid as set forth in Section 2001(a)(1) of the ACA (42 U.S.C. §1396a(a)(10)(A)(viii)) and as amended by Section 10201 of the ACA as codified at Section 1902(k)(2) of the Social Security Act (42 U.S.C. §1396a(k)(2)) and for which the state of North Dakota received CMS approval.

Medicaid Expansion Eligible Individual means any individual who has been determined eligible by STATE or its agents for coverage under the North Dakota Medicaid Expansion program.

Medicaid State Plan means the binding written agreement between STATE and CMS which describes how the Medicaid program is administered and determines the services for which STATE will receive federal financial participation.

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Medical Loss Ratio (MLR) means the percentage of Capitation Payments received by MCO from STATE in the MLR Reporting Year used to pay medical Claims from Providers consistent with 42 C.F.R. 438.8, this Contract and STATE reporting requirements.

Medically Necessary or Medical Necessity means those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary Services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such Medical Necessity and quality.

Medically Necessary Services are those Health Care Services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. To be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity, or malfunction; and (2) those for which no equally effective, more conservative, and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it does not mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Member Months mean the number of months an Enrollee or a group of Enrollees is covered by an MCO over a specified time period, such as a year.

Mental Health and Substance Use Parity means the requirement for health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care.

MLR Reporting Year means a period of 12 months consistent with the rating period selected by STATE.

Network (or In-Network) refers to the collective group of Providers who have entered into Provider agreements with MCO for the delivery of Covered Services. This includes but is not limited to physical, behavioral, pharmacy, and ancillary service Providers. Also referred to as Provider Network.

Network Adequacy refers to the Network of health care Providers for an MCO that is sufficient in numbers and types of Providers and facilities to ensure that all services are accessible to Enrollees without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, Provider patient ratios, geographic accessibility and travel distance, appointment accessibility, waiting

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times for appointments, and hours of Provider operations. Network Adequacy will be assessed on MCO's contracted Network Providers excluding single case agreements unless otherwise approved by STATE.

Network Provider means any Provider, group of Providers, or entity that has a Network Provider agreement with MCO, and receives Medicaid funding directly or indirectly to order, refer, or render Covered Services as a result of the State's contract with MCO. A Network Provider is not a Subcontractor.

No Credibility means a standard for which the experience of an MCO is determined to be insufficient for the calculation of an MLR. A MCO that is assigned No Credibility (or is non-credible) will not be measured against any MLR requirements.

Offer Point means the rate, within the Initial Actuarially Sound Capitation Rate Range, where Offeror's rate falls. The final Capitation Rate, based on STATE updates to the Initial Actuarially Sound Capitation Rate Range to incorporate more recent information, will remain at the same position in the Final Actuarially Sound Capitation Rate Range relative to the Initial Actuarially Sound Capitation Rate Range.

Offeror means an organization that submits a proposal to serve as an MCO under this Contract.

Operational Start Date refers to the first date on which MCO is responsible for providing Covered Services to their Enrollees and is responsible for compliance with all aspects of the Contract. This date is at the discretion of STATE but is anticipated to be January 1, 2022. The Operational Start Date may be delayed by STATE for one or more MCOs depending on readiness review results.

Out-of-Network (OON) Provider is an appropriately licensed individual, facility, agency, institution, organization, or other entity that has not entered into a contract or agreement with MCO for the delivery of MCO Covered Services to MCO's Enrollees. Also referred to as Non-Participating Provider.

Participating Provider means a Provider that has signed a Network Provider agreement with MCO.

Partial Credibility means a standard for which the experience of an MCO is determined to be sufficient for the calculation of an MLR but with a non-negligible chance that the difference between the actual and target Medical Loss Ratios is statistically significant.

Performance Measures means tools that quantify healthcare processes, outcomes, patient perceptions, and organizational structures and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

Physician Incentive Plan means any MCO compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

Physician Services means the services provided by an individual licensed under state law to practice medicine or osteopathy. It does not include services that are offered by doctors while admitted in the hospital, and charges for which are included in the hospital bill.

Plan means an individual or group that provides, or pays the cost of, medical care.

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Potential Enrollee means a Medicaid Expansion recipient who is subject to mandatory Enrollment or may voluntarily elect to enroll in MCO but is not yet an Enrollee of MCO.

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Preauthorization is the process of determining Medical Necessity for specific services before they are rendered. Also referred to as Prior Authorization.

Premium means an amount to be paid for an insurance policy.

Prescription Drugs refer to drugs that can be obtained only by means of a prescription.

Primary Care Physician or Provider (PCP) means an individual physician, nurse practitioner, or physician assistant who accepts primary responsibility for the management of an Enrollee's health care. The Primary Care Provider is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a Specialist (secondary/tertiary care), or admit the patient to a hospital.

Primary Care means Health Care Services and laboratory services customarily furnished by or through a PCP for diagnosis and treatment of acute and chronic illnesses, disease prevention and screening, health maintenance, and health promotion either through direct service to the Enrollee when possible or through appropriate referral to Specialists and/or ancillary Providers.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

Provider Performance Incentive means any payment or other compensation granted to, or withheld from a Provider as a result of engagement, or lack of engagement, in a targeted behavior, such as compliance with guidelines and other quality improvement initiatives, including APMs . All MCO Provider Performance Incentives must comply with CMS requirements for Physician Incentive Plans.

Provider Preventable Condition means a health care-acquired condition (HCAC) when it occurs in acute inpatient hospital settings only and other provider-preventable conditions when they occur in any health care settings. HCACs are the same as hospital-acquired conditions (HAC) for Medicare, except that STATE does not require Providers to report deep vein thrombosis/pulmonary embolism for pregnant women.

Rating Category means an identifier used by STATE to identify a specific grouping of Enrollees for which a discrete Capitation Rate applies pursuant to the Contract. See Article 4.1.2 of the Contract for more information on Rating Categories.

Region is defined for purposes of MCO Capitation Rates. North Dakota Counties designated in the urban rate region include Cass, Burleigh and Grand Forks counties. All other counties in North Dakota are designated as rural for MCO Capitation Rate purposes.

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Rehabilitation Services and Devices means services ordered by the Enrollee's PCP to help the Enrollee recover from an illness or injury. These services are provided by nurses and physical, occupational, and speech therapists.

Service Area means the designated area in which MCO is authorized to furnish Covered Services to Enrollees.

Skilled Nursing Care means a level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Social Security Act (the Act) refers to the Social Security Act of 1935, as amended, 42 U.S.C. §301-1397mm, which provides for the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Specialist is a health care professional who is not a Primary Care Physician.

STATE means the State of North Dakota, acting through its North Dakota Department of Human Services, Medical Services Division.

Subcontractor means an individual or entity that has a contract with MCO that relates directly or indirectly to the performance of MCO's obligations under its contract with STATE. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with MCO.

Technical Proposal means the portion of the Offeror's proposal in response to STATE's procurement that includes the Offeror's approach to meeting all programmatic functions under this Contract.

Third Party Liability (TPL) refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State Plan.

Transitional Care Management is the evaluation of an Enrollee's medical care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one level of care to another level of care, including referral to appropriate services.

TTY/TDD stands for Telephone Typewriter and Telecommunication Device for the Deaf, which allows for interpreter capability for deaf callers.

Urgent Care is medical care provided for a condition that, without timely treatment, could be expected to deteriorate into an emergency, or case prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require Urgent Care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected fracture. Urgent Care requires timely face-to-face medical attention within twenty-four (24) hours of Enrollee notification of the existence of an urgent condition.

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ARTICLE 2: CONTRACTOR RESPONSIBILITIES

2.1 Compliance

2.1.1 In connection with furnishing supplies or performing work under this Contract, persons who contract with or receive funds to provide services to STATE are obligated and agree to comply with:

(A) All requirements set forth in this Contract;

(B) All local, state, and federal laws, regulations, and executive orders related to the performance of this contract including the following: Fair Labor Standards Act, Equal Pay Act of 1963, Titles VI and VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the North Dakota Human Rights Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, the Drug Abuse Prevention, Treatment, and Rehabilitation Act of 1970, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Drug-Free Workplace Act of 1988, the Americans with Disabilities Act of 1990 as amended, Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992, Title IX of the Education Amendments of 1972, Executive Order 11246, "Equal Employment Opportunity," as amended by Executive Order 11375 and as supplemented by Department of Labor regulations at 41 CFR part 60, the Clean Air Act, the Federal Water Pollution Control Act, and Section 1557 of the Patient Protection and Affordable Care Act; and

(C) Federal statutes and regulations governing managed care, including, but not limited to, all applicable provisions of 42 U.S.C. §1396u-2 and 42 C.F.R. Part 438.

2.1.2 MCO must be an approved vendor with the Office of Management and Budget within the State of North Dakota as required by North Dakota Century Code §54-44.4-09.

2.1.3 Neither MCO nor any Material Subcontractor shall, for the duration of the Contract, have any interest that will conflict, as determined by STATE, with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, STATE requires that neither MCO nor any Material Subcontractor have any financial, legal, contractual, or other business interest in any entity performing MCO Enrollment functions for STATE, the Enrollment Broker, and Subcontractor(s), if any.

2.1.4 MCO shall establish and maintain interdepartmental structures and processes to support the operation and management of this Contract in a manner that fosters integration of physical and Behavioral Health care service provision. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment when such data are available.

2.1.5 MCO shall notify STATE in writing when there has been a significant change in its operations. The written notification shall include the details of the change and an assurance that it will not impact MCO's ability to comply with the requirements of this Contract.

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2.1.6 MCO shall comply with all of the reporting requirements established by this Contract.

2.1.7 MCO shall respond to all STATE requests within timeframes provided by STATE. Where there is a disagreement between MCO and STATE on final language in any document or whether information is proprietary, including in this Contract, STATE shall make the final decision.

2.2 Contract Transition and Readiness

2.2.1 As part of readiness reviews, MCO shall submit for STATE review and approval a Transition Work Plan that demonstrates how MCO will accomplish required tasks before the Operational Start Date. At a minimum, the Transition Work Plan shall include the following:

(A) Project management structure;

(B) Communication protocols between STATE and MCO;

(C) Interaction with State contractors;

(D) Schedule for key activities and milestones; and

(E) Evidence of completion of activities required for readiness review.

2.2.2 MCO agrees to provide all materials required to complete the readiness review by the dates established by STATE. The scope of the readiness review will include, but is not limited to, a review of the following elements:

(A) Network Provider composition and access;

(B) Staffing, including key personnel and functions directly impacting Enrollees;

(C) Capabilities of Subcontractors;

(D) Content of Provider agreements;

(E) Enrollee services capability (materials, processes, and infrastructure);

(F) Comprehensiveness of quality management/quality improvement and Utilization Management strategies;

(G) Internal Grievance and Appeal policies and procedures;

(H) Fraud and Abuse and program integrity policies and procedures;

(I) Financial solvency; and

(J) Information systems, including Claims payment system performance, processing Enrollment data, interfacing and reporting capabilities, and validity testing of Encounter data.

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2.2.3 MCO is required to provide a corrective action plan in response to any readiness review deficiency no later than ten (10) calendar days after notification of any such deficiency by STATE. If MCO documents to STATE's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by STATE, no corrective action plan is required.

2.2.4 MCO must successfully meet all readiness review requirements established by STATE no later than sixty (60) calendar days prior to the Contract Operational Start Date.

2.2.5 If MCO does not fully meet the readiness review prior to the Contract Operational Start Date, STATE may impose Liquidated Damages or other available remedies in accordance with Article 5.9.5 for each day beyond the contract start date that MCO is not operational. STATE may also, at its discretion, postpone the Contract Operational Start Date if MCO fails to satisfy all readiness review requirements.

2.3 Administration and Contract Management

2.3.1 Staffing Requirements

(A) MCO shall have in place organizational, operational, managerial, and administrative systems capable of fulfilling all Contract requirements. MCO shall recruit, develop, and retain a diverse and qualified staff in numbers appropriate to MCO's Enrollment, as described further below.

(B) MCO shall not employ or subcontract with any individual who has been debarred, suspended, or otherwise lawfully prohibited from participating in any federal healthcare program. MCO shall screen all potential employees and Subcontractors to determine whether any of them have been excluded from participation in federal healthcare programs utilizing, at a minimum, the following websites:

(1) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);

(2) The System of Award Management (SAM); and

(3) Other applicable sites as may be determined by STATE.

(C) MCO shall employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. MCO's resource allocation shall be adequate to achieve positive outcomes in all functional areas within the organization. Adequacy shall be evaluated based on outcomes and compliance with the requirements of the Contract, including the requirement for providing culturally competent services. MCO shall have a liaison to support Native American/Alaskan Native Enrollees.

(D) If MCO does not achieve the desired outcomes or maintain compliance with contractual obligations, STATE may take non-compliance actions as specified in Article 5.9 of this Contract, which include but are not limited to, requiring MCO to hire additional staff and the application of sanctions.

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(E) MCO shall conduct an annual criminal background check on all current or potential employees or Subcontractors who have access to Enrollee protected health information. MCO shall, upon request, provide STATE with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or Subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.

(F) MCO shall submit to STATE a listing of its Board of Directors as of the Contract execution date, and an updated listing of its Board of Directors whenever any changes are made.

(G) MCO must provide a copy of the current organizational chart with reporting structures, names, and positions to STATE annually and upon request.

(H) MCO may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law.

2.3.2 Key Personnel

(A) MCO shall have, at a minimum, the following key management personnel or persons with comparable qualifications, as listed below, employed during the term of this Contract.

Executive Positions:

(1) Chief Executive Officer (CEO): A full-time designated CEO (Contract Officer), with decision-making authority, to administer the day-to-day business activities conducted pursuant to this Contract. The CEO or person with comparable qualifications must be authorized and empowered to make operational and financial decisions, including rate negotiations for North Dakota, Claims payment, and Provider relations/contracting. The CEO or comparable person must be able to make decisions about coordinated care activities. CEO shall represent MCO at meetings at least once per quarter as required by STATE.

(2) Chief Operating Officer: A designated Chief Operating Officer to oversee day-to-day business activities conducted pursuant to this Contract.

(3) Chief Financial Officer: A professional designated to oversee financial-related functions of MCO.

(4) Medical Director: A physician who shall be responsible for all clinical decisions of MCO, and who shall oversee and be responsible for the proper provision of Covered Services to Enrollees. The Medical Director shall be responsible for overseeing functions of the Credentialing Committee. The Medical Director will also serve as a liaison between MCO and Providers; be available to MCO's staff for consultation on referrals, denials, Complaints, Grievances, and Appeals; and review potential quality of care problems and participate in the development and implementation of corrective action plans.

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(5) Care Management Director: A North Dakota licensed nurse with a minimum of five (5) years of combined experience in Care Management and disease management. This person shall be responsible for the assessment, planning, coordination, development, compliance and evaluation of Care Management and disease management programs.

(6) Behavioral Health Director: A Behavioral Health professional licensed in North Dakota who has at least five (5) years of combined experience in managing or supervising the provision of mental health and substance use services. This person shall oversee and be responsible for the implementation of Behavioral Health care services as described in Appendix B: MCO Covered Services of this Contract. The Behavioral Health Director is responsible for working with the Medical Director to support the integrated delivery of physical and Behavioral Health care services.

(7) Chief Information Officer: A professional who oversees information technology and systems to support MCO operations, including submission of accurate and timely Enrollee Encounter Data.

(8) Compliance Officer: A professional with at least five (5) years of Medicaid and/or managed care experience, and who has at least some Medicaid knowledge and relevant experience with similar complex projects. The Compliance Officer must be full-time, located in North Dakota, and available to be in Bismarck for meetings at STATE offices as needed. The Compliance Officer is designated by MCO to act as a primary point of contact for STATE.

Administrative Positions:

(9) Provider Services Manager: A dedicated professional to be responsible for Provider Services and Network development.

(10) Enrollee Services Manager: A dedicated professional to be responsible for Enrollee Services functions.

(11) Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities.

(12) Utilization Management Coordinator: A designated health care Practitioner to be responsible for utilization management functions.

(13) Complaint/Grievance Coordinator: A designated person for the processing and resolution of Complaints, Grievances, and Appeals.

(14) Claims Administrator: A designated professional to oversee Claims administration.

(B) MCO's designated compliance officer shall be authorized and empowered to represent MCO regarding all aspects of the Contract. This representative shall act as a liaison between MCO and STATE and shall be responsible for:

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(1) Monitoring compliance with the terms of the Contract;

(2) Receiving and responding to all inquiries and requests made by STATE under this Contract, within the time frames specified by the Contract;

(3) Meeting with STATE's representative(s) at least once per quarter in person and additionally as requested by STATE to address and resolve issues which arise with MCO and the Contract;

(4) Coordinating requests from STATE and related MCO activities to ensure that MCO staff with appropriate expertise in clinical, financial, data, systems, marketing/enrollment, and quality management matters, are appropriately informed and involved in MCO responses, initiatives, and meetings with STATE;

(5) Coordinating requests from STATE to ensure that appropriate MCO staff are promptly available to assist with care and service coordination activities for Enrollees, and Provider complaints and inquiries; and

(6) Making best efforts to resolve any issues identified either by MCO or STATE that are applicable to the Contract.

(C) Key management positions cannot be vacant for more than ninety (90) calendar days. MCO must notify STATE within five (5) business days of learning that any key position is vacant or anticipated to be vacant within the next thirty (30) calendar days.

(D) Prior to diverting any of the specified key personnel for any reason, MCO must notify STATE in writing, and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of Covered Services and performance of core functions under this Contract. These changes are to be reported to STATE when individuals either leave or are added to these key positions.

2.3.3 Exception to Staffing Requirements

(A) Requests for exceptions to mandatory staffing requirements shall be submitted in writing to STATE for prior approval.

(B) MCO shall address the reason for the request, the organization's ability to furnish services as contractually required with the exception in place, and duration of exception period requested.

(C) MCO may propose to STATE a staffing plan that combines positions and functions outlined in the Contract with other positions, provided MCO describes how the staffing roles delineated in the Contract will be addressed.

2.3.4 Staff Training and Licensure

(A) MCO shall ensure that all staff members, including Subcontractors, have met any applicable state or federal licensure requirements and have received appropriate training, education, experience, and orientation to fulfill the requirements of their

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position. STATE may require additional staffing if MCO substantially fails to maintain compliance with any provision of the Contract.

(B) MCO shall provide initial and ongoing staff training that includes an overview of contractual, state, and federal requirements specific to individual job functions. MCO shall ensure that all staff members having contact with Enrollees or Providers receive initial and ongoing training on health equity and social determinants of health, and with regard to the appropriate identification and handling of quality of care concerns.

(C) MCO shall educate all staff members about its policies and procedures on advance directives.

2.3.5 Policies and Procedures for Core Functions

MCO shall develop, maintain, and provide to STATE upon request policies and procedures for all core functions necessary to effectively and efficiently manage the Medicaid Expansion population and meet the requirements outlined in this Contract. All policies and procedures requiring STATE approval shall be documented and shall include the dates of approval by STATE. These policies and procedures shall include, but are not limited to, the following:

(A) Violations of Enrollees' privacy rights by staff, Providers, or Subcontractors;

(B) Non-discrimination of Enrollees;

(C) Non-restriction of Providers advising or advocating on an Enrollee's behalf;

(D) Appeal rights for certain minors who under the law may consent to medical procedures without parental consent;

(E) Enrollee cooperation with those providing Health Care Services;

(F) Marketing activities that apply to MCO, Providers, and Subcontractors, as well as MCO's procedures for monitoring these activities;

(G) Cost-sharing by Enrollees;

(H) Advance Directives;

(I) Assisting Enrollees in understanding their benefits and how to access them;

(J) Access and availability standards;

(K) Enrollees' right to be free from restraint or seclusion used as a means of coercion or retaliation;

(L) The provision of culturally and linguistically appropriate services;

(M) Practice guidelines in quality measurement and improvement activities;

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(N) Compliance with Emergency Services and Post-stabilization Care Services requirements as identified in 42 C.F.R. 438.114(b);

(O) Procedures for tracking Appeals when Enrollees become aware of the Adverse Action, in the event that no notice had been sent;

(P) Handling of Complaints/Grievances;

(Q) Process used to monitor Subcontractor performance; and

(R) Retention of medical records.

2.3.6 Service Area

The Service Area for this Contract is all counties in the state of North Dakota.

2.3.7 Physical Presence in North Dakota

MCO shall not be located outside of the United States and no operations, including that of a Material Subcontractor, may be conducted outside of the United States. MCO shall have an Administrative Office located in North Dakota and within a three (3) hour drive of the North Dakota Department of Human Services, Medical Services Division's location in East Boulevard Avenue, Bismarck, North Dakota.

2.3.8 Communication with Medicaid Agency

(A) MCO shall perform all of the services and shall develop, produce, and deliver to STATE all of the statements, reports, data, accountings, Claims, and documentation described herein, in compliance with all the provisions of this Contract.

(B) MCO shall acknowledge receipt of STATE's written, electronic, or oral requests for assistance or information no later than one (1) business day from receipt of request from STATE, and the request shall be completed by MCO to the satisfaction of STATE within five (5) business days from the date of receipt unless STATE specifies another time frame. Requests by MCO for extension of the time frame may be granted by STATE in its discretion.

(C) For urgent requests from STATE, MCO shall immediately, without unreasonable delay, acknowledge STATE's urgent requests for assistance and shall give such requests priority. Urgent requests shall be completed by MCO to the satisfaction of STATE within the time frame specified by STATE. If no time frame is specified, such requests shall be completed within two (2) business days from the date of the receipt. Such urgent requests include, but are not limited to, issues involving Executive or Legislative Branch requests, Care Management evaluation requests involving Enrollees or Providers requiring an expeditious response based on the Enrollee's health condition, and/or requests related to a state or federal emergency.

(D) For any request involving personally identifiable or proprietary information, STATE shall make the final determination of what information may be redacted.

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(E) MCO's acknowledgement of STATE requests for assistance must include the required date of resolution. If the request is received from STATE in writing or electronically, MCO shall acknowledge receipt in the same manner the request was received, either in writing or electronically. If the request was received from STATE orally, MCO shall acknowledge receipt of the request orally and immediately follow-up with a written or electronic acknowledgement. Upon completion of the request, MCO shall submit to STATE, on or before the required date of completion, a detailed completion summary advising STATE of MCO's action and resolution. The completion summary shall contain all information necessary for STATE to adequately determine whether a request has been completed and shall conform to specifications requested by STATE concerning form, format, or content of the summary, if any. STATE requests shall not be considered complete if MCO fails to submit the completion summary, and completion will not be considered timely if MCO fails to submit the summary on or before the required completion date. Submission of the completion summary in and of itself does not constitute completion of the summary request.

2.3.9 Subcontracts and Delegation of Duty

(A) General Provisions

(1) MCO shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract and may delegate performance of work required under this Contract to a Subcontractor.

(2) Prior to contracting with a Subcontractor, MCO shall evaluate the prospective Subcontractor's ability to perform the activities to be subcontracted.

(3) All subcontracts must be in writing and must comply with 42 C.F.R. §438.230 and all applicable Medicaid laws and regulations, including any other applicable State or federal law, sub-regulatory guidance, and Contract provision, that are appropriate to the service or activity delegated under this Contract.

(4) MCO shall make available all Subcontracts for inspection by STATE within fifteen (15) calendar days upon STATE's request.

(5) If STATE determines, at any time, that a Subcontract is not in compliance with a Contract requirement, MCO shall promptly revise the Subcontract into compliance. In addition, MCO may be subject to sanctions and/or Liquidated Damages pursuant to Article 5.9.

(6) No Subcontract that MCO enters into with respect to performance under this Contract shall, in any way, relieve MCO of any responsibility for the performance of duties under this Contract.

(B) Material Subcontract

(1) Any Material Subcontract, as defined in Article 1: Definition of Terms, that MCO proposes to enter into must receive prior written approval from STATE.

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(2) At least ninety (90) calendar days before the proposed effective date of the Material Subcontract or change, MCO shall make a request in writing and submit with that request a completed Material Subcontractor Checklist using the template provided by STATE in **Appendix A: Material Subcontractor Checklist** to demonstrate the Material Subcontractor's compliance with requirements as defined in this Contract. Failure to demonstrate compliance may result in STATE withholding approval of the Material Subcontract.

(3) MCO shall notify STATE within five (5) business days of a) MCO's notice to terminate a contract with a Material Subcontractor, or b) notice by a Material Subcontractor of intention to terminate a contract with MCO.

(C) Subcontract Requirements

All model and executed Subcontracts and amendments used by MCO under this Contract shall meet the following requirements:

(1) Contain provisions specifically describing the activities, service, or responsibility delegated to the Subcontractor wherein the Subcontractor agrees to perform the delegated activities and reporting responsibilities specified, in compliance with MCO's contract obligations.

(2) Provide for revoking delegation, or imposing other sanctions, if the Subcontractor's performance is inadequate.

(3) Require safeguarding of information about Enrollees according to 42 C.F.R. §438.224.

(4) Require that the Subcontract allow STATE, CMS, the DHHS Inspector General, The Comptroller General, or their designees 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 MCO's contract with STATE.

(5) Require that the Subcontractor make available, for the purposes of an audit, evaluation, or inspection by STATE, CMS, the DHHS Inspector General, the Comptroller General, or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Enrollees.

(6) Require the Subcontractor to agree that the right to audit by STATE, CMS, the DHHS Inspector General, the Comptroller General, or their designees, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(7) Require that if STATE, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, STATE, CMS, or the DHHS Inspector General or their designees may inspect, evaluate, and audit the

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Subcontractor at any time.

(8) Require an exculpatory clause, which survives Subcontract termination, including breach of Subcontract due to insolvency, which assures that Enrollees or STATE shall not be held liable for any debts of the Subcontractor.

(9) Contain a clause indemnifying, defending, and holding STATE, its designees, and MCO's Enrollees harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Subcontract agreement. This clause must survive the termination of the Subcontract, including breach due to insolvency.

(10) Specify that if the Subcontractor delegates or subcontracts any functions of its contract with MCO, that the Subcontract or delegation shall include all the requirements of this Contract, to the extent relevant to the duties performed by the Subcontractor.

2.3.10 Subcontractor Monitoring and Oversight

(A) MCO shall have a written plan for monitoring and oversight of performance under these subcontracts, including provisions for assessing Subcontractor compliance and corrective actions and/or termination as appropriate. MCO shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Contract and shall provide STATE with its monitoring schedule for all State-approved Subcontractors by December 1 of each contract year.

(B) MCO shall immediately advise STATE of the insolvency of a Subcontractor, or of the filing of a petition in bankruptcy by or against a principal Subcontractor.

(C) MCO shall have a contingency plan for each subcontract to provide for continuity of care should the Subcontractor cease to provide services that are the subject of the subcontract.

(D) STATE will consider MCO to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Subcontract.

2.4 Enrollment and Disenrollment

2.4.1 Enrollment into MCO

(A) MCO shall abide by all Medicaid managed care Enrollment and disenrollment procedures, which are at the sole discretion of STATE.

(B) MCO shall accept for Enrollment all Potential Enrollees referred by STATE in the order in which they are referred without restriction.

(C) MCO may not pre-screen or select Potential Enrollees based on pre-existing health conditions or problems.

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(D) MCO shall not discriminate against Enrollees or Potential Enrollees and shall not have any policy or practice that has the effect of discriminating, on the basis of race; ethnicity; color; national origin; disability; sex; gender; gender identity; sexual orientation; religion; religious beliefs; sources of payment for medical services; existence of an Advance Directive; or age.

(E) MCO shall not discriminate against Enrollees or against Potential Enrollees based on health status or the need for Health Care Services, including an Enrollee or Potential Enrollee's current or past history of a mental health and substance use disorder.

2.4.2 MCO Assignment for New Enrollees

Potential Enrollees shall be assigned to an MCO at the time eligibility is determined.

2.4.3 Enrollment Period

(A) Each Enrollee will be enrolled for the period of this Contract or the period of the Enrollee's eligibility for Medicaid Expansion unless the Enrollee disenrolls, or is disenrolled, whichever occurs earlier.

(B) Until and unless STATE notifies MCO that an Enrollee has been disenrolled from MCO, MCO must automatically re-enroll the Enrollee at the end of each month. MCO is responsible for verifying enrollment using the most current information provided by STATE in the secure electronic transmission file of eligibility.

2.4.4 Suspension of and/or Limits on Enrollments

(A) MCO shall identify the maximum number of Enrollees it is able to enroll and maintain under the Contract prior to initial enrollment. STATE reserves the right to approve or deny the maximum number of Enrollees to be enrolled in MCO based on STATE's determination of the adequacy of MCO's capacity.

(B) STATE's evaluation of an MCO's enrollment market share will take place on a calendar quarter basis.

2.4.5 Involuntary Disenrollment Requested by MCO

(A) MCO may not request the disenrollment of any Enrollee because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when the individual's continued enrollment seriously impairs MCO's ability to furnish services to the Enrollee or other Enrollees as permitted by Section 1903(m)(2)(A)(v) of the Act and 42 C.F.R. §438.56(b)(2).

(B) The MCO, however, may submit a written request, accompanied by supporting documentation, to STATE to disenroll an Enrollee for cause as permitted by Section 1903(m)(2)(A)(v) of the Act and 42 C.F.R. §438.56(b)(2).

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(C) MCO may not initiate or authorize the disenrollment of any Enrollee; however, MCO shall provide information to STATE if one or more of the following reasons for disenrollment occurs:

(1) Upon termination or expiration of this Contract;

(2) Death of the Enrollee;

(3) Confinement of the Enrollee in an institution when confinement is not a Covered Service under this Contract;

(4) MCO has received information indicating that an Enrollee may not be eligible for coverage under the health plan; or

(5) MCO has received an oral or written request from an Enrollee requesting disenrollment from MCO.

(D) To initiate disenrollment of an Enrollee's participation with this MCO based on information provided by MCO, STATE shall review documentation justifying the proposed disenrollment.

(E) STATE shall indicate the approval or denial of MCO's disenrollment request per the eligibility transmission file once a determination has been made.

2.4.6 Eligibility File

(A) MCO shall follow the policies and procedures found in STATE's 834 Eligibility Transmission Manual, the HIPAA 834 Best Practices Manual, or a mutually agreed upon proprietary file transfer format and any amendments to these documents.

(B) MCO shall receive, process, and update outbound 834 enrollment files from STATE. Enrollment data shall be updated or uploaded systematically to MCO's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from STATE. Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt. MCO shall accept and maintain within its system all indicators included in the file received from STATE. MCO shall report to STATE, in a form and format to be provided by STATE, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed. Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from STATE and/or persistent issues with high volumes of transitions that require manual upload may require MCO to initiate a Corrective Action Plan or resolution of the issues preventing compliance. If MCO has reason to believe they may not meet this requirement based on unusual circumstances, MCO must notify STATE and STATE may make an exception without requiring a Corrective Action Plan.

(C) MCO shall be responsible for ensuring that it is using the most recent eligibility transmission file when processing Claims.

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(D) The effective date of initial enrollment in an MCO shall be the date provided on the outbound 834 enrollment file from STATE.

(E) Enrollment shall begin at 12:01 a.m. on the effective date of enrollment in MCO and shall end at 12:00 midnight on the date that the Enrollee is disenrolled from MCO. Once enrolled in MCO, the Enrollee shall remain enrolled in MCO until or unless the Enrollee is disenrolled pursuant to Article 3.4.4 of this Contract.

2.4.7 Enrollee Orientation

(A) MCO shall ensure that each Enrollee receives an Enrollee ID card(s) within ten (10) business days after MCO has been notified through the eligibility transmission of the Enrollee's enrollment in MCO.

(B) MCO shall ensure that all eligible Enrollees receive an Enrollee handbook within thirty (30) calendar days after MCO has been notified through the eligibility transmission of the Enrollee's enrollment in MCO.

(C) MCO shall ensure that all eligible Enrollees receive any documents required to be delivered to the Enrollee per North Dakota Insurance Department requirements.

(D) MCO shall ensure that Enrollees are provided interpreters, Telecommunication Device for the Deaf (TDD), and other auxiliary aids to ensure that Enrollees understand their benefits, rights, and responsibilities.

(E) During the initial contact, MCO's representative shall provide, at minimum, the following information to the Enrollee or Potential Enrollee:

(1) Specific written and oral instructions on the use of MCO's Covered Services and procedures and Provider Network information;

(2) Availability and accessibility of all Covered Services, including the availability of family planning services, and that the Enrollee may obtain family planning services from Out-of- Network Providers;

(3) Enrollees or Providers must contact MCO to request authorization to receive services from Out-of-Network Providers;

(4) The rights and responsibilities of the Enrollee under the health plan, including the right to file a Grievance, and the process for filing the Grievance;

(5) The right to terminate enrollment with MCO; and

(6) Encouragement to make a medical appointment with a Provider.

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2.5 Enrollee Services

2.5.1 Enrollee Rights and Responsibilities

(A) MCO shall have written policies regarding Enrollee rights and responsibilities. MCO shall comply with all applicable State and federal laws pertaining to Enrollee rights and privacy. MCO shall further ensure that MCO's employees, Subcontractors, and Network Providers observe and respect those rights when providing services to Enrollees.

(B) MCO shall include all of the following Enrollee rights and protections in its written policies:

(1) The right to receive information about MCO's plan in accordance with 42 C.F.R. §438.10;

(2) The right to be treated with respect and with due consideration for his or her dignity and privacy;

(3) The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

(4) The right to obtain available and accessible MCO Covered Services;

(5) The right to participate in decisions regarding his or her health care, including the right to refuse treatment;

(6) The right to request and receive a copy of their medical records and request that they be amended or corrected, as specified in 45 C.F.R. §164.524 and 45 C.F.R. §164.526;

(7) The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion; and

(8) The right to be free to exercise all rights and that by exercising those rights, the Enrollee shall not be adversely treated by STATE, MCO, and its Network Providers.

2.5.2 Enrollee Call Center

(A) MCO shall maintain a toll-free Enrollee service call center, physically located in the United States, with dedicated staff to respond to Enrollee questions including, but not limited to, such topics as:

(1) Explanation of MCO policies and procedures;

(2) Prior Authorizations;

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(3) Access information;

(4) Information on PCPs or Specialists;

(5) Referrals to participating Specialists;

(6) Resolution of service and/or medical or Behavioral Health care service delivery problems;

(7) Enrollee rights and responsibilities;

(8) Coordination of support services available through Medicaid or community organizations;

(9) Enrollee Grievances; and

(10) Information on Behavioral Health Care Services and Providers.

(B) The toll-free number must be staffed between the hours of 8 a.m. and 6 p.m. Central Time, Monday through Friday, excluding North Dakota state designated holidays.

(C) The toll-free line shall have an automated system, available twenty-four (24) hours a day, seven (7) days a week. This automated system shall include the capability to provide callers with operating instructions on what to do in case of an emergency, and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. MCO shall ensure that the voice mailbox has adequate capacity to receive all messages and that Enrollee services staff return all calls by close of business the following business day.

(D) The toll-free phone line shall be accessible by all Enrollees, regardless of whether they are calling about physical health or Behavioral Health care services. MCO may either route the call to another entity or conduct a "warm transfer" to another entity, but MCO shall not require an Enrollee to call a separate number regarding Behavioral Health care services.

(E) If MCO's nurse triage/nurse advice line is separate from its Enrollee services line, the number for the nurse triage/nurse advice line shall be the same for all Enrollees, regardless of whether they are calling about physical health or Behavioral Health care services, and MCO may either route calls to another entity or conduct "warm transfers," but MCO shall not require an Enrollee to call a separate number.

(F) MCO shall have sufficient telephone lines to answer incoming calls. MCO shall ensure sufficient staffing to meet performance standards listed in this Contract. STATE reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or STATE determines that the call center staffing and/or processes are not sufficient to meet Enrollee needs.

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(G) MCO shall develop a contingency plan for hiring call center staff to address overflow calls and emails, and to maintain call center access standards set forth for MCO performance. MCO shall develop and implement a plan to sustain call center performance levels in situations where there is high call and/or e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses, and vacations.

(H) MCO shall develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards and emergencies. MCO shall submit these telephone help line policies and procedures, including performance standards, to STATE for written approval at least thirty (30) calendar days prior to implementation of any policies. This shall include a capability to track and report information on each call. MCO shall have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements in Appendix D: MCO Compliance, Operations, and Quality Reporting.

(I) MCO shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. MCO shall submit call center quality criteria and protocols to STATE for review and approval annually.

(J) MCO shall provide general assistance and information to individuals and their families seeking to understand how to access care.

2.5.3 Enrollee Call Center Performance Standards

(A) MCO shall meet the following requirements on a weekly basis:

(1) Answer ninety-five percent (95%) of calls within thirty (30) seconds or direct the call to an automatic call pickup system with IVR options;

(2) Have no more than one percent (1%) of incoming calls receive a busy signal;

(3) Maintain a hold time of three (3) minutes or less. Hold time, or wait time, for the purposes of this Contract includes: (1) the time a caller spends waiting for a customer service representative to assist them after the caller has navigated the IVR system and requested a live person; and (2) the measure of time when a customer service representative places a caller on hold; and

(4) Maintain abandoned rate of calls of not more than five percent (5%).

(B) MCO shall conduct ongoing quality assurance to ensure these standards are met.

(C) On a quarterly basis, MCO shall submit to STATE a report that tracks weekly performance against the call center performance standards outlined in this Article.

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2.5.4 24-Hour Behavioral Health Crisis Line

(A) MCO shall maintain a twenty-four (24) hour toll-free crisis response center to respond to Behavioral Health care service needs. The crisis line may be combined with MCO's twenty-four (24) hour nurse line or may be a separate line, but must adhere to the following requirements:

(1) Have twenty-four (24) hour, seven (7) day a week access to trained staff;

(2) Be answered by a live voice at all times; and

(3) Have sufficient telephone lines and staffing to promptly answer incoming calls.

(B) MCO shall assist and triage callers who may be in crisis by effectuating an immediate transfer to a Case Manager or other clinical staff as approved by STATE. The call shall be answered within thirty (30) seconds and only transferred via a warm transfer to a North Dakota Licensed Mental Health Professional. MCO shall respect the caller's privacy during all communications and calls.

(C) MCO shall train crisis line staff on Covered Services for Behavioral Health needs and comprehensive Provider Network. MCO shall refer Enrollees for services across the entire Provider Network.

2.5.5 Interpretation Services

(A) MCO must provide an annual plan, subject to STATE approval, for identifying non-English languages spoken by Enrollees.

(B) MCO shall make interpretation services, including real-time oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL), available free of charge to each Enrollee.

(C) Interpretation services shall be made available for all non-English languages, not just those languages that meet the definition of Prevalent Language under this Contract and must be provided at no cost to Enrollees.

(D) MCO shall ensure that its Network Providers have interpretation services available.

(E) Interpretation services must be provided for both in-person and telephone communications to ensure that an Enrollee is able to communicate with MCO and Providers.

(F) Qualified interpreters shall be provided when needed, including where technical, medical, or treatment information is to be discussed. Pursuant to 45 C.F.R. §92.201, an adult family member or friend may be used as an interpreter if this method is requested by the patient, the adult family member or friend agrees to provide such assistance, and the use of such a person would not compromise the effectiveness of services or violate the patient's confidentiality. The Enrollee must be advised that a qualified interpreter is available at no charge to the Enrollee and should be advised that they are in no way

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required to provide a family member or friend as an interpreter.

(G) MCO shall notify its Enrollees that interpretation is available for any language and how to access those services.

2.6 Enrollee Education and Marketing Activity Requirements

2.6.1 General Guidelines on Enrollee Education and Marketing

(A) Marketing, for purposes of this Contract, is defined in 42 C.F.R. §438.104(a) as any communication from an MCO to a Medicaid beneficiary who is not enrolled in that MCO that can reasonably be interpreted to influence the beneficiary to: (1) enroll in that MCO; or (2) either not enroll in, or disenroll from, another MCO.

(B) Marketing differs from Enrollee education, which is defined as communication with an Enrollee of an MCO for the purpose of retaining the individual as an Enrollee and improving the health status of Enrollees.

(C) Marketing and Enrollee education include both verbal presentations and written materials.

(D) Marketing materials are produced in any medium and include, but are not limited to, the concepts of advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts, and electronic messages designed to increase awareness and interest in MCO. This includes any information that can reasonably be interpreted as intending to market MCO to Potential Enrollees.

(E) Enrollee materials generally include, but are not limited to, Enrollee handbooks, identification cards, Provider directories, health education materials, form letters, mass mailings, e-mails, SMS messages, Enrollee letters, and newsletters.

(F) All marketing and Enrollee education guidelines are applicable to MCO, its agents, Material Subcontractors, volunteers, and/or Providers.

(G) All marketing and Enrollee education activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of beneficiaries or the general community.

(H) MCO is responsible for creation, production and distribution of Enrollee materials to its Enrollees.

(I) All marketing and Enrollee materials and activities shall comply with the information requirements in 42 C.F.R. §438.10 and STATE requirements set forth in this Contract.

(J) MCO shall provide information to Enrollees and Potential Enrollees in a manner and format that may be easily understood and is readily accessible by such Enrollees and Potential Enrollees [42 C.F.R. §438.10(c)(1)].

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(K) MCO shall not perform any direct marketing to Potential Enrollees in accordance with 42 U.S.C. §1396u-2(d)(2) and 42 C.F.R. §438.104.

(L) MCO shall ensure that marketing and Enrollee materials are accurate and do not mislead, confuse, or defraud the Enrollee/Potential Enrollee or STATE as required by 42 U.S.C. §1396u-2(d)(2) and 42 C.F.R. §438.104.

(M) MCO shall comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care, as outlined by the Department of Health and Human Services' Office of Minority Health, incorporating the standards found here: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.

(N) Any distribution of marketing materials shall be done throughout MCO's entire Service Area, as defined in this Contract.

(O) MCO sponsorships and events shall be scheduled throughout the State in a geographically equitably manner.

2.6.2 Guidelines for Written Materials

(A) MCO shall comply with the following requirements as it relates to written Enrollee materials:

(1) All Enrollee materials shall be worded at an eighth (8^{th}) grade reading level, unless STATE approves otherwise;

(2) All written materials shall be clearly legible and, unless otherwise directed by STATE, must be written with a minimum font size of 12pt. with the exception of Enrollee ID cards and certain taglines that require a minimum font size of 18pt. Any request from MCO for an exception to the written materials font size requirements shall be approved in writing by STATE prior to use;

(3) MCO must make its written materials that are critical to obtaining services, including, at a minimum, Provider directories, Enrollee handbooks, Appeal and Grievance notices, and denial and termination notices available in the Prevalent non-English languages in the Service Area at no cost to Enrollees;

(4) Written materials that are critical to obtaining services must include taglines in the Prevalent Non-English Languages in the state of North Dakota, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided, how to request auxiliary aids and services including materials in alternative formats, and the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of MCO's Enrollee/customer service unit. Prevalent non-English languages are defined by guidance issued under Section 1557, CMS, HHS, and HHS OCR lists the top 15 non-English languages spoken by individuals with LEP in North Dakota; and

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(5) All written Enrollee materials shall notify Enrollees that oral interpretation is available for any language at no expense to them and how to access those services.

(B) MCO must make written materials available in alternative formats, upon request and at no cost to Enrollees.

(C) All written Enrollee materials shall ensure effective communication with disabled/handicapped persons at no cost to the Enrollee and/or the Enrollee's representative. Effective Communication may be achieved by providing aids or services, including, but may not be limited to: Braille, large print, and audio and shall be based on the needs of the individual Enrollee and/or the Enrollee's representative.

(D) MCO and its Network Providers and direct service Subcontractors shall be required to comply with the Americans with Disabilities Act of 1990 in the provision of auxiliary aids and services to Enrollees and/or the Enrollee's representative to achieve effective communication.

(E) The following shall not be used on any written materials, including but not limited to marketing and Enrollee materials, without the written approval of STATE:

(1) The Seal of the state of North Dakota.

(2) The North Dakota Department of Human Services logo.

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

(4) The use of phrases to encourage enrollment such as "keep your doctor" implying that Enrollees can keep all of their Providers. Enrollees in MCO shall not be led to think that they can continue to go to their current Provider, unless that particular Provider is a Network Provider with MCO.

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

2.6.3 Education Activities

(A) General Enrollee Information Requirements

(1) MCO shall write all Enrollee and Potential Enrollee informational, instructional, and educational materials, including MCO's Enrollee handbook, Provider directories, Appeal and Grievance notices, and denial notices, in a manner that may be easily understood at an eighth (8th) grade reading level and in a font size no smaller than 12 point. This requirement does not apply to the Certificate of Coverage.

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(2) MCO shall utilize easily understood Enrollee handbooks in the top 15 languages spoken by individuals with LEP in North Dakota that indicate the availability of language assistance in accordance with guidance issued under Section 1557, CMS, HHS, and HHS OCR.

(3) MCO must provide the Enrollee handbook and Certificate of Coverage in a manner and format that may be easily understood, in accordance with 42 C.F.R. §438.10. This includes ensuring capacity to meet the needs of Prevalent non-English language groups within the Service Area, as outlined in Articles 2.5.5 and 2.6.2, and making available materials in alternative formats upon request.

(4) If the certificate of coverage, Enrollee handbook, formulary, and Provider directory are provided electronically, MCO must:

(a) Provide materials in a format that is Readily Accessible using JavaScript Object Notation (JSON) file format;

(b) Make materials available on both STATE and MCO's website in a location that is prominent and readily accessible;

(c) Provide materials in an electronic form that can be electronically retained and printed;

(d) Ensure materials are consistent with the content and language requirements of 42 C.F.R. §438.10; and

(e) Inform the Enrollee that these documents are available in paper form, without charge, upon request and must be provided within five (5) business days of Enrollee's request.

(5) MCO shall make Enrollee informational and instructional materials, including the Enrollee handbook, available in alternative formats, which take into consideration the special needs of those who are visually limited or have a limited reading proficiency.

(6) MCO shall annually reinforce, in writing, to Enrollees how to access emergency and urgent services and how to file an Appeal or Grievance.

(7) MCO shall make a good faith effort to give written notice of termination of a Network Provider to each Enrollee who received his or her Primary Care from, or was seen on a regular basis by, the terminated Network Provider. Notice to the Enrollee must be provided by the later of thirty (30) calendar days prior to the effective date of termination, or fifteen (15) calendar days after receipt or issuance of the termination notice.

(B) Provider Directory

(1) MCO must maintain a complete an accurate Provider directory that is made available in prevalent languages and alternative formats, upon request, and in

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compliance with 42 C.F.R. §438.10(h)(1) and (2).

(2) MCO shall review and update paper Provider directories at least monthly if MCO does not have a mobile-enabled electronic directory or quarterly if MCO has a mobile-enabled electronic Provider directory. Electronic Provider directories must be updated no later than thirty (30) calendar days after MCO receives updated Provider information.

(3) MCO shall audit Provider directory information for accuracy in accordance with this Contract for all PCPs, mental health, and SUD Providers at least quarterly, and audit at least a statistically valid sample size of its Provider directory information on a more frequent, periodic basis. Documentation of such audits shall be retained and made available to STATE upon request.

(4) MCO must provide the Provider directory in a manner easily accessible to Enrollees either by mail or by utilizing MCO's website within thirty (30) calendar days of receipt of notification of enrollment in MCO. Provider directories must be made available on MCO's website in a machine readable and searchable file. MCO must make its electronic Provider directory available through a publicly accessible, standards-based Application Programming Interface that:

(a) Conforms with the technical requirements at 42 C.F.R. §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations;

(b) Conforms with the documentation requirements at 42 C.F.R. §431.60(d); and

(c) Is accessible via a public-facing digital endpoint on MCO's website.

(5) The Provider directory must accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency.

(6) MCO must include, in both electronic and print directories, a customer service email address, telephone number, and/or electronic link that individuals may use to notify MCO of inaccurate Provider directory information.

(7) MCO's Provider directory must contain, at minimum, the following information about its Network Providers:

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

(b) Street address(es);

(c) Telephone number(s);

(d) Web site URL, as appropriate;

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(e) Specialty, as appropriate;

(f) Whether the Provider will accept new Enrollees;

(g) The Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the Provider or a skilled medical interpreter at the Provider's office; and

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

(8) At a minimum, the Provider directory must include the following types of Network Providers:

(a) Physicians, including Specialists;

(b) Hospitals;

(c) Mental health Providers;

(d) SUD Providers;

(e) LTSS Providers, as appropriate;

(f) 1915(i) Providers;

(g) FQHCs and RHCs in MCO's Service Area, as specified in Article 2.8.7; and

(h) IHCPs, as specified in Article 2.8.8.

(9) MCO's Provider directory must specify that the FQHCs and RHCs within MCO Service Area are considered Network Providers and must include telephone and address information for each location.

(C) Enrollee Handbook

(1) MCO shall use the model Enrollee handbook provided by STATE.

(2) MCO shall provide periodic changes to the Enrollee handbook as needed or directed by State, or at least once per year. Upon notice to STATE of material changes to the Enrollee handbook, MCO shall make appropriate revisions, and notify Enrollees of the change and distribute the revised handbook to Enrollees at least thirty (30) days before the effective date of the change.

(3) Once a year, MCO shall notify all Enrollees in writing of their right to request and obtain MCO's Enrollee handbook.

(4) The Enrollee handbook shall also be made available online and upon Enrollee request. The Enrollee handbook must be provided within five (5) business days

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after Enrollee request.

(5) Pursuant to 42 C.F.R. §438.10(g)(3), Enrollee is considered to be provided with the Enrollee handbook if MCO:

(a) Mails a printed copy of the information to the Enrollee's mailing address, as provided to MCO by State in enrollment file(s);

(b) Provides the information by email after obtaining the Enrollee's agreement to receive the information by email;

(c) Posts the information on its website and advises the Enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

(d) Provides the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

(6) The Enrollee handbook must include clear terms that enables the Enrollee to understand how to effectively use the Managed Care Program including, at a minimum, the following:

(a) Table of contents;

(b) The amount, duration, and scope of benefits provided by MCO described in sufficient detail to ensure that Enrollees understand scope of service and the benefits to which they are entitled;

(c) Description of Enrollee cost-sharing requirements, where applicable;

(d) MCO's policies and procedures for obtaining benefits, including service authorization requirements and/or referrals for specialty care and for other benefits not furnished by the Enrollee's Primary Care Provider;

(e) The requirement to establish a Primary Care relationship with a Network Provider, and processes for selecting or changing Primary Care Providers;

(f) Any restrictions on the Enrollee's freedom of choice among Network Providers;

(g) The extent to which, and how, Enrollees may obtain benefits, including family planning services, from Out-of-Network Providers;

(h) An explanation that MCO cannot require an Enrollee to obtain a referral before choosing a family planning Provider;

(i) How and where to access any benefits that are available to Enrollees

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under the Medicaid State Plan but are not covered under this Contract, such as prescription drug coverage, and any applicable cost-sharing for such benefits;

(j) If applicable, information about how transportation is provided for any benefits carved out of the MCO Contract and provided by the State;

(k) Include an assurance that access to medical services must be available twenty-four (24) hours a day, seven (7) days a week;

(l) The extent to which, and how, after-hours emergency coverage is provided, including:

(i) What constitutes an Emergency Medical Condition, Emergency Services, and Post-Stabilization Care Services with reference to the definitions in 42 C.F.R. §§438.114(a);

(ii) The fact that Prior Authorization is not required for Emergency Services;

(iii) The process and procedures for obtaining Emergency Services, including use of the 911-telephone system or its local equivalent;

(iv) The location of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under contract; and

(v) The fact that the Enrollee has the right to use any hospital or other setting for emergency care;

(m) The Post-Stabilization Care Services rules set forth at 42 C.F.R. §438.114;

(n) Clear information on counseling or referral services that MCO does not cover because of moral or religious objections, if any, and how the Enrollee can obtain information from STATE about how to access those services;

(o) A statement that MCO does not discriminate against any Enrollee on the basis of race; ethnicity; color; national origin; disability; sex; gender; gender identity; sexual orientation; religion; religious beliefs; medical condition, including current or past history of a mental health and substance use disorder; sources of payment for care; or age, in admission, treatment, or participation in its programs, services, and activities;

(p) The phone number of the nondiscrimination coordinator for Enrollees to call if they have questions about the nondiscrimination policy or desire to file a complaint or Grievance alleging violations of the nondiscrimination policy;

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(q) Information on the availability of oral interpretation, including the fact that it is available for any language and that written information is available in prevalent non-English languages, and includes a statement on how to access these services;

(r) Information on the availability of written materials in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency, and a statement on how to access these formats;

(s) Names, locations, telephone numbers of, and non-English languages spoken by, current Network Providers, including identification of Network Providers that are not accepting new patients (this includes, at a minimum, information on Primary Care Providers, Specialists, and hospitals);

(t) Information on how to report suspected Fraud or Abuse;

(u) Enrollee Rights and protections, as specified in **Article 2.5.1** of this Contract;

(v) Information on Grievance, Appeal, and State Fair Hearing procedures and timeframes, as provided in 42 C.F.R. §438.400 through 42 C.F.R. §438.424 (subpart F), in a State-approved description that shall include the following:

(i) The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;

(ii) The Enrollee's right to file Grievances and Appeals;

(iii) The requirements and timeframes for filing a Grievance or Appeal;

(iv) The availability of assistance in the filing process;

(v) The Enrollee's ability to file a Grievance with MCO if the Enrollee has a complaint or concern regarding a Provider;

(vi) The toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone; and

(vii) The fact that, when requested by the Enrollee, disputed services will continue if the Enrollee files an Appeal or a request for a State Fair Hearing within the timeframes specified for filing, and that the Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee;

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(w) Information to adult Enrollees on Advance Directives policies, pursuant to the requirements of 42 C.F.R. §422.128 and 42 C.F.R. §489, Subpart I, including:

(i) A description of Enrollees' rights under state law, N.D.C.C. §23-06.5, to make decisions concerning their medical care, to accept or refuse treatment, and to formulate Advance Directives and information reflecting changes in state law, which must be provided as soon as possible, but no later than 90 calendar days after the effective date of the change; and

(ii) MCO's policies respecting the implementation of those rights, including a clear and precise statement of limitation if MCO cannot implement an Advance Directive as a matter of conscience. At a minimum, the statement of limitation must: (1) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians; (2) Identify the state legal authority permitting such objection; and (3) Describe the range of medical conditions or procedures affected by conscience objection;

(x) Information to Enrollees that MCO must forward complaints concerning Advance Directives to the North Dakota Department of Health and STATE;

(y) A statement that additional information is available upon an Enrollee's request regarding structure and operation of MCO, including information on:

(i) MCO's policy for selection of Network Providers and what is required of them; and

(ii) That information is available on request regarding MCO's Physician Incentive Plans in place, if any.

(z) A description of the circumstances in which the Enrollee may be responsible for payment, including when:

(i) The Enrollee has given advanced written consent to the Provider to pay for and obtain a service(s) that is not a benefit of the plan;

(ii) The Enrollee has given advanced written consent to the Provider to pay for the service(s) and has obtained a service(s) not authorized by MCO;

(iii) The Enrollee has had an Appeal or State Fair Hearing decision adverse to the Enrollee and disputed service(s) was continued during the Appeal or State Fair Hearing process at the Enrollee's request; and

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(iv) The Enrollee has become ineligible for Medicaid for any portion of the time period during which the service(s) was provided.

(aa) Description of MCO's Enrollee Services function, including the toll-free telephone number for Enrollee Services, Medical/Care Management, and any other department/unit providing services directly to Enrollees;

(bb) Description of the Coordinated Services Program, which includes a prescriber and pharmacy lock-in program, and the criteria that will be used to place an Enrollee in the program, as defined by STATE;

(cc) Information and requirements of Section 5006(d) of the American Recovery and Reinvestment Act (ARRA) of 2009 (42 U.S.C. §1396u-2(h)) relative to IHCPs as a Primary Care Provider as defined in Article 2.8.8;

(dd) Information and requirements of Section 5006(d) of the ARRA (42 U.S.C. §1396u-2(h)) relative to Native Americans who are in a non-Indian managed care plan and would like to receive services from an IHCP;

(ee) Reasons MCO may initiate disenrollment of an Enrollee; and

(ff) Information to Enrollees about the transition of care policy and how to access continued services upon transition between FFS Medicaid and MCO when an Enrollee, in the absence of continued services would suffer serious detriment to health or be at risk of Hospitalization or institutionalization, pursuant to the requirements of 42 C.F.R. §438.62(b)(3).

(D) Health Promotion

MCO must provide a range of health promotion and wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. MCO shall:

(1) Implement innovative Enrollee education strategies for wellness care and immunizations, as well as general health promotion and prevention;

(2) Work with PCPs and Network Provider specialists, as appropriate, to integrate health education, wellness and prevention training into the care of each Enrollee;

(3) Submit all proposed health promotion and wellness information, activities, and material to STATE for approval prior to distribution. The Contractor shall submit such information, activities, and material to STATE for approval at least 30 days prior to distribution;

(E) Enrollee Notices

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Pursuant to 42 C.F.R. §438.10(c)(4)(ii), MCO shall use the model Enrollee notices as designated by STATE. STATE will provide written notification to MCO of any changes to the model notices. The model Enrollee notices must include information in clear terms that enables the Enrollee to understand the intent of the applicable notice.

2.6.4 Allowable Marketing Activities

MCO and its Subcontractors shall be permitted to perform the following activities:

(A) Distribute general information through mass media (i.e., newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, billboards, and other media outlets) in keeping with prohibitions to placement as detailed in this Contract;

(B) Make telephone calls and home visits only to Enrollees currently enrolled in MCO (Enrollee education and outreach) for the purpose of educating them about services offered by or available through MCO;

(C) Respond to verbal or written requests for information made by Potential Enrollees, in keeping with the response plan outlined in the marketing plan approved by STATE prior to response;

(D) Provide promotional giveaways that do not exceed $15.00 value to current Enrollees only;

(E) Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to STATE must be made of the activity and details must be provided about the planned marketing activities;

(F) Attend activities at a business at the invitation of the entity. Notification to STATE shall be made of the activity and details shall be provided about the planned marketing activities;

(G) Conduct telephone marketing only during incoming calls from Potential Enrollees. MCO may return telephone calls to Potential Enrollees only when requested to do so by the caller. MCO shall utilize the response plan outlined in the marketing plan, approved by STATE, during these calls; and

(H) Send plan-specific materials to Potential Enrollees at the Potential Enrollee's request.

2.6.5 Prohibited Marketing Activities

MCO and its Subcontractors are prohibited from engaging in the following activities:

(A) Marketing directly to Medicaid beneficiaries or MCO Potential Enrollees, including persons currently enrolled in Medicaid or other MCOs (including direct mail advertising, "spam," door-to-door, telephonic, e-mail, texting, or other Cold-Call Marketing techniques);

(B) Asserting that MCO is endorsed by CMS, the federal or state government, or similar

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entity;

(C) Distributing plans and materials or making any statement (written or verbal) that STATE determines to be inaccurate, false, confusing, misleading, or intended to defraud Enrollees or STATE. This includes statements which mislead or falsely describe Covered Services, membership or availability of Providers and qualifications and skills of Providers, and assertions the recipient of the communication must enroll in a specific plan in order to obtain or not lose benefits;

(D) Portraying competitors or potential competitors in a negative manner;

(E) Attaching a Medicaid application and/or enrollment form to marketing materials to any Enrollee not currently enrolled with MCO;

(F) Assisting with enrollment or disenrollment or improperly influencing MCO selection;

(G) Distributing marketing information (written or verbal) that implies that joining MCOs or a particular MCO is the only means of preserving Medicaid coverage or that MCOs or a particular MCO is the only Provider of Medicaid services, and the Potential Enrollee must enroll in MCO or MCOs to obtain benefits or not lose benefits;

(H) Comparing its MCO to another organization / MCO by name;

(I) Sponsoring or attending any marketing or community health activities or events without notifying STATE within the timeframes specified in this Contract;

(J) Engaging in any marketing activities, including unsolicited personal contact with a Potential Enrollee, at an employer-sponsored enrollment event where employee participation is mandated by the employer;

(K) Marketing or distributing marketing materials, including Enrollee handbooks, and soliciting Enrollees in any other manner, inside, at the entrance, or within one hundred (100) feet of check cashing establishments, public assistance offices, or other locations as identified by STATE without prior approval from STATE;

(L) Conducting marketing or distributing marketing materials in hospital emergency departments (EDs), including the ED waiting areas, patient rooms, or treatment areas;

(M) Purchasing or otherwise acquiring or using mailing lists of Medicaid beneficiaries from third party vendors, including Providers and State offices;

(N) Using raffle tickets or event attendance or sign-in sheets to develop mailing lists of Potential Enrollees;

(O) Charging Enrollees for goods or services distributed at events;

(P) Charging Enrollees a fee for accessing MCO website;

(Q) Influencing enrollment in conjunction with the sale or offering of any private insurance or

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Medicare Advantage Plan;

(R) Using terms that would influence, mislead or cause Potential Enrollees to contact MCO, rather than STATE-designated Enrollment Broker, for enrollment;

(S) Referencing the commercial component of MCO in any of its Medicaid MCO Enrollee marketing materials, if applicable; and

(T) Using terms in marketing materials such as "choose," "pick," "join," etc. unless the marketing materials include the Enrollment Broker's contact and mobile application information.

2.6.6 Review and Approval of Enrollee and Marketing Materials

(A) MCO shall obtain prior written approval from STATE for all Enrollee and marketing materials for Potential or current Enrollees. This includes, but is not limited to, print, television, web, and radio advertisements; Enrollee handbook, identification cards, and Provider directories; call scripts for outbound calls or Enrollee call centers; MCO website screen shots; promotional items; brochures; letters; and mass mailings; and e-mailings. Neither MCO nor its Subcontractors may distribute any MCO marketing or Enrollee materials without prior STATE consent.

(B) All proposed materials shall be submitted via email to STATE with a request of delivery receipt, and in a format approved by STATE.

(1) MCO shall notify STATE when it makes changes to the Enrollee handbook or other Enrollee Material at least forty-five (45) calendar days prior to the changes taking effect.

(2) STATE has fourteen (14) business days to review and approve, or disapprove, any changes with the fourteen (14) business day review clock beginning on the date STATE receives the changes from MCO.

(3) If STATE deems the changes being made to the Enrollee handbook or other Enrollee Material to be "significant," MCO shall give each Enrollee written notice of the change at least thirty (30) calendar days prior to the intended effective date of the change, or as soon as State decides.

(4) If STATE deems the changes being made to the Enrollee handbook or other Enrollee Materials to not be "significant," STATE will determine the appropriate timeline in which the updated information must be distributed by MCO to each Enrollee highlighting the updates.

2.7 Covered Services

2.7.1 MCO Covered Services

(A) MCO shall arrange for all services included in STATE's Alternative Benefit Plan, as described in this Article and in Appendix B: MCO Covered Services, except for

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prescription drugs provided by STATE as described in Article 2.7.3. MCO shall possess the expertise and resources to ensure the delivery of quality healthcare services to its Enrollees in accordance with this Contract and prevailing medical community and national standards.

(B) MCO shall ensure that the benefit package includes all Essential Health Benefits and required Medicaid services, and complies with Mental Health Parity requirements as described in Article 2.7.2.

(C) MCO shall provide Covered Services that are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Enrollee. [42 C.F.R. §438.210(a)(3)]

(D) Services must be furnished in the United States.

(E) In accordance with 42 C.F.R. §438.210(a)(4), MCO may place appropriate limits on a service that are:

(1) On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity; or

(2) For the purpose of utilization control, provided that:

(a) The services furnished can reasonably be expected to achieve their purpose; and

(b) The services support Enrollees with ongoing or chronic conditions and are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports.

(F) MCO shall provide all Medically Necessary Covered Services, including quantitative and non-quantitative treatment limits, as indicated in the Alternative Benefit Plan. [42 C.F.R. §438.210(a)(5)(i)]

(G) MCO shall cover Medically Necessary Services that address:

(1) The prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;

(2) The ability for an Enrollee to achieve age-appropriate growth and development; and

(3) The ability for an Enrollee to attain, maintain, or regain functional capacity.

(H) MCO shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services, including but not limited to potentially preventable hospital emergency departments visits and inpatient readmissions.

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(I) MCO shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an Advance Directive. [42 C.F.R. §438.3(j)(1) and (2); 42 C.F.R. §489.102(a)(3).]

(J) MCO and its Network Providers shall deliver services in a culturally competent manner to all Enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds and disabilities, and regardless of gender, sexual orientation, or gender identity, and provide for cultural competency and linguistic needs, including the Enrollee prevalent language(s) and sign language interpreters in accordance with 42 C.F.R.CFR §438.206(c).

(K) At a minimum, MCO shall cover and pay for the following services:

(1) Emergency Services and Post Stabilization Services

(a) MCO is responsible for payment of Emergency Services twenty-four (24) hours a day, seven (7) days a week.

(i) MCO shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnosis or symptoms.

(ii) MCO shall not refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or MCO of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

(iii) MCO shall not hold an Enrollee who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition.

(iv) MCO is responsible for coverage and payment of services until the attending emergency physician, or the Provider actually treating the Enrollee, determines that the Enrollee is sufficiently stabilized for transfer or discharge.

(v) The determination of the attending emergency physician, or the Provider actually treating the Enrollee, of when the Enrollee is sufficiently stabilized for transfer or discharge is binding on MCO.

(b) Pursuant to Section 1932(b)(2) of the Social Security Act and 42 C.F.R. §438.114(c), MCO must cover post-stabilization care services obtained within or outside the MCO Network that are:

(i) Pre-approved by MCO's Provider or representative; not pre-approved by MCO's Provider or representative, but administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to MCO for pre-approval of further post-stabilization care services; or Administered to maintain, improve,

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or resolve the Enrollee's stabilized condition without Preauthorization, and regardless of whether the Enrollee obtains the services within MCO's Network when MCO did not respond to a request for pre-approval within one (1) hour, could not be contacted, or when MCO's representative and the treating physician could not reach agreement concerning the Enrollee's care and a MCO physician was not available for consultation.

(ii) MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

a. MCO's physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

b. MCO's physician assumes responsibility for the Enrollee's care through transfer;

c. MCO's representative and the treating physician reach an agreement concerning the Enrollee's care; or

d. The Enrollee is discharged.

(2) Family Planning

(a) MCO shall provide access to family planning services per Section 1905(a)(4)(C) of the Social Security Act (42 U.S.C. §§1396d(a)(4)(C)) and 42 C.F.R. §431.51(b)). MCO shall not restrict an Enrollee's choice of family planning services and supplies Provider, and shall not require Prior Authorization for such services.

(b) Family planning services shall be provided in a manner that protects and enables the Enrollee's freedom to choose the method of family planning to be used consistent with 42 C.F.R. §441.20.

(3) Abortions

MCO shall cover abortions under any of the following circumstances:

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

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

(4) 1915(i) Services

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MCO shall provide all 1915(i) services to any Medicaid Expansion Enrollee who is determined eligible to receive such services by STATE or its designee. MCO shall conduct electronic visit verification for any respite services provided. MCO may utilize STATE's 1915(i) provider network to offer these services.

(5) Non-Emergency Transportation (NEMT) to Covered Services, in accordance with 42 C.F.R. §431.53. MCO may utilize STATE's NEMT network to offer these services.

2.7.2 Mental Health and Substance Use Parity

(A) At a minimum, MCO must provide mental health and substance use disorder benefits to Enrollees in every classification (inpatient, outpatient, emergency care, or prescription drugs) in which Medical/Surgical Benefits are provided, and in accordance with applicable laws and regulations, including 42 C.F.R. §438.910(b)(2) and 45 C.F.R. §146.136(c)(2)(ii).

(B) MCO shall cover, in addition to services covered under the Alternative Benefit Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. part 438, subpart K.

(C) If MCO does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to Enrollees under this Contract, MCO may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(D) If MCO includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to Enrollees through this Contract, MCO must either:

(1) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(2) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

(E) If MCO includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to Enrollees through this Contract, MCO must either:

(1) Impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or

(2) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 C.F.R.

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§438.905(e)(ii).

(F) MCO must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Enrollees.

(G) If an Enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the Enrollee in every classification in which medical/surgical benefits are provided.

(H) MCO may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

(I) MCO may not impose non-quantitative treatment limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the MCP as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder 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 limitation for medical/surgical benefits in the classification.

(J) MCO must provide necessary documentation and reporting annually to STATE to establish and demonstrate compliance with parity in mental health and substance use disorder benefits.

2.7.3 Prescription Drugs

(A) General Requirements

(1) MCO shall cover prescription drugs as a Covered Service as stated under this Contract and in compliance with federal and state laws.

(a) MCO shall only be responsible for providing prescription drugs to Enrollees that are submitted as medical Claims.

(b) MCO shall be responsible for prescription drugs that are dispensed in physician offices and as part of hospital inpatient stays.

(c) In approving coverage for these drugs, MCO shall follow the preferred drug list developed by STATE pursuant to Article 2.7.3(D) of this Contract, and shall be subject to the rebate requirements outlined in Article 2.7.3(E) of this contract.

(2) Enrollees may obtain any other prescription drug services that are treated as pharmaceutical claims under the Medicaid State Plan, however STATE is

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financially responsible for these services.

(3) MCO must ensure compliance with Medicaid managed care regulations at 42 C.F.R. §438.210 for prescription drug coverage, including requirements for covered outpatient drugs, and timely and complete reporting to STATE as specified in this Contract.

(4) MCO shall be responsible for coordinating with STATE regarding pharmacy benefits, including:

(a) Educating Network Providers on STATE's preferred drug list and covered drugs; and

(b) The development and implementation of a pharmacy lock-in program.

(5) Network and Out-of-Network Providers may not use drugs purchased under the 340B Drug Pricing Program enacted by the Veterans Health Care Act of 1992, Public Law 102-585, codified in Section 340B of the Public Health Services Act to provide any prescription drugs under this Contract.

(6) All covered drugs or related products must have a valid National Drug Code (NDC) number.

(7) MCO shall, pursuant to Section 1903(m)(2)(A)(xiii) of the Social Security Act and SMDL #10-006, report to STATE, on a timely and periodic basis specified by the Secretary of the U.S. Department of Health and Human Services (DHHS), information on the total number of units of each dosage, form, strength, and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees for which MCO is responsible for coverage. Other data may be required as the Secretary determines necessary.

(8) MCO shall ensure that its Network Providers are writing prescriptions on a tamper-resistant prescription pad in accordance with Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28.

(9) MCO shall, provide full transparency of all costs and all rebates in aggregate.

(10) MCO shall ensure that program edits and other requirements from either CMS or STATE are implemented when required (e.g. quantity limits, early refill thresholds, and changes in mandatory drug coverage).

(B) Covered Drugs

MCO medical policies must comply with Section 1937(b)(2)(iv) requirements of the Social Security Act for amount, duration, and scope of drug coverage, and the non-coverage provisions of Section 1927(k)(2) & (3) of the Social Security Act.

(C) Non-Covered Drugs

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MCO shall submit a quarterly report, if applicable, of drugs which MCO has elected to cover, but which are not indicated as required to be coverable drugs in Sections 1927(k) of the Social Security Act. The report shall be in a format designated by STATE.

(D) Preferred Drug List (PDL)

(1) MCO shall administer STATE's PDL, as developed by STATE's Drug Utilization Review (DUR) Board, including adhering to STATE's prior authorization criteria for STATE's PDL drugs.

(2) MCO shall not collect rebates or discounts that MCO has negotiated with drug manufacturers.

(3) STATE shall provide written notice to MCO prior to any change in the PDL pertaining to the listed drugs and prior authorization criteria, and MCO shall implement the changes within sixty (60) calendar days of notification from STATE.

(4) MCO retains the right to manage its own prior authorization procedures, including those for administering STATE's PDL. However, for drugs on the STATE's PDL, MCO shall not impose authorization criteria which is more restrictive than what is noted within the STATE's PDL.

(E) Rebateable Drugs

(1) STATE shall retain all money collected from primary rebates available under the Medicaid Drug Rebate Program, authorized by Section 1927 of the Social Security Act, and administered by CMS.

(2) At MCO's option, MCO may retain all money from rebates or discounts that MCO has negotiated with drug manufacturers, except for PDL drugs as indicated above.

(3) If applicable, MCO shall submit a quarterly report to STATE estimating the projected amounts of savings that MCO will incur because of any rebates or discounts negotiated with drug manufacturers. MCO shall provide an annual report of any actual rebates or discounts negotiated with drug manufacturers. The quarterly and annual reports shall be in a format mutually agreed upon and designated by STATE at least thirty (30) days in advance of any such change in format.

(F) Medical Policy

(1) MCO will use its own medical policies, which will be in compliance with the Essential Health Benefit Benchmark Plan Standards as defined in 45 CFR § 156.122.

(2) MCO's rights to manage its own medical policies and operate prior authorization procedures shall not conflict with requirements under Article 2.7.3(D) of this

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Contract.

(3) MCO medical policies shall adhere to the following requirements:

(a) On a yearly basis, MCO's medical policies, and the methodology used by MCO to set its medical policies, shall be subject to review by STATE's DUR Board. MCO staff shall present in-person at a DUR Board meeting to provide an explanation of the methodology used by MCO in setting its medical policies.

(b) During the review period, MCO shall provide any documents requested by the DUR Board within fifteen (15) calendar days of the request.

(4) STATE's DUR Board may make recommendations to MCO regarding its medical policies and MCO shall provide a written summary of the outcome of all recommendations.

(a) MCO shall make its medical policies, and the criteria used to create the medical policies, available to STATE and to MCO's Enrollees, upon request.

(b) If MCO fails to respond to STATE'S DUR Board request for information in a timely manner, STATE may impose sanctions as described in **Article 5.9** of this contract.

(5) MCO shall have written policies and procedures to govern prescription drug prior authorizations. However, for drugs on the STATE's PDL, MCO shall not impose authorization criteria which is more restrictive than what is noted within the STATE's PDL. The policies and procedures shall follow those same prior authorization policies found in **Article 2.11** of this Contract and shall be in accordance with 42 CFR §§ 438.210, 438.3(s)(6), and 1927(d)(5) of the Social Security Act.

(6) MCO is responsible for ensuring that its Network Providers are familiar with MCO's medical policies and are aware of which drugs are covered drugs or Non-Covered drugs.

(G) Pharmacy Post-Adjudication History File

(1) STATE shall electronically submit a prescription drug claims file to MCO each business day for outpatient prescription drug benefit billed as pharmacy Claims deliverable through FFS to Medicaid Expansion Enrollees. The file format shall be based on the National Council for Prescription Drug Programs (NCPDP) 1700. Any changes to the format shall be agreed upon in writing between STATE and MCO.

(2) MCO shall electronically submit a post-adjudication history file to STATE. The post-adjudication history file shall be in a format requested by STATE. The file format shall be based on specifications by the National Council for Prescription Drug Programs (NCPDP).

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(3) MCO shall submit its post-adjudication history file(s) quarterly, no later than twenty-five (25) calendar days after the end of a quarter.

(4) In the event that STATE retroactively terminates an Enrollee and MCO had previously identified such Enrollee as eligible for rebates under Section 1903(m)(2)(A)(xiii) of the Social Security Act, MCO must include the identified pharmacy Claims within the applicable quarterly post-adjudication history file with an indicator reflecting it as no longer being eligible for rebates or within a separate file using the same format as the post-adjudication history file(s).

(5) MCO shall correct any errors found in the post-adjudication history file within 20 calendar days of the discovery of the error by MCO or STATE. If MCO fails to correct errors found in the post-adjudication history file, STATE may impose sanctions as described in Article 5.9 of this contract.

(6) If MCO pays for a prescription that is adjudicated more than 12 months from the date of service, the NCPDP post adjudication history file will be rejected for failure to process in accordance with 42 CFR § 447.45(d).

(H) Federal Drug Utilization Review Reporting

(1) MCO shall assist STATE in collecting any data that STATE needs to complete the Federal DUR Report.

(2) MCO shall provide STATE with any information requested by STATE to complete the Federal DUR report within thirty (30) calendar days of STATE's request, or a mutually agreed upon alternative date. If MCO fails to respond to the request in a timely manner, STATE may impose sanctions as allowed in Article 5.9 of this contract.

(I) MCO Drug Utilization Review (DUR) Program

(1) Pursuant to 42 CFR § 438.3(s)(4)-(5), MCO shall establish and operate a drug utilization review program that complies with the requirements at Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act and at 1927(g) of the Act, which includes prospective drug review, retrospective drug use review, and an educational program as specified in 42 CFR part 456, subpart K, as if such requirement applied to MCO instead of STATE.

(2) MCO does not have to adopt the same DUR activities as STATE.

(3) MCO shall provide a detailed description of its drug utilization review program activities to STATE on an annual basis.

2.7.4 Enrollee Cost-Sharing

(A) Pursuant to 42 C.F.R. §438.108, any cost-sharing imposed on Enrollees by MCO must be in accordance with 42 C.F.R. §447.50 through §447.82. If any cost sharing applies, MCO

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must exempt from cost sharing any Native American Enrollee who is currently receiving or has ever received an item or service furnished by an IHCP or through referral. [42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2)]

(B) MCO shall apply only applicable cost-sharing where it is allowed and described in Attachment 4.18-A of the Medicaid State Plan, which meets these requirements, for Covered Services within the Alternative Benefit State Plan Amendment or **Appendix B: Covered Services** of this Contract.

(C) MCO shall implement any co-payment schedule approved by Legislature and included as an amendment to the Medicaid State Plan, including any cap on out-of-pocket expenses. If this should occur, STATE shall provide written notice to MCO prior to implementation of any change in the adjusted co-payment schedule when feasible. When prior notice is not feasible, STATE will provide notice within 30 calendar days of the effective date of any such change.

2.7.5 In Lieu of Services

(A) MCO may, at its option, cover approved services or settings for Enrollees that are in lieu of those covered under the Alternative Benefit Plan if the following conditions are met, as required in 42 C.F.R. §438.3(e)(2)(i)-(iii):

(1) STATE determines that the alternative service or setting is a medically appropriate substitute for the Covered Service or setting under the Alternative Benefit Plan;

(2) STATE determines that the alternative service or setting is a cost- effective substitute for the Covered Service or setting under the Alternative Benefit Plan;

(3) The Enrollee is not required by MCO to use the alternative service or setting; and

(4) The STATE approved ILOS is authorized and identified in **Appendix F: Value-Added Benefits and Approved In Lieu of Services** of this this Contract.

(B) Approved ILOS may include substitutions for inpatient care and other services as identified by MCO and approved by STATE.

(C) The utilization and actual cost of In Lieu of Services is taken into account in developing the component of the Capitation Rates that represents the Covered Services.

2.7.6 Value-Added Benefits

(A) MCO may offer additional benefits beyond the Covered Services at no additional cost to STATE, as permitted under 42 C.F.R. §438.3(e)(1). However, these additional benefits must be pre-approved by STATE and cannot be included within the Claims experience for future rate calculations. Such services shall be identified as value-added benefits in Encounter data, as described in **Article 2.15.9**.

(B) At a minimum, MCO shall offer the value-added benefits proposed in its response to the

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Request for Proposal (RFP) and agreed upon by STATE, consistent with this Article. Additional value-added benefits may be offered, at MCO's option, and shall be reported in accordance with **Appendix D: MCO Compliance, Operations, and Quality Reporting**.

(C) At MCO's discretion, it may provide or assist Enrollees with transportation to access a value-added benefit provided that it identifies Encounters for transportation as related to a value-added benefit where appropriate.

(D) MCO shall provide an annual report to STATE of the impact of its value-added benefits and may propose to change its value-added benefits on an annual basis as pre-approved in writing by STATE. Additions, deletions, or modifications to value-added benefits shall be submitted to STATE for approval at least six (6) months in advance of the beginning of the Contract year.

(E) STATE-approved value-added benefits proposed in MCO's RFP response, and as amended annually, shall be listed in **Appendix F: Value-Added Benefits and Approved In Lieu of Services**.

(F) Annually, for the value-added benefit proposed in MCO's RFP response, and as amended, MCO shall:

(1) Indicate the PMPM actuarial value of value-added benefit based on enrollment projections for MCO's plan, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information; and

(2) Include a statement of commitment to provide the value-added benefit for the entire contract year.

(G) MCO shall revise its proposed PMPM based on any feedback from STATE, following an independent review of any statements of actuarial value provided by MCO.

(H) The proposed monetary value of value-added benefits shall be considered a binding Contract deliverable. If for any reason, the aggregated annual PMPM proposed is not expended by MCO, STATE reserves the right to require MCO to provide an alternate benefit of equal value and/or may conduct a reconciliation for the amount unexpended.

(I) Value-added benefits are not subject to Appeal and state fair hearing rights. A denial of these benefits shall not be considered an Adverse Benefit Determination for purposes of Enrollee Grievances and Appeals. MCO shall send the Enrollee a notification letter if a value-added benefit is not approved.

2.7.7 Moral or Religious Objections

(A) In accordance with 42 U.S.C. §1396u-2(b)(3)(B) and 42 C.F.R. §438.102(b)(1), MCO may elect not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds.

(B) If MCO elects not to provide, reimburse for, or provide coverage of, a counseling or

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referral service because of an objection on moral or religious grounds, MCO must furnish information about the services that it does not cover by notifying:

(1) STATE with its proposal, or whenever it adopts the policy during the term of the Contract;

(2) Potential Enrollees before and during enrollment in MCO;

(3) Enrollees at least thirty (30) days prior to the effective date of the policy with respect to any particular service; and

(4) Enrollees through the inclusion of the information in the Enrollee handbook.

(C) If MCO elects not to provide, reimburse for, or provide coverage of a Covered Service described in this Article because of an objection on moral or religious grounds, the monthly Capitation Payment MCO will be adjusted accordingly.

2.8 Provider Network, Contracts and Related Responsibilities

2.8.1 General Provisions

(A) MCO shall maintain and monitor a Network of appropriate Providers that is sufficient to provide adequate access to all services covered under this Contract for all Enrollees. MCO shall ensure that Providers provide services in a manner that is recovery-oriented, trauma- informed and person-centered. MCO will ensure that all Covered Services are responsive to physical or mental disabilities, gender, diversity, identity formation, intergenerational issues, culture, socioeconomic factors, and environmental impacts. Services must support Enrollee's communication style and needs including, but not limited to, age appropriate communication, translation/interpretation services for those that are of limited-English proficiency, translation/interpretation services for individuals who are deaf or hearing impaired, and translation/interpretation services for individuals who are blind or visually impaired or who have any other communication/language needs requiring translation. [42 C.F.R. §438.206(b)(1)]

(B) MCO shall have in place written policies and procedures for the selection and retention of Providers. These policies and procedures shall not discriminate against particular Providers that service high risk populations or specialize in conditions that require costly treatment.

(C) In establishing and maintaining MCO Network Providers, MCO must consider the anticipated Medicaid Expansion enrollment; the expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid Expansion populations represented in the Service Area; the numbers and types (in terms of training, experience, and specialization) of Providers required to furnish the contracted Medicaid Expansion services; the number of Network Providers who are not accepting new Medicaid Expansion patients; and the geographic location of Network Providers and Medicaid Expansion Enrollees within MCO Service Area, considering distance, travel time, the means of transportation ordinarily used by Medicaid Expansion Enrollees, and whether the location provides physical access for those with disabilities.

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(D) MCO must ensure that Enrollees are entitled to the full range of their health care Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of this Contract. Any contractual provisions, including gag clauses or rules, that restricts a health care Provider's ability to advise patients about Medically Necessary treatment options violate Federal law and regulations.

(E) MCO shall not prohibit or restrict a Provider acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient regarding the Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

(F) MCO shall not prohibit or restrict a Provider acting within the lawful scope of practice from providing information the Enrollee needs in order to decide among all relevant treatment options and the risks, benefits and consequences of treatment or non-treatment, and the Enrollee's rights to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

(G) MCO shall not terminate a contract or employment with a Provider or take any punitive action against a Provider for filing a Complaint, Grievance, or Appeal on an Enrollee's behalf or for requesting an expedited resolution or supporting an Enrollee's Appeal.

(H) MCO shall not discriminate or take punitive action against any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. [42 C.F.R. 438.12(a)(1)]

(I) MCO shall ensure that its Network Providers abide by the requirements of Section 1877(e)(3)(B)(i) of the Social Security Act (42 U.S.C. §§1395(e)(3)(B)(i)) prohibiting MCO from making payments directly or indirectly to a physician or other Provider as an inducement to reduce or limit Medically Necessary Services provided to Enrollees.

(J) MCO shall not execute Provider agreements with Providers who have been excluded from participation in the Medicare, Medicaid, and/or CHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not enrolled or in good standing with the North Dakota Medicaid Program.

(K) MCO shall provide written notice of the reason for its decision when it declines to include individual or groups of Providers in its Provider Network.

(L) All physicians who provide services under this Contract shall have a unique health identifier in accordance with the system established under Section 1173(b) of the Social Security Act (42 U.S.C. §§1320d-2(b)) and in accordance with the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

(M) MCO shall require all Providers who may prescribe prescription drugs to Enrollees to also be enrolled as a Provider with STATE.

(N) MCO shall permit telemedicine to be used to facilitate access to Covered Services to augment MCO's Provider Network.

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(O) MCO shall enter into provider agreements with any 1915(i) peer support specialists that STATE has enrolled as peer support specialists.

2.8.2 Provider Agreements

(A) MCO must have written agreements with a sufficient number of Providers to ensure Enrollee access to all Medically Necessary Services covered under this Contract and consistent with the requirements of this Contract.

(1) Availability and accessibility of MCO covered services, including geographic access, and appointment and wait times for Enrollees, shall be in accordance with the access and Network Adequacy standards set forth in the applicable federal regulations and this Contract.

(B) In all Provider agreements, MCO must comply with the requirements specified in 42 C.F.R. §438.214. MCO's Provider agreements must include at least the following provisions:

(1) A requirement securing cooperation with the Quality Management and Utilization Management Program standards outlined in Article 2.11, and allowing MCO access to the medical records of Enrollees being treated by Network Providers;

(2) That PCPs must comply with the requirements of Article 2.8.5 of this Contract;

(3) A requirement that MCO include in all capitated Provider agreements a clause which requires that should the Provider terminate its agreement with MCO, for any reason, the Provider will provide services to the Enrollees assigned to the Provider under the Contract up to the end of the month in which the effective date of termination falls;

(4) A requirement that the Provider must comply with all applicable laws and regulations pertaining to the confidentiality of Enrollee medical records, including obtaining any required written Enrollee consents to disclose confidential medical records;

(5) A requirement that the Provider must make referrals for social, vocational, education, or human services when a need for such service is identified;

(6) A requirement that the Provider must notify an Enrollee when a service may not be covered by MCO or STATE, and that if the service is not covered by MCO or STATE, that Enrollee may be charged for such service by Provider, and obtain Enrollee's consent to be billed if such service is not covered;

(7) In the event MCO becomes insolvent or unable to pay the Participating Provider, a requirement that the Provider shall not seek compensation for services rendered from STATE, its officers, agents, or employees, or the Enrollee or their eligible dependents; and

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(8) A requirement that the Provider must submit Claims within one hundred eighty (180) calendar days from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to MCO within ninety (90) calendar days from the date of denial.

(9) A requirement for the Provider to report to MCO when it has received an overpayment, to return the overpayment to MCO within sixty (60) calendar days after the date on which the overpayment was identified, and to notify MCO in writing of the reason for the overpayment.

(C) MCO may execute Network Provider agreements, pending the outcome of screening, enrollment, and revalidation by STATE, of up to one hundred twenty (120) calendar days but must terminate a Network Provider immediately upon notification from STATE that the Network Provider cannot be enrolled, or the expiration of the one hundred twenty (120) day period without enrollment of the Provider, and notify affected Enrollees. [42 C.F.R. §438.602]

(D) In all agreements with Network Providers, MCO must follow STATE's uniform credentialing and recredentialing policy as detailed in **Article 2.8.3** that addresses acute, primary, behavioral, substance use disorder, and LTSS providers, as appropriate.

2.8.3 Credentialing and Recredentialing

(A) MCO shall be responsible for the credentialing and recredentialing of its Provider Network. MCO must submit documentation to STATE to demonstrate that its Network Providers are credentialed as required under 42 C.F.R. §438.214. [42 C.F.R. §438.206(b)(6)]

(B) If MCO has delegated credentialing and/or recredentialing to a Subcontractor, the agreement must ensure that all Providers are credentialed in accordance with MCO's and STATE's credentialing requirements, as described in **Article 2.8.3**.

(C) MCO shall completely process credentialing applications from all types of Providers (physical health and Behavioral Health Providers) within ninety (90) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed Provider agreement. Completely process shall mean that MCO shall review, approve, and load approved applicants to its Provider files in its claims processing system or deny the application and assure that the Provider is not used by MCO.

(D) MCO shall use credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) or URAC. MCO must follow the most current version of the credentialing organization's credentialing requirements. MCO must also ensure that delegated credentialing Providers and Material Subcontractors meet these credentialing requirements

(E) MCO must maintain a Credentialing Committee that:

(1) Meets at regular intervals;

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(2) Is chaired by MCO's Medical Director or a designated physician;

(3) Includes a variety of participating Practitioners in its membership;

(4) Reviews credentialing files for Practitioners who do not meet the established criteria;

(5) Ensures credentialing files that meet criteria are reviewed and approved by the Medical Director or designated physician; and

(6) Ensures each credentialing file includes the date of the Credentialing Committee decisions.

(F) MCO shall verify and certify to STATE that all Network Providers and any Out-of-Network Providers to whom Enrollees may be referred are properly licensed in accordance with all applicable State laws and regulations, are eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by MCO and the North Dakota Insurance Department.

(G) MCO must ensure that all Network Providers are enrolled with STATE as Medicaid Providers consistent with the Provider disclosure, screening, and enrollment requirements of 42 C.F.R. part 455, subparts B and E. This provision does not require the Network Provider to render services to fee-for-service beneficiaries.

(H) In contracting with Providers, MCO will be responsible for obtaining all disclosure information from all Network Providers and Out-of-Network Providers and abide by all applicable Federal regulations, including 42 C.F.R. §455.104 and 455.106 during the credentialing and recredentialing process.

(I) MCO shall maintain a file for each Provider containing a complete Provider application including a signed attestation statement, a copy of the Provider's current license issued by STATE, a valid DEA or Controlled Dangerous Substances certificate, and such additional information as may be specified by STATE.

(J) In contracting with laboratory Providers and or any Provider who bills for laboratory services, MCO must ensure that all laboratory testing sites providing services under the Contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Provider attestation of CLIA certificate is not acceptable. MCO shall maintain copies of the CLIA certificate or waiver of the certificate of registration in the Provider's credentialing and recredentialing files.

(K) MCO shall develop written policies and procedures detailing the process for verification of Provider credentials and insurance and periodic review of Provider performance, which must be approved in writing by STATE as part of the readiness review prior to implementation. Credentialing policies and procedures must meet Federal and State requirements and shall include:

(1) The verification of the existence and maintenance of credentials, licenses,

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malpractice claims history, certificates, and insurance coverage of each admitting Provider from a primary source, site assessment, hospital admitting privileges, or admitting plan. Proof of this verification must be maintained within each Provider file.

(2) A methodology and process for recredentialing Providers every five (5) years.

(3) A process for conducting site assessments of moderate and high-risk Providers, including descriptions of:

(a) How the MCO will designate a Provider as moderate or high categorical risks to the Medicaid program, pursuant to 42 C.F.R. 435.432;

(b) The initial site assessment, prior to the completion of the initial credentialing process, of private Practitioner offices and other patient care settings conducted in-person during the Provider office visit;

(c) A site reassessment if the Provider location has changed since the previous credentialing activity; and

(d) A site reassessment of private Practitioner offices and other patient care settings, conducted in-person, when a complaint has been lodged against the specific Provider. This reassessment must be completed within 60 calendar days of the complaint.

(4) Procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges.

(5) Procedures for Practitioners to review the information submitted in support of the Practitioner's credentialing application, and to correct erroneous information.

(6) Process for making available to Practitioners MCO's confidentiality requirements to ensure that all information obtained in the credentialing process is confidential except as otherwise provided by law.

(7) Process for notifying a Practitioner of any information obtained during the credentialing process that varies substantially from the information provided to MCO by the Practitioner.

(8) Procedures for verifying that contracted nurse practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility.

(9) Procedures for verifying the inclusion of Providers including but not limited to the following databases: HHS-OIG's List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of Excluded

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Providers.

(a) MCO shall conduct monthly searches of the SAM, LEIE databases, Social Security Death Master File, and any other databases required by STATE to ensure that Providers are not restricted Providers, and shall maintain documentation showing that such searches were conducted.

(b) Within thirty (30) calendar days of either identifying an Excluded Provider or receiving exclusion information from a Network Provider, MCO shall notify STATE of the exclusion by electronically submitting the information on STATE's Disclosure of Excluded Provider Form to STATE.

(L) MCO shall notify STATE within ten (10) calendar days of MCO's denial of a Provider credentialing or recredentialing application either for program integrity-related reasons, due to limitations placed on the Provider's ability to participate for program integrity-related reasons, or MCO's decisions not to allow a Provider to participate in the Network.

(M) MCO must load Provider information into its claims processing system within thirty (30) calendar days of Provider agreement approval.

2.8.4 Availability of Primary Care Providers

(A) MCO shall ensure that there are PCPs willing and able to provide the level of care and range of services necessary to meet the medical and Behavioral Health needs of its Enrollees, including those with chronic conditions. There shall be a sufficient number and geographic distribution of PCPs who accept new Enrollees within MCO's Service Area so that MCO meets the access standards provided in **Appendix C: Network Accessibility Standards** and documented in MCO Provider Network reports.

(B) The MCO shall require each Enrollee to select a PCP. For Enrollees that do not have a choice of Medicaid Expansion health plans, any restrictions by MCO to limit an Enrollee's freedom to change PCPs cannot be more restrictive as the limitations on disenrollment from MCO as requested by the Enrollee in accordance with 42 C.F.R. 438.56(c) [42 C.F.R. 438.52(b) - (d); 42 C.F.R. 438.56(c)] and **Article 3.4.4**. If an Enrollee does not select a PCP, he or she will be assigned a PCP by MCO, and will be given the opportunity to switch PCPs within a designated time frame.

2.8.5 PCP Responsibilities

(A) MCO shall ensure that Network PCPs fulfill their responsibilities including, but not limited to, the following:

(1) Managing and coordinating the medical and Behavioral Health care service needs of Enrollees to ensure that all Medically Necessary Services are made available in a timely manner;

(2) Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;

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(3) Communicating with all other levels of medical care to coordinate, and follow-up the care of individual patients;

(4) Providing the coordination necessary for the referral of patients to Specialists;

(5) Maintaining a medical record of all services rendered by the PCP and a record of referral to other Providers and any documentation provided by the rendering Provider to the PCP for follow-up and/or coordination of care;

(6) Development of plans of care to address risks and medical needs and other responsibilities as defined in this Article;

(7) Ensuring that in the process of coordinating care, each Enrollee's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. Parts 160 and 164 and all state statutes. 45 C.F.R. Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information;

(8) Providing after-hours availability to patients who need medical advice. At a minimum, the PCP office shall have a return call system staffed and monitored to ensure that the Enrollee is connected to a designated medical Practitioner within thirty (30) minutes of the call;

(9) Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital;

(10) Working with MCO Case Managers to develop individualized plans of care for high-risk Enrollees receiving case management services; and

(11) Participating in MCO's case management team for high-risk Enrollees, as applicable and Medically Necessary; and

(12) Encourage screening and referral to ensure immediate access to treatment, including, but not limited to, depression, anxiety, trauma/Adverse Childhood Experiences (ACEs), and substance use/Screening Brief Intervention, and Referral to Treatment (SBIRT) early detection, identification of developmental disorders/delays, social-emotional health, and Social Determinants of Health.

(13) MCO shall seek to contract with PCPs that offer extended Primary Care hours and shall review Primary Care, Urgent Care, and emergency department (ED) utilization patterns across different regions to assess access to care.

2.8.6 Direct Access to Women's Health Care

MCO shall provide female Enrollees with direct access to Network Providers or Out-of-Network Providers who are women's health Specialists for Covered Services necessary to provide women's routine and preventive Health Care Services to ensure compliance with Section 1902(a)(23)(B) of the Social Security Act (42 U.S.C. §1396a(a)(23(B)). This is in addition to the Enrollee's designated source of Primary Care, if that source is not a women's health Specialist.

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2.8.7 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

(A) MCO shall ensure that the FQHCs and RHCs in MCO's Service Area are offered Network Provider agreements, and must ensure that such FQHCs and RHCs are considered Network Providers regardless of having a contract or not with MCO. The Provider directory must specify that such FQHCs and RHCs are Network Providers and include the telephone number and address information for each location.

(B) MCO must reimburse FQHCs and RHCs in accordance with the requirements of Section 1902(bb) of the Social Security Act (42 U.S.C. §1396a(bb)).

(C) STATE will provide MCO the annual prospective payment system or alternative payment methodology payment rates for each FQHC and RHC enrolled with North Dakota FFS Medicaid. MCO must pay the same rate as STATE for services provided at an FQHC or RHC, or may make supplemental payments to the FQHC and RHC to ensure the overall payment rate is not less than the rate paid by North Dakota FFS Medicaid. Payments to FQHCs and RHCs shall be reviewed no less frequently than every three (3) months to ensure payments comply with this Article.

(D) MCO shall utilize the following Medicaid Encounter rate reimbursement methodology:

(1) MCO shall pay FQHCs or RHCs the contracted reimbursement rate at the time of Claim adjudication.

(2) At the end of each quarter, MCO shall reconcile the contracted reimbursement rate to the Medicaid Encounter rate.

(3) MCO shall review FQHC or RHC Claims on an aggregate basis for all Claims paid during the quarter. MCO shall compare the aggregate amount paid to the aggregate Medicaid Encounter rate, which would have been received by the FQHC or RHC per the alternative payment methodology for FQHCs and RCHs as indicated in the Medicaid State Plan.

(4) For medical Claims, if the aggregated Medicaid Encounter rate is greater than the aggregate amount paid to the FQHC or RHC Provider, MCO processes a payment for the difference, but if the aggregated Medicaid Encounter rate is less than the aggregate paid amount, no funds are due to the FQHC or RHC Provider and no refund is due back to MCO.

(E) Within ninety (90) calendar days of the end of each quarter, MCO shall electronically send the FQHC or RHC Provider a secured reconciliation file that identifies the aggregate amount paid that was less than the Medicaid Encounter rate and if applicable payment shall be provided.

2.8.8 Indian Health Care Providers (IHCPs)

(A) MCO shall demonstrate that there are sufficient IHCPs participating in the Provider Network of MCO to ensure timely access to services available under the Contract from such Providers for Native American Enrollees who are eligible to receive services.

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(B) For services furnished by an IHCP, whether participating in MCO's network or not, MCO shall ensure reimbursement to the IHCP are at least equal to the amount determined by the alternative payment methodology for IHCPs as indicated in the Medicaid State Plan, which includes payment for multiple Encounters in one day. Payments to IHCPs shall be reviewed no less frequently than every three (3) months to ensure payments are in compliance with this Article.

(C) MCO shall utilize the following Medicaid Encounter rate reimbursement methodology:

(1) IHCPs shall be paid the contracted reimbursement rate at the time of Claim adjudication.

(2) At the end of each quarter, MCO shall reconcile the contracted reimbursement rate to the Medicaid Encounter rate.

(3) MCO shall review IHCP Claims on an aggregate basis for all Claims paid during the quarter. The MCO shall compare the aggregate amount paid compared to the aggregate Medicaid Encounter rate, which would have been received by the IHCPs per the alternative payment methodology for IHCPs as indicated in the Medicaid State Plan.

(4) For medical Claims, if the aggregated Medicaid Encounter rate is greater than the aggregate amount paid to the IHCPs, MCO processes a payment for the difference, but if the aggregated Medicaid Encounter rate is less than the aggregate paid amount, no funds are due to the IHCPs and no refund is due back to MCO.

(5) For pharmacy Claims, if the aggregate Medicaid Encounter rate is greater than the aggregate paid amount to the IHCPs, MCO processes a payment for the difference, but if the aggregated Medicaid Encounter rate is less than the aggregate paid amount, no funds are due to the IHCPs and no refund is due back to MCO.

(6) Within ninety (90) calendar days of the end of each quarter, MCO shall electronically send the IHCPs a secured reconciliation file that identifies the aggregate amount paid that was less than the Encounter rate and if applicable payment shall be provided.

(7) MCO shall make payment to all IHCPs in its Network in a timely manner as required for payments to Practitioners in individual or group practices under 42 C.F.R. §447.45 and §447.46, including paying 90% of all Clean Claims from Practitioners within thirty (30) calendar days of the date of receipt and paying 99% of all Clean Claims from Practitioners within ninety (90) calendar days of the date of receipt.

(D) MCO shall permit any Native American who is enrolled with MCO and is eligible to receive services from an IHCP Primary Care Provider participating as a Network Provider, to choose that IHCP as their PCP, as long as that Provider has capacity to provide the services.

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(E) The MCO shall permit Native American Enrollees to obtain MCO Covered Services from Out-of-Network IHCPs from whom the Enrollee is otherwise eligible to receive such services.

(F) Where timely access to Covered Services cannot be ensured due to few or no IHCPs, the MCO shall be considered to have met the requirement in 42 C.F.R. §438.14(b)(1) if Native American Enrollees are permitted by the MCO to access out-of-state IHCPs, or if this circumstance is deemed to be good cause for disenrollment from the STATE's Managed Care Program in accordance with 42 C.F.R. §438.56(c).

(G) The MCO shall permit an Out-of-Network IHCP to refer a Native American Enrollee to a Network Provider.

2.8.9 Second Opinions

If requested, MCO shall provide for a second opinion from a qualified healthcare professional within MCO Network, or arrange for the Enrollee to obtain one Out-of-Network, if a Network Provider is not available, at no cost to the Enrollee.

2.8.10 Out-of-Network Services

(A) MCO shall, pursuant to 42 C.F.R. §438.206(b)(4), provide all Medically Necessary Covered Services to an Enrollee adequately and timely even if MCO is unable to provide these services through Network Providers.

(B) For services authorized by MCO and obtained from Out-of-Network Providers, MCO shall require the Out-of-Network Provider to coordinate with MCO with respect to payment. MCO shall ensure that the cost to the Enrollee is no greater than it would be if the services were furnished within the MCO's Network.

(C) MCO must have a standard Prior Authorization process in place in which an Enrollee or Enrollee's Provider may request Medically Necessary Services to be received from Out-of-Network Providers.

(D) In instances where Medically Necessary Covered Services must be furnished by an Out-of-Network Provider, MCO shall ensure that:

(1) The particular service will be provided by a qualified and clinically appropriate Provider;

(2) The Provider is located within the shortest travel time of the Enrollee's residence, taking into account the availability of public transportation to the location;

(3) The Provider is licensed by the state of North Dakota or, if located in another state, the Provider is licensed by that state; and

(4) The Provider is licensed and accredited by a state approved accrediting organization, if required by North Dakota state or federal requirements.

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(E) MCO must reimburse Out-of-Network Providers for Covered Services if the service was Medically Necessary, authorized by MCO, and could not reasonably be obtained on a timely basis from a Network Provider. This provision applies to Out-of-Network Providers, inside and outside the State of North Dakota.

(F) MCO must pay Out-of-Network Providers for all emergency, post-stabilization, and authorized Covered Services. Out-of-Network Provider Claims must be paid at the established MCO rate in effect on the date of service for paying Network Providers, or the rate agreed to by MCO and the Out-of-Network Provider.

2.8.11 Provider Services

(A) Referral Provider Listing

MCO shall provide all PCPs with a current hard copy listing of referral Providers, including Behavioral Health Providers on a quarterly basis. MCO shall also maintain an updated electronic, web-accessible version of the referral Provider listing.

(B) Network Provider Relations

(1) MCO shall establish and maintain a formal Provider relations function to respond timely and adequately to inquiries, questions, and concerns from Network Providers;

(2) MCO shall maintain a protocol that facilitates communication to and from Providers and MCO which shall include, but not be limited to, a Provider newsletter, electronic mail, periodic Provider meetings, and updated contact information for Provider Relations representatives that includes their areas of responsibility.

(3) Except as otherwise required or authorized by STATE or by operation of law, MCO shall ensure that Providers receive thirty (30) calendar days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

(4) MCO shall work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with MCO's quality improvement goals and performance withhold measures, and all other requirements of this Contract.

(5) MCO shall provide ongoing Provider training, respond to Provider inquiries, and provide general assistance to Providers regarding program operations and requirements.

(6) MCO shall ensure regularly scheduled visits to Provider sites, as well as ad hoc visits as circumstances dictate and provide technical assistance, including assistance on MCO systems and billing practices. Documentation of these visits shall be provided upon request by STATE and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any

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distributed materials.

(7) MCO shall maintain an updated electronic, web-accessible listing of referral Providers, including mental health and SUD Providers.

(C) Provider Toll-Free Telephone Line

(1) MCO shall have trained Provider relations staff dedicated to this Contract and operate a Provider toll-free line to address Provider issues Monday through Friday from 8 a.m. to 6 p.m. Central Time and to handle non-routine Prior Authorization requests twenty-four (24) hours per day, seven (7) days per week.

(2) MCO shall have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for an Enrollee in need of urgent or Emergency Services. MCO and its Providers shall not require such verification prior to providing Emergency Services.

(3) MCO shall provide for arrangements to handle emergent Provider issues twenty-four (24) hours per day, seven (7) days per week.

(4) The telephone line shall include the ability for Providers to access interpreter services as described in the Enrollee Services Article of this Contract. The telephone line shall have the capability to track Provider call management metrics and comply with the Enrollee call center performance standards outlined in the Enrollee Services Article.

(5) MCO shall have in a place a process for measuring the quality of response from Provider relations staff and providing additional training to staff as necessary to address any shortcomings in ability to appropriately respond.

(D) Provider Website

(1) MCO shall have a Provider website. The Provider website may be developed on a page within MCO's existing website (such as a portal) to meet these requirements

(2) MCO shall maintain forms on its Provider website to allow submittal of complaints and disputes electronically. In addition, MCO shall provide Providers with an address to submit Grievances and Appeals in writing and a phone number to submit Grievances and Appeals by telephone.

(3) MCO's Provider website shall provide a secure Provider portal with the following capabilities:

(a) MCO shall use current state and federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, and DSM-5) for all Provider-used systems and maintain a uniform service and Provider taxonomy for billing and information management purposes. At a minimum this shall include the following transactions: HIPAA 834 transaction, 837 Encounter, 270/271

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eligibility, coverage or benefit inquiry/information, 267/277 Healthcare Claims Status Request/Response, 278 Healthcare Services Review/Prior Authorization, 829 Payment Order/Remittance Advice, and 835 Healthcare Claim Payment/Advice.

(b) MCO shall, with appropriate Enrollee consent, allow the Provider access to Enrollee clinical data including assessments and plans of care and/or relevant data necessary to provide for appropriate coordination of care.

(c) MCO shall provide online accessible methodology for Providers to review and update staff rosters of credentialed and Contracted Providers of mental health rehabilitation services.

(d) MCO shall grant user-defined STATE access to and training on the Provider website.

(e) MCO shall provide a link to the MCO's Provider handbook.

(4) MCO shall provide, in accordance with national standards, claims inquiry information to Providers and Subcontractors via MCO's website, including the 276/277 Claim Status Request and Response.

(5) MCO shall develop and maintain methods to communicate policies, procedures, and relevant information to Providers through its website.

(6) MCO shall remain compliant with HIPAA privacy and security requirements when providing any Enrollee eligibility or Enrollee identification information on the website.

(7) MCO website shall be in compliance with Section 508 of the Americans with Disabilities Act (ADA), and meet all standards the ADA sets for people with visual impairments and disabilities that make usability a concern.

(8) MCO is responsible for ensuring that the website is maintained with accurate and current information and is compliant with requirements of this Contract.

(E) Provider Handbook

(1) MCO shall maintain and distribute a Provider handbook which includes specific information about MCO Covered Services, non-MCO Covered Services, and other requirements of the Contract relevant to Provider responsibilities. MCO shall submit an updated Provider handbook to STATE annually and as requested by STATE.

(2) MCO shall develop and issue a Provider handbook to all Providers at the time Provider agreements are executed and annually as the Provider handbook is updated.

(3) MCO may choose not to distribute a hard copy of the Provider handbook,

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provided it submits a written notification to all Providers that explains how to obtain the Provider handbook from MCO's website. This notification shall also detail how the Provider can request a hard copy from MCO at no charge to the Provider. All Provider handbooks and bulletins shall comply with state and federal laws. The Provider handbook shall serve as a source of information regarding MCO Covered Services, policies and procedures, statutes, regulations, telephone access, and special requirements to ensure all Contract requirements are met.

(4) MCO shall disseminate bulletins as needed to incorporate any changes to the Provider handbook.

(5) MCO shall submit to STATE for approval as part of readiness reviews a Provider handbook specific to the North Dakota Medicaid Managed Care Program and thereafter on an annual basis.

(F) Provider Education and Training

(1) MCO shall provide training to all Providers and their staff regarding the requirements of the Contract, including limitations on Provider marketing and identification of special needs of Enrollees. MCO shall conduct initial training within thirty (30) calendar days of placing a newly Contracted Provider, or Provider group, on active status. MCO shall also conduct ongoing training, as deemed necessary by MCO or STATE, in order to ensure compliance with program standards and the Contract.

(2) MCO shall submit a copy of the Provider Training Manual and training schedule to STATE for approval as part of readiness reviews. Any changes to the manual shall be submitted to STATE at least thirty (30) calendar days prior to the scheduled change and dissemination of such change.

(3) MCO shall develop and offer specialized initial and ongoing training in the areas including, but not limited to, billing procedures and service authorization requirements.

(4) MCO shall provide prescriber education, training, and outreach to support the implementation, maintenance, and updating of its Behavioral Health pharmacy management activities, including, but not limited to, education and training relative to the Preferred Drug List, Prior Authorization requirements, fail first, step-therapy, approved prescribing caps, and relevant Enrollee Appeal, expedited Appeal, and peer-to-peer procedures and protocols. MCO shall submit its tentative prescriber training and education schedule or plan to STATE as part of readiness reviews for approval.

(5) MCO shall ensure that Behavioral Health Providers (i.e. organizations, Practitioners, and staff) are trained and/or meet training requirements in accordance with state laws and rules for MCO Covered Services.

(6) MCO shall provide at least seven (7) calendar days advance notice of all trainings

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to STATE, and STATE shall be invited to attend all Provider sessions. MCO shall maintain and provide upon STATE request all Provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees' lists, and organizations trained.

(7) Upon entering into Agreements, MCO shall provide its Network Providers adequate information about the Grievance, Appeal, and STATE Fair Hearing procedures and timelines so that the Provider can comply with the Grievance System's requirements including:

(a) The Enrollee's right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing;

(b) The Enrollee's right to file Grievances and Appeals;

(c) The requirements and timeframes for filing a Grievance or Appeal;

(d) The availability of assistance in the filling process;

(e) The toll-free numbers that the Enrollee can use to file a Grievance or Appeal by phone;

(f) The fact that, when requested by the Enrollee, disputed services will continue if the Enrollee files an Appeal or requests a State Fair Hearing within the timeframes specified for filing, and the Enrollee may be required to pay the cost of disputed services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and

(g) Any State-determined Provider Appeal rights to challenge the failure of MCO to cover a service.

(G) Provider Complaint System

(1) MCO shall establish and maintain a Provider complaint system that permits a Provider to dispute MCO's policies, procedures, or any aspect of MCO's administrative functions, including proposed actions, claims/billing disputes, and service authorizations.

(2) As a part of the Provider complaint system, MCO shall:

(a) Have dedicated staff for Providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a Provider complaint, and resolve problems;

(b) Identify staff specifically designated to receive and process Provider complaints;

(c) Thoroughly investigate each Provider complaints using applicable statutory, regulatory, contractual, and Provider agreement provisions,

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collecting all pertinent facts from all parties and applying MCO's written procedures; and

(d) Ensure that MCO executives with the authority to require corrective action are involved in the Provider complaint process.

(3) For Provider complaints concerning non-claims issues, MCO shall:

(a) Allow Providers forty-five (45) calendar days from the date the issue occurred to file a written complaint for issues that are not about claims;

(b) Within three (3) 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;

(c) Document why a complaint is unresolved after fifteen (15) calendar days of receipt and provide written notice of the status to the Provider every fifteen (15) calendar days thereafter; and

(d) Resolve all complaints within ninety (90) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the Provider within three (3) business days of resolution.

(4) For Provider complaints concerning claims issues, MCO shall:

(a) Allow Providers ninety (90) calendar days from the date of final determination of the primary payer to file a written complaint for claims issues;

(b) Within three (3) business days of receipt of a claim complaint, notify the Provider (verbally or in writing) that the complaint has been received and the expected date of resolution; and

(c) Resolve all claims complaints within sixty (60) calendar days of receipt and provide written notice of the disposition and the basis of the resolution to the Provider within three (3) business days of resolution.

(5) MCO shall distribute the Provider complaint system procedures, including claims issues, to non-Participating Providers upon request. MCO may distribute a summary of these procedures, if the summary includes information about how the Provider may access the full procedures on MCO's website. This summary shall also detail how the Provider can request a hard copy from MCO at no charge.

(6) MCO shall maintain a complete and accurate record of all Provider complaints related to this Contract and shall report annually to STATE.

(7) MCO is prohibited from discriminating or taking punitive action against a Provider for making a complaint to STATE in good faith.

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(8) MCO shall report Provider complaints as specified in Appendix D: MCO Compliance, Operations, and Quality Reporting.

2.8.12 Claims and Provider Payment

(A) MCO shall pay Providers on a timely basis consistent with the Claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act (42 U.S.C. §1396a(a)(37)(A)) and the implementing federal regulations at 42 C.F.R. §447.45 and 42 C.F.R. §447.46 unless MCO and the Network Provider have established an alternative payment schedule.

(B) MCO shall provide online and phone-based capabilities to Network Providers to obtain claim processing status information.

(C) MCO shall support Network Providers to request and receive electronic funds transfer (EFT) of claims payments.

(D) MCO shall have procedures, subject to STATE approval, available to Network Providers in written and web form for the acceptance of claim submissions which include:

(1) The process for documenting the date of actual receipt of non-electronic claims and date and time of receipt of electronic claims;

(2) The process for reviewing claims for accuracy and acceptability in accordance with 42 C.F.R. §438.242(b)(3);

(3) The process for prevention of loss of such claims; and

(4) The process for reviewing claims for determination as to whether claims are accepted as Clean Claims.

(E) At a minimum, MCO shall run one (1) Provider payment cycle per week, on the same day each week.

(F) MCO shall encourage its Providers, as an alternative to the filing of paper-based claims, to submit and receive claims information through electronic data interchange (EDI).

(G) MCO shall comply with the following standards regarding timely claims processing for all Providers:

(1) Within five (5) business days of receipt of a claim, MCO shall perform an initial screening, and either reject the claim, or assign a unique control number and enter it into the system for processing and adjudication.

(2) MCO shall process and pay or deny, as appropriate, ninety (90) percent of all Clean Claims submitted within thirty (30) calendar days of the date of receipt.

(3) MCO shall pay or deny, as appropriate, ninety-nine (99) percent of all Clean Claims submitted within ninety (90) calendar days of the date of receipt.

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(H) Rejected Claims

(1) MCO may reject claims because of missing or incomplete information. Paper claims received by MCO that are screened and rejected prior to scanning shall be returned to the Provider with a letter notifying them of the rejection. Paper claims received by MCO that are scanned prior to screening and then rejected, are not required to accompany the rejection letter.

(2) MCO shall not include a rejected claim on the Remittance Advice (RA) because it will not have entered the claims processing system.

(3) In the claims rejection letter, MCO shall indicate why the claim is being returned, including all defects or reasons known at the time the determination is made and at a minimum, must include the following:

(a) The date the letter was generated;

(b) The Enrollee's name;

(c) Provider identification, if available, such as Provider ID number, TIN or NPI;

(d) The date of each service;

(e) The patient account number assigned by the Provider;

(f) The total billed charges;

(g) The date the claim was received; and

(h) The reasons for rejection.

(I) Pended Claims

(1) If a claim is received, but additional information is required for adjudication, MCO may pend the claim and request in writing all necessary information in order for the claim to be adjudicated within the timeframes described above.

(2) MCO may pend claims submitted by Providers that are the subject of a payment suspension due to a credible allegation of Fraud in accordance with 42 C.F.R. §455.23 for the duration of the payment suspension. Once the suspension period has ended, MCO shall adjudicate any previously pended claims in accordance with the timeframes in Article 2.8.12.

(J) Claims Reprocessing

If MCO discover errors made by MCO when a claim was adjudicated, MCO shall make corrections and reprocess the claim within thirty (30) calendar days of discovery. MCO

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shall automatically recycle all impacted claims for all Providers and shall not require the Provider to resubmit the impacted claims.

(K) Timely Filing Guidelines

(1) MCO shall adhere to the STATE timely filing policies and require Providers to file Medicaid Expansion-only claims within six (6) months of the date of service. MCO shall deny any Medicaid Expansion-only claim not initially submitted within this timeframe, unless STATE, MCO, or its Subcontractors created the error. MCO may have more restrictive standards than STATE if it chooses.

(2) MCO shall require Providers to file claims involving Third Party Liability within three hundred sixty-five (365) calendar days from the date of service. MCO shall deny any claim involving Third Party Liability not initially submitted by the three hundred and sixty-fifth (365^{th}) calendar day from the date of service, unless STATE, MCO, or its Subcontractors created the error.

(3) MCO shall not deny claims submitted in cases of retroactive eligibility for timely filing if the claim is submitted within six (6) months from the date the MCO is notified of the enrollment, even if the claim is received after the termination date of this Contract.

(L) Remittance Advices

In conjunction with its payment cycles, MCO shall provide that:

(1) Adjustments and voids shall appear on the RA under "Adjusted or Voided Claims" either as Approved or Denied.

(2) In accordance with 42 C.F.R. §455.18 and §455.19, the following statements shall be included on each remittance advice sent to Providers:

(a) "This is to certify that the foregoing information is true, accurate, and complete."

(b) "I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws."

(M) MCO must ensure that the date of receipt is the date MCO receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

(N) Claims Dispute Management

(1) MCO shall develop an internal claims dispute process for those claims or groups of claims that have been denied or underpaid.

(2) MCO's Claims Dispute process shall allow Providers the option to request binding

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arbitration for claims that have been denied or underpaid claims or a group of claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If MCO and the Network Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Article shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) calendar days of being selected, unless MCO and the Network Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney fees, shall be shared equally by the parties.

(3) MCO shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.

(4) MCO shall adjudicate all disputed claims to a paid or denied status within thirty (30) business days of receipt of the disputed claim.

(5) The Network Provider shall have one hundred and eighty (180) calendar days from the date of denial to dispute the denied claim.

(O) Payment Recoupments

(1) MCO shall provide written prior notification to a Provider of its intent to recoup any payment.

(2) The notification shall include:

(a) The patient's name, date of birth, and Medicaid identification number;

(b) The date(s) of Health Care Services rendered;

(c) A complete listing of the specific claims and amounts subject to the recoupment;

(d) The specific reasons for making the recoupment for each of the claims subject to the recoupment;

(e) The date the recoupment is proposed to be executed;

(f) The mailing address or electronic mail address where a Provider may submit a written response;

(g) When applicable, the date STATE notified MCO of the Enrollee's disenrollment via the ASC X12N 834 Benefit Enrollment and Maintenance Transaction; and

(h) The effective date of disenrollment.

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(3) Before the recoupment is executed, the Provider shall have forty-five (45) calendar days from receipt of written notification of recoupment to submit a written response to MCO as to why the recoupment should not be put into effect on the date specified in the notice. If the Provider fails to submit a written response within the time period provided, MCO may execute the recoupment on the date specified in the notice.

(4) Upon receipt by MCO of a written response as to why the recoupment should not be put into effect, MCO shall, within thirty (30) calendar days from the date the written response is received, consider the statement, including any pertinent additional information submitted by the Provider, together with any other material bearing upon the matter, and determine whether the facts justify recoupment. MCO shall provide a written notice of determination to each written response that includes the rationale for the determination.

(5) If a recoupment is valid, the Network Provider shall remit the amount to MCO or permit MCO to deduct the amount from future payments due to the Network Provider.

(6) MCO shall develop and implement a safeguard for automated reviews to prevent subsequent reviews on a claim when the denial or exception reason is the same as a previous denial or exception reason. MCO and its Subcontractors shall not recover from a Provider via automated review for a claim for which an automated denial was reversed subsequent to Provider dispute, when the denials are for the same reason. For such claims, MCO shall ensure a complex review and consideration of the claim history or audit trail.

(7) At the Provider's request, MCO shall provide an independent review of claims that are the subject of an Adverse Determination by MCO.

(P) Claims Payment Accuracy Report

(1) On a monthly basis, MCO shall submit a claims payment accuracy percentage report to STATE. The report shall be based on an audit conducted by MCO. The audit shall be conducted by an entity or staff independent of claims management, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per month, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

(2) The minimum attributes to be tested for each claim selected shall include:

(a) Claim data is correctly entered into the claims processing system;

(b) Claim is associated with the correct Provider;

(c) Proper authorization was obtained for the service;

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(d) Enrollee eligibility at processing date correctly applied;

(e) Allowed payment amount agrees with contracted rate;

(f) Duplicate payment of the same claim has not occurred;

(g) Denial reason is applied appropriately;

(h) Co-payments are considered and applied, if applicable;

(i) Effect of modifier codes correctly applied; and

(j) Proper coding.

(3) The results of testing at a minimum should be documented to include:

(a) Results for each attribute tested for each claim selected;

(b) Amount of overpayment or underpayment for each claim processed or paid in error;

(c) Explanation of the erroneous processing for each claim processed or paid in error;

(d) Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and

(e) Claims processed or paid in error have been corrected.

(4) If MCO subcontracted for the provision of any Covered Services, and the Subcontractor is responsible for processing claims, then MCO shall submit a claims payment accuracy percentage report for the claims processed by the Subcontractor.

(Q) Claims Summary Report

MCO shall submit monthly Claims Summary Reports of paid and denied claims to STATE by claim type.

(R) Sampling of Paid Claims

(1) On a monthly basis, MCO shall provide individual explanation of benefits (EOB) notices to a sample group of Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 C.F.R. §455.20 and §433.116(e). In easily understood language, the required notice shall specify:

(a) Description of the service furnished;

(b) The name of the Provider furnishing the service;

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(c) The date on which the service was furnished;

(d) The amount of the payment made for the service; and

(e) The method for notifying MCO of services not rendered.

(2) MCO shall stratify the paid claims sample to ensure that all Provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the contract. To the extent that MCO or STATE considers a particular specialty (or Provider) to warrant closer scrutiny, MCO may over sample the group. The paid claims sample should be a minimum of two percent (2%) of paid claims per month to be reported on a quarterly basis.

(3) The notices may be performed by mail, telephonically, or in person (e.g., case management on-site visits).

(4) MCO shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be Enrollee education, Provider education, payment recovery, or referral to STATE. MCO shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.

(5) Within three (3) business days, results indicating that paid services may not have been received shall be referred to MCO's Fraud and Abuse department for review and to STATE.

(6) Reporting shall include, at a minimum, the total number of notices sent to Enrollees, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to STATE for further review.

(S) Special Rules on Payment for Provider Preventable Conditions

(1) MCO shall ensure compliance with the requirements mandating Provider identification of Provider Preventable Conditions as a condition of payment. In accordance with federal regulations and STATE requirements, MCO shall require that its Network Providers promptly identify and report to MCO on Provider Preventable Conditions associated with claims for payment or Enrollee treatments for which payment would otherwise be made.

(2) MCO shall not pay for Provider Preventable Conditions as set forth in 42 C.F.R. §438.3(g), 42 C.F.R. §434.6(a)(12)(i), and 42 C.F.R. §447.26 as noted in the North Dakota Medicaid State Plan.

(3) MCO shall not make payment for conditions as identified in the North Dakota Medicaid State Plan, found by STATE, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative

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consequence for the beneficiary, and is auditable. This also includes, at minimum: wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

(4) At least quarterly, MCO shall report to STATE on all identified Provider Preventable Conditions in a format specified by STATE.

2.9 Network Adequacy

2.9.1 Network Standards

(A) MCO is not required to contract with more Providers than necessary to meet the needs of its Enrollees as defined by this Contract and 42 C.F.R. §438.12(b)(1).]

(B) Except in rural areas of the state, MCO shall ensure that every Enrollee has a choice of PCPs whose office is located within thirty (30) minutes or thirty (30) miles driving distance from the Enrollee's North Dakota residence, as indicated on the enrollment file provided to MCO by STATE. In the case of Enrollees residing in rural areas of the state, MCO must ensure a choice of PCPs whose office is located within fifty (50) minutes or fifty (50) miles driving distance from the Enrollee's North Dakota residence.

(C) MCO's Primary Care Network must have at least one full-time equivalent Primary Care Provider (PCP) for every two thousand five hundred (2,500) patients, including Medicaid expansion Enrollees.

(D) MCO must maintain a ratio for each high volume and high impact Specialist type of one full time equivalent physician per three thousand (3,000) Enrollees.

(E) MCO must maintain a ratio for each high volume Behavioral/Mental Health and substance use disorder Practitioner type of one full time equivalent Practitioner per three thousand (3,000) Enrollees.

2.9.2 Availability and Furnishing of MCO Covered Services

(A) MCO shall ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid Enrollees with physical or Behavioral Health disabilities [42 C.F.R. §438.206(c)(3)]

(B) If MCO is unable to provide the necessary services to an Enrollee within their Network, MCO shall adequately and timely cover these services Out-of-Network for the Enrollee for as long as MCO's Provider Network is unable to provide the services. MCO shall ensure coordination with respect to authorization and payment issues in these circumstances to ensure that the cost to the Enrollee is no greater than it would be if the services were furnished within the Network [42 C.F.R. §438.206(b)(4) and (5)]

(C) MCO shall ensure parity in determining access to Out-of-Network Providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in

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determining access to Out-of-Network Providers for medical/surgical benefits in accordance with 42 C.F.R. §438.910(d)(3).

2.9.3 Timely Access to Care

(A) MCO shall meet, and require its Network Providers to meet STATE standards for timely access to care and services as specified in this Contract, taking into account the urgency of the need for services [42 C.F.R. §438.206(c)(1)(i)]

(B) MCO shall ensure that the Network Providers offer hours of operation to its Enrollees that are no less than the hours of operation offered to commercial Enrollees or comparable to Medicaid FFS, if the Provider serves only Medicaid Enrollees [42 C.F.R. §438.206(c)(1)(ii)].

(C) MCO shall regularly disseminate appointment standards and procedures to its Providers and Enrollees and include this information on MCO's Provider website. MCO must include the applicable appointment accessibility standards from **Appendix C: Network Accessibility Standards** of this Contract in its Provider agreements, either directly or through reference to MCO's Provider Manual.

(D) MCO shall make services included in the Contract available twenty-four (24) hours a day, seven (7) days a week, when Medically Necessary [42 C.F.R. §438.206(c)(1)(iii)]

(E) MCO shall develop and maintain its Provider Network in order to adhere to STATE standards for timely appointment accessibility as indicated in **Appendix C: Network Accessibility Standards**.

(F) MCO shall establish mechanisms to regularly monitor Network Providers' compliance with access requirements, and shall take corrective action if there is a failure to comply by a Network Provider [42 C.F.R. §438.206(c)(1)]

2.9.4 Network Access Requirements and Documentation

(A) MCO shall develop and maintain a Provider Network that, at a minimum, complies with travel time, distance requirements, Provider to Enrollee ratios, and appointment accessibility standards specified in **Article 2.9.1 and Appendix C: Network Accessibility Standards** of this Contract. These minimum access requirements for the Provider Network shall not release MCO from the requirement to provide or arrange for the provision of any Medically Necessary Covered Service required by its Enrollees, taking into account the urgency of the need for services. If MCO or STATE identifies or anticipates that the Network will not be sufficient to meet the timely access to care standards of this Contract for a Covered Service in any location or for any population of Enrollees, MCO shall enhance its Provider Network in order to meet such state standards.

(B) In assessing Network Adequacy and compliance with this Contract, MCO shall identify, take into consideration, and separately report on Provider Specialists with limited Provider agreements such as single case agreements and those that preclude Enrollee access to appointments outside of hospital settings.

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(C) MCO shall submit documentation, as specified by STATE that it meets Network Adequacy requirements of the Contract on an annual basis, and at any time there has been a significant change, as defined by STATE, in MCO's operations that would affect the adequacy and capacity of services, including changes in MCO services, benefits, geographic service area, or composition of or payments to its Provider Network

2.9.5 Requests for Exceptions to Access Requirements

(A) MCO shall ensure PCP services, hospital services, Behavioral Health, and other services identified in the Contract are available from Network Providers within the specified travel distance and time requirements from the Enrollee's home. Exceptions, if any, to these time and distance standards shall be at the discretion of STATE and only considered based on the prevailing community standard.

(B) MCO must submit any requests for exceptions for time, distance, or appointment accessibility standards in writing to STATE for approval. Such requests must be in a format specified by STATE and include data on the local Provider population available to the non-Medicaid population.

(C) If STATE grants MCO an exception to a time or distance or appointment accessibility standard:

(1) The exception is limited to the identified Provider type and is granted for a period of up to one (1) year, at which point MCO may submit a new request.

(2) MCO shall monitor Enrollee access to the specific Provider type on an ongoing basis and provide the findings to STATE as part of its Network Development and Management Plan. Specifically, MCO shall:

(a) Describe how it shall reasonably deliver MCO Covered Services to Enrollees who may be affected by the exception and how it will work to increase access to the Provider type; and

(b) Monitor, track, and report to STATE on the delivery of MCO Covered Services to Enrollees potentially affected by the exception.

(D) MCO shall allow an Enrollee the option of choosing to travel further than established access standards in order to access a preferred Provider. The Enrollee shall be responsible for travel arrangements and costs unless there is not a qualified Provider meeting the accessibility standards within MCO's Provider Network.

(E) As permitted by State law, telemedicine may be used to facilitate access to MCO Covered Services by licensed professionals to augment MCO's Network. Any service provided via telemedicine must be Medically Necessary, and the procedure individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the Enrollee's needs.

2.9.6 Network Access Plan

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(A) MCO must attest to and demonstrate compliance with contractual Network Adequacy and timeliness to care requirements on at least an annual basis. MCO must develop, submit, and comply with a Network Access Plan which describes its Network development and Network management activities and results. The report must include any findings of Provider non-compliance and any corrective action plan and/or measures taken by MCO to bring the Provider into compliance. The Network Access Plan must demonstrate that MCO:

(1) Offers an appropriate range of preventive, Primary Care, and specialty services that is adequate for the anticipated number of Enrollees for the Service Area;

(2) Maintains a Network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the Service Area;

(3) Maintains a Network that includes sufficient family planning Providers to ensure timely access to Covered Services; and

(4) Monitors and acts on changes or gaps in Provider Network including exceptions, if any, granted by STATE to travel standards, including how MCO monitors exceptions and need for out-of-state Providers, addresses Network gaps, and improves access and availability to health care services across Regions and Provider specialties.

(B) MCO's annual Network Access Plan shall include MCO's processes and methods to develop, maintain, and monitor an appropriate Provider Network that is sufficient to provide adequate access to all services covered under this Contract. The Network Access Plan, at a minimum, must include the following:

(1) A description of MCO's Network, criteria used to select Providers, and MCO's process for reviewing, updating, and submitting its Provider Directory consistent with this Contract;

(2) Ongoing activities for Network development, including Network management functions delegated to Subcontractors;

(3) Strategies to maximize healthcare Network access and availability for Enrollees given North Dakota's status as a rural state;

(4) MCO's process for monitoring and assuring on an ongoing basis the sufficiency of its Network to meet the health care needs of Enrollees for all Covered Services within STATE's Network Adequacy and timely access standards;

(5) Geographical access time and distance tables in the format specified by STATE of adult PCPs, outpatient Behavioral Health, and Specialists. Providers that are not accepting new patients, including Providers with some conditions on accepting new patients, must be excluded from geo-access time and distance tables;

(6) Provider coverage demonstrating compliance with time and distance standards

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in Article 2.9.1 for Enrollees in MCO's Service Area;

(7) Immediate short-term interventions to address Network gaps, including the process for Enrollees to access services;

(8) Long-term interventions to resolve Network gaps and an evaluation of the effectiveness of those interventions to resolve Network gaps and barriers;

(9) Methods for accessing a non-Participating Provider to address any potential gaps, including a description of MCO's Provider outreach strategy;

(10) The extent to which MCO utilizes telemedicine services to resolve Network gaps;

(11) MCO's procedures and time frames for making and authorizing referrals and Prior Authorizations if applicable within and outside its Network; and

(12) MCO's plan for providing continuity of care in the event of new population enrollment, changes in Service Area, covered benefits, contract termination between MCO and any of its Participating Providers including major health care groups, MCO insolvency, or other inability to continue operations.

2.9.7 Network Management

(A) MCO shall develop and implement a strategy to manage the Provider Network with a focus on timely access to services for Enrollees, quality, consistent practice patterns, the principles of rehabilitation and recovery for Behavioral Health care services, cultural and linguistic competence, and cost effectiveness.

(B) MCO's Network management strategy shall include, at a minimum:

(1) A system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;

(2) A system for MCO and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals; and

(3) Conducting on-site visits to Network Providers for quality management and quality improvement purposes.

(C) MCO must conduct profiling activities for PCPs, Behavioral Health Providers and facilities, and other Provider types as directed by STATE. MCO must describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers.

(D) MCO shall use the results of its Provider profiling activities to identify areas of improvement for Providers and/or groups of Providers and establish Provider-specific quality improvement goals for priority areas in which a Provider(s) does not meet established MCO standards or improvement goals.

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(E) MCO shall monitor and enforce access and other Network standards required by this Contract and take appropriate action with Providers whose performance is in need of improvement or out of compliance with this Contract, including when a Provider fails to meet minimum Provider qualifications or requirements, or appointment availability standards.

(F) MCO shall provide STATE with a summary of collected information, monitoring reviews and findings, corrective action plans, and follow-up related to Provider Network management on an annual basis. At STATE's direction, MCO shall modify its Network management strategy, tools, and processes to comply with the Contract.

2.10 Care Delivery, Coordination, and Care Management

2.10.1 General Care Delivery Requirements

(A) MCO shall ensure that all Enrollees experience care that is integrated across Providers (including Network Providers), that is patient-centered, and that connects Enrollees to the right care in the right settings, as described in this Article and as further specified by STATE.

(B) In accordance with all other applicable MCO requirements, MCO shall ensure that all Enrollees receive care that is timely, accessible, and Linguistically and Culturally Competent. MCO shall:

(1) Ensure that all Enrollees may access:

(a) Primary Care or Urgent Care during extended hours;

(b) Same-day appointments for certain services;

(c) Medical and diagnostic equipment that is accessible to Enrollees;

(d) Care that is Linguistically and Culturally Competent. MCO shall regularly evaluate the population of Enrollees to identify language needs, including needs experienced by Enrollees who are deaf or hard of hearing, and needs related to health literacy, and to identify needs related to cultural appropriateness of care (including through the Care Needs Screening as described in Article 2.10.2). MCO shall identify opportunities to improve the availability of fluent staff or skilled translation services in Enrollees' preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care; and

(e) All Medically Necessary Services, including Behavioral Health care services and other specialty services, in accordance with the Enrollee's wishes and in a timely, coordinated, and person-centered manner. MCO shall make best efforts to ensure timely, coordinated, and person-centered access to all such services for the Enrollee in accordance with the Enrollee's wishes, including any other services delivered to the Enrollee in FFS Medicaid or by entities other than MCO, as necessary and

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appropriate;

(2) Ensure each Enrollee's access to Providers with expertise in treating the full range of medical conditions of the Enrollee, including but not limited to direct access to specialists for Enrollees with Special Health Care Needs;

(3) Coordinate transportation to medical appointments where Medically Necessary for the Enrollee to access medical care;

(4) Ensure that all Enrollees have access to emergency Behavioral Health care services, including immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, twenty-four (24) hours a day, seven (7) days a week;

(5) Follow-up with an Enrollee within twenty-four (24) hours of when the Enrollee accesses emergency Behavioral Health care services;

(6) Follow-up with an Enrollee within seven (7) days of discharge following an inpatient mental health Hospitalization;

(7) Ensure that each Provider furnishing services to Enrollees maintains and shares, as appropriate, an Enrollee health record in accordance with professional standards;

(8) Ensure that it shares with STATE or other entities serving the Enrollee the results of any identification and assessment of the Enrollee's needs to prevent duplication of those activities; and

(9) Ensure that, in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164, Subparts A and E, to the extent that they are applicable.

2.10.2 Care Needs Screening and Appropriate Follow-Up

(A) MCO shall develop, implement, and maintain procedures for completing an initial Care Needs Screening for each Enrollee to identify their health and functional needs. MCO shall make best efforts to complete such screening within ninety (90) calendar days of the Enrollee's Effective Date of Enrollment and within thirty (30) calendar days of the date of STATE identification for Enrollees with special health care needs.

(B) MCO's Care Needs Screening shall:

(1) Be a survey-based instrument approved by STATE;

(2) Be made available to Enrollees in multiple formats including Web, print, and telephone;

(3) Be conducted with the consent of the Enrollee;

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(4) Include disclosures of how information will be used;

(5) Incorporate the following elements, at a minimum;

(a) Enrollee demographics, including preferred language;

(b) Personal health history, including chronic illness and current treatment;

(c) Self-perceived health status;

(d) Questions to identify Enrollees with special health care needs;

(e) Questions to identify Enrollees' needs for culturally and linguistically appropriate services including but not limited to hearing and vision impairment and language preference;

(f) Questions to identify Enrollees' needs for accessible medical and diagnostic equipment;

(g) Questions to identify the Enrollee's health concerns and goals;

(h) Questions to identify the Enrollees' needs for Behavioral Health-care related services, including unmet needs for mental health or substance use disorder treatment services; and

(i) Questions to identify the Enrollees' social needs, including whether the Enrollee would benefit from receiving community services to address needs with Social Determinants of the Health (SDOH).

(C) MCO shall also evaluate Enrollees' needs through means other than the Care Needs Screenings. Such means shall include, but not be limited to, regular analysis of available claims, Encounter Data, and clinical data on Enrollees' diagnoses and patterns of care.

(D) MCO shall ensure that Enrollees receive Medically Necessary and appropriate care and follow-up based on their identified needs through any assessment or screening.

2.10.3 Primary Care

(A) MCO shall implement procedures to deliver Primary Care to and coordinate Health Care Services for all Enrollees. The procedures shall ensure that each Enrollee has an ongoing source of Primary Care appropriate to his or her needs as required under 42 C.F.R. §438.208(b)(1), that MCO formally designates a Primary Care Provider as primarily responsible for coordinating services furnished to the Enrollee, and that Enrollees are informed of how to contact their Primary Care Provider.

(B) MCO shall allow Enrollees the opportunity to select a Primary Care Provider. If an Enrollee fails or refuses to select a PCP from those offered within thirty (30) calendar days of enrollment, MCO shall assign a PCP. MCO may assign a PCP in less than thirty (30) calendar days if MCO provides the Enrollee an opportunity to change PCPs upon receipt

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of notice of PCP assignment.

(C) MCO shall establish policies and procedures to provide an Enrollee reasonable opportunities to change PCPs. Such policies and procedures may not specify a length of time greater than twelve (12) months between PCP changes under normal circumstances. If the ability to change PCPs is limited, MCO shall include provisions for more frequent PCP changes with good cause. The policies and procedures shall include a definition of good cause as well as the procedures to request a change and must allow Enrollees to call or fax a change request that will facilitate an immediate change to the assigned PCP. The criteria for PCP change limitations must be approved by STATE.

(D) If an Enrollee's Primary Care Provider ceases to be a Network Provider, MCO shall offer the Enrollee the opportunity to select a new Primary Care Provider.

(E) If an Enrollee requests assignment to a PCP located outside the distance/time requirements in Article 2.9.1 and MCO has PCPs available within the distance/time requirements who accept new Enrollees, it shall not be considered a violation of the access requirements for MCO to grant the Enrollee's request. However, in such cases MCO shall have no responsibility for providing transportation for the Enrollee to access care from this selected Provider, and MCO shall notify the Enrollee in writing as to whether or not MCO will provide transportation for the Enrollee to seek care from the requested Provider. In these cases, MCO shall allow the Enrollee to change assignment to a PCP within the distance/time requirements at any time if the Enrollee requests such a change.

(F) MCO may, at its discretion, allow vulnerable populations (for example, persons with multiple disabilities, acute, or chronic conditions, as determined by MCO) to select their attending Specialists as their PCP so long as the Specialist is willing to perform all responsibilities of a PCP as defined in Article 2.8.5.

(G) MCO shall ensure that Network PCPs fulfill their responsibilities as delineated in Article 2.8.5.

2.10.4 Patient-Centered Medical Home

(A) MCO shall encourage Primary Care practices' attainment of Patient Centered Medical Home (PCMH) Recognition or Accreditation status from a nationally recognized accreditation organization.

(B) MCO shall facilitate Primary Care practices' capacity to function as a PCMH by sharing Enrollee-specific information, including, but not limited to, health needs assessment, service utilization, and population health stratification data.

2.10.5 Care Coordination

(A) MCO shall ensure that care for all Enrollees is coordinated. MCO shall perform Care Coordination activities across physical and Behavioral Health care for Enrollees; have a Transitional Care Management program to coordinate Enrollees' care during transitions such as hospital discharges; and maintain a Clinical Advice and Support Line to provide

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Enrollees access to information and assistance that supports coordinated care.

(B) MCO shall coordinate care for all Enrollees, including, but not limited to:

(1) Implementing a collaborative model of care, including integrated Behavioral Health care services along the continuum of care and considering social needs, including services the Enrollee receives from community and social support providers and the social determinants of health;

(2) Assisting Enrollees to navigate to and access Medically Necessary Services;

(3) Facilitating communication between the Enrollee and the Enrollee's Providers and among such Providers;

(4) Monitoring the provision of services, making necessary referrals and assessing Enrollees for needed changes in services, in accordance with Article 2.10.2;

(5) Ensuring that all Enrollees receive information about how to contact MCO to access Care Coordination; and

(6) Ensuring that in the process of coordinating care, each Enrollee's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 Subparts A and E, as applicable.

(C) MCO shall have a Transitional Care Management program. MCO shall develop, implement, and maintain protocols for Transitional Care Management with all Network hospitals. Such protocols shall:

(1) Ensure follow-up with an Enrollee within seventy-two (72) hours of when the Enrollee is discharged from any type of hospital inpatient stay or emergency department visit, through a home visit, in-office appointment, telehealth visit, or phone conversation, as appropriate, with the Enrollee;

(2) Ensure post-discharge activities are appropriate to the needs of the Enrollee, including identifying the need for follow-up services;

(3) Integrate MCO's other Care Management activities for Enrollees, such as ensuring that an Enrollee's Case Manager is involved in discharge planning and follow-up;

(4) Include measures such as, but not limited to, the following:

(a) Event notification protocols that ensure key Providers and individuals involved in an Enrollee's care are notified of admission, transfer, discharge. Such key Providers shall include but not be limited to an Enrollee's PCP and BH Provider if any;

(b) Medication reconciliation;

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(c) Criteria that trigger an in-person rather than telephonic post-discharge follow-up;

(d) Home visits post-discharge for certain Enrollees with complex needs;

(e) Policies and procedures to ensure inclusion of Enrollees and Enrollees' family members/guardians and caregivers, as applicable, in discharge planning and follow-up, and to ensure appropriate education of Enrollees, family members, guardians, and caregivers on post-discharge care instructions; and

(f) Inclusion of the Enrollee's BH Provider, if any, in discharge planning and follow-up; and

(5) Document all efforts related to Transitional Care Management, including the Enrollee's active participation in any discharge planning.

(D) MCO shall maintain a Clinical Advice and Support Line which shall:

(1) Be easily accessible to Enrollees twenty-four (24) hours a day, seven (7) days a week;

(2) Have a dedicated toll-free telephone number;

(3) Offer all services in all prevalent languages, at a minimum;

(4) Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees;

(5) Maintain the availability of services for the deaf and hard of hearing, such as TTY services or comparable services;

(6) Provide access to medical advice as follows:

(a) The Clinical Advice and Support Line shall be staffed by a registered nurse or similarly licensed and qualified clinician, and shall provide direct access to such clinician;

(b) Such clinician shall be available to respond to Enrollee questions about health or medical concerns and to provide medical triage, based on industry standard guidelines, to assist Enrollees in determining the most appropriate level of care for their illness or condition; and

(c) The Clinical Advice and Support Line shall have documented protocols for determining an Enrollee's acuity and need for emergent, urgent, or elective follow-up care, and for when the Enrollee should go to the emergency room versus an Urgent Care center, if it is available, versus advising the Enrollee to call his or her PCP the following business day and schedule an appointment;

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(7) Facilitate coordination of Enrollee care and shall provide the Clinical Advice and Support Line's clinicians with access to information about Enrollees and Providers, including at a minimum:

(a) Processes and capabilities to identify an Enrollee who calls the Clinical Advice and Support Line;

(b) The name, contact information, and hours of operation of the Enrollee's PCP; and

(c) The name and contact information of the Enrollee's Case Manager, if applicable;

(8) Be incorporated in MCO's policies and procedures for Care Coordination and Care Management, including policies and procedures for:

(a) The Clinical Advice and Support Line notifying Providers and Care Management staff involved in an Enrollee's care of a phone call, particularly if the call indicates a need to modify the Enrollee's documented Care Plan or course of treatment or a need for follow-up;

(b) The Clinical Advice and Support Line's clinicians being able to access relevant information from an Enrollee's Care Plan or medical record under certain circumstances to respond to an Enrollee's questions and coordinate care; and

(c) The Clinical Advice and Support Line providing appropriate information and navigation of Enrollees to Providers who can support an Enrollee's needs, including but not limited to Network Providers and Providers involved in an Enrollee's care; and

(9) Provide general health information to Enrollees and answer general health and wellness-related questions..

2.10.6 Care Management

(A) MCO shall provide Care Management activities to appropriate Enrollees as described in this Article and further specified by STATE.

(B) MCO shall proactively identify Enrollees who may benefit from Care Management activities based on the results of the care needs assessment described Article 2.10.2 as well as MCO's predictive modeling results that identify high-risk patients or high ED/inpatient usage, referrals from STATE, Providers, or an Enrollee self-referral.

(C) MCO shall outreach to all Enrollees identified as potentially benefiting from Care Management to confirm their appropriateness for inclusion in Care Management services and engage them in the program.

(D) Care Management shall include a combination of in-person and telephonic or video-

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based activities, such as, but not limited to:

(1) Providing a Comprehensive Assessment using assessment tools and methods approved by STATE within 90 days of the effective date of enrollment for all new Enrollees. MCO shall make subsequent attempts to conduct such screening if the initial attempt to contact the Enrollee is unsuccessful. Such Comprehensive Assessments shall be Enrollee-centered and shall take place in a location that meets the Enrollee's needs, including home-based assessments as appropriate, and shall include domains and considerations, as further specified by STATE, such as, but not limited to, Enrollees':

(a) Immediate care needs and current services, including, but not limited to, any Care Coordination or management activities and any services being provided by state agencies;

(b) Health conditions;

(c) Medications;

(d) ED utilization;

(e) Ability to communicate their concerns, symptoms, or care goals;

(f) Functional status, including needs for assistance with any Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs);

(g) Self-identified strengths, weaknesses, interests, choices, care goals, and personal goals;

(h) Current and past mental health and substance use;

(i) Accessibility requirements, including, but not limited to, preferred language and specific communication needs, transportation needs, and equipment needs;

(j) Housing and home environment, including, but not limited to, risk of homelessness, housing preferences, and safety;

(k) Employment status, interests, and goals, as well as current use of and goals for leisure time;

(l) Available informal, caregiver, or social supports, including peer supports;

(m) Risk factors for abuse or neglect;

(n) Food security, nutrition, wellness, and exercise;

(o) Advance Directives status and preferences and guardianship status; and

(p) Other domains and considerations identified by STATE.

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(2) Creating an individualized Care Plan for each Enrollee and update such plan at least annually. Care Plans shall:

(a) Be based on an Enrollee's Comprehensive Assessment and developed under the direction of the Enrollee (or the Enrollee's representative, if applicable);

(b) Reflect the Enrollee's preference and needs;

(c) Be updated periodically to reflect changes in the Enrollee's needs, health status, or course of treatment, including provision of care management services in person as preferred by the Enrollee. The Enrollee shall be at the center of the care planning process;

(d) Designate the Enrollee's care team, as applicable, including participants of the Enrollee's choosing;

(e) Be signed or otherwise approved by the Enrollee. MCO shall establish and maintain policies and procedures to ensure an Enrollee can sign or otherwise convey approval of his or her Care Plan when it is developed or subsequently modified. Such policies and procedures shall include:

(i) Informing an Enrollee of his or her right to approve the Care Plan;

(ii) Providing the Enrollee with a copy of the Care Plan;

(iii) Providing mechanisms for the Enrollee to sign or otherwise convey approval of the Care Plan. Such mechanisms shall meet the Enrollees accessibility needs; and

(iv) Informing an Enrollee of his or her right to an Appeal of any denial, termination, suspension, or reduction in services, or any other change in Providers, services, or medications included in the Care Plan.

(3) Providing a Case Manager who is assigned to the Enrollee's care.

(4) Designating a care team of Providers and other individuals involved in the Enrollee's care. The care team shall include, at a minimum:

(a) The Enrollee's Case Manager;

(b) The Enrollee's PCP;

(c) The Enrollee's Behavioral Health care Provider (if applicable);

(d) Any additional individual requested by the Enrollee; and

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(e) Provide team-based Care Management, including meetings of the care team at least annually and after any major events in the Enrollee's care or changes in health status, or more frequently if indicated.

(5) MCO shall develop, implement, and maintain criteria and protocols for determining which Care Management activities may benefit an Enrollee.

(E) MCO shall, at a minimum:

(1) Provide a Case Manager who is assigned to the Enrollee's care and a documented Care Plan based on a Comprehensive Assessment;

(2) Provide a Case Manager who is assigned to the Enrollee's care and a documented Care Plan based on a Comprehensive Assessment as described in Article 2.10.6(D)(2) for any Enrollee receiving Care Management and identified by MCO or STATE as at risk for adverse care events.

(F) MCO shall develop, implement, and maintain procedures for providing, and shall provide, Care Management as follows:

(1) MCO's Care Management procedures shall be submitted to STATE for review and approval and shall:

(a) Include procedures for acquiring and documenting Enrollees' consent to receive Care Management and for MCO to share information about an Enrollee's care with Enrollees' Providers to promote coordination and integration. MCO shall make best efforts to obtain such consent.

(b) Include criteria and protocols for ensuring appropriate staffing ratios and caseloads for Case Managers and other staff involved in Care Management activities in line with industry practices.

(c) Include processes for MCO to measure the effectiveness and quality of MCO's Care Management procedures. Such processes shall include:

(i) Identification of relevant measurement process or outcomes;

(ii) Use of valid quantitative methods to measure outcomes against performance goals;

(iii) Percentage of care management that is occurring in-person, by phone or by video; and,

(iv) Ensuring that activities are not duplicating care coordination efforts by the PCPs.

(2) Include protocols for providing Care Management activities in each of the following settings. MCO shall exercise best efforts to provide Care Management in such settings:

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(a) At adult and family shelters, for Enrollees who are experiencing homelessness;

(b) The Enrollee's home;

(c) The Enrollee's place of employment or school;

(d) Twenty-four (24) hour level of care facilities for mental health or substance use disorder treatment, such as a residential facility, or transitional housing; or

(e) Another setting of the Enrollee's choosing.

(3) Include criteria and protocols for discharging Enrollees from Care Management.

(4) Ensure that the Care Management activities each Enrollee is receiving are appropriately documented as further specified by STATE.

(5) Ensure regular contacts between Care Management staff, the Enrollee's PCP, and the Enrollee and that these contacts are appropriately documented.

2.11 Utilization Management

2.11.1 General Requirements

(A) MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates utilization review and service authorization that are in compliance with all applicable federal and State regulations, including 42 C.F.R. §438.210(b).

(B) MCO is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees. [42 C.F.R. §438.12(b)(3)]

(C) The UM Program policies and procedures shall include medical management criteria and practice guidelines that:

(1) Are adopted in consultation with Network Providers;

(2) Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

(3) Consider the needs of the Enrollees; and

(4) Are reviewed annually and updated periodically as appropriate.

(D) The policies and procedures shall include, but not be limited to:

(1) The methodology utilized to evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of Covered Services;

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(2) The data sources and clinical review criteria used in decision making; MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations;

(3) The requirement that the appropriateness of clinical review shall be fully documented;

(4) The process for conducting peer-to-peer reviews of Adverse Determinations;

(5) Mechanisms to ensure consistent application of review criteria and compatible decisions;

(6) Data collection processes and analytical methods used in assessing utilization of healthcare services;

(7) Provisions for ensuring confidentiality of clinical information;

(8) Service authorization criteria for Behavioral Health care services that are consistent with state and federal laws and Service authorization for use of out-of-state Providers when Medically Necessary care is not available within the State;

(9) Mechanisms for collaborating with hospitals, nursing facilities, intermediate care facilities, residential facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of Enrollees for the continuance of Behavioral Health care services and medication prior to reentry into the community, including referral to community Providers and coordination of care; and

(10) Mechanisms for collaborating with the Department of Corrections and local criminal justice systems to facilitate access to and/or continuation of prescribed medication and other Behavioral Health care services for Enrollees, including referral to community Providers and coordination of care, prior to re-entry into the community, including, but not limited to, Enrollees in the Medicaid pre-release program.

(E) MCO shall adopt clinical practice guidelines for specific conditions and shall disseminate the practice guidelines to STATE, all affected Providers, and to Enrollees and Potential Enrollees upon request. [42 C.F.R. §438.236(c)]

(F) UM Program medical management criteria and practice guidelines shall be posted to MCO's website. If MCO uses proprietary software that requires a license and which may not be posted publicly according to associated licensure restrictions, MCO may post the name of the software only on its website. Upon request by an Enrollee, their representative, or STATE, MCO shall provide the specific criteria and practice guidelines utilized to make a decision. MCO shall make its decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply in a manner consistent with the guidelines.

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(G) MCO shall have written procedures listing the information required from an Enrollee or healthcare Provider to make Medical Necessity determinations. Such procedures shall be given verbally to the Enrollee or Provider when requested. The procedures shall outline the process to be followed in the event MCO determines the need for additional information not initially requested.

(H) MCO shall have written procedures to address the failure or inability of a Provider or Enrollee to provide all the necessary information for review.

(I) MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines to determine Medical Necessity. Determinations of Medical Necessity shall be made by qualified and trained Practitioners in accordance with state and federal regulations. MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. An individual making Medical Necessity determinations shall attest that no Adverse Determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.

(J) Compensation to individuals or entities that conduct utilization management activities shall not be structured to provide incentives for denying, limiting, or discontinuing Medically Necessary Services to any Enrollee.

2.11.2 Service Authorization

(A) MCO shall have service authorization policies and procedures for Prior Authorization, concurrent authorization, and post authorization that comply with 42 C.F.R. §438.210 and any court-ordered requirements. Policies and procedures shall include, but are not limited to, the following:

(1) Written policies and procedures for processing requests for initial and continuing authorizations of services;

(2) Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting Provider as appropriate;

(3) Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease;

(4) Compliance with requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. §438.910(d);

(5) Process for MCO to consult with the requesting Provider for medical services, when appropriate;

(6) Process to arrange for another level of care if appropriate when MCO denies a

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service authorization request;

(7) A provision that if MCO denies a claim, in whole or in part, or a request for a service authorization based upon medical management criteria and/or clinical practice guidelines, MCO shall provide to the healthcare Provider submitting the claim or the request for authorization a written copy of the specific medical management criteria and/or clinical practice guidelines utilized to make the decision at the same time MCO notifies the Provider of the decision and shall not refuse to provide such information on the grounds that it is proprietary; and

(8) A mechanism in which an Enrollee may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its Enrollee manual and incorporated in the Grievance procedures.

(B) MCO's service authorization system shall provide the authorization number and effective dates for authorization to Participating Providers and applicable non-Participating Providers.

(C) MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by MCO regarding the service requests, clinical data to support the decision, and time frames for notification of Providers and Enrollees of decisions.

(D) MCO shall not deny continuation of higher-level services (e.g., inpatient hospital) for failure to meet Medical Necessity unless MCO can provide the service through an In-Network or Out-of-Network Provider at a lower level of care.

(E) MCO shall perform Prior Authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in and out-of-state, or state mental hospitals.

2.11.3 Timing of Service Authorization Decisions

(A) Standard Service Authorization

(1) MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.

(2) The service authorization decision may be extended up to fourteen (14) additional calendar days if the Enrollee or Provider requests the extension, or MCO justifies to STATE a need for additional information and how the extension is in the Enrollee's interest.

(a) If MCO extends the timeframe for the authorization decision, MCO must:

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

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

(3) MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.

(B) Expedited Service Authorization

(1) In the event a Provider indicates, or MCO determines, that following the standard service authorization timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, MCO shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

(2) MCO may extend the seventy-two (72) hour time period by up to fourteen (14) additional calendar days if the Enrollee or Provider requests the extension or if MCO justifies to STATE a need for additional information and how the extension is in the Enrollee's best interest.

(a) If MCO extends the timeframe for the authorization decision, MCO must:

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

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

(C) Post Authorization

(1) MCO shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) calendar days from the date of receipt of request for service authorization.

(2) MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the Enrollee's health condition made by the Provider.

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(3) MCO shall not use a policy with an effective date subsequent to the original service authorization request date to rescind its Prior Authorization.

(D) Timing of Approval Notice

(1) For service authorization approval for a non-emergency admission, procedure, or service, MCO shall provide written notification to the Provider within two (2) business days of making the determination.

(2) For service authorization approval for extended stay or additional services, MCO shall provide written notification to the Provider within two (2) business days of making the determination.

(E) Timing of Adverse Action Notice

(1) MCO shall notify the Enrollee, in writing using language that is easily understood by the Enrollee, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this Article. The notice of action to Enrollees shall be consistent with requirements in 42 C.F.R. §438.404, §438.10, and §438.210.

(2) MCO shall notify the requesting Provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. MCO shall provide written notification to the Provider rendering the service, whether a health care professional or facility or both, within two (2) business days of making the determination.

(3) MCO must mail the notice of Adverse Benefit Determination at least ten (10) days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

(4) MCO may mail the notice of Adverse Benefit Determination as few as five (5) days prior to the date of action if the agency has facts indicating that action should be taken because of probable Fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.

(5) MCO shall mail the notice of Adverse Benefit Determination by the date of the action when any of the following occur:

(a) The recipient has died;

(b) The Enrollee submits a signed written statement requesting service termination;

(c) The Enrollee submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result;

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(d) The Enrollee has been admitted to an institution where he or she is ineligible under the plan for further services;

(e) The Enrollee's address is determined unknown based on returned mail with no forwarding address;

(f) The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;

(g) A change in the level of medical care is prescribed by the Enrollee's physician;

(h) The notice involves an Adverse Determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act; or

(i) The transfer or discharge from a facility will occur in an expedited fashion.

(6) MCO must give notice of Adverse Benefit Determination on the date of the determination when the action is a denial of payment.

(a) Service authorization decisions not reached within the timeframes specified in this Contract constitute a denial and must follow notice requirements for Adverse Benefit Determinations.

2.11.4 Content of Adverse Action Notice

MCO's notice of adverse action shall include the following information:

(A) An explanation of the Adverse Benefit Determination MCO has made or intends to make.

(B) The right of the Enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information includes Medical Necessity criteria and any process, strategies, or evidentiary standards used in setting coverage limits.

(C) An explanation of the Enrollee's right to request an Appeal of MCO's Adverse Benefit Determination, including information on exhausting MCO's one level of Appeal and the right to request a state fair hearing after receiving notice that the Adverse Benefit Determination is upheld.

(D) An explanation of the procedures for exercising the Enrollee's rights to Appeal and the circumstances under which an Appeal process can be expedited and how to request it.

(E) An explanation of the Enrollee's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the Enrollee may be required to pay the costs of continued services.

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2.11.5 Informal Reconsideration

(A) As part of MCO's Appeal procedures, MCO shall include an Informal Reconsideration process that allows the Enrollee (or Provider/agent on behalf of a Enrollee) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing.

(B) In a case involving an initial determination or a concurrent review determination, MCO shall provide the Enrollee or a Provider acting on behalf of the Enrollee and with the Enrollee's written consent an opportunity to request an informal reconsideration of an Adverse Determination by the physician or clinical peer making the Adverse Determination [42 C.F.R. §438.402(c)(1)(ii)].

(C) The informal reconsideration shall occur within one (1) business day of the receipt of the request and shall be conducted between the Provider rendering the service and MCO's physician authorized to make Adverse Determinations or a clinical peer designated by the medical director if the physician who made the Adverse Determination cannot be available within one (1) business day.

(D) The Informal Reconsideration does not extend the thirty (30) calendar day required timeframe for a Notice of Appeal Resolution.

2.11.6 Exceptions to Requirements

(A) MCO shall not require service authorization for Emergency Services or post-stabilization services as described in this Article whether provided by an In-Network or Out-of-Network Provider.

(B) MCO shall not require service authorization for the continuation of Medically Necessary Covered Services of a new Enrollee transitioning to MCO, regardless of whether such services are provided by an In-Network or Out-of-Network Provider, however, MCO may require Prior Authorization of services beyond thirty (30) calendar days.

(C) MCO is prohibited from denying Prior Authorization solely on the basis of the Provider being an Out-of-Network Provider for the first thirty (30) calendar days of a new Enrollee's linkage to MCO's plan.

(D) MCO shall not require a PCP referral (if the PCP is not a women's health Specialist) for access to a women's health Specialist contracted with MCO for routine and preventive women's health care services.

(E) MCO may require notification by the Provider of inpatient emergency admissions within one (1) business day of admission. MCO is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the Provider does not notify MCO of inpatient emergency admission within one (1) business day of admission, except under extenuating circumstances that are documented in the Enrollee's electronic case record.

(F) All court ordered services are subject to Medical Necessity review. In order for the service to be eligible for payment, MCO shall determine that the service is Medically

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Necessary and a MCO Covered Service.

2.12 Grievances and Appeals

2.12.1 Overall System

(A) MCO shall establish and maintain a system for receiving, reviewing, and resolving Enrollee Grievances and Appeals. Components shall include a Grievance Process, an Appeal process, and a process to access a state fair hearing.

(B) MCO shall incorporate all the Grievance and Appeal requirements found in this contract into its policies and procedures for Grievances and Appeals.

(C) MCO shall ensure that all Enrollees are informed of all the processes. Forms with which Enrollees may file Grievances or Appeals shall be available through the MCO, and shall be provided upon request of the Enrollee. The MCO shall make all forms easily available on the MCO's website.

(D) MCO shall give Enrollees any reasonable assistance in completing required forms for submitting a written Appeal or taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capacity. [42 C.F.R. §438.406(a)]

(E) MCO shall allow an Enrollee to designate an individual or organization to act on their behalf in assisting with or representing the Enrollee during all aspects of the Grievances and Appeals process. MCO shall ensure it has the Enrollee's signed, written authorization stating that the individual or organization is so authorized.

(F) MCO shall submit to STATE a quarterly report of Grievances and Appeals in a format determined by STATE.

2.12.2 Process for Grievances

(A) An Enrollee, Provider, or authorized representative may communicate a Grievance only to MCO. MCO must allow grievances to be communicated orally or in writing at any time.

(B) MCO's process for handling Enrollee Grievances shall include acknowledgement in writing within five (5) business days of receipt of each Grievance.

(C) MCO shall review the Grievance and provide written notice to the Enrollee of the disposition of a Grievance as expeditiously as the Enrollee's health condition requires and no later than ninety (90) calendar days from the date the MCO receives the Grievance.

(D) MCO shall extend the timeframe of disposition for a Grievance by up to fourteen (14) calendar days if:

(1) The Enrollee requests the extension; or

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(2) MCO shows (to the satisfaction of STATE, upon its request) that there is a need for additional information and how the delay is in the Enrollee's interest.

(E) If the timeframe is extended other than at the Enrollee's request, MCO shall provide oral notice of the reason for the delay to the Enrollee by close of business on the day of the determination, and within two (2) calendar days of the determination, provide written notice informing the Enrollee of the reason for the delay and the Enrollee's right to file a grievance if he or she disagrees with the decision.

2.12.3 Appeal Requirements

(A) MCO shall only have one (1) level of Appeal for Enrollees.

(B) The Enrollee, Provider, or authorized representative may file an Appeal of an Adverse Benefit Determination either orally or in writing to MCO within sixty (60) calendar days from the date on MCO's written Notice of Adverse Benefit Determination. [42 C.F.R. §438.402(c)(2)(ii), 42 C.F.R. §438.402(c)(3)(ii)]

(C) MCO's process for Appeals shall provide that oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as an Appeal. [42 C.F.R. §438.406(b)(3)]

(D) In accordance with 42 C.F.R. §438.402(c)(3)(ii), an oral Appeal, unless an Enrollee requests an expedited resolution, must be followed up by a written, signed Appeal. MCO shall use reasonable efforts to obtain a written, signed Appeal; however, nothing in this paragraph shall be construed to require an Enrollee to submit a written Appeal prior to MCO taking action and commencing procedures to remedy the Appeal within the timeframes set forth in this contract and as specified in federal regulations. MCO shall document whether written correspondence from an Enrollee is received within each Enrollee's casefile.

(E) MCO shall acknowledge and document receipt of the Appeal, either orally or in writing, and explain to the Enrollee the process that must be followed to resolve the Appeal. [42 C.F.R. §438.406(b)(1)]

(F) MCO shall provide the Enrollee reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. MCO shall inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for the standard and expedited Appeals. [42 C.F.R. §438.406(b)(4)]

(G) If MCO denies a request for expedited resolution of an Appeal, MCO must transfer the Appeal to the standard timeframe of no longer than thirty (30) calendar days from the day MCO receives the Appeal, with a possible fourteen (14) day extension. [42 C.F.R. §438.410(c)]

(H) MCO must provide the Enrollee, Provider, or their authorized representative the opportunity, before and during the Appeal process, to examine the Enrollee's case file, including medical records and any other documents and records considered, relied upon, or generated by MCO in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge, and sufficiently in

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advance of the thirty (30) calendar days of MCO's receipt of the Appeal for standard Appeals or sufficiently in advance of the three days of MCO's receipt of the Appeal for expedited Appeals to provide enough time for review. [42 C.F.R. §438.406(5)]

(I) MCO must consider as parties to the Appeal the Enrollee and their authorized representative, or the legal representative of a deceased Enrollee's estate. [42 C.F.R. §438.408(f)(3)]

(J) MCO shall ensure that the individuals who make the decision on an Appeal are individuals who:

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

(2) Are not subordinates of any individual who was involved in a previous level of review or decision-making; and

(3) If deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by STATE, in treating the Enrollee's condition or disease:

(a) An Appeal of a denial that is based on lack of Medical Necessity;

(b) An Appeal that involves clinical issues; or

(c) A Grievance regarding denial of expedited resolution of an Appeal.

(4) Take into account all comments, documents, records, and other information submitted by the Enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination. [42 C.F.R. §438.406(b)(2)(i-ii)]

2.12.4 Timeframes for Appeal Resolution and Notification

(A) Standard Appeals

(1) MCO shall resolve each Appeal and provide notice of resolution to affected parties as expeditiously as the Enrollee's health condition requires but no later than thirty (30) calendar days for a standard Appeal from the day MCO receives the Appeal. [42 C.F.R. §438.408(b)]

(2) MCO may extend the timeframe for resolving the Appeal and providing notice by up to fourteen (14) calendar days if:

(a) The Enrollee requests the extension; or

(b) MCO shows (to the satisfaction of STATE, upon its request) that there is need for additional information, and that the delay is in the Enrollee's interest. [42 C.F.R. §438.408(c)]

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(3) If MCO extends the timeframe, and the extension was not requested by the Enrollee, MCO shall:

(a) Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

(b) Within two (2) calendar days provide the Enrollee written notice of the reason for the delay, including the right to file a Grievance if the Enrollee disagrees with the decision; and

(c) Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. [42 C.F.R. §438.408(c)(2)(iii)]

(B) Expedited Appeals

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

(2) MCO shall resolve each expedited Appeal and provide notice of resolution to affected parties as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the when MCO receives the Appeal.

(3) MCO may extend the timeframe for resolving the expedited Appeal, and providing notice, by up to fourteen (14) calendar days if:

(a) The Enrollee requests the extension; or

(b) MCO shows (to the satisfaction of STATE, upon its request) that there is need for additional information, and that the delay is in the Enrollee's interest. [42 C.F.R. §438.408(c)(1)]

(4) If MCO extends the timeline for processing an expedited Appeal not at the request of the Enrollee, MCO must:

(a) Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

(b) Within two (2) calendar days provide the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

(c) Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. [42 C.F.R.

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§438.408(c)(2)

(C) In accordance with 42 C.F.R. §438.408(c)(3), if MCO fails to adhere to the Appeal process notice and timing requirements, Enrollee is deemed to have exhausted MCO Appeal process. The Enrollee may initiate a State Fair Hearing. If MCO fails to adhere to the notice and time requirements for Appeals as outlined in this Contract, STATE may impose sanctions as described in Article 5.9 of this contract.

2.12.5 Format and Content of Notice of Appeal Resolution

(A) MCO shall provide written Notice of Appeal Resolution to the affected parties. The written Notice of Appeal Resolution must be in a format and language that, at a minimum, meets applicable notification standards and shall include the following:

(1) The results of the Appeal resolution process and the date it was completed [42 C.F.R. §438.408(2)(e)(1)]; and

(2) For Appeals not resolved wholly in favor of the Enrollee, MCO shall include the following in the written Notice of Appeal resolution [42 C.F.R. §438.408(2)(e)(2)]:

(a) The right to request a State Fair Hearing, and how to do so, including the specific timeframe for the filing the request [42 C.F.R. §438.408(2)(e)(2)(i) and §438.408(f)(2)];

(b) The right to request continuation of disputed services if the Appeal decision is to terminate, suspend, or reduce a previously authorized course of treatment that was ordered by an authorized Provider and the original period covered by the original authorization has not expired [42 C.F.R. §438.408(2)(e)(2)(ii)];

(c) How to request continuation of disputed services [42 C.F.R. §438.408(2)(e)(2)(ii)]; and

(d) A statement that the Enrollee may be liable for the cost of disputed services provided if STATE Fair Hearing decision upholds MCO's Adverse Benefit Determination [42 C.F.R. §438.408(2)(e)(2)(iii)].

(B) In the case of an expedited Appeal, in addition to providing written notice, MCO shall make reasonable efforts to provide oral notice of the resolution. [42 C.F.R. §438.408(d)(2)(ii)]

2.12.6 Continuation of Services

(A) Pursuant to 42 C.F.R. §438.420(b), MCO must continue the Enrollee's benefits while an Appeal is in process if all of the following apply:

(1) The Enrollee files the request for an Appeal within sixty (60) calendar days following the date on the Adverse Benefit Determination Notice.

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(2) The Appeal involves the termination, suspension, or reduction of a previously authorized service.

(3) The Enrollee's services were ordered by an authorized Provider.

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

(5) The request for continuation of benefits is filed on or before the later of the following:

(a) Within ten (10) calendar days of the MCO sending the Notice of the Adverse Benefit Determination, or

(b) The intended effective date of the MCO's proposed Adverse Benefit Determination.

(B) If, at the Enrollee's request, MCO continues or reinstates the Enrollee's benefits while the Appeal or State Fair Hearing is pending, the benefits must be continued until one of the following occurs:

(1) The Enrollee withdraws the Appeal or request for State Fair Hearing;

(2) The Enrollee does not request a State Fair Hearing and continuation of benefits within ten (10) calendar days from the date the MCO sends the Notice of Adverse Appeal resolution; or

(3) A State Fair Hearing decision adverse to the Enrollee is issued. [42 C.F.R. §438.420(c)]

(C) MCO may, consistent with STATE's policy on recoveries and as specified in this Contract, recover the cost of continued services furnished to the Enrollee while the Appeal or State Fair Hearing was pending, if the final resolution of the Appeal or State Fair Hearing upholds MCO's Adverse Benefit Determination. [42 C.F.R. §438.420(d)]

(D) MCO must pay for disputed services received by the Enrollee while the Appeal was pending when MCO or State Fair Hearing officer reverses a decision to deny authorization of the services. [42 C.F.R. §438.424(b)]

2.12.7 Process for State Fair Hearings

(A) An Enrollee or other party to the Appeal who has completed MCO's Appeal process may request a state fair hearing after receiving a notice of Appeal resolution indicating that MCO is upholding, in whole or in part, the Adverse Benefit Determination, or after MCO fails to adhere to the notice and timing requirements applicable to Appeals.

(B) An Enrollee or other party to the Appeal has one hundred twenty (120) calendar days from the date of MCO's notice of resolution to request a state fair hearing.

(C) MCO shall attend state fair hearings as scheduled and supply the necessary witnesses

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and evidentiary materials.

(D) MCO shall submit an evidence packet to STATE and to the Enrollee, free of charge, within ten (10) business days from the time MCO receives notification of the hearing. The evidence packet shall be submitted to STATE in accordance with any prehearing instructions. The evidence packet shall include all necessary documents, including the statement of matters (or, alternatively, the denial letter) and any medical records or other documents and/or records considered or relied upon by MCO and supporting MCO's Adverse Benefit Determination and Appeal resolution.

(E) Within two (2) business days of notification of the state fair hearing request, MCO shall provide the corresponding Notice of Adverse Benefit Determination and the Notice of Appeal Resolution that relate to the state fair hearing request to STATE.

(F) MCO shall continue the Enrollee's benefits while the state fair hearing is pending if the Enrollee timely files for continuation of benefits within ten (10) calendar days after MCO sends the notice of Appeal resolution that is not wholly in the Enrollee's favor, in accordance with 42 C.F.R. §438.420(b).

(G) MCO shall comply with all terms and conditions set forth in any orders and instructions issued by an administrative law judge.

(H) If, at the Enrollee's request, MCO continues or reinstates the benefits while the state fair hearing is pending, the benefits shall continue until one (1) of the following occurs:

(1) The Enrollee withdraws the state fair hearing request; or

(2) The state fair hearing officer issues a hearing decision adverse to the Enrollee.

(I) If MCO's action is reversed by the administrative law judge and services were not furnished while the plan Appeal was pending, MCO shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from when MCO receives the notice reversing the determination.

2.13 Quality Management and Quality Improvement

2.13.1 General Requirements

(A) MCO shall comply with 42 C.F.R. §438.330, the North Dakota Medicaid Expansion Quality Strategy Plan, and all quality requirements of the North Dakota 1915(b) Waiver.

(B) MCO shall deliver quality care that enables Enrollees to stay healthy, get better, and, if necessary, manage a chronic illness or disability. Quality care refers to:

(1) Clinical quality of physical health care;

(2) Clinical quality of Behavioral Health care focusing on recovery, resiliency, and rehabilitation;

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(3) Access and availability of primary and specialty health care Providers and services;

(4) Continuity and coordination of care across settings, and transitions in care; and

(5) Enrollee experience with respect to clinical quality, access and availability, and Cultural Competence of health care and services, and continuity and coordination of care.

(C) MCO shall apply the principles of continuous quality improvement (CQI) to all aspects of MCO's service delivery system through ongoing analysis, evaluation, and systematic enhancements based on:

(1) Quantitative and qualitative data collection and data-driven decision-making;

(2) Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

(3) Feedback provided by Enrollees and Providers in the design, planning, and implementation of its CQI activities; and

(4) Issues identified by MCO or STATE.

(D) MCO shall ensure that the QM/QI requirements of this Contract are applied to the delivery of both physical health care services and Behavioral Health care services.

2.13.2 Quality Assessment and Performance Improvement (QAPI) program

(A) MCO shall establish an ongoing comprehensive QAPI program for the services it furnishes to its Enrollees [42 C.F.R. §438.330(a)(1); 42 C.F.R. §438.330(a)(3)]. The comprehensive QAPI program must include:

(1) Performance Improvement Projects (PIP), including any required by STATE or CMS, that focus on clinical and non-clinical areas. [42 C.F.R. 438.330(b)(1); 42 C.F.R. §438.330(d)(1); 42 C.F.R. §438.330(a)(2)]

(2) Collection and submission of Performance Measurement data, including any required by STATE or CMS. [42 C.F.R. §438.330(b)(2); 42 C.F.R. §438.330(c); 42 C.F.R. §438.330(a)(2)]

(3) Mechanisms to detect both underutilization and overutilization of services. [42 C.F.R. §438.330(b)(3)]

(4) Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs, as defined by STATE in the quality strategy. [42 C.F.R. §438.330(b)(4); 42 C.F.R. §438.340]

(B) MCO must develop a process to evaluate the impact and effectiveness of its own QAPI.

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[42 C.F.R. §438.330(e)(2); 42 C.F.R. §438.310(c)(2)]

(C) Each PIP must:

(1) Be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction; [42 C.F.R. §438.330(d)(2)]

(2) Include measurement of performance using objective quality indicators; [42 C.F.R. §438.330(d)(2)(i)]

(3) Include implementation of interventions to achieve improvement in the access to and quality of care; [42 C.F.R. §438.330(d)(2)(ii)]

(4) Include an evaluation of the effectiveness of the interventions based on the Performance Measures collected as part of the PIP; and [42 C.F.R. §438.330(d)(2)(iii)]

(5) Include planning and initiation of activities for increasing or sustaining improvement. [42 C.F.R. §438.330(d)(2)(iv)

(D) MCO must report the status and results of each performance improvement project to STATE semi-annually as required in **Appendix D: MCO Compliance, Operations, and Quality Reporting**, consistent with42 C.F.R. §438.330(d)(1) and (3).

2.13.3 Health Plan Accreditation

(A) MCO shall be accredited by NCQA or URAC for its Medicaid product covered by this Contract.

(1) If MCO has obtained NCQA or URAC accreditation as of the Operational Start Date of this Contract, MCO shall maintain such accreditation throughout the term of this Contract.

(2) If MCO is not NCQA or URAC accredited for its Medicaid product covered by this Contract, MCO shall attain such accreditation.

(a) The cost of accreditation shall not be included in the calculation of MCO's MLR.

(b) MCO's application for accreditation shall be submitted at the earliest point allowed by the accrediting body. MCO shall provide STATE with a copy of all correspondence with the accrediting body regarding the application process and the accreditation requirements.

(B) MCO shall provide documentation of its accreditation status to STATE within ten (10) calendar days of receipt of the final accreditation report for each accrediting cycle. Such documentation shall include:

(1) Accreditation status, survey type, and level (as applicable);

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(2) Accreditation results, including recommended actions or improvements, corrective action plan, and summaries of findings; and

(3) Expiration date of the accreditation.

(C) MCO shall provide STATE with updates of its NCQA or URAC accreditation status if there are any changes within the accreditation period or upon request by STATE.

(D) If MCO achieves provisional accreditation status from NCQA OR URAC:

(1) STATE may restrict automatic and voluntary enrollment in MCO; and

(2) STATE shall require MCO to initiate a corrective action plan within thirty (30) calendar days of receipt of the Final Report from NCQA or URAC and work to address the findings contributing to the provisional accreditation status.

(E) MCO's failure to attain full NCQA or URAC accreditation under this Contract or failure to maintain full accreditation at any time may be considered a breach of the Contract and may result in termination of the Contract.

2.14 Performance Evaluation and External Quality Review

2.14.1 Performance Evaluation

MCO shall:

(A) Annually measure and report to STATE on its performance, using the standard measures required by STATE, including but not limited to identified HEDIS measures, and submit data specified by STATE, which enables STATE to calculate MCO's performance using the standard measures identified by STATE as required in 42 C.F.R. §438.330(c)(1) and (2), including but not limited to reports identified in Appendix D: MCO Compliance, Operations, and Quality Reporting.

(B) Contract with an NCQA-certified HEDIS auditor to validate the processes of the MCO in accordance with NCQA requirements. Audited HEDIS results shall be submitted to STATE, NCQA and the STATE's EQRO annually according to NCQA's data submission timeline for health plans to submit final Medicaid HEDIS results.

(C) Report quality measure results overall and stratified for both Native Americans/Alaskan Native Enrollees and non-Native American/Alaskan Native Enrollees using data obtained from STATE eligibility information on Enrollees.

(D) Have processes in place to monitor, self-report, and implement CQI on all performance measures.

(E) Bi-annually measure and report to STATE on Enrollee satisfaction with MCO utilizing the most recent Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and methodology. MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.

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(F) Participate in two (2) to four (4) quality assurance and improvement meetings per year with STATE, pursuant to requirements in this Contract and the North Dakota Medicaid Expansion Quality Strategy.

(G) Participate in collaborative quality improvement projects, as directed by STATE.

(H) Participate in the development of annual quality improvement (QI) goals with STATE.

(I) Actively participate in an annual quality assurance and improvement goal meeting with STATE prior to June 30, for the primary purpose of reviewing progress toward the achievement of annual improvement goals in the prior Calendar Year and applicable Contract requirements, including, but not limited to, progress made toward performance measures and objectives.

(1) For purposes of such annual meetings, MCO shall provide to STATE, no later than fourteen (14) calendar days prior to each QI goal meeting, a written update detailing MCO's progress toward meeting applicable Contract requirements and annual QI goals; and explain its performance regarding applicable Contract requirements and the annual QI goals.

(J) Meet with STATE in person if STATE determines that MCO is not in substantial compliance with the Contract, including any aspect of quality assurance and quality improvement.

2.14.2 External Quality Review

(A) MCO shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by STATE to conduct External Quality Review (EQR) activities, in accordance with 42 C.F.R. §438.358, to assess MCO's management of quality, timeliness, and access to Covered Services.

(B) MCO shall maintain, and make available to the EQRO, all clinical and administrative records for use in EQRs.

(C) MCO shall support any additional quality assurance reviews, focused studies, or other projects that STATE may require as part of EQRs.

(D) EQR Activities shall include, but are not limited to:

(1) Annual validation of Performance Measures reported to STATE, as directed by STATE;

(2) Annual validation of performance improvement projects (PIPs) required by STATE; and

(3) At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and, at the direction of STATE, regarding access, structure and operations, and quality of care and services furnished to Enrollees.

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(E) MCO shall designate a qualified individual to serve as Project Director for EQR Activities who shall, at a minimum:

(1) Oversee and be accountable for compliance with all aspects of the EQR activity;

(2) Designate MCO representatives as needed, including, but not limited to, a quality improvement representative and a data representative to assist with EQR;

(3) Coordinate with staff responsible for aspects of the EQR activity and ensure that MCO staff respond to requests by the EQRO and STATE staff in a timely manner;

(4) Serve as the liaison to the EQRO and STATE and answer questions or coordinate responses to questions from the EQRO and STATE in a timely manner;

(5) Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR Activity and as requested by the EQRO or STATE;

(6) Maintain data and other documentation necessary for completion of EQR Activities; MCO shall maintain such documentation for a minimum of seven (7) years;

(7) Review the EQRO's draft EQR report and offer comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or STATE;

(8) Participate in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and STATE;

(9) Implement actions, as directed by STATE, to address recommendations for quality improvement made by the EQRO, and share outcomes and results of such activities with the EQRO and STATE in subsequent years; and

(10) Participate in any other activities deemed necessary by the EQRO and approved by STATE.

(F) MCO shall be responsible for making all EQR-requested documentation, including Enrollee information, available prior to EQR activities and during an on-site review. Document copying costs are the responsibility of MCO.

(1) Enrollee information includes, but is not limited to, medical records, administrative data, Enrollee Encounter Data, and Claims data, maintained by MCO or its Contracted Providers.

(G) On-Site EQRs shall be performed during hours agreed upon by STATE and MCO. MCO shall assure adequate workspace, access to a telephone, and a copy machine for individuals conducting on-site EQRs.

(H) MCO shall assign appropriate staff to assist during on-site EQRs.

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(I) MCO shall provide requested EQR data and documentation necessary to conduct EQR activities within the timeframes required by STATE.

2.15 Data Management, Information Systems, and Reporting Requirements

2.15.1 General Requirements

(A) MCO shall meet the requirements of 42 C.F.R. §438.242 and maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, claims, Grievances and Appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

(B) MCO shall report to STATE any system changes that could significantly disrupt operations including, but not limited to, major system upgrades.

(C) MCO must ensure 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 STATE to meet the requirements of 42 U.S.C. §1396b(r)(1)(F). Specific elements shall include the capacity to:

(1) Uniquely capture, edit, and retain the attending and billing Provider of each service;

(2) Capture, edit, and retain the date of receipt of the claim by MCO as indicated by the date stamp on the claim;

(3) Capture, edit, and retain real-time accurate history with dates of adjudication results of each claim such as paid, denied, pended, adjusted, voided, Appealed, etc., and follow-up information on disputed claims;

(4) Capture, edit, and retain the date of payment as indicated on the check or other form of payment, and the number of the check or electronic funds transfer (EFT);

(5) Capture, edit, and retain all data elements as required by STATE for Encounter data submission;

(6) Accept submission of paper-based claims and electronic claims by Network Providers, and non-Participating Providers;

(7) Accept submission of electronic adjustments and void transactions;

(8) Accept submission of paper adjustments and void transactions; and

(9) Have capability to pay claims at $0.00.

(D) Claim System Edits

(1) MCO shall perform system edits including, but not limited to:

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(a) Confirming eligibility on each Enrollee;

(b) Validating Enrollee name;

(c) Validating unique Enrollee identification number;

(d) Validating date of service – Perform system edits for valid dates of service, and ensure that dates of services are valid dates, such as not in the future or outside of an Enrollee's Medicaid eligibility span;

(e) Determination of Medical Necessity;

(f) Covered Services – ensure that the system verifies that a service is a Covered Service and is eligible for payment;

(g) Prior Authorization – the system shall determine whether a Covered Service required Prior Authorization and if so, whether MCO granted such authorization;

(h) Duplicate Claims – the system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;

(i) Provider Validation – ensure that the system shall approve for payment only those claims received from qualified Providers eligible to render the service for which the claim was submitted and that the Provider has not been excluded from receiving Medicaid payments; and

(j) Quantity of Service – ensure that the system shall evaluate claims for services provided to ensure that any applicable benefit limits are applied.

(2) MCO shall perform post-payment review on a statistically valid sample of claims to ensure services provided were Medically Necessary.

(3) MCO shall notify Providers as to when system updates will be in production and of MCO's process for the recycling of denied claims that are due to system update delays. The recycling of these denied claims shall be completed no later than fifteen (15) calendar days after the system update.

(4) Except as otherwise specified by STATE, MCO shall use only national standard code sets such as CPT/HCPCS, ICD-10-CM, etc. MCO shall also comply with deadlines for communication, testing, and implementation of code sets established by CMS and/or STATE.

(5) MCO shall have the ability to update national standard code sets such as CPT/HCPCS, ICD-10-CM, and move to future versions as required by CMS or STATE. Updates to code sets are to be complete no later than thirty (30) calendar days after notification, unless otherwise directed by STATE. This includes annual and other fee schedule updates.

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(6) In addition to CPT, ICD-10-CM, ICD-10-PCS and other national coding standards, MCO shall use applicable HCPCS Level II and Category II CPT codes to aid both MCO and STATE in evaluating Performance Measures.

(7) MCO shall perform regular internal audit reviews to confirm claim edits are functioning properly and provide STATE with confirmation of this process. STATE shall be provided the results of internal audit reviews upon request.

(8) MCO shall employ CMS mandated edits for Medicaid and nationally recognized clinical editing standards as outlined below:

(a) At a minimum, these edits shall be maintained and updated annually unless otherwise appropriate and apply to Practitioners, outpatient hospitals, and DME services.

(b) Edits shall be based on current industry benchmarks and best practices, including, but not limited to, specialty society criteria, American Medical Association CPT coding guidelines, and CMS mandated edits for Medicaid, which include the quarterly National Correct Coding Initiative (NCCI) edits or its successor.

(c) These edits include, but are not limited to, units of service, unbundling, mutually exclusive and incidental procedures, pre/post-op surgical periods, modifier usage, multiple surgery reduction, add-on codes, cosmetic, and assistant surgeon. Editing shall include the ability to apply edits to the current claim as well as paid history claims when applicable.

(d) MCO shall attest annually that they are adhering to these requirements and are subject to periodic requests from STATE for validation of the edits.

(e) MCO shall update CMS mandated edits and NCCI edits quarterly as directed by CMS and adhere to LDH timelines for the updates.

(E) MCO must ensure the collection of data on Enrollee and Provider characteristic as specified by STATE, and on all services furnished to Enrollees through an encounter data system or other methods as may be specified by STATE.

(F) MCO shall ensure that the data received from Providers are accurate and complete by:

(1) Verifying the accuracy and timeliness of reported data, including data from Network Providers that MCO is compensating on the basis of Capitation Payments;

(2) Screening the data for completeness, logic, and consistency; and

(3) Collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for State Medicaid quality improvement and Care Coordination efforts.

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(G) MCO shall make all collected data available to STATE, CMS, independent quality review examiners, and other state agencies as allowed by law.

2.15.2 Beneficiary Access to and Exchange of Data

(A) MCO must implement and maintain a standards-based Application Programming Interface (API) that permits third-party applications to retrieve, with the approval and at the direction of an Enrollee or the Enrollee's personal representative, data specified in Article 2.15.2(B) below through the use of common technologies and without special effort from the Enrollee.

(B) MCO must make the following information accessible to its Enrollees or the Enrollee's personal representative through the API described in Article 2.15.2(A) above:

(1) Data concerning adjudicated claims, including claims data for payment decisions that may be Appealed, were Appealed, or are in the process of Appeal, and Provider remittances and Enrollee cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

(2) Clinical data, including laboratory results, if MCO maintains any such data, no later than one (1) business day after the data is received by MCO; and

(3) Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information.

(C) MCO must:

(1) Implement, maintain, and use API technology conformant with 45 C.F.R. §170.215;

(2) Conduct routine testing and monitoring, and update as appropriate, to ensure the API functions properly, including assessments to verify that the API is fully and successfully implementing privacy and security features such as, but not limited to, those required to comply with HIPAA privacy and security requirements in 45 C.F.R. parts 160 and 164, 42 C.F.R. parts 2 and 3, and other applicable law protecting the privacy and security of individually identifiable data; and

(3) Comply with the content and vocabulary standards requirements in 42 C.F.R. §431.60(c), as applicable to the data type or data element, unless alternate standards are required by other applicable law.

(D) For each API implemented in accordance with this Article, MCO must make publicly accessible, by posting directly on its website or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the following information:

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(1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions, and exception handling methods and their returns;

(2) The software components and configurations an application must use in order to successfully interact with the API and process its response(s); and

(3) All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.

For the purposes of this Article, "publicly accessible" means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation; a requirement to receive a copy of the material via email; a requirement to register or create an account to receive the documentation; or a requirement to read promotional material or agree to receive future communications from the organization making the documentation available.

(E) MCO may deny or discontinue any third-party application's connection to the API required under this Article if the MCO:

(1) Reasonably determines, consistent with its security risk analysis under 45 C.F.R. part 164 subpart C, that allowing an application to connect or remain connected to the API would present an unacceptable level of risk to the security of protected health information on STATE's systems; and

(2) Makes this determination using objective, verifiable criteria that are applied fairly and consistently across all applications and developers through which Enrollees seek to access their electronic health information, as defined at 45 C.F.R. §171.102, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

(F) MCO must provide in an easily accessible location on its public website and through other appropriate mechanisms through which it ordinarily communicates with Enrollees seeking to access their health information held by MCO, educational resources in non-technical, simple, and easy-to-understand language explaining at a minimum:

(1) General information on steps the individual may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application, including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they will entrust their health information; and

(2) An overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to:

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(a) The HHS Office for Civil Rights (OCR); and

(b) The Federal Trade Commission (FTC).

2.15.3 Privacy and Security of Personal Data and HIPAA Compliance

(A) MCO acknowledges that it is a covered entity, as defined at 45 C.F.R. §160.103.

(B) MCO shall comply with all applicable requirements regarding the privacy, security, use, and disclosure of personal data (including protected health information), including, but not limited to, requirements set forth in 42 C.F.R. §431, Subpart F, and 45 C.F.R. Parts 160, 162 and 164.

(C) MCO represents and warrants that:

(1) It shall conform to the requirements of all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations;

(2) It shall work cooperatively with STATE on all activities related to ongoing compliance with HIPAA requirements, as directed by STATE; and

(3) It shall execute, at STATE's direction, a Trading Partner Agreement and any other agreements STATE determines are necessary to comply with HIPAA requirements.

(D) MCO shall seek and obtain from STATE prior written authorization for the use of any data pertaining to this Contract for research or any other purposes not directly related to MCO's performance under this Contract.

2.15.4 Medical Records

(A) MCO shall require its Network Providers to maintain a medical record keeping system that complies with 42 C.F.R. §456.111, 42 C.F.R. §456.211, and with state and federal laws.

(B) Pursuant to 42 C.F.R. §456.111, MCO's utilization review plan for all medical services must include, if applicable, items such as: the identification of the beneficiary, the name of the beneficiary's physician or Provider, the date of admission, and the dates of application for and authorization of Medicaid benefits if the application is made after admission, the plan of care required under 42 C.F.R. §456.70, initial and subsequent continued stay review dates described under 42 C.F.R. §456.128 and 42 C.F.R. §456.133, the dates of operating room reservation, justification of emergency admission, reasons and plan for continued stay, and other supporting material that the committee believes appropriate to be included in the record.

(C) Pursuant to 42 C.F.R. §456.211, MCO's utilization review plan for all mental hospitals must include, if applicable, the identification of the beneficiary, the name of the beneficiary's physician or Provider, the date of admission, and dates of application for and authorization of Medicaid benefits if the application was made after the admission,

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the plan of care required under 42 C.F.R. §456.172, the initial and subsequent stay review dates described under 42 C.F.R. §456.233 and §456.234, reasons and plan for continued stay, and other supporting material that the committee believes appropriate to be included in the record.

2.15.5 Document Retention Requirements for Awards

(A) MCO shall comply with the record retention and record access requirements for award recipients found in 45 C.F.R. §75.361, which requires MCO to maintain financial records, supporting documents, statistical records, and all other records pertaining to an award to be retained for a period of three (3) years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.

(B) The three (3) year retention requirement does not apply to the following circumstances:

(1) If any litigation, Claim, financial management review, or audit is started before the expiration of the three (3) year period, the records shall be retained until all litigation, Claims, or audit findings involving the records have been resolved and final action apply;

(2) To records for real property and equipment acquired with federal funds which shall be retained for three (3) years after final disposition;

(3) When records are transferred to or maintained by the awarding agency, the three (3) year retention is not applicable to the recipient; and

(4) To indirect cost rate computations or proposals, cost allocation plans, and any similar computations of the rate at which a particular group of costs is chargeable (such as computer usage chargeback rates or composite fringe benefit rates).

2.15.6 Record Retention Requirements, Generally

In accordance to 42 C.F.R. §438.3(u), unless otherwise specified by this Contract or by state or federal law, MCO and MCO's subcontractors shall retain base data in §438.5(c), Medical Loss Ratio reports in §438.8(k), and the data, information, and documentation specified in §438.604, §438.606, §438.608, and §438.610 for a period of ten (10) years. Such documents include, but are not limited to, the attestation forms required by **Articles 2.3.1 and 2.8.3**, MCO's policies and procedures, MCO's Enrollee handbooks, and copies of reports required by STATE.

2.15.7 Recordkeeping Requirements for Grievances and Appeals

(A) MCO and its Material Subcontractors shall retain Enrollee Grievance and Appeal records in accordance with 42 C.F.R. §438.416, for a period of no less than ten (10) years, and will review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to STATE quality strategy.

(B) The record for each Grievance or Appeal must contain, at a minimum, all of the following

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information:

(1) A general description of the reason for the Appeal or Grievance;

(2) The date received;

(3) The date of each review or, if applicable, review meeting;

(4) Resolution at each level of the Appeal or Grievance, if applicable;

(5) Date of resolution at each level, if applicable; and

(6) Name of the Enrollee for whom the Appeal or Grievance was filed.

(C) The record must be accurately maintained in a manner accessible to STATE and available upon request to CMS.

2.15.8 Reporting Requirements

(A) Enrollment, Cost, and Utilization Reports

(1) MCO shall submit enrollment, cost, and utilization reports in an electronic format designated by STATE. The reports shall be in Excel, and MCO shall utilize the Managed Care Reporting Template (MRT) provided by STATE. MCO is not allowed to customize or change the format of this report. STATE may amend the MRT at its discretion and will provide any updates to MCO as needed.

(2) MCO shall certify, in writing, the accuracy and completeness, to the best of its knowledge, of all cost and utilization data provided to STATE on a MRT.

(3) A minimum of two completed MRT reports shall be submitted covering dates of service for each contract year as requested by STATE. STATE's request shall indicate the reporting time period, paid through date, and submission due date. STATE's request should be provided to MCO sixty (60) calendar days before the submission due date whenever possible.

(4) MCO may request, in writing, an extension of the due date up thirty (30) calendar days beyond the required due date. MCO shall request any extension prior to the due date and STATE shall approve or deny the extension request within seven (7) calendar days of receiving the request.

(B) Case Management Reports

MCO shall submit annual Case Management reports no later than August 1 of each year for the preceding calendar year **(See Appendix D: MCO Compliance, Operations, and Quality Reporting)**.

(C) Development of New Reports

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(1) STATE may request other reports deemed necessary to STATE to assess areas including, but not limited to, access and timeliness or quality of care.

(2) MCO agrees to submit any report requested by STATE within the timeframes specified by STATE.

(D) Quarterly and Annual Reports Due Date

(1) For the purpose of reports throughout this document, unless otherwise indicated, all quarterly and annual reports are due the last day of the month following the four standard quarters and the last day of the month following the twelve (12) calendar months of the year.

(2) If reporting requirements cannot be met due to matters beyond the control of MCO, STATE shall provide written documentation to MCO attesting to such matters, and grant allowances, as appropriate, for MCO to meet deadlines as required in this Contract.

(E) Overpayments and Recoveries

No later than February 1 of each year, MCO shall submit to STATE a report of overpayment recoveries from the previous calendar year using a STATE-defined template.

2.15.9 Encounter Data

(A) Enrollee Encounter Data must follow the format, rules, and data elements as described in the most current HIPAA-compliant 837 Implementation Guide. The professional, and institutional Encounter Claims shall comply with state or federal requirements and use HIPAA standard transaction formats. The HIPAA Electronic Data Interchange "Implementation Guide" is the federal guide that provides instructions on the submission of HIPAA-compliant X12 data files.

(B) MCO must submit to the North Dakota Health Enterprise MMIS any Claim-level Enrollee Encounter Data on a monthly basis according to the following requirements:

(1) Claim-level Enrollee Encounter Data in an X12 837 standard format for physician, professional services and physician-dispensed pharmaceuticals (837P), and inpatient and outpatient hospital services (837I) that are the responsibility of MCO.

(2) Enrollee Encounter Data are Enrollee-specific, detailed Claim-level records of individual single healthcare services, examinations, and medical diagnostic and treatment services, supplies, and medical equipment dispensed for services provided to Medicaid Expansion Enrollees. MCO shall provide STATE with access to detailed transactional Claims records of health care and related services, including transportation, that are provided to Medicaid Expansion Enrollees. The records must be shared with STATE on a monthly basis and must include both original Claims, and adjustment Claims and payment information. If MCO

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chooses to resubmit a Claim previously paid or denied on MCO's remittance advice, MCO must resubmit the Claim as a replacement Claim or a voided Claim.

(3) MCO shall ensure that Enrollee Encounter Data include all paid lines associated with a Claim and those denied Claims or lines for which Medicare or a third party has paid in full. This information should be extracted from MCO Claim files for submission to STATE.

(4) MCO's claim processing for both paper and electronic claims shall comply with the requirements of the X12 837. This will produce consistent and verifiable data, whether self-reported by MCO or produced by STATE, from the Enrollee Encounter Data warehouse.

(5) MCO shall provide records of the services that are rendered to Medicaid Expansion program Enrollees, regardless of the payment mechanism employed by MCO for its Providers. If MCO subcontracts with another organization to process Enrollee Encounter Data or provide services, such as laboratory services, MCO is responsible for assuring that data from these Providers contain all the information necessary to create the appropriate HIPAA compliant Encounter record. MCO is responsible for verifying the accuracy of this data, particularly with respect to the edits it would apply if the data were received directly from MCO rather than through a subcontracted Provider.

(6) If MCO contracts or pays any services under a "global billing arrangement", MCO must provide STATE with Enrollee Encounter Data records for all services that were rendered under the arrangement, not just the global Encounter that triggered the payment. MCO is responsible for ensuring that Providers submit all appropriate records in connection with services paid under a global billing arrangement. MCO shall collect and report to STATE individual Enrollee-specific, Claim level Enrollee Encounter Data that identifies the Enrollee's treating Provider's NPI (the Provider that actually provided the service), when the Provider is part of a group practice that bills on 837P format or 837D format.

(7) MCO shall submit all Encounter Claims no later than twenty-five (25) calendar days after the date MCO adjudicates the Claim. Encounter submissions are due no later than the fifteenth (15th) of the month following the month of payments that is included in the Enrollee Encounter Data file. If the fifteenth (15th) falls on the weekend or a holiday, the submission is due on the next business day. If MCO is unable to make a submission during a certain month, MCO shall notify STATE of the reason for the delay and the estimated date when STATE can expect the submission. For all Enrollee Encounter Claims, when STATE returns or rejects a file of Claims, MCO shall have twenty (20) calendar days from the date MCO receives the file to resubmit the file with all of the required data elements in the correct file format.

(8) Enrollee Encounter Data must follow the format, rules, and data elements as described in the most current HIPAA-compliant 837 Implementation Guide and NCPDP Implementation Guide, and includes, but is not limited to:

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(a) Enrollee name;

(b) STATE issued Enrollee Medicaid ID number;

(c) Enrollee date of birth;

(d) MCO name;

(e) Provider name (if different from MCO) and Practitioner name;

(f) Provider NPI numbers or, if applicable, atypical Provider identifiers;

(g) Identify Provider as Network or Out-of-Network;

(h) Reason code for Out-of-Network services;

(i) Date(s) of service;

(j) Units of service;

(k) Diagnosis code or description of services rendered or both;

(l) Valid procedure codes;

(m) Provider paid amounts (amount paid to the Provider excluding Third Party Liability, Provider withhold, and incentives, and any Medicaid cost-sharing);

(n) Provider allowed amounts (the Provider contracted rate prior to any exclusions or add-ons);

(o) Amount billed to MCO by Provider, if applicable;

(p) Amount paid by other Health Insurance to a Provider;

(q) Amount paid by MCO to Provider and date of payment;

(r) Date of denial and reason, if applicable;

(s) National Drug Code (NDC), if applicable.

(9) Enrollee Encounter Data for all outpatient physician administered drugs (commonly referred to as, but not limited to, J-codes) must include the NDC used by the Provider as originally required by the Deficit Reduction Act (DRA) of 2005 and further required by STATE. MCO must have Claims payment systems that will ensure the NDC submitted by the Provider is appropriate for the associated CPT® or HCPCS codes.

(10) MCO must ensure that if a Provider is using 340B product, they must identify it on the Claim and that designation must be included in the Enrollee Encounter

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Data sent to STATE.

(C) MCO must ensure compliance with data, information, and documentation requirements as specified in 42 C.F.R. §438.604.

2.15.10 Enrollee Encounter Data Certification

(A) By electronically submitting its Enrollee Encounter Data to the North Dakota Enterprise MMIS maintained by STATE, MCO is certifying that the Enrollee Encounter Data is in accordance with 42 C.F.R. §438.606 including:

(1) Ensuring the data has been certified by one of the following:

(a) MCO's Chief Executive Officer;

(b) MCO's Chief Financial Officer; or

(c) An individual who reports directly to the CEO or CFO with delegated authority to sign for the DEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

(2) Ensuring the person certifying the Enrollee Encounter Data attests to the completeness and truthfulness of the data and documents based on the person's best knowledge, information, and belief.

2.16 Program Integrity and Operational Audits

2.16.1 Compliance Program

MCO and its Material Subcontractors shall implement and maintain a compliance program, as described 42 C.F.R. §438.608, that includes, at a minimum:

(A) Written policies, procedures, and standards of conduct that demonstrate compliance with all applicable requirements and standards under the Contract, as well as all Federal and state requirements, related to program integrity.

(B) A designated Compliance Officer who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. The Compliance Officer shall report to the CEO and the Board of Directors.

(C) The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing MCO's compliance program and its compliance with the requirements under this Contract.

(D) A system for training and education for the Compliance Officer, directors, managers, and employees regarding MCO's compliance program and program integrity-related requirements.

(E) Effective lines of communication between MCO's Compliance Officer and employees.

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(F) Enforcement of compliance program standards and program integrity-related requirements through well-publicized disciplinary guidelines.

(G) A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, correction of identified compliance problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with program integrity-related requirements.

(H) Procedures for promptly notifying STATE when MCO or its Material Subcontractor:

(1) Identifies or recovers overpayments, which includes specifying the overpayments due to potential Fraud;

(2) Receives information about changes in an Enrollee's circumstance that may affect the Enrollee's eligibility, including changes in the Enrollee's residence and death of an Enrollee; or

(3) Receives information about a change in a Network Provider's circumstances that may affect the Network Provider's eligibility to participate in the program, including the termination of the Provider agreement with MCO.

(I) Provisions to regularly verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Enrollees.

(J) A mechanism for a Network Provider to report to MCO When it has received an overpayment, to return the overpayment to MCO within sixty (60) calendar days after the date on which the overpayment was identified, and to notify MCO in writing of the reason for the overpayment.

(K) MCO's retention policies for the treatment of recoveries of all overpayments from MCO to a Provider, including specifically the retention policies for the treatment of recoveries of overpayments due to Fraud, waste, or Abuse.

(L) The process, timeframes, and documentation required for reporting the recovery of all overpayments.

(M) The process, timeframes, and documentation required for payment of recoveries of overpayments to STATE in situations where MCO is not permitted to retain some or all of the recoveries of overpayments.

2.16.2 Operational Audits

(A) MCO or its Material Subcontractor shall cooperate and facilitate STATE's conduct of periodic on-site visits. At the time of such visits, MCO or Material Subcontractor shall assist STATE or its designee in activities pertaining to an assessment of all facets of the

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Plan's operations, including, but not limited to, financial, administrative, clinical, pharmacy, and claims processing functions and the verification of the accuracy of all data submissions to STATE as described herein.

(B) MCO or Material Subcontractor shall respond to requests for information associated with such on-site visits in a timely manner and shall make senior managers available for on-site reviews.

2.16.3 Inspection

(A) MCO shall allow the State, CMS, the OIG, the Comptroller General, and their designees to inspect and audit any records or documents of MCO at any time [42 C.F.R. §438.3(h)]

(B) MCO shall allow the State, CMS, the OIG, the Comptroller General, and their designees to inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time. [42 C.F.R. §438.3(h)]

(C) MCO shall allow the Secretary of the U.S. Department of Health and Human Services and the State (or any person or organization designated by either) to audit and inspect any books or records of the MCO or its Subcontractors pertaining to the ability of MCO to bear the risk of financial losses or the services performed or payable amounts under the Contract. [Section 1903(m)(2)(A)(iv) of the Act]

2.16.4 Fraud, Waste and Abuse

(A) Pursuant to 42 C.F.R. §438.608, MCO shall have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against Fraud, Waste, and/or Abuse on the part of the Providers, Enrollees, and other patients who falsely represent themselves as being Medicaid eligible.

(B) MCO's compliance plan shall be designed to identify and refer suspected Fraud, Waste, and Abuse activities. MCO shall submit the Fraud, Waste and Abuse compliance plan to STATE, upon STATE's request, and the compliance plan shall be subject to STATE's approval.

(C) MCO shall submit an annual monitoring and investigation plan, which shall include an annual risk assessment, schedule of planned investigations, and how other program integrity methods will be used.

(D) MCO shall cooperate and coordinate with STATE in any Fraud, Waste, and Abuse activities and investigations.

(E) MCO shall attend and participate in quarterly Fraud, Waste, and Abuse meetings with STATE.

(F) MCO must provide a quarterly Fraud report to STATE which includes:

(1) A log of the suspected Provider and Enrollee Fraud and Abuse complaints received by MCO; and

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(2) For each complaint, the following information:

(a) Provider or Enrollee name;

(b) Provider or Enrollee ID number;

(c) Date of suspected Fraud or Abuse;

(d) Source of complaint;

(e) Type of Provider;

(f) Nature of complaint;

(g) Suspected duration or when the incident took place;

(h) Approximate dollars involved; and

(i) Any legal or administrative actions taken.

(3) Any updates on each complaint until the case is closed.

2.16.5 Reporting Incidences of Potential Provider-Related Fraud, Waste, and Abuse

(A) Pursuant to N.D.A.C. §75-02-05-06, if MCO or any subcontractor becomes aware of potential Provider-related Fraud, Waste, or Abuse, MCO shall report the incident utilizing STATE's Surveillance and Utilization Review Section (SURS) Referral form identified as State Form Number (SFN 20) to STATE. MCO must report to STATE all suspected Provider Fraud or Abuse within one (1) business day of discovery.

(B) When Provider Fraud is reported to STATE by a source other than MCO, STATE will notify MCO regarding the reported Fraud. MCO shall investigate and include the findings in the quarterly Fraud report to STATE.

2.16.6 Reporting Incidences of Enrollee-Related Fraud, Waste, and Abuse

(A) If MCO becomes aware of potential Enrollee Fraud, related to the Enrollee's eligibility for Medicaid (such as the potential Enrollee misrepresented facts in order to become, or maintain, Medicaid eligibility), MCO or Provider shall report the potential Enrollee Fraud to STATE using STATE's SURS Referral form identified as State Form Number (SFN) 20.

(B) All types of potential Fraud and all types of potential Enrollee Waste or Abuse related to the Medicaid program shall be reported to STATE within one (1) business day of discovery.

2.16.7 Obligation to Suspend Payments to Providers

(A) MCO shall have written policies and procedures to comply with 42 C.F.R. §455.23.

(B) MCO shall provide notice to the ND Medicaid Program Integrity Unit prior to suspending

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payments.

2.16.8 Subrogation of Claims Arising from Fraud

(A) MCO agrees to be subrogated to STATE for any and all Claims MCO has, or may have, against pharmaceutical companies, retailers, Providers or others, medical device manufacturers, laboratories, or Durable Medical Equipment manufacturers in the Marketing, pricing, and quality of their products.

(B) MCO shall not be entitled to any portion of the recovery obtained by STATE or any entity acting on behalf of STATE or federal government.

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ARTICLE 3: STATE RESPONSIBILITIES

3.1 Contract Management

3.1.1 STATE shall designate a representative authorized and empowered to represent STATE regarding all aspects of the Contract. The representative shall act as a liaison between MCO and STATE for the duration of the Contract and be responsible for:

(A) Monitoring compliance with the terms of the Contract;

(B) Receiving and responding to all inquiries and requests made by MCO under this Contract, in the time frames specified by the Contract;

(C) Meeting with MCO's representative on a periodic or as needed basis and resolving issues which arise;

(D) Coordinating requests and activities from MCO to ensure that STATE staff with appropriate expertise in clinical, financial, data, systems, Marketing/enrollment, and Quality Management matters are involved in MCO initiatives;

(E) Coordinating requests and activities from MCO to ensure that appropriate staff from STATE are available to assist MCO with care and service coordination activities;

(F) Making best efforts to resolve any issues identified either by MCO or STATE that may arise that are applicable to the Contract; and

(G) Informing MCO of any discretionary action by STATE under the provisions of the Contract.

3.1.2 STATE shall assess MCO's performance before and after the begin date for operations in accordance with 42 C.F.R. §438.66(d). STATE shall start the readiness review at least three (3) months prior to the contract start date. STATE will provide MCO with the readiness review schedule and dates for any onsite review and interviews. Each readiness review shall include an assessment of the MCO's ability and capability to perform satisfactorily in the areas set forth in 42 C.F.R. §438.66(d)(4) and this Contract.

3.1.3 STATE shall not enroll potential enrollees into the MCO until STATE determines that the MCO is ready and able to perform its obligations under the Contract as demonstrated during the readiness review, except as provided below.

(A) STATE shall identify to the MCO all areas where the MCO is not ready and able to meet its obligations under the Contract and may, in its discretion:

(1) Allow MCO to propose a plan to remedy all deficiencies prior to the Contract operational start date;

(2) Postpone the Contract operational start date for an MCO that fails to satisfy all readiness review requirements; or

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(3) Enroll enrollees into the MCO as of the Contract operational start date provided the Contractor and STATE agree on a corrective action plan to remedy any deficiencies.

(4) If, for any reason, MCO does not fully satisfy STATE that it is ready and able to perform its obligations under the Contract prior to the Contract operational start date, and STATE does not agree to postpone the Contract operational start date, or extend the date for full compliance with the applicable Contract requirement, then STATE may terminate the Contract and shall be entitled to recover damages from the Contractor.

3.2 Determination of Covered Services

3.2.1 STATE shall be responsible for an annual review and update, as needed, to its Alternative Benefit Plan and determining which services within the ABP shall be covered through MCO or carved out of this Contract.

(A) STATE shall be responsible for provision of pharmaceuticals to Enrollees, unless they are provided in an inpatient facility or in a medical office.

(B) At its option, STATE may select to directly cover services provided by Indian Health Care Providers.

3.2.2 STATE shall be responsible for reviewing and approving any request by MCO to provide an In Lieu of Service as described in Article 2.7.5. At a minimum, STATE shall approve MCO's request to provide a medically necessary, cost effective service which substitutes for an inpatient hospitalization or other covered inpatient stay.

3.2.3 STATE shall be responsible for reviewing and approving any request by MCO to provide a value-added benefit on an annual basis, as described in Article 2.7.6.

3.3 Coordination of Benefits

3.3.1 STATE shall, via the HIPAA 834 Outbound Enrollment file, provide MCO with all third party Health Insurance information on Enrollees where it has verified that third party Health Insurance exists.

3.3.2 STATE shall refer to MCO the Enrollee's name and pertinent information where STATE knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

3.3.3 STATE shall develop Base Capitation Rates that are net of expected TPL recoveries, consistent with MCO's obligation under this Contract, including Article 4.14, to recover claims paid to Providers where the other insurer was primary.

3.4 Enrollment, Assignment and Disenrollment Process

3.4.1 Enrollment

3.4.2 STATE shall maintain responsibility for the enrollment of individuals into MCO's Plan Enrollment Verification

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STATE shall verify and inform MCO of each Enrollee's eligibility and enrollment status in MCO's Plan, through the Eligibility Verification System (EVS) and through the HIPAA 834 Outbound Enrollment file.

3.4.3 Enrollment Information

(A) On a daily basis, STATE shall make available to MCO, via the HIPAA 834 Outbound Daily Enrollment file, information pertaining to all enrollments, including the Effective Date of Enrollment, which will be updated on a daily (business day) basis.

(B) At its discretion, STATE shall automatically re-enroll on a prospective basis in MCO's Plan, Enrollees who were disenrolled due to loss of eligibility and whose eligibility was reestablished by STATE.

(C) At time of enrollment, STATE shall provide MCO with the most current demographic information available to STATE, including the Enrollee's name, address, Medicaid identification number, date of birth, telephone number, race, gender, ethnicity, and primary language.

(D) STATE shall review and respond to written complaints from MCO about the enrollment process and any vendor with whom STATE contracts to provide Enrollment Broker services. STATE may request additional information from MCO in order to perform any such review.

3.4.4 Disenrollment

(A) Disenrollment Conditions

STATE shall disenroll an Enrollee from MCO and he or she shall no longer be eligible for services under such Plan following:

(1) Loss of Medicaid Expansion eligibility;

(2) STATE approval of a request by MCO for involuntary termination pursuant to Article 2.4.5; or

(3) STATE approval of a request by an Enrollee to disenroll voluntarily. Except as otherwise provided under federal law or waiver, an Enrollee may disenroll voluntarily as follows:

(a) For cause, at any time, in accordance with 42 C.F.R. §438.56(c)(2) under the following circumstances:

(i) The Enrollee moves out of MCO's Service Area;

(ii) MCO does not, because of moral or religious objections, cover the service the Enrollee seeks;

(iii) The Enrollee needs related services to be performed at the same

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time and not all related services are available within MCO's Provider Network, and the Enrollee's PCP or another Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(iv) Poor quality of care by MCO as determined by STATE;

(v) Lack of access to MCO Covered Services as determined by STATE; or

(vi) Lack of access to Providers experienced in dealing with the Enrollee's care needs as determined by STATE.

(b) Without cause, at any time, in accordance with 42 C.F.R. §438.56(c)(2) under the following circumstances:

(i) Within ninety (90) calendar days of initial enrollment or within ninety (90) calendar days of notification of enrollment, whichever is later;

(ii) At least once every twelve (12) months during a plan selection period, if there is another health plan participating in the Enrollee's Service Area; or

(iii) Upon reenrollment if a temporary loss of enrollment has caused the Enrollee to miss the annual plan selection period.

(B) Disenrollment Information

On each business day of the Contract Year, STATE shall make available to MCO, via the HIPAA 834 Outbound Enrollment File, information pertaining to all disenrollments, including the Effective Date of Disenrollment and the disenrollment reason code

(C) Effective Date of Disenrollment

(1) The effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the Enrollee requests disenrollment or MCO refers the request to STATE.

(2) If STATE fails to make a disenrollment determination within the specified timeframe, the disenrollment is considered approved for the effective date that would have been established had STATE made a determination in the specified timeframe.

3.5 Provider Enrollment

3.5.1 As required by Section 1932(d)(6) of the Social Security Act and 42 C.F.R. §438.602, STATE shall enroll all Medicaid Providers, both those in Medicaid FFS and MCOs, as a Medicaid Provider within North Dakota. STATE's enrollment of MCO's Network Provider does not require such

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Provider to render services to individuals who are not enrolled with MCO.

3.5.2 STATE shall require all 1915(i) Providers who enroll with STATE to agree to participate in the MCO's Provider Network at rates set by STATE for 1915(i) services.

3.6 Performance Evaluation

3.6.1 STATE shall annually review the impact and effectiveness of the Quality Management/Quality Improvement program by reviewing MCO results related to performance improvement projects, MCO performance on standard measures, performance withhold measures, and other quality initiatives required under the Contract.

3.6.2 Annually, STATE will identify clinical and other performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) measures to be monitored and publicly reported, including but not limited to measures and results from the Performance Withhold. STATE will align the selection of clinical incentive-based measures with the North Dakota Medicaid Quality Strategy.

3.6.3 On an ongoing basis, STATE shall monitor and evaluate MCO's compliance with the terms of this Contract, including, but not limited to, the reporting requirements in Appendix D: MCO Compliance, Operations, and Quality Reporting and the performance measurement, performance withhold and performance improvement projects. STATE shall, at its discretion, monitor and evaluate any or all of MCO's operational processes and metrics that indicate MCO's organizational health. STATE will provide MCO with the written results of such evaluations, including, at its discretion, a quarterly and annual scorecard that shows how MCO has performed relative to its own previous quarter's or annual performance.

3.6.4 STATE shall conduct periodic audits of MCO, as further described in Article 3.7, including, but not limited to, annual External Quality Review activities, as specified in Article 2.14, and on-site reviews pursuant to Article 3.7.3.

3.6.5 STATE shall evaluate, in conjunction with the U.S. Department of Health and Human Services, through inspection or other means, the quality, appropriateness, and timeliness of services performed by MCO and all Network Providers.

3.7 Program Integrity Oversight and Operational Audits

3.7.1 STATE shall review, approve, and monitor MCO's outreach and orientation materials, Enrollee Handbook, marketing materials, wellness program materials, and Complaint, Grievance, and Appeals procedures.

3.7.2 STATE shall conduct annual validity studies to determine the completeness and accuracy of Encounter Data, including comparing utilization data from medical records of Enrollees (chosen randomly by STATE) with the Encounter Data provided by MCO. If STATE determines that MCO's Encounter Data are less than ninety-nine percent (99%) complete or less than ninety-five percent (95%) accurate, STATE will provide MCO with written documentation of its determination and MCO shall be required to implement a corrective action plan to bring the accuracy to the acceptable level. STATE may conduct a validity study following the end of a twelve-month period after the implementation of the corrective action plan to assess whether MCO has attained

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ninety-nine percent (99%) completeness. STATE, at its discretion, may impose intermediate sanctions or terminate the Contract if MCO fails to achieve a ninety-five percent (95%) accuracy level following completion of the corrective action plan as determined by the validity study or as otherwise determined by STATE.

3.7.3 At its discretion, STATE shall conduct periodic on-site visits. At the time of such visits, MCO shall assist STATE in reviewing activities pertaining to an assessment of all facets of the Plan's operations, including, but not limited to:

(A) Administrative capabilities;

(B) Governing body;

(C) Material Subcontracts;

(D) Provider Network capacity and services;

(E) Provider complaints;

(F) Enrollee services;

(G) PCP assignments and changes;

(H) Value-based payment;

(I) Enrollee Grievances and Appeals;

(J) Quality improvement;

(K) Utilization review;

(L) Data reporting;

(M) Population health;

(N) Care management;

(O) Coordination of care;

(P) Claims processing;

(Q) Encounter data;

(R) Fraud, waste, and abuse; and

(S) Reporting requirements.

3.7.4 STATE shall provide the MCO with the right to review and comment on any of the findings and recommendations resulting from Contract monitoring and audits, except in the cases of Fraud investigations or criminal action. Once STATE finalizes the results of monitoring and/or the audit

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report, MCO shall comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in monetary penalties, sanctions and/or enrollment restrictions.

3.7.5 If STATE determines that MCO is in violation of any of the terms of the Contract stated herein, at its sole discretion, STATE shall apply one or more of the sanctions provided in Article 5.9, including termination of the Contract in accordance with Article 5.10; provided, however, that STATE shall only impose those sanctions that it determines to be reasonable and appropriate for the specific violation(s) identified.

3.7.6 STATE shall notify MCO, as promptly as is practicable, of any Providers suspended or terminated from participation in the Medicaid program so that MCO may take action as necessary, in accordance with Article 2.8.3.

3.8 State Responsibility for Payment

3.8.1 STATE must ensure that no payment is made to a Network Provider other than by MCO for services covered under this Contract, except when these payments are specifically required to be made by STATE in Title XIX of the Act, in 42 C.F.R., or when STATE makes direct payments to Network Providers for graduate medical education costs approved under the Medicaid State Plan. [42 C.F.R. §438.60]

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ARTICLE 4: PAYMENT AND FINANCIAL PROVISIONS

4.1 Payment Methodology

4.1.1 STATE shall make payment to MCO for Covered Services provided under this Contract, in accordance with the MCO Cost Proposal as part of the procurement, payment provisions in this Article 4 and the Capitation Rates incorporated into the Contract in Appendix E: Payment Methodology, MLR, and Capitation Rates.

(A) This Contract is classified as a Comprehensive Risk Contract between STATE and MCO under which MCO assumes risk for the cost of services covered under the Contract and incurs loss if the cost of furnishing the services exceeds the payments under the Contract. MCO shall provide all services required by this contract. Pursuant to 42 C.F.R. §447.15, MCO must accept STATE's payment as payment in full.

(B) In developing actuarially sound Capitation Rates, STATE will apply the elements required in 42 C.F.R. §438.4 and §438.5 in accordance with generally accepted actuarial principles and practices, appropriate for the populations to be covered and the services to be furnished under the Contract. When determining the Capitation Rates, appropriate adjustments will be made based on Third Party Liability payments received by MCO.

(C) Capitation Payments shall only be made by STATE and retained by MCO for Medicaid Expansion Eligible Enrollees. [42 C.F.R. §438.3(c)(2)]. The Capitation Rates will be determined to be actuarially sound by an actuary that meets the qualifications and standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

(D) If used in the payment arrangement between STATE and MCO, any and all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, will be described in Appendix E: Payment Methodology, MLR and Capitation Rates of the Contract. [42 C.F.R. §438.6(b)(1)]

4.1.2 MCO Rating Categories

Subject to all required federal approvals, STATE shall pay MCO for providing Covered Services to Enrollees based on the Rating Categories in Appendix E: Payment Methodology, MLR and Capitation Rates. STATE will determine the appropriate rating cohort to which an Enrollee is assigned for payment purposes. For purposes of MCO Capitation Rates, urban counties are designated as Cass, Burleigh and Grand Forks counties. All other counties in North Dakota are designated as rural.

4.1.3 Capitation Rates for Contract Year One (Calendar Year 2022)

(A) Capitation Rates shall be comprised of the medical component of the Capitation Rate, and the non-medical loading component of the Capitation Rate. The non-medical loading component of the Capitation Rate shall reflect the cost of administering medical benefits, underwriting gain, care management, and other non-medical costs.

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(B) To ensure the most recent data available is used to set MCO Capitation Rates, STATE's actuary may update the rate development data used during the competitive bidding process to potentially include additional data, such as data from CY2020 as well as emerging CY2021 data. Using the updated data to determine actuarial soundness, the STATE's actuary will convert the offer point agreed to during the procurement process into the Capitation Rate paid by MCO Rating Category and Region.

(C) STATE will allow a 1.0 percent profit/risk/contingency in developing the Capitation Rates. If the MCO's Cost Proposal reflects lower medical expenditures and MCO meets performance standards defined by STATE during Contract Year One, MCO may earn up to a total of 2.0 percent profit/risk/contingency. At STATE's discretion, MCO may not earn additional profit if MCO has received a Corrective Action Plan or Intermediate Sanction during the Contract Year.

(D) For each Rating Category and Region, the medical and non-medical loading component of MCO's Capitation Rate for Contract Year One will be determined based on the procurement and as follows:

(1) If the sum of the medical and non-medical loading component of the capitation rate falls within the actuarially sound rate ranges as developed by STATE's actuaries, that sum shall be MCO's Capitation Rate for Contract Year One.

(2) If the sum of the medical and non-medical loading component of the capitation rate is below STATE's actuarially sound rate range for Contract Year One, MCO's Capitation Rate for Contract Year One shall be the lower bound of STATE's actuarially sound rate range.

(3) If the sum of the medical and non-medical loading component of the capitation rate is above STATE's actuarially sound rate range for Contract Year One, MCO's Capitation Rate for Contract Year One shall be the higher bound of STATE's actuarially sound rate range.

4.1.4 Capitation Rates for Subsequent Contract Years

(A) After the first Contract Year, STATE shall annually develop the Capitation Rates for each Rating Category for both urban and rural counties taking into account the Contract Year One Capitation Rates and Offer Point, and experience to date.

(B) STATE will allow a 1.0 percent profit/risk/contingency. If the MCO exceeds annual cost efficiency and medical trend measures defined by STATE and STATE's Actuary, MCO may earn up to a total of 3.0 percent profit/risk/contingency as an achieved savings bonus if the MCO meets performance standards as defined by STATE. At STATE's discretion, MCO may not earn additional profit if MCO has received a Corrective Action Plan or Intermediate Sanction during the Contract Year.

(C) STATE shall meet with MCO annually, upon request, to announce and explain the Capitation Rates, including the medical component and non-medical loading component of the Capitation Rates.

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(D) Prior to the beginning of the Contract year, STATE shall incorporate, by amendment, the Capitation Rates by Rating Category and Region into the Contract at Appendix E: Payment Methodology, MLR and Capitation Rates; provided, however, that STATE may amend the Capitation Rates at such other times as may be necessary as determined by STATE, or as a result of changes in federal or state law, including but not limited to, to account for changes in eligibility, Covered Services, or co-payments.

4.1.5 Failure to Accept Capitation Rates

(A) In the event that MCO does not accept the Capitation Rates for the new Contract Year before thirty (30) calendar days prior to the first day of the new Contract Year, STATE shall pay MCO the prior year's Capitation Rates or the Capitation Rates for the new Contract Year, whichever is lower, and MCO shall accept such payment as payment in full under the Contract.

(B) In the event that the Capitation Rates paid subject to Paragraph A above are lower than the Capitation Rates for the new Contract Year and MCO does not accept the Capitation Rates offered by STATE by the beginning of the new Contract Year, STATE will not retroactively adjust the Capitation Rate for the interim rate period.

(C) In the event that MCO does not accept the Capitation Rates for the new Contract Year within sixty (60) days following the end of the prior Contract Year, STATE may terminate the Contract and MCO shall be obligated to continue to provide Covered Services to Enrollees in accordance with Article 5.11.1.

4.2 Payment Schedule

4.2.1 STATE shall pay MCO a monthly Capitation Rate for each Enrollee on the eligibility file transaction by the 15th calendar day of each month or a mutually agreed upon alternative date. The capitated payment is made whether or not the Enrollee receives a Covered Service during that month. Refer to Appendix E: Payment Methodology, MLR and Capitation Rates with regard to the separate Capitation Rates for each rating cohort within each Region.

4.2.2 The Capitation Rates are based upon the availability of funding. In the event that any funding source becomes unavailable, STATE reserves the right to amend the rates to reflect the change in funding. STATE shall notify MCO of any change in the Capitation Rates due to a loss of funding. When possible, STATE shall make reasonable efforts to notify MCO at least thirty (30) calendar days prior to the change in rates. In the event of a change in Capitation Rates pursuant to a loss of funding, if MCO determines that the new rates are unacceptable, MCO may terminate this contract after it provides one hundred fifty (150) calendar days written notice of intent to terminate to STATE.

4.3 Payment Procedures

4.3.1 STATE shall make payments to MCO through its Medicaid Management Information System (MMIS) for all Enrollees under this Contract.

4.3.2 Unless a sanction provision applies, STATE shall pay MCO the Capitation Rates designated in Appendix E: Payment Methodology, MLR and Capitation Rates for all current Enrollees listed in

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STATE eligibility file transaction.

4.3.3 MCO must accept and correctly process HIPAA compliant 820 and 834 transactions and convert STATE's current eligibility file data into compliant 820 and 834 files for use in MCO's system.

4.3.4 STATE shall provide MCO an electronic MCO reimbursement file which contains the following transmission information:

(A) Premiums: data on individuals that STATE certifies as being eligible for a Medicaid Expansion Premium payment for the report month the file was generated and any new retroactive eligibility spans.

(B) Recoupments: data on individuals that STATE had previously made a Medicaid Expansion Premium payment for that have since been determined by STATE as not being eligible for a Medicaid Expansion Premium payment.

(C) Adjustments: data on individuals that STATE had previously made a Medicaid Expansion Premium payment for that have since been determined by STATE that a different Premium payment amount should have been made.

(D) STATE acknowledges that MCO is not receiving HIPAA 820 transactions, thus excusing any obligation related thereto as long as MCO takes reasonable precautions to protect non-public information by using a secure file portal.

(E) Critical Fields found in the MCO reimbursement file shall include: Enrollee's identification number, name, date of birth, gender, race, Capitation Rate basic code, eligibility start date, eligibility end date (if applicable), county, address, phone number, Premium payment indicator, and Premium amount.

(F) When STATE implements managed care for Medicaid Expansion within the ND Health Enterprise MMIS, MCO shall follow the policies and procedures found in STATE's 820 Premium Payment Manual, the HIPAA 834 Best Practices Manual, or a mutually agreed upon proprietary file transfer format and any amendments to these documents.

(G) Upon implementation of the Enterprise Medicaid Management Information System (Enterprise MMIS) and functionality to produce the HIPAA transactions, the following provisions will apply to the enrollment and Capitation Payment files:

(1) Benefit enrollment and maintenance eligibility information will be securely transmitted in an electronic HIPAA compliant data file using the 834 "Benefit Enrollment and Maintenance" transaction. Enrollment and maintenance information will be generated daily by STATE, but the transaction will only be put in outbound directory when the transaction contains data. This file will contain enrollments, disenrollments, site transfers, and demographic changes processed by STATE. Final monthly eligibility information will be securely transmitted using the HIPAA 834 transaction and will contain members enrolled in the plan for the following month. No payment, site transfer, or disenrollment information will be included in this file.

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(2) Capitation Payment information will be securely transmitted monthly in an electronic HIPAA compliant data file using the 820 "Group Premium Payment for Insurance Products" transactions. The 820 transaction will be transmitted on a schedule that is consistent with STATE current payment and remittance reporting process.

4.4 Payment Adjustments, Recoupments and Suspensions

4.4.1 Errors and Adjustments in Capitation Payments

(A) If MCO discovers errors in Capitation Payments made by STATE within the past six (6) months, MCO shall notify STATE. MCO shall supply supporting documentation for STATE's review. If appropriate, STATE shall adjust MCO's payment. No adjustments will be made if the error, discovered by MCO, is older than six (6) months unless the adjustment is delayed on the part of STATE.

(B) STATE shall automatically adjust Capitation Rates, prospectively to the first of the month following the date an Enrollee provided notification of a change impacting an Enrollee's rate cohort. This information will be transmitted to MCO via STATE's eligibility and reimbursement files.

(C) STATE shall automatically adjust Capitation Payments paid to MCO that were paid in error when an Enrollee's rate cohort is changed retroactively. This information will be transmitted to MCO via STATE's eligibility and reimbursement files.

(D) STATE shall recoup any Capitation Payment paid to MCO that was paid in error. Such errors may pertain to human or mechanical error on the part of MCO or STATE; including, but not limited to, lack of eligibility, death of Enrollee, or computer error. This information will be transmitted to MCO via STATE's eligibility and reimbursement files.

(E) STATE shall reconcile Capitation Payment adjustments and recoupments from STATE's next payment(s) to MCO.

(F) If MCO disagrees with STATE's Capitation Payment adjustment and recoupment reconciliation that has been made, MCO may request an Appeal within 30 calendar days of STATE's reconciliation.

(G) Pursuant to 42 C.F.R. § 95.7, STATE may file a claim with CMS for a State agency expenditure within two (2) years after the calendar quarter in which the State agency made the expenditure. Thus, STATE may not make Capitation Payments or retroactive adjustments to Capitation Payments resulting in an expenditure increase if more than two years prior.

4.4.2 Payments for a State Program No Longer Authorized by Law

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), MCO must do no work on that part after the effective date of the loss of program authority. STATE must adjust

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Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If MCO works on a program or activity no longer authorized by law after the date the legal authority for the work ends, MCO will not be paid for that work. If STATE paid MCO 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 STATE. If MCO worked on a program or activity prior to the date legal authority ended for that program or activity, and STATE included the cost of performing that work in its payments to MCO, MCO may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

4.4.3 Capitation Payment Suspension

(A) Capitation Payment Suspension, Generally

(1) STATE may suspend MCO's Capitation Payment in the event that MCO fails to comply with any provision of this Contract.

(2) STATE may suspend MCO's Capitation Payment for any failure to submit or comply with a corrective action plan within the timeframes required by STATE.

(B) Procedure for Capitation Payment Suspension

(1) STATE shall notify MCO, in writing, of any suspension of a Capitation Payment and the reason for that suspension. STATE shall inform MCO what action needs to be taken by MCO to receive payment and the timeframe in which MCO must take action in order to avoid suspension of the Capitation Payment. If MCO fails to cure the deficiency, STATE may continue the suspension of Capitation Payments until MCO comes into compliance. Once MCO comes into compliance, all Suspended Capitation Payments will be paid to MCO within 14 calendar days.

(2) If MCO disagrees with the reason for the suspension of the Capitation Payments, MCO may request a STATE fair hearing within 30 calendar days of receipt of STATE's notice of intent to suspend the Capitation Payments. STATE may continue to withhold Capitation Payments through the duration of STATE fair hearing, unless ordered by STATE fair hearing officer to release the Capitation Payments.

4.5 Non-Payment

4.5.1 Provider Preventable Conditions

(A) Pursuant to 42 C.F.R. §438.3(g), all payments to MCO are conditioned on MCO's compliance with all provisions related to Provider Preventable Conditions. MCO agrees to take such action as is necessary in order for STATE to comply with and implement all federal and state laws, regulations, and policy guidance relating to the identification, reporting, and non-payment of Provider preventable conditions, including Section 2702 of the Patient Protection and Affordable Care Act and regulations promulgated thereunder.

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(B) In accordance with 42 C.F.R. §438.3(g), MCO shall:

(1) As a condition of payment, comply with the requirements mandating Provider identification of Provider-Preventable Conditions, as well as the prohibition against payment for Provider-Preventable Conditions as set forth in 42 C.F.R. §434.6(a)(12) and §447.26;

(2) Develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions, including but not limited to a process for ensuring non-payment or recovery of payment for preventable hospital readmissions;

(3) Report at least annually all identified Provider-Preventable Conditions in a form and format specified by STATE; and

(4) Have policies and procedures consistent with the following:

(a) MCO shall not pay a Provider for a Provider Preventable Condition;

(b) MCO shall require, as a condition of payment from MCO, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. 447.26(d) and as may be specified by MCO and/or STATE.

4.5.2 Other Items and Services Prohibited from Payment

MCO 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):

(A) Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.

(B) 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 sections 1128, 1128A, 1156, or 1842(j)(2) of the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

(C) Furnished by an individual or entity to whom 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 STATE determines there is good cause not to suspend such payments.

(D) With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

(E) With respect to any amount expended for roads, bridges, stadiums, or any other item or

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service not covered under the Medicaid State Plan. [Section 1903(i)(2)(A) - (C) of the Act; section 1903(i)(16) - (17) of the Act]

4.6 Covered Services Received Out-of-Network but Paid by MCO

4.6.1 MCO shall not be required to pay for Covered Services when the Enrollee receives the services from Out-of-Network Providers that are not arranged for nor authorized by MCO, except as follows:

(A) Emergency Services;

(B) Court ordered services that are Covered Services defined in Appendix B: MCO Covered Services;

(C) Cases where the Enrollee demonstrates that such services are Medically Necessary Covered Services and were unavailable in MCO Network; or

(D) In cases of eligibility for the three (3) month period prior to MCO enrollment, If STATE and MCO determine that an Enrollee could not reasonably have known that the Provider was an Out-of-Network Provider.

4.6.2 Notwithstanding the foregoing, MCO shall ensure, pursuant to Section 1902(a)(23) of the Social Security Act (42 U.S.C. §1396a(a)(23)), the free choice of Provider for family planning; MCO shall reimburse Out-of-Network Providers for family planning services at the established MCO rate in effect on the date of service for paying Network Providers or at the rate agreed to by MCO and the Provider.

4.7 Payment for Services to Pregnant Women

If a baby is born to an Enrollee, MCO is responsible for all MCO Covered Services for the mother associated with the birth.

4.8 Payment for Emergency Services

4.8.1 MCO shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with MCO.

4.8.2 MCO shall not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

4.8.3 MCO shall not deny payment for treatment obtained when a representative of MCO instructs the Enrollee to seek Emergency Services.

4.8.4 Payment by MCO to an Out-of-Network Provider for Emergency Services shall not exceed the Medicaid Fee-for-Service rate.

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4.9 Payment to Indian Health Care Providers

(A) When an ICHP is enrolled in FFS as a FQHC but not a participating provider of MCO, it must be paid an amount equal to the amount MCO would pay a FQHC that is a Network Provider but is not an IHCP, including any supplemental payment from STATE to make up the difference between the amount MCO pays and what the IHCP FQHC would have received under FFS. [42 C.F.R. 438.14(c)(1)]

(B) When an ICHP is not enrolled in FFS as a FQHC, regardless of whether it participates in the MCO's Provider Network, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Services (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were paid under the Medicaid State Plan's FFS payment methodology. [42 C.F.R. 438.14(c)(2)]

(C) When the amount an IHC receives from MCO is less than the amount required under Article 4.9(B), MCO shall make a quarterly supplemental payment to the IHCP to make up the difference between the amount MCO paid and the amount the IHCP would have received under FFS or the applicable encounter rate. [42 C.F.R. 438.14(c)(3)]

4.10 Enrollee Transition between MCO and Fee-for-Service

4.10.1 Inpatient Hospital Stays

When an Enrollee is in an inpatient hospital setting and becomes Fee-for-Service any time prior to discharge from the hospital, MCO is financially responsible until midnight on the date in which ND Medicaid Expansion eligibility ends and coverage under MCO terminates.

4.10.2 Enrollee Transition, Medical Equipment

(A) When medical equipment is ordered for an Enrollee by MCO and the Enrollee becomes Fee-for-Service before receiving the equipment, MCO is responsible for the payment of such equipment for the Enrollee.

(B) Medical equipment includes, but is not limited to, specialized wheelchairs or attachments, prostheses, and other equipment designed or modified for an individual Enrollee. Any attachments to the equipment, replacements, or new equipment are the responsibility of the Health Plan in which the individual is enrolled at the time the equipment is ordered.

4.10.3 STATE Acceptance of MCO's Prior Authorization

For Covered Services other than inpatient, Home Health Services, and medical equipment, if authorization has been given for a Covered Service and an Enrollee transitions to Medicaid Fee-for-Service prior to the delivery of such Covered Service, STATE shall be bound by MCO's Prior Authorization until STATE has evaluated the Medical Necessity of the service and agrees with MCO's Fee-for-Service Prior Authorization or has made a different determination.

4.10.4 Provision of Medical Information to Enrollee's Health Plan or STATE

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(A) When Medicaid Expansion Eligible Individuals are transitioned from MCO's Health Plan to Fee-for-Service, and STATE, as applicable, MCO shall submit upon request any critical medical information about the transitioning Medicaid Expansion Eligible Individual prior to the transition, including, but not limited to, whether the Enrollee is hospitalized, pregnant, involved in the process of organ transplantation, scheduled for surgery or post-surgical follow-up on a date subsequent to transition, names of the treating physicians, types of equipment ordered and dates, if in the Coordinated Services Program, scheduled for prior-authorized procedures or therapies on a date subsequent to transition, receiving dialysis, or is chronically ill. Chronic illness includes, but is not limited to, diabetes, hemophilia, substance use disorder, or HIV.

(B) MCO is required to notify Enrollees that if they become pregnant, they will have a choice to change to Fee-for-Service if they should choose. Inclusion of this notice in the Enrollee's Certificate of Coverage satisfies this requirement.

4.10.5 Acceptance of Pre-Enrollment Prior Authorizations

(A) For Covered Services other than inpatient services, if authorization has been given for a Covered Service and a Medicaid Expansion Eligible Individual transitions between FFS Medicaid and MCO prior to the delivery of such Covered Service, the receiving MCO or Medicaid shall be bound by the relinquishing Health Plan's Prior Authorization until MCO or Medicaid has evaluated the Medical Necessity of the service and agrees with the relinquishing Health Plan's Prior Authorization or has made a different determination.

(B) STATE will routinely report to MCO, in a mutually agreeable format, prior-authorization information upon Enrollee's transition from Medicaid Fee-for-Service to MCO.

4.10.6 Organ Transplant Prior Authorization

MCO shall honor Prior Authorizations for organ transplantations and any other ongoing services initiated by STATE while the Enrollee was covered under Medicaid Fee-For Service until the Enrollee is evaluated by MCO and a new plan of care is established.

4.11 Prohibition on Balance Billing and Payment in Full

4.11.1 Pursuant to 42 C.F.R. §447.15, MCO shall ensure its Contracted Providers, including Network and Out-of-Network Providers, shall not Balance Bill the Enrollee. The reimbursement from MCO shall be payment in full.

(A) MCO shall require, as a condition of payment, that the Provider (contract or non-contract Provider) accept the amount paid by MCO or appropriate denial made by MCO (or, if applicable, payment by MCO that is supplementary to the Enrollee's third party payer) plus any applicable amount of cost-sharing or patient liability responsibilities due from the Enrollee as payment in full for the service.

4.11.2 MCO must accept STATE's payment as payment in full.

4.12 Organ Transplant Prior Authorization

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MCO shall not, pursuant to Section 1903(i) (final sentence) and Section 1903(i)(1) (42 U.S.C. §1396b(i), (i)(1)), pay for organ transplants unless the Medicaid State Plan provides, and MCO follows, written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Enrollees. [Section 1903(i) of the Act, final sentence; section 1903(i)(1) of the Act]

4.13 IMD Exclusion

STATE will only make a monthly Capitation Payment to MCO for an Enrollee aged 21–64 receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 C.F.R. §435.1010, if the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than fifteen (15) calendar days during the period of the monthly Capitation Payment. [42 C.F.R. §438.6I]

4.14 Third Party Liability

4.14.1 Policies and Procedures for Third Party Liability Recovery

(A) MCO shall have written policies and procedures describing how it intends to conduct Third Party Liability discovery and recovery. Such policies and procedures shall be consistent with the requirements of 42 U.S.C. §1396(A)(25), 42 C.F.R. §433 Subpart D, and 42 C.F.R. §447.20. The policies and procedures shall contain:

(1) Procedures and mechanisms to identify potentially liable third parties;

(2) Procedures and mechanisms to identify the amount owed by a third party; and

(3) Procedures and mechanisms for recovery of Third Party Liability payments.

(B) In order to assist MCO, STATE shall include on the eligibility transmission other known Health Insurance plans available to each Enrollee. MCO may not rely on third party information received from STATE as its sole solution to discover third party information about a Medicaid Expansion Enrollee.

4.14.2 Pay and Chase, and Cost Avoidance

(A) Except as otherwise provided in this Contract, when MCO is aware of the probable existence of Third Party Liability at the time a Claim from a Provider is filed with MCO, MCO must reject the Claim and return it to the Provider for a determination of the amount of liability. The establishment of Third Party Liability takes place when MCO receives confirmation from the Provider or a third party resource indicating the extent of Third Party Liability.

(B) When MCO has received information indicating that the Enrollee has other health coverage that precludes eligibility for Medicaid Expansion, MCO may pend the Claim while STATE determines the Enrollee's eligibility.

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(C) MCO must pay the Provider's Claim first and then seek reimbursement from the liable third party:

(1) In accordance with the Bipartisan Budget Act of 2018, Section 53102, if MCO cannot differentiate the costs for prenatal services from labor and delivery on a Claim, it will cost avoid the entire Claim.

(D) MCO shall notify STATE within ten (10) business days after MCO becomes aware that an Enrollee may be:

(1) Entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Social Security Act;

(2) Otherwise eligible for and enrolled for coverage under another Medicaid program in North Dakota or any other state; or

(3) Enrolled in commercial insurance.

(E) Upon expiration of STATE's forty-five (45) day review period, or earlier, if appropriate, MCO shall either pay or reject the Claim based on the information provided in the most recent eligibility transmission file. If the Enrollee's eligibility has not been terminated, as indicated in the eligibility transmission file, MCO may continue to pend claims in alignment with its Provider agreements and this Contract, as appropriate, in order to comply with applicable laws and regulations.

(F) If the probable existence of Third Party Liability cannot be established or third party benefits are not available to pay the Enrollee's medical expenses at the time the Claim is filed, MCO must pay the Claim pursuant to its payment schedule. If MCO later determines that Third Party Liability exists, MCO must seek reimbursement from the third party within 60 calendar days of discovery of the Third Party Liability, except in instances described above.

(G) MCO has one hundred twenty (120) calendar days from the date of adjudication of a claim that is subject to TPL to attempt recovery of the costs for services that should have been paid through a third party.

(1) MCO shall provide to STATE, on a monthly basis, by the tenth day of each month, a report indicating the claims where MCO has billed or made a recovery up to the 120th day from adjudication of a claim that is subject to TPL. After one hundred twenty (120) calendar days, STATE will attempt recovery for any claims in which MCO did not attempt recovery and will retain, in full, all funds received as a result of any STATE initiated TPL billing. MCO will be precluded from attempting to bill for any recovery after one hundred twenty (120) calendar days from claim adjudication date. Any collections by MCO billed after one hundred (120) calendar days from the claim adjudication date must be sent to STATE. MCOs are to continue to cost avoid and cost recover where applicable.

(2) After 365 Days from adjudication of a claim, MCO loses all rights to pursue or collect any recoveries subject to TPL, STATE will have the sole authority for

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recoveries of any claim subject to TPL after three hundred sixty-five (365) calendar days from the date of adjudication of a claim. Should MCO receive payment on a STATE initiated recovery, MCO must send the payment to STATE.

(H) Except as otherwise noted in this Article, MCO shall retain any payment it receives stemming from Third Party Liability. MCO shall report applicable Third Party Liability recoveries on the 837 File. Third party payments must be reported as part of the annual reconciliation described in Appendix E: Payment Methodology, MLR and Capitation Rates. When determining the Capitation Rates, appropriate adjustments will be made based on Third Party Liability payments received by MCO and by STATE.

4.15 Provider and Subcontractor Payments

4.15.1 MCO shall agree to reasonable reimbursement standards to Providers for Covered Services, to be determined in conjunction with actuarially sound rate setting. MCO shall not agree to reimbursement rate methodology that provides for an automatic increase in rates.

4.15.2 The Contract does not preclude MCO from using different reimbursement amounts for different specialties or for different Practitioners in the same specialty. [42 C.F.R. 438.12(b)(2)].

4.15.3 All reimbursement paid by MCO to Providers and amounts paid by MCO to any other entity is subject to audit by STATE. Per Section 50-24.1-37 of the North Dakota Century Code, provider reimbursement rate information received by the Department under this Section of the Century Code is an open record.

4.15.4 Consistent Payment Methodology

(A) MCO Responsibilities

(1) Pursuant to Section 50-24.1-37 of the North Dakota Century Code, MCO shall:

(a) Reimburse Providers within the same Provider type and specialty at consistent levels and with consistent methodology;

(b) Reimburse all North Dakota substance use providers of American Society of Addiction Medicine level 2.5 at consistent levels and with consistent methodology.

(c) Not pay Critical access hospitals less than 100 percent of Medicare allowable costs; and

(d) Ensure payments to IHCP, FQHC, and RHC meet the federally required minimum levels of reimbursement.

(e) May consider urban and rural Providers as different Provider types; and

(f) May not provide incentive, quality, or supplemental payments to Providers, unless part of a value-based program offered to all eligible Providers and approved by STATE and, if applicable, by CMS.

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(B) State Responsibilities

Pursuant to Senate Bill 2012 Section 17 of the ND 66th Legislative Assembly, STATE shall ensure MCO Provider reimbursement complies with the provisions as outlined within Article 4.15.4 of this Contract and ensure the Capitation Rates under Comprehensive Risk Contracts are actuarially sound and are adequate to meet MCO contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care.

4.16 Medical Loss Ratio

4.16.1 MCO shall calculate and submit a Medical Loss Ratio (MLR) Report for each MLR Reporting Year consistent with MLR standards, 42 C.F.R. §438.8(a), this Contract, and STATE reporting requirements, including but not limited to Contractual requirements defined in Appendix E: Payment Methodology, MLR and Capitation Rates. All documentation related to the MLR calculation shall not be considered proprietary and shall be available for public review.

(A) The MLR calculation in a MLR Reporting Year is the ratio of the numerator (as defined in accordance with 42 C.F.R. §438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. 438.8(f)). [42 C.F.R. §438.8(d) - (f)]

(B) MCO must submit the MLR reports in a timeframe and manner determined by STATE, which must be within 12 months of the end of the MLR Reporting Year. [42 C.F.R. §438.8(k)(2); 42 C.F.R. §438.8(k)(1)]

(C) Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities. [42 C.F.R. §438.8(g)(2)(i) - (iii)]

(D) MCO will aggregate data for all Medicaid eligibility groups covered under the Contract unless STATE requires separate reporting and a separate MLR calculation for specific populations. [42 C.F.R. §438.8(i)] MCO must submit MLR reports to STATE in accordance with Appendix E: Payment Methodology, MLR and Capitation Rates.

(E) MCO must submit the required MLR reports within twelve (12) months of the end of the MLR Reporting Year and in a timeframe and manner determined by STATE including as specified in Appendix E: Payment Methodology, MLR and Capitation Rates.

4.16.2 MCO shall maintain a minimum MLR in aggregate for MCO's Enrollee population. Pursuant to 42 C.F.R. §438.8(c) and (j), STATE will mandate a minimum MLR equal to or higher than eighty-five percent (85%). If MCO's MLR for a reporting year does not meet the minimum MLR standard specified by STATE in Appendix E: Payment Methodology, MLR and Capitation Rates, monies will be remitted by or recouped from MCO to achieve the targeted MLR threshold. [42 C.F.R. §438.8(j); 42 C.F.R. §438.8(c)]

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4.17 Performance Withhold Arrangements

4.17.1 STATE shall establish performance withhold arrangement for MCO to incentivize specific performance improvement. MCO withhold amount will be established annually by STATE. The withhold percent shall not exceed three (3) percent of the MCO's Capitation Payment. Each month, STATE shall withhold a percentage of the monthly MCO's Capitation Payment equal to the identified withhold percent. STATE will set the withhold percent at least ninety (90) days prior to the applicable calendar year measurement period.

4.17.2 The MCO performance withhold may incentivize MCO performance on any or all of the following:

(A) Achievement of a certain pre-specified clinical goal;

(B) Demonstrable improvement toward a pre-specified clinical goal, reducing the performance gap between MCO's or the Program's prior performance and the pre-specified clinical goal;

(C) Improvements in the completeness and accuracy of encounter data and/or clinical data; and

(D) Use of alternative payment models in provider agreements consistent with Section 4.20 of the Model Contract (see excerpt at end of this document).

4.17.3 For each measurement year, the MCO will earn back the performance withhold based on its performance relative to incentive-based measures and targets as established by STATE. Measure descriptions and targets for incentive-based measures will be specified by STATE at least 90 days prior to the start of the measurement period. When identifying the measures, STATE shall indicate how incentive-based measures are weighted in terms of the MCO earning back the Performance Withhold.

4.17.4 In Contract Year One, STATE anticipates identifying up to 10 clinical measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) measures to be included in the Performance Withhold. STATE will align the selection of clinical incentive-based measures with the North Dakota Medicaid Quality Strategy. Clinical measures of interest to STATE include measures that assess MCO performance related to care for substance use disorder, depression and anxiety, asthma, diabetes, and hypertension.

4.17.5 STATE shall determine whether MCO has met, partially met, or fallen below any and all such performance standards and shall provide MCO with written notice of such determinations and may publicly share MCO performance on withhold measures and other performance measures.

4.17.6 To earn back the full withhold amount associated with each incentive-based measure, MCO performance must meet or exceed the target for that measure. Targets for HEDIS® incentive-based measure scores will be based on NCQA Quality Compass Medicaid National percentile values for the most recent applicable measurement year and in consideration of past MCO and past North Dakota Medicaid Expansion program experience.

4.17.7 For some incentive-based measures, MCO will be able to earn partial credit based on specifications defined by STATE and updated annually by STATE.

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4.17.8 If NCQA makes changes to any of the measures selected by STATE, such that valid comparison to prior years will not be possible, or if it is determined that a measure is not reasonably attainable, STATE, at its sole discretion, may elect to eliminate the measure from incentive eligibility, change the affected measure to be reporting only, or replace it with another measure.

4.17.9 STATE shall determine the amount of the Performance Withhold earned back by the MCO based on the MCO's performance. For all measures, the MCO's results will be reviewed, and where feasible validated, by STATE's contracted External Quality Review Organization.

4.17.10 STATE, and the STATE's actuary shall take into consideration any portion of the withhold that is not reasonably achievable as determined by an actuary. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted to CMS as part of the STATE documentation of actuarially sound capitation rates as required under § 438.7(b)(6).

4.17.11 STATE shall retain the amount of Performance Withhold not earned back by the MCO. No interest shall be due to the MCO on any sums withheld or retained under this Section.

4.17.12 Consistent with CMS requirements, the Performance Withhold arrangement shall not be renewed automatically. MCO performance shall be measured during the rating period in which the withhold arrangement is applied. The withhold arrangement will be made available to both public and private MCO contractors under the same terms of performance. The withhold arrangement does not condition MCO participation in the withhold on MCO entering into or adhering to intergovernmental transfer agreements. The withhold arrangement is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in STATES's quality strategy. [42 C.F.R. §438.6(b)(3)(i) - (v); 42 C.F.R. §438.3.

4.17.13 In the case of a Public Health Emergency, STATE reserves right to modify the Performance Withhold arrangement.

4.18 Reinsurance

4.18.1 MCO shall purchase reinsurance from a company authorized to do business in North Dakota, to cover medical costs that exceed at a minimum, eighty (80) percent (coinsurance level) of inpatient costs incurred by one (1) Enrollee in one (1) year in excess of $200,000 (attachment point) per Enrollee for the duration of the Contract period. Such reinsurance policy shall meet specifications, such as attachment points and coinsurance level, identified by STATE. MCO shall submit to STATE for its prior approval the reinsurance policy documenting the type and scope of coverage, and the estimated cost of purchasing the private reinsurance policy. Such documentation must be submitted to STATE no later than forty-five (45) calendar days, or another date specified by STATE, prior to the effective date of purchase or renewal of the reinsurance policy and at least thirty (30) calendar days prior to the Operational Start Date.

4.18.2 MCO may be granted an exemption from purchasing reinsurance if the MCO can demonstrate it has sufficient liquid assets to cover medical costs that exceed a threshold per Enrollee for the duration of the Contract period. MCO shall submit to STATE for its consideration documents that demonstrate that assets are available to cover medical costs that exceed a threshold per Enrollee for the duration of the Contract period. Such documentation must be submitted to STATE at least

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ninety (90) calendar days prior to the Operational Start Date, or ninety (90) days prior to expiration of the of an existing policy. STATE will approve or deny the exemption request.

4.19 Financial Stability Requirements

4.19.1 MCO shall remain fiscally sound as demonstrated by the following:

(A) MCO shall be licensed as a Health Maintenance Organization by the North Dakota Insurance Department (NDID).

(B) MCO shall maintain sufficient cash flow and liquidity to meet obligations as they become due. MCO shall submit to STATE annually and upon request a cash flow statement to demonstrate compliance with this requirement and a statement of its projected cash flow for a period specified by STATE.

(C) Throughout the term of this Contract, MCO shall maintain a minimum cash reserve of $1,000,000 to be held in a restricted reserve. Funds from this restricted cash reserve may be dispersed only with prior written approval from STATE during the term of this Contract.

(D) MCO shall demonstrate and maintain working capital as specified below. For the purposes of this Contract, working capital is defined as current assets minus current liabilities. Throughout the term of this Contract, MCO shall maintain a positive working capital balance, subject to the following conditions:

(1) If, at any time, MCO's working capital decreases to less than seventy-five percent (75%) of the amount reported on the prior year's audited financial statements, MCO shall notify STATE within two (2) business days and submit, for approval by STATE, a written plan to reestablish a positive working capital balance at least equal to the amount reported on the prior year's audited financial statements.

(2) STATE may take any action it deems appropriate, including termination of the Contract, if MCO does not maintain a positive working-capital balance; or violates a corrective plan approved by STATE.

(E) Throughout the term of this Contract, MCO shall remain financially stable and maintain adequate protection against insolvency, as determined by STATE. To meet this general requirement, MCO, at a minimum, shall comply with, and demonstrate such compliance to the satisfaction of STATE, the solvency standards imposed on HMOs by the North Dakota Insurance Department (NDID). MCO shall submit copies of its NDID financial reports to STATE on an annual basis.

4.20 Provider Incentives and Alternative Payment Methodologies

4.20.1 Provider Performance Incentives

(A) MCO shall implement Provider Performance Incentives as appropriate, to promote compliance with guidelines, other QI initiatives, and the North Dakota Quality Strategy. MCO shall:

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(1) Collaborate with Network Providers in development and revision of the incentives;

(2) Monitor the effectiveness of such Provider Performance Incentives, and revise incentives as appropriate, with consideration of Provider feedback, and

(3) Ensure that all Provider Performance Incentives comply with all applicable state and federal laws.

4.20.2 Physician Incentive Plan

(A) MCO 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 incentive to reduce or limit medically necessary services to an enrollee. [Section 1903(m)(2)(A)(x) of the Act; 42 CFR 422.208(c)(1); 42 CFR 438.3(i)]

(B) Substantial Financial Risk

(1) If MCO's Physician Incentive Plan places the physician/group at substantial financial risk for services not provided by the physician/group resulting in referral services which exceeds the risk threshold (twenty-five (25) percent of potential payment), MCO shall ensure adequate stop-loss protection to individual physicians and conduct annual Enrollee surveys.

(2) If MCO puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, MCO must ensure that the physician/physician group has adequate stop-loss protection. [Section 1903(m)(2)(A)(x) of the Act; 42 C.F.R. §422.208(c)(2); 42 C.F.R. §438.3(i)]

(C) Information to Enrollees

(1) MCO shall provide information on its Physician Incentive Plan to any Enrollee upon request. If MCO is required to conduct Enrollee surveys, MCO shall disclose the survey results to Enrollees upon request.

(D) MCO shall notify STATE if MCO plans to operate a Physician Incentive Plan. MCO shall report to STATE the following information in sufficient detail to determine whether the incentive plan complies with the regulatory requirements:

(1) Whether services not furnished by the physician or physician group are covered by the incentive plan. No further disclosure is required if the Physician Incentive Plan does not cover services not furnished by the physician or physician group;

(2) The type of incentive arrangement (e.g., withhold, bonus, capitation arrangement, etc.);

(3) The percent of withhold or bonus, if applicable;

(4) The panel size and, if Enrollees are pooled, the method used;

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(5) If the physician or physician group is at substantial financial risk, proof the physician/group has adequate stop-loss coverage, including the amount and type of stop- loss; and If required to conduct Enrollee surveys, the survey results.

4.20.3 Alternative Payment Methodologies

(A) MCO shall implement Alternative Payment Methodologies (APMs) in its agreements with Network Providers and meet the following targets:

(1) 30% of total payments to providers within APM agreements in Year 1 of the Contract.

(2) 40% of total payments to providers within APM agreements in Year 2 of the Contract

(3) 50% of total payments to providers within APM agreements in Year 3 of the Contract

(B) MCO shall develop an APM strategic plan which details how MCO will meet the APM targets in the first three years of the Contract. MCO shall share and discuss a draft of its APM strategic plan with STATE during the readiness review process. MCO submit its APM strategic plan no later than January 15, 2022 consistent with STATE feedback and reporting requirements.

4.20.4 MCO shall report on its use of APMs in a form and format and at a frequency specified by STATE, including reporting information, such as, but not limited to:

(A) A list of MCO's APM models utilized with Network Providers, by LAN APM Framework Categories (2A through 4C) and Provider type.

(B) A list of MCO's APM provider agreements and the Network Providers, PCMHs, and ACOs, involved in each such agreement;

(C) The quality measures and range of performance benchmarks used by MCO in APMs by Provider type; and

(D) The total amount paid by MCO to Providers under agreements with APMs, as a total dollar amount and as a percent of the total amount paid by MCO to Providers for all Provider agreements under this Contract.

(E) Cost savings and quality improvement resulting from APMs.

4.20.5 STATE reserves the right to modify requirements of this section in the case of a Public Health Emergency.

4.21 Liability for Payment

4.21.1 MCO, its Subcontractors or Network Providers shall not hold its Enrollees liable for any of the following:

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(A) MCO's debts in the event of its insolvency.

(B) Covered services provided to the Enrollee, for which:

(1) STATE does not pay MCO; or

(2) STATE, or MCO, does not pay the individual or health care Provider that furnished the services under a contractual, referral, or other arrangement.

(C) Payments for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if MCO covered the services directly.

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ARTICLE 5: ADDITIONAL TERMS AND CONDITIONS

5.1 Applicable Law and Venue

This Contract is governed by and construed according to the laws of the State of North Dakota. Any action to enforce this Contract must be adjudicated exclusively in the State District Court of Burleigh County, North Dakota. Each party consents to the exclusive jurisdiction of such court and waives any claim of lack of jurisdiction or *forum non conveniens*.

5.2 Authority to Contract

MCO may not contract for or on behalf of or incur obligations on behalf of STATE.

5.3 Assignment

MCO may not assign this Contract without STATE's express written consent, provided, however, that MCO may assign its rights and obligations hereunder in the event of a change of control or sale of all or substantially all of its assets related to this Contract, whether by merger, reorganization, operation of law, or otherwise. Should the assignee be a business or entity with whom STATE is prohibited from conducting business, STATE shall have the right to terminate without cause. This Contract is equally binding on the respective parties and their successors and assigns.

5.4 MCO's Understanding of Term of Funding

MCO understands that this Contract is a one-time contract and acknowledges that it has received no assurances that this Contract may be extended beyond its expiration date.

5.5 Term of the Contract

5.5.1 Contract Duration

This contract runs from January 1, 2022 through December 31, 2025.

5.5.2 Extension Option

STATE reserves the right to extend the contract period for an additional period of time, not to exceed twelve (12) months, beyond the normal expiration date of the contract, upon mutual written agreement by both parties.

5.5.3 Renewal Option

STATE may renew this contract upon availability of additional funding and satisfactory completion of the initial contract term. STATE reserves the right to execute up to two (2) options to renew this contract annually under the same terms and conditions for a period of twelve (12) months each subject to re-negotiation of the payment methodology. This contract will not automatically

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renew. STATE will provide written notice of its intent to renew this contract at least fifteen (15) calendar days before the scheduled contract expiration date.

5.5.4 Notice of Non-Renewal or Intent to Terminate

(A) MCO shall provide STATE with at least one hundred fifty (150) calendar days' written notice prior to the end of the contract term if MCO chooses not to renew or extend this contract at the end of the contract term. If MCO provides STATE with such notice, the contract will end on the termination date.

(B) If MCO provides STATE written notice prior to the end of the contract term but less than one hundred fifty (150) calendar days prior to, the contract will end at 11:59:59 p.m. on the last day of the month which falls one hundred fifty (150) calendar days from the date the notice is given, unless the parties agree in writing to a different date.

5.6 Integration, Modification, and Conflict in Documents

5.6.1 This Contract, including the following documents, constitutes the entire Contract between MCO and STATE. Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Contract, the documents must control in this order of precedence:

(A) The terms of this Contract as may be amended;

(B) State's Solicitation Amendment #6 to RFP number 325-20-415-050, dated December 17, 2020;

(C) State's Solicitation Amendment #5 to RFP number 325-20-415-050, dated May 21, 2021;

(D) State's Solicitation Amendment #4 to RFP number 325-20-415-050, dated December 11, 2020;

(E) State's Solicitation Amendment #3 to RFP number 325-20-415-050, dated December 4, 2020;

(F) State's Solicitation Amendment #2 to RFP number 325-20-415-050, dated November 25, 2020;

(G) State's Solicitation Amendment #1 to RFP number 325-20-415-050, dated October 28, 2020;

(H) State's RFP number 325-20-415-050, dated October 20, 2020;

(I) MCO's second Best and Final Offer, dated May 6, 2021, in response to RFP number 325-20-415-050;

(J) MCO's first Best and Final Offer, dated April 28, 2021, in response to RFP number 325-20-415-050;

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(K) MCO's proposal, dated December 23, 2020, in response to RFP number 325-20-415-050.

5.6.2 All terms and conditions contained in any end user agreements (e.g., automated click-throughs, shrink wrap, or browse wrap) are specifically excluded and null and void, and shall not alter the terms of this Contract.

5.6.3 If any inconsistency exists between this Contract and other provisions of collateral contractual agreements, which are made a part of this Contract by reference or otherwise, the provisions of this Contract control.

5.7 Contract Amendment

5.7.1 No modification of, or change in, this Contract, or waiver of any of its provisions, or additional contractual relationship with MCO shall be valid unless approved in the form of a written amendment to this Contract, signed by the authorized representatives of MCO and STATE.

5.7.2 Formal contract amendments will be negotiated by STATE with MCO whenever necessary to address changes to the terms and conditions, the costs of, or the scope of work included under this Contract. An approved contract amendment means one approved by STATE, MCO, and all other applicable State and Federal agencies prior to the effective date of such change.

5.7.3 MCO agrees to provide a signed amendment no later than thirty (30) calendar days after being provided the final amendment by STATE. Failure to return a signed amendment within thirty (30) calendar days to STATE may result in, but not be limited to, the imposition of Liquidated Damages in accordance with Article 5.9.5, a hold on the approval of member materials or suspension of enrollment of members, to be in place until the return of an executed copy of the amendment.

5.7.4 STATE and MCO shall use contract amendments to reduce or increase Capitation Payments caused either through changes in the scope of benefits as a result of changes in Federal or State law or regulations or any other reason, scope of benefits otherwise covered by STATE, the beneficiaries covered by this Contract, and/or extension of the term of this Contract. Annual adjustments in Capitation Payments shall be made in conformance with actuarial soundness provisions found in 42 C.F.R. 438.4for actuarial soundness, for any applicable period of time.

5.8 Notice

5.8.1 Any notice or other communication required under this Contract must be given by registered or certified mail and is complete on the date mailed when addressed to the parties at the following addresses:

MCO NAME		ND Department of Human Services
	OR	Medical Services Division
		600 E. Boulevard Avenue
		Bismarck, ND 58501

5.8.2 In the event that the above contact information changes, the party changing the contact information shall notify the other party, in writing, of such change.

5.8.3 Notice provided under this provision does not meet the notice requirements for monetary claims

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against State found at North Dakota Century Code §32-12.2-04.

5.9 Contract Violations and Non-Compliance

5.9.1 General Requirements

(A) MCO shall comply with all requirements and performance standards set forth in this Contract.

(B) MCO agrees that failure to comply with all provisions of this Contract may result in the assessment of administrative actions, a corrective action plan, intermediate sanctions, and/or termination of this Contract, in whole or in part, in accordance with Article 5.10.

(C) STATE shall be responsible for imposing sanctions for Contract violations or other non-compliance and requiring corrective actions for a violation of or any other non-compliance with this Contract and its Exhibits.

(D) STATE may make publicly available notices of deficiency(ies) and/or sanctions imposed on MCO for non-compliance with the terms of this Contract.

5.9.2 Administrative Actions

Administrative actions exclude monetary penalties, corrective action plans, intermediate sanctions, and Contract termination and include, but are not limited to:

(A) A warning through written notice or consultation;

(B) Education requirement regarding program policies and procedures;

(C) Review of MCO's business processes;

(D) Referral to the North Dakota Insurance Department for investigation;

(E) Referral for review by appropriate professional organizations;

(F) Referral to the North Dakota Office of the Attorney General, Medicaid Fraud Control Unit for Fraud investigation; and/or

(G) Exclusion from Automatic Assignment – STATE may exclude MCO from any or all components of the automatic assignment process described in Article 2.4.2 for the duration of the noncompliance. During this period of exclusion, Enrollees shall be automatically assigned under the terms of Article 2.4.2 as if the excluded MCO were not a participant in the assignment process. Upon determining that the noncompliance has been satisfactorily cured and the thirty (30) calendar day minimum exclusion period has lapsed, STATE shall return MCO to the automatic assignment process but shall not take any action to return MCO to the position it would have been in had it not been excluded.

5.9.3 Corrective Action Plans

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(A) If STATE determines that MCO is not in compliance with one or more requirements in this Contract, STATE may issue a notice of deficiency identifying the deficiency or deficiencies and any follow-up recommendations or requirements in the form of a corrective action plan.

(B) MCO shall be required to provide CAPs to STATE within ten (10) business days of receipt of a non-compliance notice from STATE.

(C) CAPs are subject to review and approval by STATE. If STATE disapproves the CAP, MCO shall submit a new CAP within ten (10) business days, or an expedited timeframe if required by STATE, that addresses the concerns identified by STATE. MCO shall accept and implement a STATE-defined CAP if required by STATE.

(D) STATE may impose a monetary sanction of $200 per day on MCO for each day MCO does not implement, to the satisfaction of STATE, the approved CAP.

5.9.4 Intermediate Sanctions

(A) STATE may impose any or all of the sanctions described in this Article upon STATE's reasonable determination that MCO failed to comply with any CAP described under Article 5.9.3 of this Contract, or is otherwise deficient in performance of its obligations under the Contract, which shall include, but not be limited to the following:

(1) Fails substantially to provide Medically Necessary Services that MCO is required to provide, under law or under the Contract, to an Enrollee covered under the Contract;

(2) Imposes on Enrollees Premiums or charges that are in excess of the Premiums or charges permitted under the North Dakota Medicaid Managed Care Program;

(3) Acts to discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment, refusal to reenroll an Enrollee, except as permitted in Article 2.4.5, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;

(4) Misrepresents or falsifies information that it furnishes to CMS or to STATE;

(5) Misrepresents or falsifies information that it furnishes to an Enrollee, Potential Enrollee, or a health care Provider;

(6) Fails to comply with the requirements for Physician Incentive Plans, as set forth in 42 C.F.R. §438.3(i), §422.208, and §422.210;

(7) Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by STATE or that contain false or materially misleading information; or

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(8) Violates any of the other applicable requirements of 42 U.S.C. §1396b(m), §1396d(t)(3), or §1396u-2 and any implementing regulations.

(B) STATE also may impose sanctions against MCO if it finds any of the following non-exclusive actions/occurrences:

(1) MCO has failed to correct deficiencies in its delivery of service after having received written notice of these deficiencies from STATE;

(2) MCO or any of its owners, officers, or directors has been convicted of a criminal offense relating to performance of the Contract with STATE or of fraudulent billing practices or of negligent practice resulting in death or injury to MCO's Enrollee;

(3) MCO has failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments;

(4) MCO has failed to keep or make available for inspection, audit, or copying, such records regarding payments claimed for providing services;

(5) MCO has failed to furnish any information requested by STATE regarding payments for providing goods or services; or

(6) MCO has furnished goods or services to an Enrollee which at the sole discretion of STATE, and based on competent medical judgment and evaluation are determined to be 1) insufficient for his or her needs, 2) harmful to the Enrollee, or 3) of grossly inferior quality.

(C) STATE shall only impose those sanctions it determines to be appropriate for the deficiencies identified. However, STATE may impose intermediate sanctions on MCO simultaneously with the development and implementation of a CAP if the deficiencies are severe and/or numerous. STATE may utilize intermediate sanctions as described in 42 C.F.R. §438.700 that may include the following:

(1) Civil monetary penalties in the following specified amounts:

(a) A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to Enrollees, Potential Enrollees, or health care Providers; failure to comply with Physician Incentive Plan requirements; or Marketing violations.

(b) A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or STATE.

(c) A maximum of $15,000 for each recipient STATE determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

(d) A maximum of $25,000 or double the amount of the excess charges

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(whichever is greater) for charging co-payments in excess of the amounts permitted under the Medicaid program. STATE will deduct from the penalty the amount of overcharge and return it to the affected Enrollee(s).

(2) Appointment of temporary management for MCO when MCO repeatedly fails to meet substantive requirements in Sections 1903(m) or 1932 of the Act or 42 C.F.R. §438. Imposition of temporary management shall not be delayed to provide a hearing, and temporary management shall not be terminated until STATE determines that MCO can ensure the sanctioned behavior will not occur. STATE may only impose temporary management when STATE finds, through onsite surveys, Enrollee or other complaints, financial status, or any other source that:

(a) There is continued egregious behavior by MCO;

(b) There is substantial risk to Enrollees' health; or

(c) The sanction is necessary to ensure the health of MCO's Enrollees while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of MCO.

(3) Granting Enrollees the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll.

(4) Suspension of all new enrollments, including auto-assigned enrollment, after the effective date of the sanction.

(5) Disenrollment of members

(6) Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or STATE is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

(7) Liquidated Damages as described in Article 5.9.5.

(8) Additional sanctions allowed under state statute or regulation that address areas of noncompliance.

(D) STATE will give MCO timely written notice before imposing any intermediate sanction (other than required temporary management) that that specifies the basis and nature of the sanction and explains any appeal rights STATE elects to provide.

5.9.5 Liquidated Damages

(A) General Provisions

(1) MCO agrees that:

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(a) If MCO does not provide or perform the requirements referred to or listed in this provision, damage to STATE may result.

(b) Estimating such damages is impracticable or extremely difficult and proving such damages shall be costly, difficult, and time-consuming.

(c) Should STATE choose to impose Liquidated Damages, MCO shall pay STATE those damages for not providing or performing the specified requirements; if damages are imposed, collection shall be from the date STATE placed MCO on notice or as may be specified in the written notice.

(d) Additional damages may occur in specified areas by prolonged periods in which MCO does not provide or perform requirements.

(e) The damage figures listed in this Article represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract.

(f) STATE may, at its discretion, withhold Capitation Payments in whole or in part, or offset with advanced notice Liquidated Damages from Capitation Payments owed to MCO.

(g) STATE shall have the right to deny payment or recover reimbursement for those services or deliverables which have not been performed and which, due to circumstances caused by MCO, cannot be performed or if performed would be of no value to STATE. Denial of the amount of payment shall be reasonably related to the amount of work or deliverable lost to STATE.

(B) Program Issues Subject to Immediate Imposition of Liquidated Damages

For MCO's failure to perform specific responsibilities or requirements enumerated in the chart below, STATE may impose Liquidated Damages immediately without the development or implementation of a CAP.

	Program Issue	Liquidated Damages Amount
1.	Failure to comply with time frames for distributing (or providing access to) Enrollee Handbooks, ID cards, Provider directories, and educational materials to Enrollees (or potential Enrollees) as required by Article 2.4.7 of this Contract	$1,000 per violation
2.	Failure to obtain STATE review and approval of Enrollee materials prior to distribution as required by Article 2.6.6 of this Contract	$5,000 per violation
3.	Failure to acknowledge or act timely upon a request for prior authorization in accordance with Article 2.11.3 this Contract	$1,000 per occurrence
4.	Failure to meet prompt payment requirements as described in Article 2.8.12 of this Contract	$15,000 per violation
5.	Failure to submit audited HEDIS and CAHPS results annually as described in Article 2.14 of this Contract	$10,000 per violation
6.	Submission of a late, incorrect, or incomplete report or deliverable (excludes encounter data and other financial reports) as described in	$500 per day of violation

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	Article 2.15.8 and Appendix D: MCO Compliance, Operations, and Quality Reporting	
7.	Failure to obtain and/or maintain national accreditation as described in Article 2.13.3 this Contract	$500 per day for every day beyond the day accreditation status must be in place as described in this Contract
8.	Failure to disclose or comply with conflict of interest requirements as described in Article 2.1.2, Article 5.2.1 and Article 5.16 of this Contract	$500 per occurrence
9.	Failure to terminate Providers who become ineligible for Medicaid participation as required by Article 2.8.1(J) of this Contract	$500 per occurrence, in addition to $250 per day until the Provider is terminated
10.	Failure to respond to STATE redaction requests within the time frames required in Article 2.3.8 of this Contract	$500 per violation
11.	Failure to submit and obtain STATE review and approval for applicable Material Subcontracts as required by Article 2.3.9(B) of this Contract	$15,000 per violation
12.	Failure to review and update Provider directories within the timeframes specified by Article 2.3.6(B) of this Contract	$1,000 per violation
13	Failure to sign Contract amendment within 30 days as required by Article 5.7 of this Contract.	$1,000 per day per violation

(C) Program Issues Requiring the Development and Implementation of a CAP

For MCO's failure to perform specific responsibilities or requirements enumerated in the chart below, STATE may impose Liquidated Damages simultaneously with the development and implementation of a CAP.

	Program Issue	Liquidated Damages Amount
1.	Failure to comply with Grievances and Appeals processes as described in Article 2.12 of this Contract	$10,000 per violation
2.	Discriminating among Enrollees on the basis of their health status or need for health care services as prohibited by Article 2.4.1 of this Contract	$50,000 per violation
3.	Imposing arbitrary utilization management criteria, quantitative coverage limits, or prior authorization requirements prohibited by Article 2.11 of this Contract	$25,000 per violation
4.	Failure to comply in any way with financial reporting requirements (including timeliness, accuracy, and completeness) as described in Article 2.15.8 and Article 4 of this Contract	$15,000 per violation
5.	Failure to comply in any way with Encounter data submission requirements as described in Article 2.15.9 of this Contract (excluding the failure to address or resolve problems with individual Encounter records in a timely manner as required by STATE)	$25,000 per occurrence
6.	Failure to cost avoid claims of known Third Party Liability (TPL) as required by Article 4.14 of this Contract	$250 per member per claim and total claim amount paid that should have been cost avoided
7.	Failure to maintain the privacy and/or security of data containing protected health information (PII), as required by Article 2.5.3 of this	$50,000 per violation

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	Contract, which results in a breach of the security of such information and/or timely report violations in the access, use, and disclosure of PII	
8.	Continuing failure to comply with the Mental Health Parity and Addiction Equity Act if 2008, 42 C.F.R. part 438, subpart K, which prohibits discrimination in the delivery of mental health and substance use disorder services and in the treatment of members with, at risk for, or recovering from a mental health or substance use disorder, as required by Article 2.7.2 of this Contract	$25,000 per violation for continuing failure
9.	Failure to meet readiness review timeframes or address readiness deficiencies in a timely manner as required under Article 2.2 of this Contract	$5,000 per violation (STATE reserves the right to suspend enrollment of individuals into MCO until deficiencies in MCO's readiness activities are rectified).

5.9.6 Notice of Sanctions

(A) Except as noted in 42 C.F.R. Part 438, Subpart I (Sanctions), before imposing any of the sanctions specified in this Article, STATE shall provide written notice to MCO that explains the basis and nature of the sanction, cites the specific Contract article(s) and/or provision of law and the methodology for calculation of any fine, and the process to dispute sanctions. (42 C.F.R. §438.710(a)(1))

(B) Unless STATE specifies the duration of a sanction, a sanction shall remain in effect until STATE is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

5.9.7 Dispute of Sanctions

(A) To dispute a sanction, MCO must request that STATE's Medicaid Director or designee hear and decide the dispute.

(B) MCO must submit a written dispute of the sanction directly to the Medicaid Director or designee by U.S. mail and/or commercial courier service (hand delivery shall not be accepted); this submission must be received by STATE within twenty-one (21) calendar days after the issuance of a sanction and shall include all arguments, materials, data, and information necessary to resolve the dispute (including all evidence, documentation, and exhibits). An MCO submitting such written requests for Appeal or dispute, as allowed under this Contract by U.S. mail and/or commercial courier service, shall submit such Appeal or dispute to the Medicaid Director at 600 East Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250.

(C) Regardless of whether delivered by U.S. mail or commercial courier service, Appeals or disputes not delivered to the address above will be denied.

(D) MCO waives any dispute not raised within twenty-one (21) days of receiving the sanction. It also waives any arguments it fails to raise in writing within twenty-one (21) days of receiving the sanction, and waives the right to use any materials, data, and/or information not contained in or accompanying MCO's submission submitted within the

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twenty-one (21) days following its receipt of the sanction in any subsequent legal, equitable, or administrative proceeding (to include circuit court, federal court, and any possible administrative venue).

(E) The Medicaid Director or his/her designee shall decide the dispute under the reasonableness standard, reduce the decision to writing, and serve a copy to MCO. This written decision shall be final.

5.10 Termination

5.10.1 Termination for Cause

If STATE determines that MCO has failed to carry out the substantive terms of this Contract or meet the applicable requirements of Sections 1932, 1903(m), or 1905(t) of the Social Security Act, STATE may terminate this Contract and place Enrollees into a different MCO or provide Medicaid benefits through other state plan authority. [42 C.F.R. 438.106(a); 42 C.F.R. 438.708(b); sections 1903(m); 1905(t); 1932 of the Act]

5.10.2 Termination for Convenience

(A) STATE may terminate this Contract for convenience and without cause upon sixty (60) calendar days' written notice. STATE shall not be responsible to MCO or any other party for any costs, expenses, or damages occasioned by said termination, i.e., this termination is without penalty.

(B) MCO may terminate this Contract without cause by giving STATE written notice of termination at least one hundred fifty (150) calendar days prior to the termination date. Upon MCO providing notice of termination, the contract will end at 11:59:59 p.m. on the last day of the month which falls one hundred fifty (150) calendar days from the date the notice is give, unless the parties agree in writing to a different date.

5.10.3 Termination for MCO Insolvency, Bankruptcy, or Instability of Funds

(A) MCO's insolvency or the filing of a petition in bankruptcy by or against MCO shall constitute grounds for termination for cause. If STATE determines MCO has become financially unstable, STATE shall immediately terminate this Contract upon written notice to MCO effective the close of business on the date specified.

(B) MCO shall cover continuation of services to Enrollees for the duration of any period for which payment has been made, as well as for inpatient admissions up until discharge.

5.10.4 Termination for Unavailability of Funds

(A) In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated Contract expiration date, STATE may terminate the Contract without penalty. This notification shall be made in writing. Availability of funds shall be determined solely by STATE.

(B) MCO has the duty to fully cooperate with STATE and provide any and all requested

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information, documentation, etc. at its earliest convenience to STATE when requested. This applies even if a contract is terminated and/or a lawsuit is filed. Specifically, MCO does not have the right to limit or impede STATE's right to audit or to withhold STATE-owned documents.

5.10.5 Early Termination in the Public Interest

STATE is entering into this Contract for the purpose of carrying out the public policy of the state of North Dakota, as determined by its Governor, Legislative Assembly, and Courts. If this Contract ceases to further the public policy of the state of North Dakota, STATE, in its sole discretion, by written notice to MCO, may terminate this Contract in whole or in part.

5.10.6 CMS Direction to Terminate

In the even that CMS directs STATE to terminate this Contract, STATE shall not be permitted to renew this Contract without CMS consent.

5.10.7 Notice of Termination and Pre-Termination Hearing

(A) In accordance with 42 C.F.R. §438.710, before terminating this Contract for cause, STATE must provide to MCO a pre-termination hearing. STATE shall:

(1) Give advance written notice of intent to terminate, which includes the reason for termination and the time and place of the hearing;

(2) After the hearing, give MCO written notice of the decision affirming or reversing the proposed termination of this Contract and, for an affirming decision, the effective date of termination; and

(3) For an affirming decision, give Enrollees notice termination and provide information consistent with 42 C.F.R. §438.710 on their options for receiving Medicaid services following the effective date of termination, which may include disenrolling from MCO immediately and without cause.

5.10.8 Contract Termination Procedures

(A) Both parties shall cooperate in notifying all MCO Enrollees covered under this Contract, in writing, of the date of termination and the process by which those Enrollees will continue to receive medical care, at least sixty (60) calendar days in advance of the effective date of termination, or immediately as determined by STATE, if termination is for a material breach (such as fraudulent action by MCO, criminal action by MCO, etc.).

(B) Written notices shall be sent by the parties via U.S. Postal Service certified mail, return receipt requested. The required notice periods shall be measured from the date the receipt is signed.

(C) Termination under this contract shall be effective on the last day of the calendar month in which the notice becomes effective. Payment shall continue and services shall continue to be provided during that calendar month.

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5.11 Turnover Requirements

5.11.1 General Turnover Requirements

In the event of Contract termination initiated by STATE or MCO, expiration, or non-renewal, MCO shall:

(1) Comply with all terms and conditions stipulated in the Contract, including continuation of Covered Services under the Contract until midnight of the last day of the calendar month in which the termination becomes effective.

(2) Pay claims for Covered Services submitted for Enrollees, including those who are entitled to retroactive coverage, even if the timely claim filing is beyond the Contract termination date.

(3) Be responsible for the entire hospital stay (including physician and other ancillary charges) if an Enrollee is an inpatient in a hospital setting on the Contract termination date, until discharge or thirty days following termination, whichever comes first.

(B) Assist in the transfer of medical records of enrollees from participating providers to other providers, upon request and at no cost to the enrollee;

(C) Promptly return to STATE any funds advanced to MCO for coverage of Enrollees for periods after the termination of coverage;

(D) Promptly supply all information necessary for the reimbursement of any outstanding claims;

(E) Comply with direction provided by STATE to assist in the orderly transition of equipment, services, software, leases, etc. to STATE or a third party designated by STATE;

(F) Provide all reasonably necessary assistance to STATE in transitioning Enrollees out of MCO's plan upon expiration of the Contract or to the extent specified in the notice of termination. Such assistance shall include the forwarding of medical and other records; facilitation and scheduling of Medically Necessary appointments for care and services; and identification of Enrollees with Special Health Care Needs, including those that are chronically ill, high risk, hospitalized, or pregnant; and

(G) Identify and maintain sufficient key personnel and support staff based in North Dakota to support all required Contract functions. MCO's transition team shall assist with Enrollee transitions to a new MCO and ensure the sharing of documentation such as active Prior Authorizations, current assessments and care plans, and other necessary information to support continuity of care, particularly for Enrollees with Special Health Care Needs.

5.11.2 Turnover Plan

(A) Upon written notification of termination of the Contract by either party, MCO shall submit a Turnover Plan within thirty (30) calendar days from the date of notification,

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unless other appropriate timeframes have been mutually agreed upon by both MCO and STATE. If the Contract is not terminated by written notification, MCO shall propose a Turnover Plan six (6) months prior to the end of the Contract period, including any extensions to such period. The Turnover Plan shall:

(1) Be approved by STATE;

(2) Detail the proposed schedule, activities, and resource requirements associated with the turnover tasks;

(3) Address the turnover of records and information maintained by MCO to either STATE or a third party designated by STATE;

(4) Describe MCO's approach for the transfer of all records, data, and operational support information, as applicable, to either STATE or a third party designated by STATE; and

(5) Include copies of all relevant Enrollee and Covered Services data, documentation, or other pertinent information necessary, as determined by STATE, for STATE or a subsequent MCO to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation.

5.11.3 Transfer of Data

(A) MCO shall transfer all data regarding the provision of Enrollee Covered Services to STATE or a third party, at the sole discretion of STATE and as directed by STATE. All transferred data must be transferred in compliance with HIPAA.

(B) All required transfers of data and information specified in this Contract shall be made electronically, unless otherwise directed by STATE, and according to the format and schedule approved by STATE.

(C) All relevant data shall be received and verified by STATE or the subsequent MCO. If STATE determines that not all of the data regarding the provision of Covered Services to Enrollees was transferred to STATE or the subsequent MCO, as required, or the data was not transferred in a HIPAA compliant manner, STATE reserves the right to hire an independent contractor to assist STATE in obtaining and transferring all the required data and to ensure that all the data was transferred in a HIPAA compliant manner. Payment of the reasonable costs incurred for providing these services shall be the responsibility of MCO.

5.11.4 Post-Turnover Services

(A) Thirty (30) calendar days following turnover of operations, MCO shall provide STATE with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover shall not be considered complete until this document has been approved by STATE.

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(B) If MCO does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for STATE or the subsequent MCO to assume the operational activities successfully, MCO agrees to reimburse STATE for all reasonable costs, including, but not limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction, and transfer functions at the location(s) of such records.

(C) MCO shall also pay any and all additional costs incurred by STATE that are the result of MCO's failure to provide the requested records, data, or documentation within the time frames agreed to in the Turnover Plan.

(D) MCO shall maintain all files and records related to Enrollees and Providers for ten (10) years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review, or audit pertaining to the Contract, whichever is longer. Under no circumstances shall MCO or any of its Material Subcontractors destroy or dispose of any such records, even after the expiration of the mandatory ten (10) year retention period, without the express prior written permission of STATE.

(E) MCO agrees to repay any valid, undisputed audit exceptions taken by STATE in any audit of the Contract.

5.11.5 Withholding in Last Month of Payment

In the event of Contract termination or non-renewal, for the last month of the Contract, STATE shall withhold seventy-five percent (75%) of the final payment to MCO for a maximum of ninety (90) calendar days from the due date of such amount to ensure that MCO fulfills its contractual obligations.

5.12 Work Product, Equipment, and Materials

All work product, equipment, and materials created for STATE or purchased by STATE under this Contract belong to STATE and must be delivered to STATE at STATE's request upon expiration or termination of this Contract. MCO acknowledges that all work(s) under this Contract are "works for hire" within the meaning of the United States Copyright Act (Title 17 United States Code) and assigns to STATE all rights and interests MCO may have in the work(s) it prepares under this Contract, including any right to derivative use of the work(s). All software and related materials developed by MCO in performance of this Contract for STATE shall be the sole property of STATE, and MCO hereby assigns and transfers all its right, title, and interest therein to STATE. MCO shall execute all necessary documents to enable STATE to protect STATE's intellectual property rights under this section.

5.13 Confidential Information

MCO shall not use or disclose any information it receives from STATE under this Contract that STATE has previously identified as confidential or exempt from mandatory public disclosure

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except as necessary to carry out the purposes of this Contract or as authorized in advance by STATE. STATE shall not disclose any information it receives from MCO, that MCO has previously identified as confidential, and that STATE determines, in its sole discretion, is protected from mandatory public disclosure under a specific exception to the North Dakota open records law found in North Dakota Century Code chapter 44-04. The duty of STATE and MCO to maintain confidentiality of information under this section continues beyond the term of this Contract, including any extensions or renewals.

5.14 Compliance with Public Records Laws

MCO understands that, in accordance with this Contract's Confidential Information section, STATE must disclose to the public upon request any records it receives from MCO. MCO further understands that any records obtained or generated by MCO under this Contract, except for records that are confidential under this Contract, may, under certain circumstances, be open to the public upon request under certain circumstances under the North Dakota open records law. MCO agrees to contact STATE immediately upon receiving a request for information under the open records law and to comply with STATE's instructions on how to respond to the request.

5.15 Prohibited Affiliations

5.15.1 In accordance with 42 C.F.R. §438.610, MCO and its Subcontractors are prohibited from knowingly having a relationship with:

(A) An individual or entity that is (or is affiliated with a person/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 No. 12549; or

(B) An individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

5.15.2 MCO shall not have a contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly, with:

(A) An individual convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act;

(B) Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

(C) Any individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act.

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Nothing in this section shall prevent MCO from contracting with a peer support specialist who has been credentialed by STATE to provide 1915(i) services to Enrollees.

5.15.3 MCO is prohibited from employing or contracting, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services with:

(A) Any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549;

(B) Any individual or entity that is excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a;

(C) Any individual or entity that would (or is affiliated with a person/entity that would) provide those services through an individual or entity debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

(D) Any individual or entity that would provide those services through an individual or entity excluded from participation in any Federal health care program under 42 U.S.C. §1320a-7 and §1320a-7a.

5.15.4 MCO is prohibited from being controlled by a sanctioned individual under Section 1128(b)(8) of the Act.

5.15.5 If STATE finds MCO is not in compliance with 42 C.F.R. §438.610(a) and (b), STATE:

(A) Shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) of the noncompliance;

(B) May continue an existing agreement with MCO unless the Secretary of HHS directs otherwise; and

(C) May not renew or otherwise extend the duration of an existing agreement with MCO unless the Secretary of HHS provides to STATE and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

5.15.6 Nothing in this Article shall be construed to limit or otherwise affect any remedies available to the U.S. under 42 U.S.C. §1320a-7, §1320a-7a, and §1320a-7b.

5.15.7 MCO and its Subcontractors shall comply with all applicable provisions of 42 C.F.R. §438.608 and §438.610 pertaining to debarment and/or suspension including written disclosure to STATE of any prohibited affiliation. MCO and its Subcontractors shall screen all employees, contractors, and Network Providers to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, MCO shall conduct screenings to comply with the

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requirements set forth at 42 C.F.R. §455.436.

5.15.8 MCO and its Subcontractors shall conduct a search of Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), The System of Award Management (SAM), and other applicable sites as may be determined by STATE, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to STATE within three (3) business days. Any individual or entity that employs or contracts with an Excluded Provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the Excluded Provider or individual. This is a prohibited affiliation. This prohibition applies even when the Medicaid payment itself is made to another Provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 C.F.R. §1003.102(a)(2)]

5.15.9 An individual who is an affiliate of a prohibited person or entity described above can include:

(A) A director, officer, or partner of MCO;

(B) A Subcontractor of MCO;

(C) A person with an employment, consulting, or other arrangement with MCO for the provision of items and services which are significant and material to MCO's obligations under this Contract; or

(D) A Network Provider.

5.15.10 MCO shall notify STATE in writing within three (3) calendar days of the time it receives notice that action is being taken against MCO or any person defined above or under the provisions of 42 U.S.C. §1320a-7(a) or (b) or any contractor which could result in exclusion, debarment, or suspension of MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549 of February 18, 1986, which states that debarment or suspension of a participant in a program by one agency shall have government-wide effect.

5.15.11 MCO, through its Contract Compliance Officer, shall attest monthly to STATE that it has screened all employees and Subcontractors as specified in the Debarment/Suspension/Exclusion article to capture all exclusions.

5.16 Disclosure of Ownership and Control Information

5.16.1 Disclosure Information

Using State's Managed Care Entity Disclosure Form, and in accordance with 42 C.F.R. § 455.104, MCO shall submit to STATE the following information:

(A) The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.

(B) The date of birth and Social Security Number (SSN) of any individual with an ownership or

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control interest in MCO and its subcontractors.

(C) Other tax identification number of any corporation with an ownership or control interest in MCO and any subcontractor in which MCO has a five percent (5%) or more interest.

(D) Information on whether an individual or corporation with an ownership or control interest in the MCP is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling.

(E) Information on whether a person or corporation with an ownership or control interest in any Subcontractor in which the MCP has a five percent (5%) or more interest is related to another person with ownership or control interest in the MCO as a spouse, parent, child, or sibling.

(F) The name of any other disclosing entity in which an owner of MCO has an ownership or control interest.

(G) The name, address, date of birth, and SSN of any managing employee of MCO.

5.16.2 Reporting Timeframes

MCO shall electronically submit STATE's Ownership/Controlling Interest and Conviction Information form, identified as SFN 1168, at the following times:

(A) Upon MCO submitting a proposal in accordance with STATE's procurement process.

(B) Upon MCO executing this Contract with STATE.

(C) Upon renewal or extension of this Contract.

(D) Within 35 calendar days after any change in persons with ownership or control interest

(E) Within 35 calendar days after any change in Managing Employees.

5.16.3 STATE Review of Disclosures

STATE shall review the ownership and control disclosures submitted by MCO and any of its Subcontractors.

5.16.4 Consequences for Failure to Provide Disclosures

FFP is not available in payments made to MCO if MCO or its Subcontractors performing administrative functions fail to disclose Ownership or Control Interest information as required in this Article. Without FFP, no payments will be made to MCO or its Subcontractors.

5.17 Transactions Reportable to STATE

5.17.1 MCO shall, pursuant to Section 1903(m)(4)(B) of the Social Security Act (42 U.S.C. §1396b(m)(4)(B)), report transactions between MCO and STATE, parties of interest, or other

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agencies and make that information available to MCO Enrollees, upon reasonable request.

5.17.2 MCO shall, pursuant to Section 1903(m)(4)(A) of the Social Security Act (42 U.S.C. §1396b(m)(4)(A)), report to STATE, and, upon request, to the Secretary of the DHHS, the Inspector General of DHHS, and the Comptroller General a description of transactions between MCO and a party in interest (as defined in section 1318(b) of United States Code Chapter 42), including the following transactions:

(A) Any sale or exchange, or leasing of any property, between MCO and such a party;

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

(C) Any lending of money or other extension of credit between MCO and such a party.

5.18 False Claims Act

5.18.1 False Claims Act, Generally

(A) In accordance with 42 C.F.R. §438.608(a)(6), if MCO receives or makes annual payments of at least five million dollars ($5,000,000.00) from STATE, MCO shall have written policies and procedures for all of its Employees, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in Section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

(B) For purposes of this Article, the following definitions apply:

(1) Employee: includes any officer or employee of MCO.

(2) Agent or Contractor: includes any contractor, Subcontractor, agent, or other person which, or who, on behalf of MCO, furnishes or otherwise authorizes the furnishing of Medicaid Covered Services, performs billing or coding functions, or is involved in monitoring of health care provided by or on behalf of MCO.

5.18.2 Information Required in False Claims Act Policies

(A) MCO's written policies shall provide detailed information about the False Claims Act, established under Sections 3729 through 3733 of Title 31 of the United States Code, administrative remedies for false Claims and statements established under Chapter 38 of Title 31 of the United States Code, any state laws pertaining to civil or criminal penalties for false Claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting Fraud, Waste, and Abuse in Federal Health Care Programs.

(B) MCO shall include as part of its written policies detailed provisions regarding MCO's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

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5.18.3 Dissemination of False Claims Act Policies and Procedures

(A) MCO shall have written procedures for disseminating its False Claims Act policies to its Employees, Agents, and Contractors.

(B) MCO shall require that its Network Providers comply with MCO's False Claims Act policies and procedures.

(C) MCO shall use all reasonable efforts, including Provider attestations, to ensure that its Network Providers are either disseminating MCO's or equivalent False Claims Act policies and procedures to the Network Providers' Employees and Agents.

5.19 Alternative Dispute Resolution – Jury Trial

STATE does not agree to binding arbitration, mediation, or any other form of mandatory alternative dispute resolution. The parties may enforce their rights and remedies in judicial proceedings. STATE does not waive any right to a jury trial.

5.20 Byrd Anti-Lobbying Amendment

5.20.1 As required by 31 U.S.C. §1352, MCO certifies that no federal appropriated funds have been paid or will be paid, by or on behalf of MCO, to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative contract, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract.

5.20.2 If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the federal contract, grant, loan, or cooperative contract, MCO shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

5.20.3 MCO shall require that the language of this certification be included in the award documents for all Subcontracts and that all Subcontractors shall certify and disclose accordingly.

5.21 Independent Entity

MCO shall perform as an independent entity under this Contract. MCO, its employees, agents, or representatives are not employees of STATE for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the Federal Unemployment Act, the North Dakota Unemployment Compensation Law, and the North Dakota Workforce Safety and Insurance Act. No part of this Contract may be construed to represent the creation of an employer/employee relationship between STATE and MCO. MCO will retain sole and absolute discretion in the manner and means of carrying out MCO's activities and responsibilities under this Contract, except to the extent specified in this Contract.

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5.22 Conflict of Interest

STATE and MCO shall maintain written standards of conduct governing the performance of its employees engaged in the award and administration of contracts and subcontracts. No employee, officer, or agent shall participate in the selection, award, or administration of a contract supported by federal funds if a real or apparent conflict of interest would be involved. Such a conflict would arise when the employee, officer, or agent, or any member of his or her immediate family, his or her partner, or an organization which employs or is about to employ any of the parties indicated herein, has a financial or other interest in the firm selected for an award. The officers, employees, and agents of STATE or MCO shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors, or parties to subcontracts. STATE and MCO may set minimum rules where the financial interest is not substantial, or the gift is an unsolicited item of nominal intrinsic value. To the extent permitted by state law or regulations, such standards of conduct will provide for penalties, sanctions, or other disciplinary actions for violations of such standards by officers, employees, or agents, or by subcontractors or their agents.

5.23 Delay or Default Force Majeure

Neither party shall be held responsible for delay or default caused by fire, flood, riot, terrorism, pandemics, acts of God, or war if the event is beyond the party's reasonable control, and the affected party gives notice to the other party immediately upon occurrence of the event that caused, or is reasonably expected to cause, the delay or default.

5.24 Insurance

5.24.1 MCO shall secure and keep in force during the term of this Contract and MCO shall require all subcontractors, prior to commencement of an agreement between MCO and the subcontractor, to secure and keep in force during the term of this Contract, from insurance companies, government self-insurance pools, or government self-retention funds, authorized to do business in North Dakota, the following insurance coverages:

(A) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of $1,000,000 per occurrence.

(B) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.

(C) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this Contract.

(D) Employer's liability or "stop gap" insurance of not less than $1,000,000 as an endorsement on the workers compensation or commercial general liability insurance.

(E) Professional errors and omissions with minimum limits of $1,000,000 per claim and in the

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aggregate, MCO shall continuously maintain such coverage during the contract period and for three years thereafter. In the event of a change or cancellation of coverage, MCO shall purchase an extended reporting period to meet the time periods required in this section.

5.24.2 The insurance coverages listed above must meet the following additional requirements:

(A) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of MCO.

(B) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State. The policies shall be in form and terms approved by the State.

(C) The duty to defend, indemnify, and hold harmless the State under this Contract shall not be limited by the insurance required in this Contract.

(D) The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy on a primary and noncontributory basis, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights, and coverages of an additional insured under these policies that shall not be limited to the minimum limits of insurance required by this Contract or by the contractual indemnity obligations of MCO.

(E) A "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State.

(F) MCO shall furnish a certificate of insurance to the undersigned State representative prior to commencement of this Contract. A renewal certificate will be provided 10 days prior to coverage expiration. An updated, current certificate of insurance shall be provided in the event of any change to a policy. All endorsements shall be provided as soon as practicable.

(G) MCO shall provide at least 30-day notice of any cancellation or material change to the policies or endorsements. MCO shall provide on an ongoing basis, current certificates of insurance during the term of the contract. A renewal certificate will be provided 10 days prior to coverage expiration.

(H) Failure to provide insurance as required in this Contract is a material breach of contract entitling State to terminate this Contract immediately.

5.25 Indemnity

MCO agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers, and employees (State), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct.

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This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors and omissions. The legal defense provided by MCO to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under North Dakota Century Code §54-12-08. MCO also agrees to defend, indemnify, and hold the State harmless for all costs, expenses, and attorneys' fees incurred if the State prevails in an action against MCO in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this Contract.

5.26 Severability

If any term of this Contract is declared by a court having jurisdiction to be illegal or unenforceable, the validity of the remaining terms will not be affected and, if possible, the rights and obligations of the parties are to be construed and enforced as if the Contract does not contain the illegal or unenforceable term.

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APPENDIX A: MATERIAL SUBCONTRACTOR CHECKLIST

Item Number	Checklist Item	Location in Subcontract
1	Signature page that contains an MCO and subcontractor name with titles that are typed or legibly written, Subcontractor company name, and dated signature of all appropriate parties (applicable for executed contracts).	
2	Effective dates of the subcontract agreement.	
3	Provision that the subcontract and its appendices contain all the terms and conditions agreed upon by both parties.	
4	Requirement that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	
5	Provision specifying the procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed, and attached to the original of the subcontract.	
6	Provision specifying that the MCO and Subcontractor recognize that in the event of termination of the contract between the MCO and STATE for any reasons described in the contract, the MCO shall immediately make available to STATE or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and Subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to STATE.	
7	Provision ensuring the Subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	
8	Requirement that if any requirement in the subcontract is determined by STATE to conflict with the contract between STATE and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	
9	Contain provisions specifically describing the activities, service, or responsibility delegated to the Subcontractor wherein the Subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations.	
10	Specify that the subcontract complies with 42 C.F.R. §438.230 and all applicable Medicaid laws and regulations, including any other applicable State or federal law, sub-regulatory guidance, and contract provision, that are appropriate to the service or activity delegated under the agreement.	

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Item Number	Checklist Item	Location in Subcontract
11	Provision that the MCO may revoke delegation, or impose other sanctions, if the Subcontractor's performance is inadequate.	
12	Requirement for the safeguarding of information about Enrollees according to 42 C.F.R. Part §438.224.	
13	Requirement that the Subcontractor make available, for the purposes of an audit, evaluation, or inspection by STATE, CMS, the DHHS Inspector General, the Comptroller General, or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid Enrollees.	
14	Requirement that the Subcontractor agrees that the right to audit by STATE, CMS, the DHHS Inspector General, the Comptroller General, or their designees, will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.	
15	Requirement that if STATE, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, STATE, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.	
16	Inclusion of an exculpatory clause, which survives subcontract termination, including breach of subcontract due to insolvency, which assures that Enrollees or STATE shall not be held liable for any debts of the Subcontractor.	
17	Clause indemnifying, defending, and holding STATE, its designees, and the MCO's Enrollees harmless from and against all claims, damages, causes of action, costs, or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the subcontract agreement. This clause must survive the termination of the subcontract, including breach due to insolvency.	
18	Requirement that if the Subcontractor delegates or subcontracts any functions of its contract with the MCO, that the subcontract or delegation shall include all the requirements of the Contract between the MCO and STATE, to the extent relevant to the duties performed by the Subcontractor.	
19	Requirement that the Subcontractor not have any financial, legal, contractual, or other business interest in any entity performing MCO enrollment functions for STATE, the Enrollment Broker, and Subcontractor(s), if any.	

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APPENDIX B: MCO COVERED SERVICES

MCO shall provide to each Enrollee each of the MCO Covered Services listed below, in an amount, duration, and scope that is Medically Necessary, consistent with the Alternative Benefit Plan approved by CMS. The general descriptions below of MCO Covered Services do not limit MCO's obligation to provide all Medically Necessary Services.

1915(i) services: Covers services allowed as part of STATE's Medicaid State Plan under 1915(i) for eligible Enrollees, including Care Coordination, training and supports for unpaid care givers, peer support, family peer support, respite, non-medical transportation, community transition services, benefits planning services, supported education, pre-vocational training, supported employment, and housing supports.

Allergy care: Covers testing and treatment, allergy injections, and allergy serum.

Ambulance and emergency transportation services: Covers ground and air ambulance trips, attendant, oxygen, and mileage when Medically Necessary to transport an Enrollee to the closest health care facility meeting his or her needs.

Amino acid-based elemental oral formula: Covers medical foods and low-protein modified food products determined by a physician to be Medically Necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

Chiropractic services: Covers X-rays and manual manipulation of the spine for certain diagnoses.

Diabetes supplies, equipment, and education: Covers equipment needed to monitor and manage diabetes; also provides limited coverage of education to support monitoring and managing of diabetes.

Diagnostic and treatment services: Covers medical and surgical services performed by a doctor; supplies and drugs given at the doctor's office.

Dialysis: laboratory; prescribed drugs; tubing change; adapter change; and training related to hemodialysis; intermittent peritoneal dialysis; continuous cycling peritoneal dialysis; continuous ambulatory peritoneal dialysis.

Durable medical equipment (DME): Covers medical supplies such as oxygen and catheters and reusable equipment that is primarily medical in nature.

Emergency Services: Covers screening and stabilization of Enrollee where a prudent layperson would believe an Emergency Medical Condition existed.

Emergency Medical Transportation: Covers transportation for an Emergency Medical Condition.

Family planning and contraceptive services: Covers diagnosis and treatment, drugs, supplies, devices, procedures, and counseling for persons of childbearing age.

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Foot care: Routine foot care limited to Enrollees with diabetes. Non-routine diagnostic testing and treatment of the foot due to illness or injury for all Enrollees.

Habilitation Services: Covers services that help Enrollees keep, learn, or improve skills and functioning for daily living.

Hearing services: Covers the evaluation and treatment of hearing. MCO is responsible for providing and dispensing hearing aids; ear molds; ear impressions; batteries; accessories; aid and instruction in the use, care, and maintenance of the hearing aid; and loan of a hearing aid to the Enrollee, when necessary.

Home health services: Covers nursing care, therapy, and medical supplies when provided in a recipient's home. Care must be ordered by a physician.

Hospice care: Provides health care and support services to terminally ill individuals and their families.

Implants/simulators: Covers implants and stimulators prescribed by an attending practitioner and/or Provider.

Infertility services: Covers testing related to diagnosis of infertility.

Inpatient Hospital Services: Covers room and board, regular nursing services, supplies, drugs and equipment, operating and delivery room, X-rays, lab, and therapy.

Lab, x-ray and other diagnostic tests: Covers x-rays and laboratory tests needed for diagnosis and treatment.

Maternity Care: Covers prenatal through postnatal care and delivery, including maternity screenings, breastfeeding support, ultrasounds, and inpatient stays of at least 48 hours for a vaginal delivery and at least ninety-six (96) hours for a cesarean delivery.

Mental health services: Covers psychiatric and psychological evaluations; inpatient services in a psychiatric unit of a hospital; individual, group and family psychotherapy; partial Hospitalization services; and medication management.

Non-emergency transportation: Transportation to a Covered Service where the Enrollee does not have access to free transportation.

Occupational Therapy: Covers the evaluation and treatment designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.

Orthotic and prosthetic devices: Covers orthotic devises and prosthetics to support or correct any defect of form or function of the human body, including coverage of the evaluation, fabrication, fitting, and the provision of a prosthesis.

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Outpatient hospital services: Covers outpatient hospital appointments and emergency room services and supplies, lab, X-ray, therapies, drugs and biologicals, and outpatient surgery.

Phenylketonuria (PKU): Covers testing, diagnosis and treatment of Phenylketonuria and inherited metabolic disease of amino acid or organic acid including dietary management, medical foods and low-protein modified food products determined by a physician to be Medically Necessary, formulas, Case Management, intake and screening, assessment, comprehensive care planning, and service referral.

Physical Therapy: Covers the evaluation, treatment, and restoration to normal or best possible functioning of neuromuscular, musculoskeletal, cardiovascular, and respiratory systems.

Physicians Services: Covers medical and surgical services performed by a doctor; supplies and drugs given at the doctor's office; and X-rays and laboratory tests needed for diagnosis and treatment.

Preventive care: Covers service to promote wellness, including well-visits, immunizations, and screenings as recommended by the United States Preventive Services Task Force.

Skilled nursing facility services: Covers up to thirty (30) consecutive days in a twelve (12) month period of room and board, nursing care, therapies, general medical supplies, wheelchairs, and Durable Medical Equipment.

Speech Therapy: Covers the evaluation and treatment of speech language, voice, hearing, and fluency disorders.

Substance use disorder services: Covers addiction management services for alcohol and drug dependency, and gambling issues; detoxification; medication management; outpatient therapy services; partial Hospitalization and intensive outpatient programs; for Enrollees aged nineteen (19) and twenty (20), also covers residential treatment facilities.

Tobacco cessation treatment: Covers face-to-face individual and group tobacco cessation counseling.

Vision services: Limited non-routine vision services for all Enrollees related to acute disease or injury to eye.

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APPENDIX C: NETWORK ACCESSIBILITY STANDARDS

General	Behavioral/Mental Health and/or Substance Use Disorder	High Volume and High Impact Specialty
Emergency Services – available twenty-four (24) hours a day, seven days a week Urgent Care – within twenty-four (24) hours Non-Urgent Sick Care – within seventy-two (72) hours, or sooner, if condition deteriorates into urgent or emergency condition Routine, Non-Urgent or Preventative Care Visits – within six weeks of Enrollee request	Emergency Services, Life Threatening – Immediate Emergency Services, Non- Life Threatening – Within 6 hours Urgent Care – within twenty-four (24) hours Initial Visits, Routine Care – within ten (10) working days Follow-Up Visits, Routine Care – within thirty (30) days	Consultation within one month of referral or as clinically indicated

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APPENDIX D: MCO COMPLIANCE, OPERATIONS, AND QUALITY REPORTING

MCO shall provide STATE with all reports described in this Contract including Article 2.15.8, and the table below. MCO shall also provide STATE with any ad hoc reports requested by STATE within thirty (30) days of STATE's request or a longer timeframe as agreed upon by STATE.

Report Title	Description
Administration and Contract Management	
Notification of Termination	Within five (5) business days, notice of MCO's termination of any Material Subcontractor, or notice by any Material Subcontractor of intention to terminate a contract
Staffing	Annually and upon request from STATE, a copy of the current organizational chart with reporting structures, names, and positions
Key Personnel Changes	As relevant, changes to MCO personnel in key positions
Enrollment	
Enrollment Discrepancy Report	Monthly report of Enrollees identified on NDMA's file but not enrolled in MCO's plan, Enrollees not identified on NDMA's file but enrolled in MCO's plan, and other information potentially impacting eligibility such as Enrollee's address, death, or obtaining pharmacy services outside of ND or its contiguous states
Unreachable Enrollees	Monthly report of Enrollees identified on NDMA's file but not enrolled in MCO's plan, Enrollees not identified on NDMA's file but enrolled in MCO's plan, and other information potentially impacting eligibility such as Enrollee's address, death, or obtaining pharmacy services outside of ND or its contiguous states
Enrollment Timeliness Report	Monthly report of outbound 834 transactions not processed within twenty-four (24) hours of receipt from STATE and timeline for completion of transactions
Disenrollment Reasons	Annual report of mortality data
Enrollee Services	
Telephone Statistics Report	Quarterly report detailing weekly telephone answer statistics (e.g., number of calls received, number /percentage of calls abandoned, number/ percentage calls answered w/in thirty (30) seconds, average speed of answer)
Enrollee Inquiries	Semiannual report identifying the number and type of the top ten (10) inquiries received
Covered Services	
Mental Health and Substance Use Parity	Annual report documenting compliance with the Mental Health Parity and Addiction Equity Act of 2008
Value-Added Benefits	As relevant, any changes to value-added benefits offered
Value-Added Benefits	Annually, a report on the impact of its value-added benefits
Provider Networks, Contracts and Related Responsibilities	
Credentialing Policy	As relevant, changes to credentialing policies and procedures

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Report Title	Description
Service Area Expansions	As relevant, proposed Service Area expansions including, #/type of Providers included by specialty and town/city, rationale, quality and access standards used to select Providers, description of methods to assure compliance with federal/state laws and Contract, distance from city/town center to each PCP, and Specialist by Specialty Type
Provider Suspension and Termination Notification	Immediate notice of any independent action taken by MCO to suspend or terminate Network Provider
Provider Suspensions and Termination Report	Annual list of Providers that MCO suspended or terminated upon notice of suspension or termination MCO, and list of provides suspended or terminated by MCO independently
Certification of Suspended/Terminated Providers	Quarterly certification of compliance with MCO Provider suspensions and terminations requirements and report
Provider Handbook	Annual, Provider Handbook which includes specific information about MCO Covered Services, non MCO Covered Services, and other requirements relevant to Provider responsibilities
Provider Complaints Report	Annual report on the number and type of the top ten (10) Provider complaints received, and MCO actions to address them
Claims Summary Report	Monthly report on paid and denied claims by claim type
Claims Payment Accuracy Report	Monthly report on claims payment accuracy based on an audit conducted by MCO
Sampling of Paid Claims Report	Monthly report of sampling of paid claims result, including total number of notices sent to Enrollees, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to STATE for further review
Network Development and Management Plan	Annual plan describing MCO's Network development and Network management activities and results, including findings of Provider non-compliance and any corrective action plan and/or measures taken by MCO to bring Provider into compliance, and Enrollee access to Provider types where STATE has granted MCO an exception to a time or distance or appointment accessibility standard
Network Adequacy	
PCP Geographic-Access Report	Semi-annual report of percent of Enrollees by County with access to open PCPs within the network accessibility standards in Appendix C.
PCP to Enrollee Ratio Report	Semi-annual report of open PCPs per number of Enrollees by geographic region as defined by STATE (includes data collection methodologies)
Top 5 High Volume Specialists Geographic Access Report	Semi-annual report of Enrollee's geographic access to top five (5) high volume specialty types by geographic region as defined by STATE
Significant Changes in Provider Network Report	Immediate notice and Semi-Annual Summary report of significant changes in Provider Network that will affect the adequacy and capacity of services
Summary Access and Availability Analysis Report	Annual report of key findings from all access reports and data sources (e.g. Grievance system, telephone contacts with access/availability associated reason codes, Provider site visits, use of Out-of-Network alternatives due to access/availability, use of limited Provider agreements, care management staff experiences with scheduling appointments)

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Report Title	Description
Care Management	
Care Management	Annually report on care management program
Utilization Management	
Service Authorization and Utilization Review Report	Quarterly report regarding services authorized and denied
Network Provider Profiling	Quarterly utilization review of like Specialists across Provider Network to determine if services billed are Medically Necessary
Emergency Department (ED) Visits	Annual report on ED visits and the volume of distribution by ED with top ten (10) diagnosis codes
Potentially Preventable ED visits and Inpatient Readmissions	Quarterly report on potentially preventable hospital ED visits and inpatient readmissions.
Provider Preventable Conditions	Annual report on Provider Preventable Conditions
Grievance Systems	
Enrollee Grievances	Quarterly report identifying the number and type of administrative Grievances received from an Enrollee or his/her Appeal representative (quality of care, access, attitude/service, billing/finance), the action taken for the Grievances for which trends are observed, the average time frame for resolution of Grievances in each category
Report of number and types of complaints and Appeals filed by Enrollees	Monthly report of complaints and Appeals, including reporting on how and in what time frame the complaints were resolved
Quality Management and Quality Improvement	
HEDIS® Clinical Topic Review (CTR)	Annual report, prepared by an external contractor of Performance Measurement
HEDIS® Clinical Topic Review (CTR) Satisfaction Survey	Annual report, prepared by an external contractor of Performance Measurement
CAHPS® Survey	Bi-annual report of CAHPS® survey results
Quality Assessment and Program Improvement goal report	Semiannual reports of progress toward QAPI goals including status and outcomes of performance improvement projects
Health Plan Accreditation Report	As relevant, copy of final accreditation report for each accrediting cycle
Performance Evaluation and External Quality Review	
Report of mandatory EQR activities Program	Validation of performance improvement projects, Validation of Performance Measures, and Compliance with strategy standards
Data Management and Information Systems	
Encounter data	Monthly by the fifteenth (15th) of the following month for all claims paid in the previous month
Program Integrity and Operational Audits	
Fraud & Abuse Report	Immediate reporting of Provider and Enrollee Fraud and Abuse
Fraud & Abuse Report	Quarterly report regarding any areas of Provider and Enrollee Fraud and Abuse
Coordination of Benefits/Third Party Liability	
Benefit Coordination Plan	As relevant, benefit coordination plan and proposed changes submitted for review and approval
Financial	
MLR Reports	Annually, within twelve (12) months of the end of the MLR Reporting Year as defined in in this Contract.

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Report Title	Description
Managed Care Reporting Template	Semi-annual
Cash Flow Statement	Annually and upon request, cash flow statements to demonstrate compliance with requirement to maintain sufficient cash flow and liquidity to meet obligations
Audited Financial Statements	Annual copies of NDID financial reports
Third Party Liability	Monthly report indicating the claims where MCO has billed or made a recovery of a claim subject to TPL
Alternative Payment Methodology Report	Annual report on use of APMs including a list of APM models used with Network Providers, list of APM Provider agreements and the Network providers, PCMHs and ACOs involved in such agreements, the quality measures and range of performance benchmarks used in APMs by Provider type, and total amount paid to Providers for all Provider agreements

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APPENDIX E: PAYMENT METHODOLOGY, MLR, AND CAPITATION RATES

Article 1: Risk Based Contract

In calculating the Capitation Rate, STATE shall include allowable administrative expenditures. Allowable administrative expenditures shall be determined by STATE/STATE's actuaries based on plan financial data submitted by MCO and after consultation with MCO. The Allowable Administrative Expenditures will be reviewed for reasonableness, which shall include being reviewed for consistency compared to historical figures; monitored for growth on a per member per month basis (in general, Administrative Expenditures should trend at a rate much lower than Medical Expenditures); and benchmarked to other states on a per member per month basis to ensure that it is appropriate for rate setting.

STATE and MCO agree that, to the extent there are differences between medical and allowable administrative expenditures, as reflected in the Encounter Data, or the financial data submitted by MCO, STATE and MCO would confer and make a good faith effort to reconcile those differences prior to the final development of actuarially sound Capitation Rates. STATE reserves the right to audit Medical and Allowable Administrative Expenditures.

(A) For each applicable rate year, the Capitation Rates will be determined to be actuarially sound by an actuary that meets the qualifications and standards established by the American Academy of Actuaries and follows the practice standards established by the Actuarial Standards Board.

(B) In accordance with 42 C.F.R. §438.8, the MLR experienced for each MCO Reporting Year is the ratio of the numerator (as defined in paragraph (C) of this article) to the denominator (as defined in paragraph (D) of this article). An MLR may be increased by a Credibility Adjustment in accordance with paragraph (F) of this article.

(C) The MLR Numerator includes the following elements:

(1) The numerator of an MCO's MLR for a MLR Reporting Year as determined by STATE and STATE's actuary is the sum of MCO's incurred claims (as defined in (C)(2) of this article); MCO's expenditures for activities that improve health care quality (as defined in paragraph (C)(3) of this article); and Fraud reduction activities (as defined in paragraph (C)(4) of this article).

(2) Incurred claims:

(a) Incurred claims must include the following:

(i) Direct claims that MCO paid to Providers (including under capitated contracts with Network Providers) for services or supplies covered under the contract and services meeting the requirements of 42 C.F.R. §438.3(e) provided to Enrollees.

(ii) Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but

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not reported.

(iii) Withholds from payments made to Network Providers.

(iv) Claims that are recoverable for anticipated coordination of benefits.

(v) Claims payments recoveries received as a result of subrogation.

(vi) Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

(vii) Changes in other claims-related reserves.

(viii) Reserves for contingent benefits and the medical claim portion of lawsuits.

(b) Amounts that must be deducted from incurred claims include the following:

(i) Overpayment recoveries received from Network Providers.

(ii) Prescription drug rebates received and accrued.

(c) Expenditures that must be included in incurred claims include the following:

(i) The amount of incentive and bonus payments made, or expected to be made, to Network Providers.

(ii) The amount of claims payments recovered through Fraud reduction efforts, not to exceed the amount of Fraud reduction expenses. The amount of Fraud reduction expenses must not include activities specified in paragraph (B)(4) of this article.

(d) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to STATE mandated solvency funds.

(e) Amounts that must be excluded from incurred claims:

(i) Non-claims costs which include the following:

(a) Amounts paid to third party vendors for secondary Network savings.

(b) Amounts paid to third party vendors for Network development, administrative fees, claims processing, and utilization management.

(c) Amounts paid, including amounts paid to a Provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 C.F.R. §438.3(e) and provided to an Enrollee.

(d) Fines and penalties assessed by regulatory authorities.

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(ii) Amounts paid to STATE as remittance under paragraph (G) of this article.

(iii) Amounts paid to Network Providers under to 42 C.F.R. § 438.6(d).

(f) Incurred claims paid by one MCO that is later assumed by another entity must be reported by the assuming MCO the entire MLR Reporting Year and no incurred claims for that MLR Reporting Year may be reported by the ceding MCO, as applicable.

(3) Activities that improve health care quality that are in one of the following categories:

(a) Activities that improve health care quality that are in one of the following categories:
(i) An MCO activity that meets the requirements of 45 C.F.R. §158.150(b) and is not excluded under 45 C.F.R. §158.150(c).
(ii) An MCO activity related to any EQR-related activity as described in 42 C.F.R. §438.358(b) and (c).
(iii) Any MCO expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. §158.151, and is not considered incurred claims, as defined in paragraph (C)(2) of this article.

(b) An MCO activity related to any EQR-related activity as described in 42 C.F.R. §438.358(b) and (c).

(c) Any MCO expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. §158.151, and is not considered incurred claims, as defined in paragraph (C)(2) of this article.

(4) Fraud prevention activities include MCO expenditures on activities related to Fraud prevention as adopted for the private market at 45 C.F.R. Part 158. Expenditures under this subparagraph must not include expenses for Fraud reduction efforts in paragraph (B)(2)(c)(ii) of this article.

(D) The MLR Denominator includes the following elements:

(1) The denominator of an MCO's MLR for a MLR Reporting Year must equal the adjusted premium revenue. The adjusted premium revenue is MCO's premium revenue (as defined in paragraph (D)(2) of this article) minus MCO's Federal, State, and local taxes and licensing and regulatory fees (as defined in paragraph (D)(3) of this article) and is aggregated in accordance with paragraph (F) of this article.

(2) Premium revenue includes the following for the MLR Reporting Year:

(a) STATE Capitation Payments, developed in accordance with 42 C.F.R. § 438.4, to MCO for all Enrollees under a Comprehensive Risk Contract approved under 42 C.F.R. §438.3(a), excluding payments made under to 42 C.F.R. §438.6(d).

(b) STATE-developed one-time payments, for specific life events of Enrollees.

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(c) Other payments to MCO approved under 42 C.F.R. §438.6(b)(3).

(d) Unpaid cost-sharing amounts that MCO could have collected from Enrollees under the contract, except those amounts MCO can show it made a reasonable, but unsuccessful, effort to collect.

(e) All changes to unearned premium reserves.

(f) Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 C.F.R. §438.5 or 42 C.F.R. §438.6.

(3) Federal, State, and local taxes and licensing and regulatory fees for the MLR Reporting Year include:

(a) Statutory assessments to defray the operating expenses of any State or Federal department.

(b) Examination fees in lieu of premium taxes as specified by State law.

(c) Federal taxes and assessments allocated to MCOs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

(d) State and local taxes and assessments including:

(i) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

(ii) Guaranty fund assessments.

(iii) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(iv) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

(v) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

(e) Payments made by an MCO that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 C.F.R. § 158.162(c), limited to the highest of either:

(i) Three percent of earned premium; or

(ii) The highest premium tax rate in the State for which the report is being submitted, multiplied by MCO's earned premium in the State.

(4) The total amount of the denominator for a MCO which is later assumed by another entity must be reported by the assuming MCO for the entire MLR Reporting Year and no amount

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under this paragraph for that year may be reported by the ceding MCO.

(E) Per 42 C.F.R. §438.8(g)(1), allocation of expense requirements includes the following:

(1) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(2) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

(3) Methods used to allocate expenses.

(a) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

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

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

(F) Credibility adjustment.

(1) MCO may add a credibility adjustment to a calculated MLR if the MLR Reporting Year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by STATE as described in paragraph (G) of this article.

(2) MCO may not add a credibility adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.

(3) Per 42 C.F.R. §438.8(h), if MCO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this article.

(4) On an annual basis, CMS will publish base credibility factors for MCOs that are developed according to the methodology in 42 C.F.R. §438.8(i). An MCO with a number of Enrollee Member Months between the levels established for non-credible and fully credible plans will be deemed partially credible, and CMS will develop adjustments, using linear interpolation, based on the number of Enrollee Member Months.

(G) MCO shall aggregate data for all Medicaid eligibility groups covered under the contract with STATE unless STATE requires separate reporting and a separate MLR calculation for specific populations.

(H) Pursuant to 42 C.F.R. §438.8(c) and (j), and Article 4.16 of this Contract, STATE has elected to mandate a minimum MLR higher than 85 percent. For this Contract, STATE has elected to mandate a MLR threshold of the pricing MLR minus 2.0 percent. If MCO does not maintain such minimum MLR,

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MCO shall remit or STATE shall recoup an amount equal to the difference between actual medical expenditures and the amount of medical expenditures that would have resulted in the minimum MLR as defined by STATE.

(I) All of the items above (A-H) shall be included in the Federal MLR. The following adjustments will not be incorporated when the targeted STATE MLR threshold calculation is performed for purposes of remittance:

(1) The credibility adjustment using latest year worth of member months;

(2) Federal/state income taxes;

(3) Expenditures for activities that improve health care quality; and

(4) Expenditures for Fraud prevention activities.

(J) Reporting requirements

(1) MCO shall submit two reports to STATE that includes at least the following information for each MLR Reporting Year, one of which excludes the adjustments identified in (I) and (C)(3)(d) above:

(a) Total incurred claims.

(b) Expenditures on quality improving activities.

(c) Expenditures related to activities compliant with program integrity requirements (42 C.F.R. §438.608(a)(1) through (5), (7), (8) and (b)).

(d) Non-claims costs.

(e) Premium revenue.

(f) Taxes, licensing, and regulatory fees.

(g) Methodology(ies) for allocation of expenditures.

(h) Any credibility adjustment applied.

(i) The calculated MLR.

(j) Any remittance owed to STATE, if applicable.

(k) A comparison of the information reported in this paragraph with the audited financial report required under 42 C.F.R. §438.3(m).

(l) A description of the aggregation method used under paragraph (F) of this article.

(m) The number of Member Months.

(2) MCO must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that MCO within 180 days of the end of the MLR Reporting Year or within 30 days of being requested by MCO whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(3) Prior to ten (10) months following the applicable MLR Reporting Year, MCO must submit the report required in paragraph (I)(1) of this article based on data including eight (8) months of claims run-out.

(4) MCO shall attest to the accuracy of the calculation of the MLR in accordance with requirements of this article when submitting the report required under this paragraph.

(K) Prior to eleven (11) months following the applicable MLR Reporting Year or a mutually agreed upon alternative date, STATE shall finalize the MLR Reporting Year with any balance due to STATE as required in paragraph (H) of this article within sixty (60) days.

(L) In accordance to 42 C.F.R. 438.8(m), if STATE makes a retroactive change to the Capitation Payments for a MLR Reporting Year and the report has already been submitted to STATE, MCO must re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new report meeting the requirements in paragraph (I) of this article within one hundred eighty (180) days following the end of calendar year in which the retroactive change was made.

Article 2: Capitation Rates

(A) For Enrollees having a full month of eligibility, the following table indicates the separate Capitation Rates for each rating cohort within each Region.

(B) STATE will determine the appropriate rating cohort to which an Enrollee is assigned for payment purposes.

(C) For Enrollees having a partial month of eligibility, the Capitation Rate for said partial month shall be the applicable Capitation Rate as indicated in the below table divided by the total number of days in the month then multiplied by the number of days the Enrollee is eligible in that month.

(D) For the period of January 1, 2022, to December 31, 2022, rates are as follows. Updated rates will be calculated to incorporate more recent information, and will remain at the same position in the final actuarially sound capitation rate range relative to the initial actuarially sound capitation rate range:

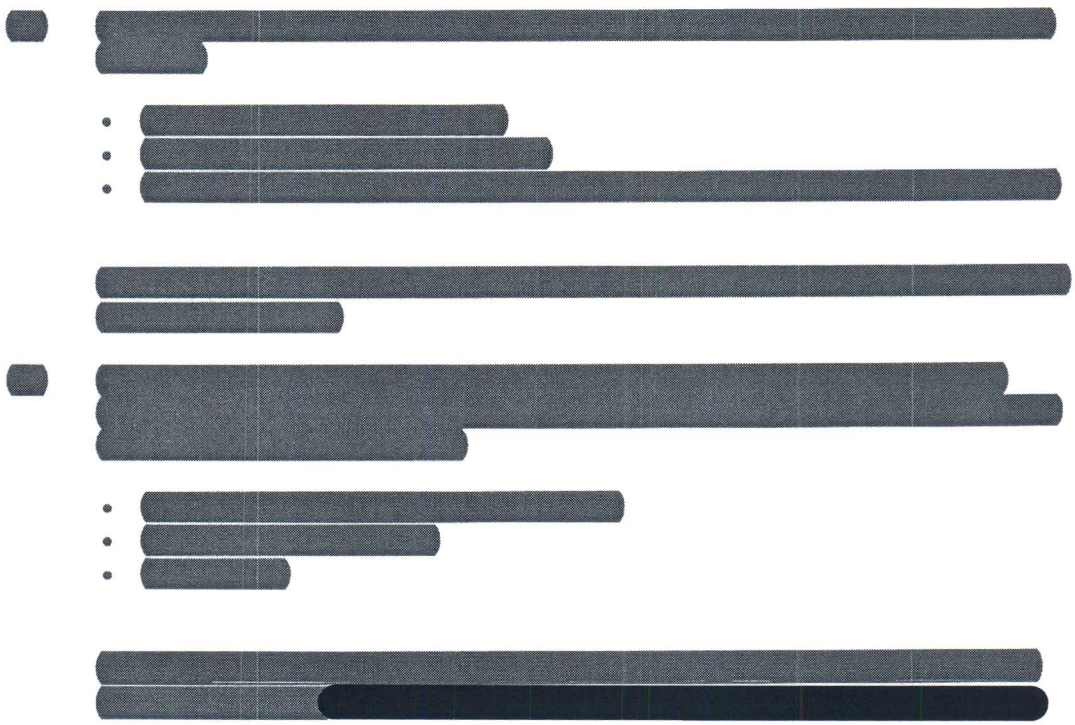
Capitation Rates	Age Cohort	Gender	Urban	Rural
Child/Childless Adults	21-44	M	[redacted]	[redacted]
Child/Childless Adults	21-44	F	[redacted]	[redacted]
Child/Childless Adults	45-64	M	[redacted]	[redacted]
Child/Childless Adults	45-64	F	[redacted]	[redacted]

Retroactive Only, Not Currently Eligible	N/A	N/A	[redacted]	[redacted]

Article 3: MCO Rating Categories

MCO Rating Category	Age Cohort	Gender	Region
M1: Child/Childless Adults	21-44	M	Urban/Rural
F1: Child/Childless Adults	21-44	F	Urban/Rural
M2: Child/Childless Adults	45-64	M	Urban/Rural
F2: Child/Childless Adults	45-64	F	Urban/Rural

APPENDIX F: VALUE-ADDED BENEFITS AND APPROVED IN LIEU OF SERVICE



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BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

By _____ June 25, 2021
DATE

Its CEO

45-0173185
MCO's Federal Taxpayer Identification Number

STATE OF NORTH DAKOTA

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

By _____ 6/25/21
CHRISTOPHER D. JONES DATE
EXECUTIVE DIRECTOR

By _____ 6-25-21
AMY JANGULA JOHNSON DATE
CONTRACT OFFICER
Approved for form and content