STATE OF GEORGIA

AMENDED AND RESTATED CONTRACT BETWEEN

THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH

AND

[CONTRACTOR]

FOR

PROVISION OF SERVICES TO GEORGIA FAMILIES

RFP No.: DCH0000100
Contract No.

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THIS AMENDED AND RESTATED CONTRACT is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as "DCH" or the "Department") and **[CMO]** (hereinafter referred to as the "Contractor") and is made effective on the date signed by the DCH Commissioner (hereinafter referred to as the "Contract Effective Date"). This document amends and restates, in its entirety, Contract #2016004 between the Department and Contractor.

WHEREAS, DCH is responsible for health care policy, purchasing, planning, and regulation pursuant to the Official Code of Georgia Annotated (O.C.G.A.) § 31-2-1 *et seq.*;

WHEREAS, DCH is the single State agency designated to administer medical assistance in Georgia under Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. §§ 49-4-140 *et seq*. (the "Georgia Medical Assistance Act of 1977"), and is charged with ensuring the appropriate delivery of health care services to Medicaid recipients and PeachCare for Kids® Members;

WHEREAS, DCH, through the Department of Administrative Services ("DOAS"), issued an electronic Request for Qualified Contractors ("eRFQC"), ES-RFQC-40199-465, in November 2014 to pre-determine the suppliers who met the qualifications to be eligible to respond to a Request for Proposals;

WHEREAS, DCH caused Request for Proposals Number DCH0000100 (hereinafter the "RFP") to be issued through DOAS, which is attached to this Contract as ***Exhibit 1*** and is expressly incorporated as if completely restated herein, to obtain the services of a Vendor to administer the provisions of the State's Medicaid Managed Care Program, Georgia Families, and the Section 1115 family planning waiver, Planning for Healthy Babies Program;

WHEREAS, Contractor, having been determined to be an eligible supplier pursuant to the eRFQC, submitted to DCH and DOAS a Technical Proposal in response to the RFP (attached to this Contract as ***Exhibit 2*** and hereinafter referred to as "Contractor's Proposal"), which is expressly incorporated into this Contract as if completely restated herein;

WHEREAS, Contractor, including its Subcontractors, represents that it has the skills, qualifications, expertise, financial resources and experience necessary to perform the services described in Contractor's Proposal and this Contract in compliance with all applicable federal and state laws and regulations, including but not limited to Chapters 21 and 21A respectively of Title 33 of the Official Georgia Code Annotated;

WHEREAS, DCH accepts Contractor's Proposal and enters into this Contract with Contractor for the provision of various services for the Department; and

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

NOW, THEREFORE, **FOR AND IN CONSIDERATION** of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Department and the Contractor (each individually a "Party" and collectively the "Parties") hereby agree as follows:

1.0 SCOPE OF SERVICES

1.0.1 The Contractor will provide care management services to Georgia Families, Medicaid and PeachCare for Kids ® Members and Planning for Healthy Babies (P4HB) Participants. PeachCare for Kids ® is Georgia's Children's Health Insurance Program (CHIP), and the P4HB program is Georgia's Section 1115 family planning waiver program. A summary of the required responsibilities to be carried out by the Contractor include:

1.0.1.1 Provision of access to health care services, including but not limited to physical health service, behavioral health services, dental services and Care Coordination;

1.0.1.2 Provision of access to P4HB services;

1.0.1.3 Provision of Member education and outreach including:

1.0.1.3.1 Member call center
1.0.1.3.2 Member handbook and Member ID cards
1.0.1.3.3 Ongoing education and outreach to Members
1.0.1.3.4 Provider directory

1.0.1.4 Development and maintenance of a network of Providers and facilities adequate to deliver all Covered Services;

1.0.1.5 Provision of a primary care physician (PCP) to serve as the medical home for all Members. The PCP serves as the single point of accountability and coordination—primarily for primary care;

1.0.1.6 Provision of a Dental Home for Members under the age of twenty-one (21). The Dental Home is responsible for coordinating all dental care for the Member;

1.0.1.7 A Provider services function to act as the point of contact for its Provider network, provide educational material, maintain a Provider Call Center, facilitate provider complaints and address provider contract and payment issues;

1.0.1.8 Ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, second opinion, Discharge Planning, and case management;

1.0.1.9 Provision of a System of Care approach to Care Coordination and continuity of care, which ensures a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member

receives needed services in a supportive, effective, efficient, timely and cost-effective manner. This includes: Transition of Care, Discharge Planning, Care Coordination, Disease Management, and Case Management;

1.0.1.10 Provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s);

1.0.1.11 Develop an adequate system and staff to ensure the provision of health care services under this Contract are properly documented, paid for and reported; and

1.0.1.12 Design and implement an information management system for the purpose of integrating all components of the delivery of care to the Members. The system shall have the capability to securely store and transmit information, interface with other relevant systems and report data in a format specified by DCH.

1.0.2 The Parties agree that DCH retains Contractor to furnish all of the goods, services, and other deliverables contemplated by this Contract.

1.0.3 The Parties agree that the Department shall not pay or otherwise compensate the Contractor for any services, goods, or deliverables outside of the above Scope of Services, which includes Contractor's Proposal to the extent agreed upon by DCH and this Contract. The Department shall not make any exceptions or waivers on this matter. In the event of a dispute regarding whether an item is within the Scope of Services, the Parties will attempt to reach a mutually agreeable solution. If the Parties fail to reach a mutually agreeable solution, Section 30, Conflict Resolution, of this Contract shall govern and not be subject to appeal.

1.0.4 If written correspondence is received by the Contractor from DCH and the Contractor believes that the correspondence will cause a change to the Scope of Services contemplated by this Contract, the Contractor shall advise the Project Leader listed in Section 32, Notice, of this Contract (hereinafter referred to as "DCH Project Leader") in writing within ten (10) Business Days of receiving the initial correspondence from DCH at the address indicated in Section 32 of this Contract. The Contractor shall request the DCH Project Leader's written confirmation that the Scope of Services has changed.

1.0.4.1 The Notice shall state the following:

1.0.4.1.1 The nature and circumstances of the communication regarded as a change in the Scope of Services by the Contractor;

1.0.4.1.2 The date of the communication;

1.0.4.1.3 The identification of the documents involved;

1.0.4.1.4 The particular technical requirements or contract requirements regarded as changed;

1.0.4.1.5 The direct and foreseeable effect of the communication regarded as a change in the Scope of Services contemplated by the Contract, including the number of hours required from Contractor's staff to accomplish the change and the manner and sequence of performance or delivery of supplies or services, identifying which supplies or services are or will be affected; and

1.0.4.1.6 A detailed cost analysis of the alleged change, including a schedule setting forth the associated staffing costs (including staff names and hourly costs), with the totals for these categories not exceeding amounts based upon specific assumptions.

1.0.5 The DCH Project Leader shall respond within ten (10) Business Days of receipt of the Contractor's notice.

1.0.5.1 The DCH Project Leader's response shall either:

1.0.5.1.1 Countermand the correspondence that Contractor regards as a change;

1.0.5.1.2 Deny that the correspondence constitutes a change in the Scope of Services contemplated by the Contract;

1.0.5.1.3 Confirm in writing that the correspondence is a change to the Scope of Services contemplated by the Contract; or

1.0.5.1.4 Advise the Contractor that additional information is required to evaluate the Notice and establish the deadline by which the Contractor must provide such information.

1.0.6 If the Contractor complies with any order, direction, interpretation, or determination, written or oral, without providing notice in accordance with this

subsection, DCH shall not be liable for any increased price, delay in performance, or contract non-conformance by the Contractor.

1.1 BACKGROUND

1.1.1 In 2003, the DCH identified unsustainable Medicaid growth and projected that without a change to the system, Medicaid would require fifty percent (50%) of all new State revenue by 2008. In addition, Medicaid Utilization was driving more than thirty-five percent (35%) of total growth each year. For that reason, DCH decided to employ a care management approach to organize its fragmented System of Care, enhance access, achieve budget predictability, explore possible cost containment opportunities and focus on system-wide performance improvements. Furthermore, DCH believed that managed care could continuously and incrementally improve the quality of Health Care and services provided to patients and improve efficiency by utilizing both human and material resources more effectively and more efficiently.

1.1.2 The DCH Division of Managed Care and Quality submitted a State Plan Amendment to CMS in 2004 to implement Georgia Families, a full-risk mandatory Medicaid Managed Care program. Georgia Families includes the following Members:

1.1.2.1 *Recipients of Medicaid and PeachCare for Kids®:* Effective June 1, 2006, the State of Georgia implemented Georgia Families through which Health Care services are delivered to eligible recipients of Medicaid and PeachCare for Kids®.

1.1.2.2 *Planning for Healthy Babies:* In 2011, DCH implemented the P4HB program to reduce the number of low birth weight (LBW) and very low birth weight (VLBW) births in Georgia. Through the Georgia Families program, P4HB participants receive Family Planning Services and *interpregnancy* care (IPC) services. Additionally, women participating in the IPC component of P4HB receive Primary Care visits; management and treatment of chronic diseases; substance use disorder (SUD) treatment (detoxification and intensive outpatient rehabilitation); Case Management; Resource Mother Outreach (support services such as supportive counseling, non-emergency transportation, and linkage to community resources); limited dental services; and additional prescription drugs (non-family planning).

1.1.3 DCH's intent in maintaining a care management approach to serve Georgia Families Members is to:

1.1.3.1 Continually and significantly improve the Quality of health care *and* services provided to Members;

1.1.3.2 Offer Care Coordination to Members;

1.1.3.3 Enhance access to Health Care services;

1.1.3.4 Achieve budget predictability as well as cost containment;

1.1.3.5 Create system-wide performance improvements; and

1.1.3.6 Improve efficiency at all levels.

1.1.4 Georgia Families is designed to:

1.1.4.1 Improve the Health Care status of the Member;

1.1.4.2 Establish a member-provider relationship through its use of Medical Homes;

1.1.4.3 Establish a climate of contractual accountability for improving health outcomes;

1.1.4.4 Slow the rate of expenditure growth in the Medicaid program; and

1.1.4.5 Expand and strengthen Members' responsibility and engagement in their Health Care.

1.1.5 Since 2006, Georgia Families has evolved from a startup program focused on operations to a more mature program focusing on Quality of care, Care Management Organization (CMO) accountability and Member outcomes. DCH has regularly gathered meaningful stakeholder feedback about the program and has used this feedback to enhance the program. For example, in 2011, DCH conducted over thirty (30) focus groups with Members and Advocates, Providers, Vendors and Legislators; solicited feedback through online surveys; and convened three (3) Task Forces and one (1) Workgroup. Through this collaborative process, DCH worked with the CMOs to implement a variety of Quality Improvement Initiatives to improve Quality and health outcomes of Members, broadened its Georgia Families Monitoring and oversight activities and has implemented or is in process of implementing administrative simplifications to improve the Member and Provider experience. Below are examples of initiatives DCH has implemented specific to Georgia Families and overarching Medicaid initiatives that also impact Georgia Families.

1.1.5.1 *Quality Improvement Initiatives*

1.1.5.1.1 DCH is collaborating with the National Initiative for Children's Healthcare Quality (NICHQ) and the Georgia OB/Gyn Society to increase postpartum care rates,

incorporate the reproductive life plan discussion into the postpartum care visit, and encourage reproductive life plan and long-acting reversible contraceptive discussions in the antepartum visits.

1.1.5.1.2 In 2014, DCH collaborated with the then CMOs to consolidate Performance Improvement Projects (PIPs) into one common, "Bright Futures" PIP to drive improvements in all of the activities performed during each preventive health visit as described in the Bright Futures Periodicity Schedule.

1.1.5.1.3 In partnership with the then CMOs, DCH implemented a statewide PIP to reduce avoidable emergency room visits.

1.1.5.1.4 DCH engaged its External Quality Review Organization to provide tutorials to the then CMOs on conducting PIPs.

1.1.5.1.5 DCH encourages Provider use of electronic health record systems through Health Information Technology (Health IT) incentive programs. Increased use of electronic health records was an intervention employed by the then CMOs to decrease avoidable emergency room visits. In 2014, Georgia reported an increased percentage of practices using electronic health records through Referral to Georgia-HITREC. Through May 2014, Georgia issued more than $217 million in payments of federal funds to eligible providers for their Medicaid Electronic Health Records (EHR) Incentive Program, including payments to Providers serving Georgia Families Members.

1.1.5.1.6 DCH developed a program that awarded the then CMOs with auto-assignment of Members based on the CMOs' Quality of the services provided. DCH reviews nineteen (19) performance measures as part of the auto-assignment algorithm per each six (6)-month cycle. Being awarded auto-assignees for high-quality services encouraged the CMOs to achieve better Quality outcomes for their Members.

1.1.5.2 *Monitoring and Oversight Activities*

1.1.5.2.1 DCH has enhanced its oversight and Monitoring of CMO performance through the expansion and accreditation of HEDIS®-based performance measurement, demonstrated improvement though performance improvement projects

(PIPs) and cross-state agency collaboration initiatives. In 2014, DCH measured fifty-four (54) HEDIS/NCQA Quality Metrics.

1.1.5.3 *Administrative Simplifications*

1.1.5.3.1 DCH plans to implement a real-time eligibility system in 2016 to streamline the eligibility determination, program Enrollment and facilitate the service authorization process.

1.1.5.3.2 DCH is implementing a Credentialing Verification Program to simplify the Medicaid and Georgia Families Enrollment process for Providers and improve efficiencies by reducing administrative burden. Providers will submit electronic applications and other required materials to a Credentialing Verification Organization (CVO) contracted by DCH. The CVO will process the Provider credentialing or re-credentialing Information to apply to the fee-for-service and managed care delivery Systems. The CMOs will not conduct separate credentialing and re-credentialing processes.

1.1.5.3.3 DCH implemented standardized prior authorization request forms and an electronic portal through which Providers submit all prior authorization requests. This Information, in turn, is provided to the appropriate CMO for review, as CMOs retain authority for prior authorization of services for their Members. The CMOs then return the disposition of the prior authorization request to the common portal. Using such a portal allows for standardization and creates efficiencies for Providers. For example, if a Provider submits a prior authorization request for a surgery and the Member is in process of transitioning to a new CMO, the Provider is not required to resubmit the prior authorization request to the new CMO. The new CMO will access the Information submitted for the initial CMO to review for its review and approval process.

1.2 ELIGIBILITY FOR GEORGIA FAMILIES

1.2.1 Medicaid

1.2.1.1 The following Medicaid eligibility categories are required to enroll in Georgia Families (hereinafter referred to as "GF"):

1.2.1.1.1 Low Income Families – Adults and children who meet the standards of the former AFDC (Aid to Families with Dependent Children) program.

1.2.1.1.2 Transitional Medicaid – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit.

1.2.1.1.3 Pregnant Women (Right from the Start Medicaid – RSM) – Pregnant women with family income at or below two hundred twenty percent (220%) of the federal poverty level who receive Medicaid through the RSM program.

1.2.1.1.4 Children (Right from the Start Medicaid – RSM) – Children less than nineteen (19) years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family.

1.2.1.1.5 Children (newborn) – A child born to a woman who is eligible for Medicaid on the day the child is born.

1.2.1.1.6 Women Eligible Due to Breast and Cervical Cancer – Women less than sixty-five (65) years of age who have been screened through Title XV Center for Disease Control (CDC) screening and have been diagnosed with breast or cervical cancer.

1.2.1.1.7 Refugees – Individuals, as defined under O.C.G.A. § 38-3-3, including but not limited to those who have the required Immigration and Naturalization Service (INS) documentation showing they meet a status of asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims.

1.2.1.1.8 Planning for Health Babies 1115 Demonstration Waiver Participants (otherwise known as P4HB participants) – This Demonstration includes three distinct groups: Women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal poverty level and are eligible for Family Planning Only Services; Women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal poverty level who have delivered a very low birth weight infant and are eligible for Family Planning Services and Interpregnancy

Care Services; and Women ages eighteen (18) through forty-four (44) who are current Medicaid recipients, have delivered a very low birth weight infant and are eligible for Resource Mother services only.

1.2.2 PeachCare for Kids®

1.2.2.1 PeachCare for Kids® – The Children's Health Insurance Program (CHIP) in Georgia. Children less than nineteen (19) years of age who have family income that is less than two hundred forty-seven percent (247%) of the federal poverty level, who are not eligible for Medicaid, or any other health insurance program, and who cannot be covered by the State Health Benefit Plan are eligible for services under PeachCare for Kids®.

1.2.3 Exclusions

1.2.3.1 The following recipients are excluded from Enrollment in GF, even if the recipient is otherwise eligible for GF per Section 1.2.1 and Section 1.2.2:

1.2.3.1.1 Recipients eligible for Medicare.

1.2.3.1.2 Recipients that are Members of a Federally Recognized Indian Tribe.

1.2.3.1.3 Recipients that are enrolled in fee-for-service Medicaid through Supplemental Security Income prior to enrollment in GF.

1.2.3.1.4 Medicaid children enrolled in the Children's Medical Services program administered by the Georgia Department of Public Health.

1.2.3.1.5 Children enrolled in the Georgia Pediatric Program (GAPP).

1.2.3.1.6 Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.

1.2.3.1.7 Individuals enrolled in a Hospice category of aid.

1.2.3.1.8 Individuals enrolled in a Nursing Home category of aid.

1.2.3.1.9 Individuals enrolled in a Community Based Alternatives for Youths (CBAY).

1.2.3.2 The following recipients are excluded from the P4HB 1115 Demonstration (hereinafter referred to as "the Demonstration"):

1.2.3.2.1 Women who become pregnant while enrolled in the Demonstration.

1.2.3.2.2 Women determined to be infertile (sterile) or who are sterilized while enrolled in the Demonstration.

1.2.3.2.3 Women who became eligible for any other Medicaid or commercial insurance program.

1.2.3.2.4 Women who no longer meet the Demonstration's eligibility requirements.

1.2.3.2.5 Women who are or become incarcerated.

1.3 SERVICE REGIONS

1.3.1 For the purposes of coordination, planning, and analysis, DCH has divided the State, by county, into six (6) Service Regions. See **Attachment I** for a listing of the counties in each Service Region.

1.3.2 Members will choose or will be assigned to a CMO.

1.3.3 Contractor shall provide health care services and meet all other requirements set forth in this Contract in all six (6) Service Regions within the State.

1.4 DEFINITIONS

For purposes of this Contract the following terms are defined as follows:

340B Drug Pricing Program: The program administered by HRSA that requires drug manufacturers to provide covered outpatient drugs to eligible health care organizations/covered entities at significantly reduced rates. Eligible organizations/covered entities must register and be enrolled with the 340B program and comply with all 340B Program requirements.

Abandoned Call: A call in which the caller elects a valid option and is either not permitted access to that option or disconnects from the system.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs 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 costs to the Medicaid program.

Activities of Daily Living (ADL): Daily self-care activities including bathing, dressing, feeding, toileting, grooming, and transferring (walking, transferring from bed to wheelchair or wheelchair to toilet, etc.) and continence.

Adverse Benefit Determination: Shall mean any of the following:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by the State.
(5) The failure of the Contractor to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
(6) For a resident of a rural area with only one CMO, the denial of a Member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.
(7) The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Administrative Claiming for Education (ACE): The Georgia Medicaid Administrative Claiming for Education (ACE) program allows reimbursement to Local Education Agencies (LEA) for approved administrative activities that support the Medicaid program. Reimbursement is available through a quarterly claiming process.

Administrative Law Hearing: The appeal process administered by the State in accordance with O.C.G.A. §49-4-153 and as required by Subpart E of 42 CFR § 431 available to Members and Providers after they exhaust the Contractor's Appeals Process.

Administrative Review: The formal reconsideration of a proposed Action, as a result of the proper and timely submission of a Provider's request, Member's request, or a request by DCH.

Administrative Service(s): The contractual obligations of the Contractor that include but are not limited to Utilization Management, network management, Quality improvement, marketing, enrollment, Member Services, Claims payment, Information Systems, financial management, and reporting.

Advance Directives: 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.

After-Hours: Provider office/visitation hours extending beyond the normal business hours of a Provider. This may include Saturday hours.

Aged, Blind or Disabled (ABD): Medical assistance for persons who are aged (sixty-five (65) years of age or older), legally blind, and/or disabled. These individuals receive Fee-for-Service Medicaid and are not eligible for the Georgia Families Program.

Agent: An entity that contracts with the State of Georgia to perform administrative functions, including but not limited to: Fiscal Agent Contractor activities; outreach, eligibility, and Enrollment activities; Information Systems and technical support, etc.

Aim Statement: A written and measurable description of desired improvement that defines a clear and firm intention for improvement and is time-specific, measurable and focused on the population that will be affected by the improvement activity. The Aim Statement should be easy to remember and answer the following questions: What will we improve? For whom? How much? By when?

Appeal: A review by the Contractor of an adverse benefit determination.

Appeals Process: The overall process that includes Appeals at the Contractor level and access to the State Fair Hearing process (the State's Administrative Law Hearing).

Assess: The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

Attestation: The Contractor attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.

Authoritative Host: A system that contains the master or "authoritative" data for a particular data type, e.g. Member, Provider, CMO, etc. The Authoritative Host may feed data from its master data files to other systems in real time or in batch mode. Data in an Authoritative Host is expected to be up-to-date and reliable.

Authorized Representative: A person authorized by the Member in writing to make health-related decisions on behalf of a Member, including, but not limited to Enrollment and Disenrollment decisions, filing Appeals and Grievances with the Contractor, and choice of a Primary Care Physician (PCP). The Authorized Representative is the Parent, Adoptive Parent or legal guardian for a child. For an adult, this person is the legal guardian (guardianship action), health care power of attorney, other person that has power of attorney, or another signed HIPAA compliant document indicating who can make decisions on behalf of the Member. For Foster Care Members and Juvenile Justice Members, the Authorized Representative is DFCS or DJJ respectively.

Automatic Assignment (Auto-Assign or Auto-Assignment): The assignment of a Member to a CMO or PCP pursuant to the provisions of this Contract.

Bed Days: A day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

Behavioral Health: The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five [DSM 5] published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in Behavioral Health usually have symptoms, behaviors and/or skill deficits which impede their functional abilities and affect their quality of life.

Behavioral Health Crisis: An intensive behavioral, emotional or psychiatric situation that exceeds an individual's current resources and coping mechanisms which, if left untreated, could result in an emergency situation.

Behavioral Health Home (BHH): A Behavioral health home is responsible for the integration and coordination of the individual's health care (physical as well as behavioral health care services). Behavioral Health Home providers do not need to provide all the services themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated.

Behavioral Health Services: Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Benefits: The Health Care services set forth in this Contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible for.

Blocked Call: A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Border Provider: Providers located within fifty (50) miles of the Georgia border. Border Providers are located in Alabama, Florida, North Carolina, South Carolina and Tennessee.

Business Days: Monday through Friday from 9:00 a.m. to 5:00 p.m. EST, excluding State holidays.

Calendar Days: All seven days of the Week.

Calendar Years: January through December.

Capitated Service: Any Covered Service for which the Contractor receives an actuarially sound Capitation Payment.

Capitation: A Contractual arrangement through which a Contractor agrees to provide specified Health Care services to Members for a fixed amount per Member per month.

Capitation Payment: A payment, fixed in advance, and based upon an actuarially sound capitation rate, that DCH makes to the Contractor for each Member covered under this Contract for the provision of Covered Services and who are assigned to the Contractor. Capitation Payments are unique for each program. For instance, Capitation Payments may be referred to as P4HB Capitation Payments, Foster Care/Juvenile Justice Capitation Payments, or Adoption Assistance Capitation Payments. This payment is made regardless of whether the Member receives Covered Services or Benefits during the period covered by the payment. Payments are contingent upon the availability of appropriated funds. Capitation Payments may only be made for Medicaid, CHIP, and Planning for Healthy Babies-eligible enrollees. Capitation payments may only be made by the state and retained by the Contractor for Medicaid-eligible Members. Capitation payments may not be made for deceased Members.

Capitation Rate: The fixed monthly amount, including the Value-Based Purchasing (VBP) withhold, that the Contractor is paid by DCH for each Member assigned to the Contractor, to ensure that Covered Services and Benefits under this Contract are provided. Capitation Rates are actuarially sound and are unique for each program. For instance, Capitation Rates may be referred to as Georgia Families Capitation Rates, P4HB Capitation Rates, Foster Care/Juvenile Justice Capitation Rates or Adoption Assistance Capitation Rates. Payments are contingent upon the availability of appropriated funds. Capitation Rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of this Contract and are based upon services covered in the State Plan and additional services deemed by the state to be necessary to comply with the parity standards of the Mental Health Parity and Addiction Equity Act, and represent a payment amount that is adequate to allow the Contractor to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements.

Care Coordination: The process of actively linking a Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified.

Care Management Organization (CMO): An entity organized for the purpose of providing Health Care, with a health maintenance organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers, and furnishes Health Care services on a capitated basis to Members.

Case Management: A Person-centric, collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote Quality cost-effective outcomes. Case Management serves as a means for achieving Member wellness and autonomy through advocacy, communication, education, and identification of services and resources. Interventions are undertaken with the purpose of helping Members receive appropriate care. Case Management is distinguished from Utilization

Management in that it is voluntary and it is distinguished from Disease Management by its intensity and focus on any disease(s) or condition(s) the Member has.

Category of Eligibility: Defined set of requirements used to identify individuals who are eligible for Medicaid, Peach Care for Kids and P4HB and the services the individuals are eligible for. Requirements may include age; being pregnant, disabled, or blind; meeting income and asset requirements and being a U.S. citizen or a qualified alien. Non-qualified aliens or undocumented immigrants may be eligible for emergency assistance only.

Category of Service (COS): Classifications of the service types and the Providers authorized to deliver the services as defined by DCH.

Centers for Medicare & Medicaid Services (CMS): The Agency within the U.S. Department of Health and Human Services responsible for the Medicare, Medicaid and the Children's Health Insurance Programs.

Certified Nurse Midwife (CNM): A registered professional nurse who is legally authorized under State law to practice as a nurse-midwife, and has completed a program of study and clinical experience for nurse-midwives or equivalent.

Children's Health Insurance Program (CHIP formerly State Children's Health Insurance Program (SCHIP)): A joint federal-state Health Care program for targeted, low-income children, established pursuant to Title XXI of the Social Security Act. Georgia's CHIP is called PeachCare for Kids®.

Children's Intervention School Services (CISS): The Georgia Medicaid program that provides reimbursement for specified medically-necessary services that are received in schools and provided by or arranged by a Local Education Agency (LEA) for Medicaid-eligible students under the age of twenty-one (21) with an Individualized Education Program (IEP).

Children's Medical Services: Administered by the Department of Public Health, the Children's Medical Services program provides care coordination and other needed medical/health services for eligible children and their families who are not enrolled in managed care. Children's Medical Services program may provide, arrange for and/or pay for comprehensive physical evaluations, diagnostic tests, inpatient/outpatient hospitalization, medications, and other medical treatments, therapy, Durable Medical Equipment, hearing aids related to the child's eligible condition, and genetic counseling.

Chronic Condition: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is considered Routine Care.

Claim: A bill for services, a line item of services, or all services for one recipient within a bill.

Claim Adjustment: A claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, payment amount can be changed.

Claims Administrator: The entity engaged by DCH to provide Administrative Service(s) to the CMOs in connection with processing and adjudicating risk-based payment, and recording Encounter Claims data for Members.

Classifications: The four benefit classifications required for the analysis of mental health parity compliance are: Inpatient, Outpatient, Prescription Drugs, and Emergency Care.

Clean Claim: A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: (i) A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; (ii.) A Claim for which Fraud is suspected; and (iii.) A Claim for which a Third Party Resource should be responsible.

Cold-Call Marketing: Any unsolicited personal contact by the CMO, with a Potential Member, for the purposes of influencing a Member's selection or Enrollment in a particular CMO as defined in 42 C.F.R. § 438.104.

Community Mental Health Rehabilitation Services (CMHRS): Services that are intended for the maximum reduction of mental disability and restoration of an individual to his or her best possible functional level.

Completion/Implementation Timeframe: The date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the Contractor.

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

Consecutive Enrollment Period: The consecutive twelve (12) month period beginning on the first day of Enrollment or the date the notice is sent, whichever is later. For Members that use their option to change CMOs without cause during the first ninety (90) Calendar Days of Enrollment, the twelve-month Consecutive Enrollment Period will commence when the Member enrolls in the new CMO. This is not to be construed as a guarantee of eligibility during the Consecutive Enrollment Period.

Consulting Provider: The Provider who evaluates a Member at the request of the Member's Primary Care or referring Provider. The consultation may occur via a Telemedicine mode of delivery.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): CAHPS surveys ask Medicaid and PeachCare for Kids® Members or their parents/guardians to report on and evaluate their experiences with their health care. The surveys cover topics that are important to Members and focus on aspects of quality that Members and parents/guardians are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The acronym CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). DCH uses the Adult and Child CAHPS surveys.

Contested Claim: A Claim that is denied because the Claim is an ineligible Claim, the Claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount claimed is in dispute, or the Claim requires special treatment.

Continuing Care Provider: A Provider who formally agrees: to provide to enrolled individuals in Medicaid, screening, diagnosis, and treatment for conditions identified during EPSDT screening visits (within the Provider's capacity) or referral to a Provider capable of providing the appropriate services; maintains a complete health history, including information received from other Providers; is responsible for providing needed physician services for acute, episodic and/or chronic illnesses and conditions; and ensures accountability by submitting reports reasonably required by the Contractor and/or DCH.

Contract: The written agreement between the State and the Contractor; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Award: The date upon which the Apparent Successful Vendor Letter(s) is issued by the Department of Administrative Services.

Contract Effective Date: The date when the rights and obligations under the Contract become operational. For purposes of this Contract, the Effective Date is the date upon which the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS) approves the Terms and Conditions of the Contract.

Contract Execution Date: The date upon which all Parties have signed the Contract.

Contractor: The Care Management Organization with a valid Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner that contracts hereunder with the State for the provision of comprehensive Health Care services to Members on a capitated basis.

Contractor's Representative: The individual legally empowered to bind the Contractor, using his/her signature block, including his/her title.

Coordination of Care: The deliberate organization of Member care activities by a CMO between two or more Providers involved in a Member's care, in order to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required Member care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Co-payment: The part of the cost-sharing requirement for Members in which a fixed monetary amount is paid for certain services/items received from the Contractor's Providers.

Core Services: Those supports/services provided by outpatient Behavioral Health agencies offering a comprehensive range of Mental Health, addictive disease, and/or specialty services that meet conditions of the Medicaid program specifically under the Medicaid Rehabilitation Option. Also known as Community Behavioral Health Rehabilitation Services.

Corrective Action: A reaction to a problem, complaint or issue that has already occurred. The actions initiated are intended to fix the problem/issue and modify the quality system so that the process that caused it is monitored to prevent a recurrence. Documentation for a Corrective Action provides evidence that the problem was recognized, corrected and proper controls were implemented to make sure that it does not happen again. The process for reacting to problems, complaints or other issues includes:

i. Reviewing and defining the problem/issue
ii. Finding the cause of the problem/issue
iii. Developing an action plan to correct the problem/issue and prevent a recurrence
iv. Implementation of the action plan
v. Evaluating the effectiveness of the correction

Corrective Action Plan: The detailed written plan required by DCH to correct or resolve a deficiency or event that may result in the assessment of a Liquidated Damage or sanction against the CMO.

Corrective Action Preventive Action (CAPA) Process: A step-by-step process for completing and documenting preventive and corrective actions. The steps assist investigators in detecting potential problems or reacting to existing problems and eliminating or correcting them. The CAPA process may be linked to liquidated damages.

Corrective Action Preventive Action (CAPA) Program: A fundamental management tool that provides a simple step by step process for completing and documenting corrective or preventive actions. The end result of implementation of this program is a complete, well documented investigation and solution that will satisfy DCH's

requirements and form the basis for an effective continuous improvement plan. Liquidated damages may be linked to this program.

Cost Avoidance: A method of paying Claims in which the Provider is not reimbursed until the Provider has demonstrated that all available health insurance has been exhausted.

Cost Sharing: Premium charges, copayment, or other similar fees that the Member has responsibility for paying.

Covered Outpatient Drug: Drugs which are treated as a prescribed drug for the purposes of section 1905(a)(12) of the Social Security Act which may be dispensed upon a prescription. Such drugs are approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or are approved under section 505(j) of the Act. Such drugs may have been commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962.

Covered Services: Those Medically Necessary Health Care services provided to Members, the payment or indemnification of which is covered under this Contract.

Credentialing Verification Organization (CVO): An entity contracted by the State to determine the qualifications and ascribed privileges of providers to render specific Health Care services. The entity will make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families.

Crisis: A condition of instability/danger or dramatic emotional or circumstantial upheaval in a person's life requiring action or change.

Critical Access Hospital (CAH): A hospital that meets the CMS requirements to be designated as a Critical Access Hospital and that is recognized by DCH as a Critical Access Hospital for purposes of Medicaid.

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

Deliverable: A document, manual or report submitted to DCH by the Contractor to fulfill requirements of this Contract.

Demonstration (also Family Planning Waiver, Planning for Health Babies, or the P4HB Program): The 1115 Demonstration waiver program in Georgia supported by CMS that expands the delivery of family planning services to uninsured women, ages eighteen (18) through forty-four (44), who have family income at or below 200 percent of the Federal Poverty Level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). Georgia's only 1115 Demonstration waiver is referred to as the Family Planning Waiver, Planning for Healthy Babies, or the P4HB Program. This Demonstration includes three distinct groups: women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the FPL and are eligible for Family Planning Only Services; women ages eighteen (18) through forty-four (44) who are otherwise uninsured with family income at or below two hundred percent (200%) of the FPL who have delivered a very low birth weight (VLBW) infant and are eligible for Family Planning Services and Interpregnancy Care Services; and women ages eighteen (18) through forty-four (44) who are current Medicaid recipients, have delivered a VLBW infant and are eligible for Resource Mother services only.

Demonstration Disenrollment: The removal of a P4HB participant from participation in the Demonstration.

Demonstration Enrollee: An individual meeting P4HB Program eligibility requirements who selects or is otherwise assigned to a Georgia Families CMO in order to receive Demonstration services.

Demonstration Enrollment: The process by which an individual eligible for the P4HB program applies to utilize a Georgia Families CMO to receive Demonstration services and such application is approved by DCH or its Agent.

Demonstration Period: The period during which the Demonstration is effective based on approval from CMS.

Demonstration Provider: A physician, advanced practice nurse or other health care provider who meets the State's Medicaid provider enrollment requirements for the Demonstration; hospital, facility, or pharmacy licensed or otherwise authorized to provide Demonstration related Services to P4HB participants within the State or jurisdiction in which they are furnished. Also known as a P4HB Provider.

Demonstration Related Emergency Medical Condition: A medical condition resulting from a Demonstration related Service and manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the woman in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. A Demonstration related Emergency Medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

Demonstration Related Post Stabilization Services: Covered Services related to a Demonstration related Emergency Medical Condition that are provided after a P4HB participant is stabilized in order to maintain the stabilized condition or to improve or resolve the P4HB participant's condition.

Demonstration Related Services: Those Demonstration Services identified in the CMS Special Terms and Conditions and approved by CMS that are available to P4HB participants.

Demonstration Related Urgent Care Services: Medically Necessary treatment of a Demonstration related injury, illness or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Dental Home: A Primary Dental Provider who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the State Plan. P4HB members are not eligible for a Dental Home.

Dental Subspecialty Providers: Specialized dental providers including endodontists, oral pathologists, orthodontists, oral surgeons, periodontists, pedodontists, and prosthodontists.

Department of Behavioral Health and Developmental Disabilities (DBHDD): The Georgia state agency that provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD serves people of all ages with the most severe and likely to be long-term conditions, including consumers with forensic issues.

Department of Community Health (DCH): The single state Agency in the State of Georgia responsible for oversight and administration of the Medicaid program, the PeachCare for Kids® program, the Planning for Healthy Babies Program and the State Health Benefit Plan (SHBP).

Department of Community Health Performance, Quality and Outcomes Unit (DCH PQO Unit): A unit within the DCH Medicaid Division charged with ensuring that all aspects of the department's Quality Strategic Plan are implemented, and defining enhancements to the plan that would drive health improvements for Georgia's Medicaid population served by the CMOs.

Department of Public Health: The Georgia state agency with the ultimate responsibility for the health of communities and the entire population.

Diagnostic Related Group (DRG): Any of the payment categories that are used to classify patients and especially Medicare patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred. The payment category is determined primarily by the principal diagnosis, surgical procedure used, age of patient, and expected length of stay in the hospital.

Diagnostic Services: Any medical procedures or supplies recommended by a physician or other licensed medical practitioner, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature or extent of illness, injury, or other health deviation in a Member.

Discharge: Point at which Member is formally released from a hospital, by the treating physician, an authorized member of the physician's staff or by the Member after they have indicated, in writing, their decision to leave the hospital against medical advice.

Discharge Planning Pilot Program: A pilot program the CMOs will implement with hospitals(s) that agree to participate to improve coordination for Members being discharged from the hospital. The intent of this program is to improve quality of care and outcomes, as well as to reduce readmissions.

Disenrollment: The removal of a Member from enrollment with a CMO, but not necessarily from the Medicaid or PeachCare for Kids® programs.

Documented Attempt: A bona fide, or good faith, attempt on the part of a CMO to contract with a Provider. Such attempts may include written correspondence that outlines contracted negotiations between the parties, including rate and contract terms disclosure, as well as documented verbal conversations, to include date and time and parties involved.

Driver Diagrams: A road map for changes and interventions that provides a way to organize thoughts around what needs to be done in order to achieve the aim. There are two types of drivers:

i. Primary drivers – system components that will contribute to improving outcomes; and
ii. Secondary drivers – elements of the associated primary drivers that help create the changes. The secondary drivers are interventions expected to affect primary drivers and thus outcomes, and are evidence-based, necessary and sufficient for improvement.

Durable Medical Equipment (DME): Equipment, including assistive technology, which:

i. Can withstand repeated use;
ii. Is used to service a health or functional purpose;
iii. Is ordered by a qualified practitioner to address an illness, injury or disability; and
iv. Is appropriate for use in the home, work place, or school.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit: A comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age twenty-one (21), as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is designed to assure

that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The EPSDT benefit also covers Medically Necessary diagnostic services. The Contractor is required to arrange for and cover, under the EPSDT benefit, any Medicaid covered service listed in Section 1905(a) of the Act if that treatment or service is determined to be Medically Necessary to correct or ameliorate defects and physical and mental illnesses or conditions. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age twenty-one (21) enrolled in the Medicaid and PeachCare for Kids® programs. P4HB Members are not eligible for the EPSDT Benefit.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program: The program that defines the policy, reimbursement, and oversight for the EPSDT services described under the EPSDT Benefit. The goal of the EPSDT program is to ensure that individual children get the health care they need when they need it.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

Emergency Medical Screening: An examination: (i.) provided on hospital property, and provided for that patient for whom it is requested or required, (ii.) performed within the capabilities of the hospital's emergency room (ER) (including ancillary services routinely available to its ER), (iii.) the purpose of which is to determine if the patient has an Emergency Medical Condition, and (iv.) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or Physician Assistant as permitted by State statutes and regulations and hospital bylaws .

Emergency Services: Covered inpatient and outpatient services furnished by a qualified Provider needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the Prudent Layperson standard.

Encounter: Information relating to the receipt of any item(s) or service(s) by a Member enrolled in Georgia Families or Georgia Families 360.

Encounter Claims: Records of Claims paid by the CMO, or by its Subcontractors, to Providers that have provided Health Care services to Members. The CMO is required to submit Encounter Claims to the State's Data Warehouse vendor and Fiscal Agent Contractor that include required, optional, and situational data fields as specified in the

Encounter Data Companion Guides, relevant 837 and National Council for Prescription Drug Programs standards, and other Encounter Claims data reporting documentation, where applicable.

Enrollment: The process by which an individual eligible for Medicaid or PeachCare for Kids® applies (whether voluntary or mandatory) to utilize the Contractor's plan in lieu of the Fee-for-Service program and such application is approved by DCH or its Agent.

Enrollment Broker: The entity engaged by or on behalf of DCH to assist in outreach, education and Enrollment activities associated with the Georgia Families and P4HB programs.

Enrollment Period: The twelve (12) month period commencing on the effective date of Enrollment.

Evaluate: The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

Expedited Review: For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision with twenty-four (24) hours and provide notice as expeditiously as the Member's health condition requires and no later than three (3) Business Days after receipt of the request for service. The Contractor may extend the twenty-four (24) hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's interest.

External Quality Review (EQR): The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the Health Care services that a CMO or its Subcontractors furnish to Members.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, and other related activities.

Family Planning Provider: A physician, advanced practice nurse, or other Health Care provider who meets the State's Medicaid provider enrollment requirements for providing family planning services to eligible Members.

Family Planning Services: Family planning services and supplies include at a minimum:

i. Education and counseling necessary to make informed choices and understand contraceptive methods;

ii. Initial and annual complete physical examinations;
iii. Follow-up, brief and comprehensive visits;
iv. Pregnancy testing;
v. Contraceptive supplies and follow-up care;
vi. Diagnosis and treatment of sexually transmitted diseases; and
vii. Infertility assessment.

Family Planning Waiver: See Demonstration.

Federally Qualified Health Center (FQHC): An entity that provides outpatient health programs pursuant to Section 1905(l) (2) (B) of the Social Security Act.

Federal Financial Participation (FFP): The funding contribution that the Federal government makes to the Georgia Medicaid and PeachCare for Kids® programs.

Federal Poverty Level (FPL): A measure of income level issued annually by the Department of Health and Human Services. Federal Poverty Levels are used to determine eligibility for certain programs and benefits.

Fee-for-Service (FFS): A method of reimbursement based on payment for specific services rendered to eligible Medicaid and PeachCare for Kids® individuals that are not participants in the Georgia Families or Georgia Families 360˚ programs.

Financial Relationship: A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity that equates to at least five percent (5%) or more of the disclosing entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation arrangement with an entity. This includes a mortgage, deed of trust, note or other obligation.

Fiscal Agent Contractor (FAC) or Fiscal Agent: The entity contracted with DCH to process Medicaid and PeachCare for Kids® Claims and other non-Claim specific payments.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law.

Full Month: All Calendar Days included in a month (i.e., all 28, 30 or 31 days of the month in consideration).

Full Quarter: Three consecutive Full Months starting with the first Full Month of the Calendar Year.

Full Time Provider: defined as a location operating for more than sixteen (16) hours in an office location each Week.

Geographic Access: A Provider Network fulfilling access criteria within set geographic restrictions.

Georgia Crisis and Access Line (GCAL): A twenty-four (24)-hour phone line sponsored by DBHDD to assist with coordinating access to care or provide support in an emergency or crisis.

Georgia Families: The risk-based managed care delivery program for Medicaid and PeachCare for Kids® in which DCH contracts with CMOs to manage the care of eligible Members.

Georgia Families 360°: The risk-based managed care delivery program for Foster Care Members, Adoption Assistance Members and Juvenile Justice Members.

Georgia Health Information Network (GaHIN): The technical infrastructure used to facilitate secure electronic exchange of electronic health records among authorized health care providers throughout the entire State of Georgia.

GaHIN Authorized User/Member Affiliate: Qualified Entities and GaHIN Member Users having authorized access to the GaHIN.

GaHIN Member Agreements: Written agreements that GaHIN and/or its Agents determine are required as a condition for a Qualified Member's participation in the network.

GaHIN Member Users/Member Affiliates: Any entity, organization or individual person who has been identified and authorized by a Qualified Member to access the GaHIN, in a manner defined by the respective Qualified Member, in compliance with an agreement between the Member User and the Qualified Member and applicable law. Member Users may include, but are not limited to, hospitals or Health Care systems, and employees, Contractors, or agents of a Qualified Member.

Georgia Pediatric Program (GAPP): The Fee for Service program serving medically fragile children.

Georgia Technology Authority (GTA): The State agency that manages the State's information technology (IT) infrastructure, i.e. data center, network and telecommunications services and security, establishes policies, standards and guidelines for State IT, promotes an enterprise approach to State IT, and develops and manages the State portal.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to,

the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. A Grievance includes a Member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

Grievance and Appeal System: The processes the Contractor implements to handle appeals of an Adverse Benefit Determination and/or Grievances, as well as the processes to collect and track information about them.

Health Care: Health Care means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental Condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Healthcare Effectiveness Data and Information Set (HEDIS®): A widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA).

Health Care Professional: A physician or other Health Care Professional, including but not limited to podiatrists, optometrists, chiropractors, psychologists, dentists, pharmacists, physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians licensed in the State of Georgia.

Health Check Program: The Early and Periodic Screening components of the EPSDT benefit are covered under this program pursuant to Title XIX of the Social Security Act.

Health Information Technology: Hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. Source is ARRA - H.R.1 -115 Sec. 3000 (5).

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV: Enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, the legislation was signed into law on February 17, 2009, to promote the adoption and meaningful use of Health Information Technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic

transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

Health Insurance Portability and Accountability Act (HIPAA): A federal law that includes requirements to protect the privacy of individually identified health information in any format, including written or printed, oral and electronic, to protect the security of individually identified health information in electronic format, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers. When referenced in this Contract it includes all related rules, regulations and procedures.

Health Maintenance Organization: an entity organized for the purpose of providing Health Care and has a Health Maintenance Organization Certificate of Authority or Consent Order issued by the Office of the Insurance and Safety Fire Commissioner, which contracts with Providers and furnishes Health Care services on a capitated basis to Members.

Health Professional Shortage Area (HPSA): An area designated by the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental or mental health providers. These areas can be geographic, demographic or institutional in nature. A care area can be found using the following website: http://hpsafind.hrsa.gov/.

Health Risk Screening: The Health Risk Screening is used to collect comprehensive information on FC Members or AA Members.

Historical Provider Relationship: A Provider who has been the main source of Demonstration, Medicaid or PeachCare for Kids® services for the Member or P4HB participant during the previous year (decided on by the most recent Provider on the Member's or P4HB participant's Claim history).

Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)): A law enacted by the Georgia state legislature and codified as O.C.G.A. § 31-8-179 et seq. The Hospital Medicaid Financing Program Act establishes (i) a hospital provider fee that is assessed by the State on Hospital Medicaid Financing Program Act Providers and (ii) an additional add-on payment with each CMO Claim payment that is equal to 11.88% of the Hospital Medicaid Financing Program Act Provider's contracted reimbursement rate with the CMO.

Hospital Medicaid Financing Program Act Provider: An institution licensed pursuant to Chapter 7 of Title 31 of the Official Code of Georgia Annotated which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, and other specialty hospitals but shall not include psychiatric hospitals as

defined in paragraph (7) of Code Section 37-3-1, Critical Access Hospitals as defined in paragraph (3) of Code Section 33-21A-2, or any state owned or state operated hospitals.

Immediately: Within twenty-four (24) clock hours.

Implementation Phase: The period of time from the Contract Effective Date through the Operational Start Date.

Incentive Arrangement: Any mechanism under which a Contractor may receive additional funds over and above the Capitation Payments, excluding Provider incentive payments made under Value Based Purchasing, for exceeding targets specified in the Contract.

Incurred-But-Not-Reported (IBNR): Estimate of unpaid Claims liability, includes received but unpaid Claims.

Indian: Any individual defined at 25 U.S.C. 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 CFR 136.12. This individual is a member of a Federally recognized Indian tribe, resides in an urban center and meets the federal criteria outlined in 42 C.F.R. § 438.14.

Individualized Education Program (IEP): A mandate of the IDEA that defines the individualized objectives of a child who has been found with a disability, as defined by federal regulations. The IEP is intended to help children reach educational goals more easily than they otherwise would and refers both to the educational program to be provided to a child with a disability and to the written document that describes that educational program.

Individualized Family Service Plan (IFSP): A document developed when a child under the age of three (3) is found eligible for early-intervention services. The IFSP focuses on the child and family and the services that a family needs to help them enhance the development of their child.

Individually Identifiable Health Information: See Protected Health Information**.**

Individuals with Disabilities Education Act (IDEA): A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Individuals with Disabilities Education Act (IDEA) Part B: A law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to infants, toddlers, children and youth with disabilities. Part B focuses on children and youth ages three (3) to twenty-one (21) and their receipt of special education and related services. For Medicaid Members aged three (3) to twenty-one (21), the CMOs are not responsible for reimbursing Local

Education Agencies for the provision of Medically Necessary IDEA Part B services, provided pursuant to an IEP in the school setting.

Individuals with Disabilities Education Act (IDEA) Part C: Part C of IDEA serves infants and toddlers through age two (2) with developmental delays or who have diagnosed physical or mental conditions with high probabilities that these conditions will result in developmental delays.

Information: (i) Structured Data: Data that adhere to specific properties and Validation criteria that is stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; and (ii.) Document: Information that does not meet the definition of Structured Data that includes, at minimum, text, files, spreadsheets, electronic messages and images of forms and pictures.

Information System/Systems: A combination of computing hardware and software that is used in: (i.) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. Structured Data (which may include digitized audio and video) and documents; and/or (ii.) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

In-Network Provider: A Provider that has entered into a Provider contract with the Contractor to provide Health Care services.

Inpatient Facility: Hospital or clinic for treatment that requires at least one overnight stay.

Insolvent: Unable to meet or discharge financial liabilities.

International Classification of Diseases (ICD): The ICD is based on the World Health Organization's manual of international classification of diseases and is published by the American Medical Association.

Interpregnancy Care (IPC): A benefit available to those P4HB participants who meet the Demonstration's eligibility requirements and who delivered a Very Low Birth Weight baby on or after initiation of the Demonstration.

Interpregnancy Care Service Providers: Those Demonstration Providers serving the IPC P4HB participants including Nurse Case Managers and Resource Mothers.

Interpregnancy Care Services: Services available under the Demonstration for P4HB participants who meet the eligibility criteria for the IPC program. These services are in addition to Family Planning Services and include: limited primary care services; management and treatment of chronic diseases; Substance Abuse treatment (detoxification and intensive outpatient rehabilitation); case management, including Resource Mothers outreach; limited dental; prescription drugs (non-family planning) for

the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery and Non-Emergency Transportation.

Interpretation Services: The act or result of explaining, discovering, or ascertaining the meaning of all non-English language between speakers who speak different languages. Interpretation Services allow the transference of meaning between spoken languages. The interpreter must be fluent in both the original language and the target language and must translate the language to make it understandable. Interpretation Services are available free of charge to Potential Members and enrolled Members.

Key Staff: Contractor's staff which includes the Chief Executive Officer, Member Services Director, Provider Services Director, Utilization Management Director, Medical Director, Quality Management Director, Health Services Director and the Program Implementation Manager. Key Staff must be full-time employees located in Georgia with no other client responsibilities other than the Georgia Families, Georgia Families 360˚ or P4HB programs**.**

Limited-English-Proficient Population: Individuals with a primary language other than English, with a limited ability to read, write, speak or understand English, and who must communicate in their primary language if the individual is to have an equal opportunity to participate effectively in, and benefit from, any aid, service or benefit provided by the Health Care Provider.

Local Education Agency (LEA): The official designation for a school district in the State of Georgia.

Long Term: A period greater than thirty (30) Calendar Days.

Low Birth Weight (LBW): Birth weight below 2,500 grams (5.5 pounds).

Mandated Reporters: People in professions who have regular contact with vulnerable people such as children, disabled persons and senior citizens and are therefore legally required to report (or cause a report to be made) when abuse, neglect or exploitation is observed or are suspected. The specific professionals are typically named in state law. Georgia identified Mandated Reporters in the Official Code of Georgia Annotated for adults and children §§ 30-5-1, et seq. and 19-7-5(c)(1) which include, but are not limited to: Physicians licensed to practice medicines, interns or residents; dentists; psychologists; chiropractors; podiatrists; pharmacists; physical therapists; occupational therapists; licensed professionals and counselors; nursing personnel; social work personnel; day care personnel; employees of a public or private agency engaged in professional health-related services; and law enforcement personnel.

Mandatory Enrollment: The process whereby an individual eligible for the Demonstration, Medicaid or PeachCare for Kids® is required to enroll in a CMO, unless otherwise exempted or excluded, to receive covered Demonstration, Medicaid or PeachCare for Kids® services.

Marketing: Any communication from a CMO to any Demonstration, Medicaid or PeachCare for Kids® eligible individual, who is not enrolled in that CMO that can reasonably be interpreted as intended to influence the individual to enroll in that particular CMO, or not enroll in or disenroll from another CMO.

Marketing Materials: Materials that are produced in any medium, by or on behalf of a CMO, and can reasonably be interpreted as intended to market to any Member.

Material Subcontractor: A Subcontractor, excluding Providers, receiving Subcontractor payments from the Contractor in amounts equal to or greater than ten (10) million dollars annually during the State fiscal year.

Measurable: Applies to a Contractor objective and means the ability to determine definitively whether or not the objective has been met, or whether progress has been made toward a positive outcome.

Medicaid: The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act, which in Georgia is administered by DCH.

Medicaid Care Management Organizations Act: O.C.G.A. §33-21A-1, *et seq*. Medicaid Care Management Organizations Act. A bill passed by the Georgia General Assembly, signed into law by the Governor, and effective July 1, 2008 which outlines several administrative requirements with which the administrators of the Medicaid Managed Care plan must comply. Some of the requirements include dental Provider networks, emergency room Claims payment requirements, eligibility verification, and others.

Medicaid Eligible: An individual eligible to receive services under the Medicaid Program but not necessarily enrolled in the Medicaid Program.

Medicaid Management Information System (MMIS): Computerized system used for the processing, collecting, analysis, and reporting of Information needed to support Medicaid and CHIP functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manual.

Medical Director: The Georgia-licensed physician designated by the Contractor to exercise general supervision over the provision of health service Benefits by the Contractor.

Medical Home: A person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers, and where appropriate, the individual's family and other supports. A focal point for information sharing and referral to specialists and sub-specialists as well as community evaluations and interpretation of specialists.

Medical Loss Ratio: A mechanism or tool utilized for various CMO program purposes including, but not limited to, ensuring that program dollars are spent on health care services, covered benefits, and quality improvement efforts rather than on potentially unnecessary administrative activities, assessing whether capitation rates are appropriate, and for rebating purposes. MLR must be calculated and reported in accordance with the provisions of 42 CFR § 438.8. The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR § 438.8(e)) to the denominator (as defined in accordance with 42 CFR §438.8(f)) and subject to any applicable adjustments, as provided under this Contract and Attachment X**.**

Medical Records: The complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's participating Primary Care or Demonstration Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

Medical Screening: An examination used to identify an unrecognized or recognized disease in individuals without signs or symptoms.

Medical/Surgical (M/S) Benefits: Benefits for items or services for medical conditions or surgical procedures, defined by the State for the analysis of mental health parity compliance as diagnostic codes listed in all Chapters other than Chapter 5 of the current ICD manual.

Medically Necessary Services (includes concepts of Medically Necessary and Medical Necessity): Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary Services are those that are:

i. Required to correct or ameliorate a defect, physical or mental illness, or a Condition
ii. Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's medical Condition
iii. Compatible with the standards of acceptable medical practice
iv. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
v. Not provided solely for the convenience of the Member or the convenience of the Health Provider
vi. Not primarily custodial care unless custodial care is a Covered Service or benefit under the Member's evidence of coverage
vii. Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available

Member: A Medicaid, P4HB, or PeachCare for Kids® recipient who is currently enrolled in a CMO unless otherwise noted.

Mental Health: A state of emotional and psychological well-being in which the individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.

Mental Health/Substance Use Disorder (MH/SUD) Benefits: Benefits for items or services for mental health or substance abuse conditions, defined by the State for the analysis of mental health parity compliance as diagnostic codes listed in Chapter 5 of the current ICD manual.

Mental Illness: A behavioral or psychological syndrome or disorder that presents as a mental or behavioral anomaly and reflects an underlying psychobiological dysfunction the consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning).

Methodology: The planned process, steps, activities or actions taken by the Contractor to achieve a goal or objective, or to progress toward a positive outcome.

Monitoring: The process of observing, evaluating, analyzing and conducting follow-up activities.

National Committee for Quality Assurance (NCQA): An organization that sets standards, and evaluates and accredits health plans and other managed care organizations.

National Provider Identifier (NPI): A unique ten digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). Providers must use their NPI to identify themselves in all HIPAA transactions.

Neonatal Intensive Care Unit (NICU): Hospital unit which provides intensive care services for sick and premature newborns.

Neonatal Intensive Care Unit (NICU) Supplemental Payments: Payments made to the Care Management Organizations for Georgia Families Members when those Members receive certain services in a NICU.

Net Capitation Payment: The Capitation Payment, adjusted for the applicable VBP Withhold, made by DCH to the Contractor excluding NICU Supplemental Payments, Obstetrical Delivery Payments, or other medical services that are on a per occurrence basis rather than a per Member basis.

Non-Capitated Services: Services not included in the CMO's Capitation Rate.

Non-Emergency Transportation (NET): A ride, or reimbursement for a ride, provided so that a Member or P4HB participant with no other transportation resources can receive services from a medical provider. NET does not include transportation provided on an emergency basis, such as trips to the Emergency Room in life threatening situations.

Non-Institutional Claims: Claims submitted by a medical Provider other than a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF/ID).

Non-Quantitative Treatment Limit (NQTL): Non-quantitative types of limits on the scope or duration of benefits, such as: medical management standards, prior authorization standards, provider network admission standards, reimbursement rates, or step therapy.

Normal Birth Weight: Birth weight greater than or equal to 2,500 grams (5.5 pounds).

Nurse Practitioner Certified (NP-C): A registered professional nurse who is licensed by the State of Georgia and meets the advanced educational and clinical practice requirements beyond the two (2) or four (4) years of basic nursing education required of all registered nurses.

Objective: Measurable step, generally in a series of progressive steps, to achieve a goal.

Obstetrical Delivery Payment: A one-time payment made to the Care Management Organization for the delivery of a Georgia Families newborn. This payment is in addition to the Georgia Families Capitation Payment for the newborn. The Care Management Organization is eligible for the Obstetrical Delivery Payment based on submission of the paid Claim associated with the related obstetrical and/or hospital services as defined by DCH. Also known as the OB Kick Payment.

Office of Insurance and Safety Fire Commissioner: The Agency in the State of Georgia responsible for licensing, overseeing, regulating, and certifying insuring entities.

Ombudsman Coordinator: An employee of the Contractor who is responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that Members have access to Covered Services and non-Covered Services. The Ombudsman Coordinator is also responsible for interacting with DCH's equivalent Ombudsman staff and submitting reports to DCH.

Ombudsman Liaison:. An employee of the Contractor who is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to Health Care services, and identifying the communication and education needs of Members, Providers and caregivers. The Ombudsman Liaison must assist Members and Providers in coordinating services with local community organizations and working with advocacy organizations. The Ombudsman Liaison is also responsible for interacting with DCH's equivalent Ombudsman staff and submitting reports to DCH.

Operational Start Date: The date upon which the Contractor begins providing services to Members under the Contract. The anticipated Operational Start Date is July 1, 2016; however, DCH reserves the right to set a later date in its sole discretion.

Ordering, Prescribing, Referring (OPR) Provider: Pursuant to the Patient Protection and Affordable Care Act and resulting regulations at 42 CFR 455.410(b), a physician or non-physician practitioner that orders, prescribes or refers services for a Member. OPR providers must be enrolled in Medicaid as either a participating Medicaid Provider or as an OPR Provider and his or her National Provider Identifier (NPI) number must be included on submitted claims.

Out-of-Network Provider: A Provider of services that does not have a Provider contract with the Contractor.

Parent Company: A company which owns and controls other companies, usually known as subsidiaries.

Part Time Practice: A location operating for less than sixteen (16) hours in an office location each Week.

Participating Provider: A Provider that has signed a contract with CMOs to provide services to Members.

Pass-through Payment: Any amount required by DCH to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the Contractor and hospitals, physicians, or nursing facilities that is not for the following purpose: A specific service or benefit provided to a specific Member covered under this contract; a provider payment methodology permitted for services and Members covered under this contract; a subcapitated payment arrangement for a specific set of services and Members covered under this contract; GME payments; or FQHC or RHC wrap around payment.

Patient Centered Medical Home (PCMH): Georgia recognizes Providers as PCMHs if they have received NCQA PCMH recognition. A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care. A medical home achieves these goals through a high level of accessibility, providing excellent communication among patients, physicians and staff and taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.

Patient Protection and Affordable Care Act (PPACA): The Patient Protection and Affordable Care Act is a federal statute, signed into law on March 23, 2010. The law includes numerous health-related provisions that will take effect over a four year period, including expanding Medicaid eligibility, subsidizing insurance premiums, establishing health insurance exchanges and support of medical research. Also known as ACA.

PeachCare for Kids®: The State of Georgia's Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act.

Performance Improvement Project (PIP): A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy benefit management services including but not limited to claims processing and maintenance of associated systems and related processes.

Physical Health: The treatment focused on the care and oversight of the general medical Condition of a person and related Physical Health Care services.

Physician Assistant (PA): A trained, licensed individual who performs tasks that might otherwise be performed by physicians or under the direction of a supervising physician.

Physician Incentive Plan: Any compensation arrangement between a Contractor and a Provider that is designed to identify and reward desired behavior or outcomes.

Physician Practice Connections-Patient Centered Medical Home (PPC®-PCMH): The PPC-PCMH is a Recognition Program that emphasizes systematic use of patient-centered, coordinated care management processes. In order to obtain the PPC-PCMH Recognition, the entity must meet specific elements in the following categories: (1) Access and Communication, (2) Patient Tracking and Registry Functions, (3) Care Management, (4) patient Self-Management and Support, (5) Electronic Prescribing, (6) Test Tracking, (7) Referral Tracking, (8) Performance Reporting and Improvement, and (9) Advanced Electronic Communication.

Planning for Healthy Babies Program (P4HB): The name of the 1115 Family Planning Demonstration Waiver Program in Georgia. See definition of Demonstration.

Population Health Management (PHM): The management, integration and outcome measurement of any program affecting the health and productivity of your organization, i.e. corporate wellness, disease management, catastrophic case management, Utilization Management, Employee Assistance Program (EAP), disability, and/or worker's compensation programs.

Post Stabilization Services: Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

Potential Member: A Medicaid or CHIP recipient who is subject to mandatory Enrollment in a CMO but is not yet the Member of a specific CMO.

Potential P4HB Participant: An individual meeting the eligibility requirements for the Demonstration who is subject to mandatory Enrollment in a CMO but is not yet enrolled in a specific CMO.

Pre-Certification: Review conducted prior to a Member's admission, stay or other service or course of treatment in a hospital or other facility.

Preconception Health Care: The primary prevention of maternal and perinatal morbidity and mortality comprised of interventions that identify and modify biomedical, behavioral and social risks to pregnancy outcomes for women and their offspring. To have maximal impact on pregnancy outcomes, strategies to address risks must occur before conception or before prenatal care is typically initiated.

Preferred Health Organization (PHO): A coordinated care plan that: (i.) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (ii.) provides for reimbursement for all covered benefits regardless of whether the benefits are provided with the network of providers; and (iii.) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

Pregnancy Rate: The number of pregnancies occurring to females in a specified age group per 1,000 females in the specified age group. The rate is calculated by using the following formula: Pregnancy rate = [Number of pregnancies in age group / Female population in age group] * 1000. Rates that use Census Population Estimates in the denominator are unable to be calculated when the selected population is unknown.

Prevalent Non-English Language: A language other than English, spoken by a significant number or percentage of Members, Potential Members or P4HB participants who are Limited-English-Proficient.

Preventive Action: An intervention initiated to stop a potential problem from occurring. A Preventive Action assumes that adequate monitoring and controls are in place in the Quality system to assure that potential problems are identified and eliminated before they happen. If something in the Quality system indicates that a possible problem is or may develop, a Preventive Action must be implemented to avert and then eliminate the potential situation. Documentation for a Preventive Action provides evidence that an effective Quality system has been implemented that is able to anticipate, identify and eliminate potential problems. The process for detecting potential problems/issues and eliminating them includes:

i. Identifying the potential problem/issue
ii. Finding the cause of the potential problem/issue
iii. Developing a plan to prevent the occurrence of the problem/issue
iv. Implementing the plan
v. Reviewing the actions taken and the effectiveness in preventing the problem

Preventive Services: Services provided by a physician or other licensed health practitioner within the scope of his or her practice under State law to: prevent disease, disability, and other health Conditions or their progression; treat potential secondary Conditions before they happen or at an early remediable stage; prolong life; and promote physical and mental health and efficiency.

Primary Care: All Health Care services and laboratory services, including periodic examinations, preventive Health Care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of Referrals to specialty Providers described in this Contract, and for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner or alternative Provider types such as specialists to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP): A licensed health care practitioner, usually a doctor, nurse practitioner, or physician assistant who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required Primary Care services to Members. A PCP shall include general/family practitioners, pediatricians, internists, OB/GYNs, Physicians' Assistants, or nurse practitioners. The PCP's role is to:

i. Provide preventive care and teach healthy lifestyle choices
ii. Identify and treat common medical conditions
iii. Assess the urgency of your medical problems and direct you to the best place for that care
iv. Make referrals to medical specialists when necessary

Primary Dental Provider (Dentist): A licensed dentist who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required general dental services to Georgia Families and Georgia Families 360º Members. A Dentist shall include general dental practitioners provided that the Dentist is able and willing to carry out all Dentist responsibilities in accordance with these Contract provisions and licensure requirements. The Dentist is responsible for coordinating referrals, as needed, with Dental Subspecialty Providers and all subsequent dental care.

Prime Contractor: Primary Contractor of the Contract who holds full responsibility of the completion of the job. The Contractor, regardless of use of Subcontractors, is the Prime Contractor of this Contract.

Prior Authorization: Authorization granted in advance of the rendering of a service after appropriate medical review. Also known as Pre-Authorization or Prior Approval.

Prior Authorization Portal: The electronic web-based system through which Providers and the CMOs communicate about Prior Authorization requests submitted by Providers.

Proposed Action: The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMO to act within the time frames provided in 42 CFR 438.408(b).

Prospective Payment System (PPS): A method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Protected Health Information (PHI): A subset of health information, including demographic information collected from an individual and (1) created or received by a health care provider, health plan, employer, or health care clearinghouse, and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) is a reasonable basis to believe the information can be used to identify the individual. This information is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health information (i) in education records covered by the Family Educational Rights and Privacy Act, (ii) in employment records held by a covered entity in its role as employer; (iii) regarding persons who have been deceased for more than fifty (50) years; and (iv) in records described at 20 U.S.C. § 1232g (a) (4) (B) (iv).

Provider: Any person (including physicians or other Health Care Professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide Health Care Services that has contracted with a Care Management Organization to provide health care services to Members.

Provider Complaint: A written expression by a Provider, which indicates dissatisfaction or dispute with the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.

Provider Contract: Any written contract between the Contractor and a Provider that requires the Provider to perform specific parts of the Contractor's obligations for the provision of Health Care services under this Contract.

Provider Directory: A listing of health care service Providers under contract with the CMO that is prepared by the CMO as a reference tool to assist Members in locating Providers available to provide services.

Provider Number (or Provider Billing Number): An alphanumeric code utilized by health care payers to identify providers for billing, payment, and reporting purposes.

Provider Preventable Condition: A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in 42 CFR 447.26(b). Payment for provider preventable conditions are prohibited.

Provider Withhold: A percentage of payments or set dollar amounts that a Contractor deducts from a Provider's payment or fee, or salary payment, and that may or may not be returned to the Provider, depending on specific predetermined factors.

Prudent Layperson: A person with average knowledge of health and medicine who could reasonably expect the absence of immediate medical attention to result in an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that could cause:

i. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
ii. Serious impairment to bodily functions; or
iii. Serious dysfunction of any bodily organ or part.

Psychiatric Residential Treatment Facility (PRTF): A separate, standalone entity providing a range of comprehensive psychiatric services to treat the psychiatric Condition of residents under age twenty-one (21) years on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's Condition or prevent further regression so that the services will no longer be needed. (42 CFR §483.352, subpart D of part 441).

Qualified Electronic Health Record: "An Electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists; and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relevant to health care quality; and to exchange electronic health information with and integrate such information from other sources." Source is ARRA - H.R.1 -115 Sec. 3000 (13)

Qualified Entities (QEs): Entities that have permission from DCH and/or its designee to access services available on the GaHIN Network and meet a set of DCH-established criteria, have completed an approval process, and have signed participation documentation with Contractor. QEs ensure that Participant Users and/or vendors with which they have agreements comply with the applicable terms of participation and related policy documentation.

Qualified Member: Individuals who meet a set of established criteria, successfully complete the approval process, and sign agreements to abide by GaHIN policies. GaHIN Member Users have permission to access, consume, and make available data transport services on the statewide health information network.

Quality: The degree to which a CMO increases the likelihood of desired health outcomes of its Members through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

Quantitative Treatment Limit (QTL): Types of limits on the scope or duration of benefits that are represented numerically, such as: number of visits, days of coverage, or days in a waiting period.

Query-Based Exchange: Technology and functionality that GaHIN Authorized Users/Member Affiliates will use to search for and locate individual Member records.

Rapid Cycle Process Improvement: A quality improvement method that identifies, implements, and measures changes made to improve a process or a system. Rapid-cycle improvement implies that changes are made and tested over short time frames (weeks to months) rather than years.

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

Re-admission: Subsequent admissions of a patient to a hospital or other health care institution for treatment within thirty (30) Calendar Days of the date of Discharge.

Recoupment: The recovery by the Contractor of any Medicaid debt by reducing present or future Medicaid payments and applying the amount withheld to the indebtedness.

Referral: A request by a PCP for a Member to be evaluated and/or treated by a different physician, usually a specialist.

Referral Services: Those Health Care services provided by a Health Care Professional other than the Primary Care Provider and which are ordered and approved by the Primary Care Provider or the Contractor.

Referring Provider: The Provider who has evaluated the Member, determined the need for a consultation (or other service), and has arranged the services of the consulting provider for the purpose of diagnosis and/or treatment.

Reinsurance: An agreement whereby the Contractor transfers risk or liability for losses, in whole or in part, sustained under this Contract. A reinsurance agreement may also exist at the Provider level.

Remedial Action: Action required immediately to remedy a situation until a thorough investigation and a permanent solution is implemented. When remedial actions are necessary, the actions and the resources required must be listed and the steps that must be taken immediately to avoid any further adverse effects are explained. All actions taken are documented and become part of the 'Action Plan' section of the Corrective Action/Preventive Action actions. If a remedial action is all that is needed, a rationale for that decision and appropriate follow up must be documented.

Remedy: The State's means to enforce the terms of the Contract through performance guarantees and other actions.

Reprocessing (Claims): Upon determination of the need to correct the outcome of one or more Claims processing transactions, the subsequent attempt to process a single Claim or batch of Claims.

Requirements Analysis Documents (RADs): A set of documents that describe the technical and business process requirements of each Deliverable identified in the Contract. Each requirement is defined in such way that its achievement is capable of being objectively verified by a prescribed method (for example inspection, demonstration, analysis, or test) and serves as a contractual basis between DCH and Contractor. DCH shall post such RADs on the DCH website and the Contractor shall access this information as determined by DCH. DCH reserves the right to modify the RADs as needed. The initial RADs will be developed by DCH during the Implementation Phase.

Resource Mother: A paraprofessional that provides a broad range of services to P4HB IPC participants and their families.

Resource Mother Outreach: Service under the P4HB program made available to women who receive Medicaid benefits and gives birth to a VLBW baby. The Resource Mother Outreach section offers support to mothers and provides them with information on parenting, nutrition, and healthy lifestyles.

Responsible Health Organization: Includes CMOs and FFS and is the party stated on the DCH MMIS portal as evidenced by the Provider's screen print out when the service is rendered within seventy-two (72) hours of that screen shot.

Revenue Codes: A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).

Risk Adjustment: A methodology that accounts for the health status of Members via relative risk factors when predicting or explaining costs of services covered under the

contract for defined populations or for evaluating retrospectively the experience of the Contractor.

Risk Corridor: A risk sharing mechanism in which DCH and Contractor may share in profits and losses under the contract outside of a predetermined threshold amount.

Routine Care: Treatment of a Condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physicians' office) or by the patient.

Rural Health Clinic (RHC): A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to Primary Care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, Physician Assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least fifty percent (50%) of the time with a mid-level practitioner. RHCs may also provide other Health Care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs.

Rural Health Services: Medical services provided to rural sparsely populated areas isolated from large metropolitan counties.

Security Rule: Establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic Protected Health Information. Ref. 45 CFR Part 160 and Subparts A and C of Part 164.

Service Authorization: A Provider's request for services for Georgia Families Members.

Service Region: A geographic area defined by the State that is used for reporting and analytical purposes.

Short Term: A period of thirty (30) Calendar Days or less.

Span of Control: Information systems and telecommunications capabilities that the CMO itself operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The CMO span of control also includes Information Systems and telecommunications capabilities outsourced by the CMO.

Stabilized: With respect to an Emergency Medical Condition; that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a woman in labor, the woman has delivered (including the placenta).

State: The State of Georgia.

State Fair Hearing: See Administrative Law Hearing.

State Health Benefit Plan (SHBP): The health benefit plan administered by the Georgia Department of Community Health covering State employees, public school teachers, public school employees, retirees and their eligible dependents, and other entities under such acts for health insurance.

State Plan: A comprehensive written statement submitted by DCH describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal Financial Participation (FFP) in the State program.

State-Vaccine-Eligible Child: With respect to a State and a qualified pediatric vaccine, a child who is within a class of children for which the State is purchasing the vaccine pursuant to subsection (d)(4)(B) of the Social Security Act.

Subcontract: Any written contract between the Contractor and a third party, including a Provider, to perform a specified part of the Contractor's obligations under this Contract.

Subcontractor: An individual or entity that has a contract with Contractor that relates directly or indirectly to the performance of the Contractor's obligations under this contract.

Subcontractor Payments: The all-inclusive amount the Contractor pays a Subcontractor for services rendered.

Substance Abuse: Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. The term may also reference the field of clinical study and treatment of individuals who have experienced chronic disease related to substance abuse.

System Access Device: A device used to access Information System functions; can be any one of the following devices if it and the System are so configured: (i.) Workstation (stationary or mobile computing device), (ii.) Network computer/"winterm" device, (iii.) "Point of Sale" device, (iv.) Phone, or (v.) Multi-function communication and computing device, e.g. Personal Digital Assistant (PDA).

System Function Response Time: Based on the specific sub-function being performed:

i. *Record Search Time*: The time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.

ii. *Record Retrieval Time*: The time elapsed after the retrieve command is entered until the record data begins to appear on the monitor.

iii. *Print Initiation* Time: The elapsed time from the command to print a screen or report until it appears in the appropriate queue.

iv. *On-line Claims Adjudication Response Time*: The elapsed time from the receipt of the transaction by the Contractor from the Provider and/or switch vendor until the Contractor hands-off a response to the Provider and/or switch vendor.

System of Care: A spectrum of effective, highly-coordinated community-based services and supports for children and youth with or at risk for mental health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families' and youths' needs to help them to function better at home, in school, in the community, and throughout life.

System of Care core values and philosophy include an expectation that services and supports: are culturally and linguistically competent; ensure availability and access to effective traditional and nontraditional services as well as natural and informal supports that address physical, emotional, social, and educational needs; are planned in true partnership with the child and family and a family peer professional representative; and include intensive care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

This definition is culled from an Issue Brief by the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, http://gucchdtacenter.georgetown.edu/resources/. The Contractor will reference and incorporate revised definitions, protocol, and operations as indicated according to published updates issued by the National Technical Assistance Center for Children's Mental Health.

System Unavailability: Failure of the system to provide a designated user access based on service level agreements or software/hardware problems within the Contractor's Span of Control.

Telecommunication Device for the Deaf (TDD): Special telephony devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones.

Telemedicine: Delivery of medical or other health services provided to a patient utilizing real-time interactive communication equipment to exchange the patient's information from one site to another via an electronic communication system.

The Joint Commission (TJC): An agency that certifies and accredits healthcare organizations who have complied with and met certain standards.

Third Party Resource: Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a Member applicant for or recipient of medical assistance.

Transition of Care: A process or mechanism to ensure a Member's continued access to services during a transition from Fee-for-Service to a CMO, from a CMO to Fee-for-Service, or from one CMO to another CMO. This may also include the movement of patients between health care practitioners and/or settings as their condition and care needs change during the course of a chronic or acute illness. For FC Members, JJ Members and AA Members, Transition of Care planning may involve activities or needs related to a Member's placement in DFCS custody, DJJ supervision, transition from FFS Medicaid or commercial health plans to the Georgia Families 360º program; transition from a CMO to the Georgia Families 360º CMO, changes in Residential Placement, aging out of Foster Care or exiting DJJ supervision. Access to services must be consistent with the services previously received and available for a limited period of time.

Translation Services: The act or process of changing or converting one language to another language. The translator must be fluent in both the original source language and the target language and must translate the language to make it understandable. Translation Services may also include the use of computer tools or technology. Translation Services are available free of charge to Potential Members and enrolled Members.

Unique Provider: A provider who furnishes, bills, or is paid for health care services provided to Members and who has been assigned a designated National Provider Identifier (NPI). The provider is identified utilizing the designated NPI number. Multiple practice locations are not taken into consideration when identifying the Provider.

Unique Provider Identifier: The National Provider Identifier (NPI) number assigned to an individual provider notwithstanding the provider's multiple office or practice locations.

Urgent Care: Medically Necessary treatment for an injury, illness, or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Utilization: The rate patterns of service usage or types of service occurring within a specified time.

Utilization Management (UM): A service performed by the Contractor which seeks to assure that Covered Services provided to Members are in accordance with, and

appropriate under, the standards and requirements established by the Contract, or a similar program developed, established or administered by DCH.

Utilization Review (UR): Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of Health Care services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, Discharge Planning, or retrospective review.

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Value-Based Purchasing: An enhanced approach to purchasing and program management that focuses on value over volume. It is part of a comprehensive strategy that aligns incentives for Members, Providers, Contractor and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.

Value-Based Purchasing (VBP) Performance Management Team (PMT): Monitors CMO performance on VBP initiatives. Members of the VBP Performance Management Team include:

i. Medicaid Director
ii. DCH senior level employee(s)
iii. Leadership from Georgia healthcare departments that support Medicaid: quality management, provider networks, medical management, member services, community outreach and finance
iv. Contract Liaisons
v. Representatives from DCH and Contractor's legal departments, as appropriate
vi. As appropriate, management from enterprise functions (e.g., communications, information technology)
vii. Key leadership from the Contractor (e.g., Medical Director Chief Operating Officer or other designee approved by DCH)
viii. As appropriate, operational-level Contractor staff

Value-Based Purchasing Withhold: DCH will withhold five percent (5%) of the Contractor's Capitation Payments for the Value-Based Purchasing program. DCH may return all, part or none of the withheld funds to the Contractor as incentive payments based on the Contractor achieving identified VBP performance targets. The maximum incentive payment to the Contractor will be the full five percent (5%) VBP Withhold.

Very Low Birth Weight (VLBW): Birth weight below 1,500 grams (3.3 pounds).

Virtual Health Record (VHR): A virtual view of many data sources that contain patient health records. The VHR enables authorized users to query Member health information.

Week: The traditional seven-day week, Sunday through Saturday.

Withhold arrangement: Any payment mechanism under which a portion of a capitation rate is withheld from Contractor and a portion of or all of the withheld amount will be paid to the Contractor for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract.

Work Week: The traditional work week, Monday through Friday.

Working Days: Monday through Friday but shall not include Saturdays, Sundays, or State and Federal holidays.

1.5 ACRONYMS

For purposes of this Contract the following acronyms are defined as follows:

AA Member – Adoption Assistance Member

AAPD – American Academy of Pediatric Dentistry

ABD – Aged Blind Disabled

ACE – Administrative Claiming for Education

ACIP – Advisory Committee on Immunization Practices

AD – Addictive Disease

ADL – Activities of Daily Living

AFDC – Aid to Families with Dependent Children

AHRQ – Agency for Healthcare Research and Quality

AICPA – American Institute of Certified Public Accountants

BHH - Behavioral Health Home

BIN – Bank Identification Number

CAH – Critical Access Hospital

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CAPA – Corrective Action Preventive Action

CAPTA – Child Abuse Prevention and Treatment Act

CASA – Court Appointed Special Advocate

CBAY – Community-Based Alternatives for Youth

CCFA – Comprehensive Child and Family Assessment

CCP – Comprehensive Community Providers

CDC – Centers for Disease Control and Prevention

CFR – Code of Federal Regulations

CFT – Child and Family Team

CHIP – Children's Health Insurance Program – formerly known as the State Children's Health Insurance Program (SCHIP)

CISS – Children's Intervention School Services

CLIA – Clinical Laboratory

CMHRS – Community Mental Health Rehabilitation Services

CMO – Care Management Organization

CMP – Community Medicaid Providers

CMS – Centers for Medicare & Medicaid Services
CNM – Certified Nurse Midwives

COA – Certificate of Authority

COMP – Comprehensive Supports Waiver Program

COS – Category of Service

CPS – Child Protective Services

CSB – Community Service Boards

CVO – Credentialing Verification Organization

DBHDD – Department of Behavioral Health and Developmental Disabilities

DCH – Department of Community Health

DECAL – Department of Early Care and Learning

DFCS – Division of Family and Children Services

DJJ – Department of Juvenile Justice

DMAP – Division of Medical Assistance Plans

DME – Durable Medical Equipment

DO – Doctor of Osteopathy

DOE – Department of Education

DPH – Department of Public Health

DRG – Diagnostic Related Group

EB – Enrollment Broker

ED - Emergency Department

EDI – Electronic Data Interchange

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

ER – Emergency Room

eRFP – electronic Request for Proposal

eRFQC – electronic Request for Qualified Contractors

EVS - Eligibility Verification System

FAC - Fiscal Agent Contractor

FC Member – Foster Care Member

FFP – Federal Financial Participation

FFS – Fee-for-Service

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

GaHIN – Georgia Health Information Network

GAPP – Georgia Pediatric Program

GCAL – Georgia Crisis and Access Line

GEPS – Georgia Enterprises for Products and Services

GF – Georgia Families

GF 360 – Georgia Families 360º

GFMOC – Georgia Families Monitoring and Oversight Committee

GTA - Georgia Technology Authority

HEDIS – Healthcare Effectiveness Data and Information Set

HHS – US Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Maintenance Organization

HPSA – Health Professional Shortage Area

IBNR – Incurred-But-Not-Reported

ICAMA – Interstate Compact on Adoption and Medical Assistance

ICF/ID – Intermediate care facility for the intellectually disabled

ICPC – Interstate Compact on the Placement of Children

ICWP – Independent Care Waiver Program

ICD – International Classification of Diseases

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IFI – Intensive Family Intervention

IFSP – Individualized Family Service Plan

INS – U.S. Immigration and Naturalization Services

IPC – Interpregnancy Care component of the 1115 Demonstration Waiver

JJ Member – Juvenile Justice Member

JPPS – Juvenile Parole/Probation Specialist

LBW – Low Birth Weight

LEAs – Local Education Agencies

LIM – Low-Income Medicaid

LIPT – Local Interagency Planning Team

MDT – Multidisciplinary Team

MH/SUD – Mental Health/Substance Use Disorder

MLR – Medical Loss Ratio

M/S – Medical/Surgical

MMIS – Medicaid Management Information System

MSHCN – Members with Special Health Care Needs

NAIC – National Association of Insurance Commissioners

NCM – Nurse Care Manager

NCQA – National Committee for Quality Assurance

NCTSN – National Child Traumatic Stress Network

NET – Non-Emergency Transportation

NICU – Neonatal Intensive Care Unit

NOIA – Notice of Intent to Award

NOW – New Options Waiver Program

NP-C – Certified Nurse Practitioners

NPI – National Provider Identifier

O.C.G.A. – Official Code of Georgia Annotated

OSAH – Office of State Administrative Hearings

P4HB – Planning for Healthy Babies 1115 Demonstration Waiver

PA – Physician Assistant

PBM – Pharmacy Benefit Manager

PCMH - Patient Centered Medical Home

PCP – Primary Care Provider

PDF – Portable Document Format file

PDSA – Plan Do Study Act

PHI – Protected Health Information

PHM – Population Health Management

PHO – Preferred Health Organization

PIP – Performance Improvement Project

PMPM – Per Member Per Month

PPACA – Patient Protection and Affordable Care Act

PPC®-PCMH - Physician Practice Connections-Patient Centered Medical Home

PPS – Prospective Payment System

PQO – Performance, Quality and Outcomes

PRTF – Psychiatric Residential Treatment Facility

QAPI – Quality Assessment Performance Improvement

QEs – Qualified Entities

RBWO – Room Board and Watchful Oversight

RFP – Request for Proposal

RHC – Rural Health Clinic

RIAT – Regional Interagency Team

RSM – Right from the Start Medicaid

SED – Severe Emotional Disorder

SHBP – State Health Benefit Plan

SHD – Systems Help Desk

SP – Specialty Providers

SSA – Social Security Act

SSI – Supplemental Security Income

SUD – Substance use Disorder

SUCCESS – System for the Uniform Calculation and Consolidation of Economic Support

TANF – Temporary Assistance for Needy Families

TCN – Transaction Control Number

TJC – The Joint Commission

TDD – Telecommunication Device for the Deaf

UM – Utilization Management

UPIN – Unique Provider Identifier Number

UR – Utilization Review

VBP – Value Based Purchasing

VFC – Vaccines for Children

VHR – Virtual Health Record

VLBW – Very Low Birth Weight

W3C – World Wide Web Consortium

2.0 DCH RESPONSIBILITIES

2.1 GENERAL PROVISIONS

2.1.1 DCH is responsible for administering the GF program. The Department will administer the Contract, monitor Contractor performance, and provide oversight in all aspects of the Contractor operations.

2.2 LEGAL COMPLIANCE

2.2.1 DCH will comply with, and will monitor Contractor's compliance with, all applicable State and federal laws and regulations, including but not limited to, implementing and abiding by all requirements established by CMS.

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

2.3 ELIGIBILITY AND ENROLLMENT

2.3.1 The State of Georgia has the sole authority for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for Enrollment

in GF. DCH or its Agent will determine eligibility for PeachCare for Kids® and will collect applicable premiums. DCH or its Agent will continue responsibility for the electronic eligibility verification system (EVS).

2.3.2 DCH has sole authority for determining the enrollment process subject to compliance with all applicable laws and the State Plan.

2.3.2.1 Following the Contract Execution Date, DCH shall determine whether an initial open enrollment period for all Georgia Families members will be provided to allow members to select a CMO in accordance with the enrollment process established by DCH including any threshold percentage limiting the number of enrolled Members in a single plan. Any such initial open enrollment period shall be conducted in accordance with RFP Section 1.1.5 Transition Planning or such other transition plan approved by DCH in its sole discretion. DCH's approved transition plan shall support each CMO reaching a minimum of 200,000 enrolled members during the initial open enrollment period; however, thereafter, notwithstanding anything to the contrary herein, DCH shall have no obligation to ensure any CMO receives or maintains a minimum number of enrolled members.

2.3.2.2 DCH or its Agent will review the Medicaid Management Information System (MMIS) file daily and automatically assign Members who are determined eligible for GF. Within two (2) Business Days, written notification of the assignment will be issued to the Member. Thereafter, a Member shall have ninety (90) Calendar Days to select a different CMO. DCH or its Agent will issue a daily notice of all Enrollments to the CMO.

2.3.3 DCH or its Agent will Auto-Assign the individual to a CMO using the following algorithm:

2.3.3.1 If an immediate family member(s) of the Member is already enrolled in one CMO, the Member will be Auto-Assigned to that plan;

2.3.3.2 If there are no immediate family members already enrolled and the Member has a Historical Provider Relationship with a Provider, the Member will be Auto-Assigned to the CMO where the Provider is contracted;

2.3.3.3 If the Member does not have a Historical Provider Relationship with a Provider in any CMO, or the Provider contracts with all plans, the Member will be Auto-Assigned based on an algorithm determined by DCH that may include quality, cost or other measures.

2.3.3.4 For the Potential P4HB participant DCH or its Agent will Auto-Assign the individual to a CMO using the algorithm described in Section 2.3.3 for Members.

2.3.3.5 Women already enrolled in GF due to pregnancy will have an expedited enrollment into the Demonstration upon termination of their pregnancy benefits. Members determined to be eligible for the Demonstration must be afforded the opportunity to choose a new CMO, if desired, for the delivery of Demonstration related Services. All P4HB participants will have ninety (90) Calendar Days from the date of eligibility notification to choose a CMO.

2.3.3.6 The Contractor will notify its current pregnant Members at least thirty (30) Calendar Days prior to the expected date of delivery and prior to the date upon which the Member will end RSM, that they may be eligible to enroll in the Demonstration and may choose to switch to a different CMO for receipt of Demonstration services. Members who do not make a choice will be deemed to have chosen to remain in their current CMO for receipt of the Demonstration services they are eligible to receive.

2.3.4 Enrollment will be effective at 12:01 a.m. on the first (1st) Calendar Day after receipt of the Member's eligibility.

2.3.5 DCH or its Agent may include quality measures in the Auto-Assignment algorithm. Members will be Auto-Assigned to those plans that have higher scores based on quality, cost, or other measures to be defined by DCH. This factor will be applied after determining that there are no Historical Provider Relationships.

2.3.6 In any Service Region or on a statewide basis, DCH may, at its discretion, set a threshold percentage for the enrollment of Members in a single plan and change this threshold percentage at its discretion. Members will not be Auto Assigned to a CMO that exceeds this threshold unless a family member is enrolled in the CMO or a Historical Provider Relationship exists with a Provider that does not participate in any other CMO in the Service Region. When DCH changes the threshold percentage applicable statewide or in any Service Region, DCH will provide the CMOs with a minimum of fourteen (14) days advance notice in writing.

2.3.7 DCH or its Agent will have five (5) Business Days to notify Members and the CMO of the Auto-Assignment. Notice to the Member will be made in writing and sent via surface mail. Notice to the CMO will be made via file transfer.

2.3.8 DCH or its Agent will be responsible for the consecutive Enrollment period and re-Enrollment functions. Unless a Member is disenrolled or ineligible, the Member will remain enrolled with the selected or auto-assigned CMO for a period of twelve (12) consecutive months. The consecutive twelve (12) month period begins on the first day of Enrollment or the date the notice is sent to the Member, whichever is later. Prior to month twelve (12), DCH or its Agent will notify the Member of the upcoming option to change to a different CMO. This is considered the Member's enrollment anniversary. If the Member does not elect to

change CMO effective on their enrollment anniversary, the Member shall remain in its current CMO.

2.3.9 Conditioned on continued eligibility, all Members will be enrolled in a CMO for a period of twelve (12) consecutive months.

2.3.10 DCH or its Agent will automatically enroll a Member into the CMO in which he or she was most recently enrolled if the Member has a temporary loss of eligibility, defined as sixty (60) Calendar Days or less. In this circumstance, the consecutive Enrollment period will continue as though there has been no break in eligibility, keeping the original twelve (12) month period.

2.3.11 DCH or its Agent will notify Members at least once every twelve (12) months, and at least sixty (60) Calendar Days prior to the date upon which the consecutive Enrollment period ends (the annual Enrollment opportunity), that they have the opportunity to switch CMOs. Members who do not make a choice will be deemed to have chosen to remain with their current CMO.

2.3.12 In the event a temporary loss of eligibility has caused the Member to miss the annual Enrollment opportunity, DCH or its Agent will enroll the Member in the CMO in which he or she was enrolled prior to the loss of eligibility. The Member will receive a new sixty (60) Calendar Day notification period beginning the first day of the next month.

2.3.13 In accordance with current operations, DCH or its Agent will issue a Medicaid number to a newborn upon notification from the hospital, or other authorized Medicaid Provider.

2.3.14 DCH will notify Contractor that a Member is an expectant mother based on the pregnancy Category of Service. Alternatively, the member may have existing eligibility and is updated with an expected due date. Upon notification from DCH, the CMO shall mail a newborn enrollment packet to the expectant mother. This packet shall include information that the newborn will be Auto-Assigned to the mother's CMO and that she may, if she wants, select a PCP for her newborn prior to the birth by contacting her CMO. The mother shall have ninety (90) Calendar Days from the day a Medicaid number was assigned to her newborn to choose a different CMO.

2.3.15 DCH may, at its sole discretion, elect to modify the Auto-Assignment algorithm, threshold percentage and/or use quality, cost, or other measures to conduct auto-assignments for reasons it deems necessary and proper.

2.4 DISENROLLMENT

2.4.1 Individuals that are no longer Medicaid eligible must be disenrolled from the Contractor's plan. DCH or its Agent will process all CMO Disenrollments. This includes Disenrollments due to non-payment of the PeachCare for Kids® premiums, loss of eligibility for GF due to other reasons, and all Disenrollment

requests Members or P4HB participants or the Contractor submits via telephone, surface mail, internet, facsimile, and in person.

2.4.2 DCH or its Agent will make final determinations about granting Disenrollment requests and will notify the Contractor via file transfer and the Member or P4HB participant via surface mail of any Disenrollment decision within five (5) Calendar Days of making the final determination.

2.4.3 If a Member is hospitalized in an acute inpatient facility on the first day of the month their Disenrollment is to be effective, the Member will remain enrolled until the end of the month of their Discharge from the inpatient facility. When Disenrollment is necessary due to a change in eligibility category, or eligibility for GF, the Member will be disenrolled according to Section 2.4.2.

2.4.4 When Disenrollment is necessary because a Member loses Medicaid or PeachCare for Kids® eligibility (for example, he or she has died, been incarcerated, or moved out-of-state) Disenrollment shall be immediate.

2.5 MEMBER SERVICES AND MARKETING

2.5.1 Contractor shall produce and make available all marketing materials in English and all prevalent, non-English languages spoken within the State of Georgia. Prevalent, non-English languages shall be identified (1) on a county basis in accordance with the methodology outlined within Appendix A of the CMS Memo dated September 18, 2013 and attached hereto as **Attachment F** or (2) utilizing such other methodology approved by DCH. On a semi-annual basis or upon DCH's request, Contractor shall apply the approved methodology to reassess prevalent, non-English languages and translate all marketing materials into any newly identified prevalent, non-English languages.

2.5.2 DCH will review and prior approve all marketing materials.

2.5.3 DCH will provide the Contractor with DCH logos and designs when such logos and designs are appropriate to the written materials being produced.

2.6 COVERED SERVICES & SPECIAL COVERAGE PROVISIONS

2.6.1 For Medicaid and PeachCare for Kids®, Medically Necessary Services and Benefits pursuant to the Georgia State Medicaid and CHIP State Plans and the Georgia Medicaid Policies and Procedures Manuals are covered. Such Medically Necessary Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

2.6.2 Specific services available under the P4HB Demonstration are outlined in **Attachment L** to this Contract.

2.7 NETWORK

2.7.1 DCH will provide to the Contractor up to date changes to the State's list of excluded Providers, as well as any additional information that will affect the Contractor's Provider network.

2.7.1.1 DCH may consider Contractors' requests to waive network geographic access requirements in rural areas with insufficient potential Providers. All such requests shall be submitted in writing.

2.7.1.2 DCH will provide the State's Provider Credentialing policies and processes to the Contractor upon execution of this Contract.

2.7.1.3 DCH will screen and enroll and periodically revalidate all network providers enrolled in Contractor's network.

2.8 QUALITY MONITORING

2.8.1 General Provisions

2.8.1.1 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor. In accordance with 42 CFR 438.204, this strategy will, at a minimum, monitor:

2.8.1.1.1 The availability of services;

2.8.1.1.2 The adequacy of the Contractor's capacity and services;

2.8.1.1.3 The Contractor's coordination and continuity of care for Members;

2.8.1.1.4 The coverage and authorization of services;

2.8.1.1.5 The Contractor's policies and procedures for selection and retention of Providers;

2.8.1.1.6 The Contractor's compliance with Member information requirements in accordance with 42 CFR §438.10;

2.8.1.1.7 The Contractor's compliance with State and federal privacy laws and regulations relative to Member's confidentiality;

2.8.1.1.8 The Contractor's compliance with Member Enrollment and Disenrollment requirements and limitations;

2.8.1.1.9 The Contractor's Grievance System;

2.8.1.1.10 The Contractor's oversight of all Subcontractor relationships and delegations;

2.8.1.1.11 The Contractor's adoption of practice guidelines, including the dissemination of the guidelines to Providers and Providers' application of them;

2.8.1.1.12 The Contractor's quality assessment and performance improvement program; and

2.8.1.1.13 The Contractor's health information systems.

2.8.1.2 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor for the Demonstration and the outcomes resulting from those services. This strategy is incorporated in **Attachment M**.

2.8.2 Value-Based Purchasing

2.8.2.1 Prior to the Operational Start Date, DCH will establish the VBP Performance Management Team, which will be responsible for planning, implementing and executing the VBP initiative. Key responsibilities include:

2.8.2.1.1 Overseeing execution of the VBP model;

2.8.2.1.2 Working collaboratively with the Contractor to meet identified performance measures and targets;

2.8.2.1.3 Reviewing Contractor progress monthly, quarterly and annually;

2.8.2.1.4 Identifying lessons learned and necessary adjustments;

2.8.2.1.5 Determining incentive payouts;
2.8.2.1.6 Assessing liquidated damages; and

2.8.2.1.7 Communicating results to stakeholders.

2.8.2.2 DCH will publish a VBP Operations Manual and will be responsible for updates to such manual as determined by DCH.

2.8.2.3 Value-Based Purchasing is a withhold arrangement that is for a fixed period of time. Contractor's performance is measured during the rating period in which the withhold arrangement is applied. Value-Based Purchasing must be made available to both public and private contractors under the same terms of performance. Contractor's participation in Value-Based Purchasing does not require Contractor to enter into or adhere to intergovernmental transfer agreements.

2.9 COORDINATION WITH CONTRACTOR'S KEY STAFF

2.9.1 DCH will make diligent good faith efforts to facilitate effective and continuous communication and coordination with the Contractor in all areas of GF operations.

2.9.2 Specifically, DCH will designate individuals within the Department who will serve as a liaison to the corresponding individual on the Contractor's staff, including:

2.9.2.1 A program integrity staff Member;

2.9.2.2 A quality oversight staff Member;

2.9.2.3 A Grievance System staff Member who will also ensure that the State Administrative Law Hearing process is consistent with the Rules of the Office of the State Administrative Hearings Chapter 616-1-2 and with any other applicable rule, regulation, or procedure whether State or federal;

2.9.2.4 An information systems coordinator; and

2.9.2.5 A contract compliance staff Member.

2.10 FORMAT STANDARDS

2.10.1 DCH will provide to the Contractor its standards for formatting all Reports requested of the Contractor. DCH will require that all Reports be submitted electronically.

2.11 FINANCIAL MANAGEMENT

2.11.1 In order to facilitate the Contractor's efforts in using Cost Avoidance processes to ensure that primary payments from the liable third party are identified and collected to offset medical expenses, DCH will include information about known Third Party Resources on the electronic Enrollment data given to the Contractor.

2.11.2 DCH will monitor Contractor compliance with federal and State physician and member incentive plan rules and regulations.

2.12 INFORMATION SYSTEMS

2.12.1 DCH will supply the following information to the Contractor:

2.12.1.1 Application and database design and development requirements (standards) that are specific to the State of Georgia.

2.12.1.2 Networking and data communications requirements (standards) that are specific to the State of Georgia.

2.12.1.3 Specific information for integrity controls and audit trail requirements.

2.12.1.4 State web portal (Georgia.gov) integration standards and design guidelines.

2.12.1.5 Specifications for data files to be transmitted by the Contractor to DCH and/or its agents.

2.12.1.6 Specifications for point-to-point, uni-directional or bi-directional interfaces between Contractor and DCH systems.

2.13 READINESS AND ANNUAL REVIEW

2.13.1 DCH or its Agent will conduct a readiness review of each Contractor at least ninety (90) Calendar Days prior to Enrollment of Members in the CMO. DCH or its Agent will conduct the reviews to provide assurances that the Contractor is able and prepared to perform all administrative functions and is providing high quality of services to Members.

2.13.2 Specifically, DCH's review will document the status of the Contractor with respect to meeting program standards set forth in this Contract, as well as any goals established by the Contractor. A multidisciplinary team appointed by DCH will conduct the readiness and annual review. The scope of the reviews will include, but not be limited to, review and/or verification of the Contractor's Progress on the following:

2.13.2.1 Statewide network access;

2.13.2.2 System readiness;

2.13.2.3 Member and Provider call center readiness;

2.13.2.4 Staffing plan and staffing levels;

2.13.2.5 Progress and status in hiring and training staff and cross-training staff;

2.13.2.6 Transition of Care plan;

2.13.2.7 Training plan and training of Providers and CMO staff;

2.13.2.8 Development of policies and procedures, such as those addressing privacy and PCP and Dental Home assignment;

2.13.2.9 Provider education and outreach, including outreach plan for encouraging Providers to serve as Medical Homes or Dental Homes;

2.13.2.10 Care Management / Care Coordination;

2.13.2.11 Quality Management / Quality Improvement;

2.13.2.12 System of Care;

2.13.2.13 Utilization Management;

2.13.2.14 Physical Health and Behavioral Health Coordination;

2.13.2.15 Participation in the Georgia Families Monitoring and Oversight Committee;

2.13.2.16 Policies and procedures for the Grievance System and Complaint System; and

2.13.2.17 Financial solvency.

2.13.3 The review will assess the Contractor's ability to meet any requirements set forth in this Contract and documents referenced herein.

2.13.4 Members may not be enrolled in a CMO until DCH has determined that the Contractor is capable of meeting these standards. A Contractor's failure to pass the readiness review thirty (30) Calendar Days prior to the beginning of service delivery may result in the assessment and payment of liquidated damages against Contractor, delayed operations and/or immediate Contract termination. Contractor's failure to pass the annual review may result in liquidated damages, corrective action and/or Contract termination.

2.13.5 DCH will provide the Contractor with a summary of the findings as well as areas requiring remedial action after each readiness review phase.

3.0 GENERAL CONTRACTOR RESPONSIBILITIES

3.0.1 Contractor shall promptly deliver all required goods and services in a professional and workmanlike manner according to the Contract including all applicable professional standards.

3.0.2 Contractor shall maintain qualified staff and any other necessary business resources throughout the duration of the Contract to meet scheduled deadlines and all other performance requirements.

3.0.3 Comply with all State and DCH policies and standards in effect during the performance of the Contract, including but not limited to DCH's policies and standards relating to personnel conduct, security, safety, confidentiality, privacy and ethics.

3.04 Contractor shall immediately notify DCH of any of the following changes with respect to Contractor:

3.0.4.1 Change in business address, telephone number, facsimile number or e-mail address;

3.0.4.2 Change in entity status or nature;

3.0.4.3 Change in business location;

3.0.4.4 Change to a condition of insolvency (i.e. a state in which Contractor is unable to meet or discharge financial liabilities);

3.0.4.5 Change in entity officers, executive employees, or entity structure;

3.0.4.6 Material change in ownership or control (i.e. more than 5%);

3.0.4.7 Change in federal employee identification number or federal tax identification number;

3.0.4.8 Change in current litigation, audits and other governmental investigations, both in Georgia and in other states as well as at the federal level.

3.0.5 Contractor shall notify DCH of any of the following changes with respect to any Subcontractor(s):

3.0.5.1 Change in corporate status or nature;

3.0.5.2 Change in solvency; or

3.0.5.3 Material change in ownership or control (i.e. more than 5%).

3.0.6 Contractor shall request and receive DCH's prior written consent (which shall not be unreasonably withheld) before taking any of the following actions:

3.0.6.1 Change its legal status;

3.0.6.2 Change its legal structure; or

3.0.6.3 Sell, transfer, convey, or assign more than 5% ownership interest in the Contractor.

3.0.7 Should DCH not consent to any of the actions set forth in Section 3.0.6 and the Contractor desires to proceed with such action, then DCH may, at its option, elect to terminate this Contract at such date as determined by DCH.

3.0.8 Contractor shall authorize DCH, CMS, the Office of the Inspector General, the Comptroller General, and their designees to inspect and audit any records or documents of the Contractor, or its subcontractors. Further, Contractor shall authorize DCH, CMS, the Office of the Inspector General, the Comptroller General, and their designees to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. This authorization shall exist for 10 years from the final date of this contract period or from the date of completion of any audit, whichever is later.

3.09 Contractor shall meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

4.0 SPECIFIC CONTRACTOR RESPONSIBILITIES

The Contractor shall complete the following actions, tasks, obligations, and responsibilities:

4.1 ENROLLMENT

4.1.1 Enrollment Procedures

4.1.1.1 DCH or its Agent is responsible for Enrollment, including Auto-Assignment to a CMO, Disenrollment, education on enrollment options, and outreach activities. The Contractor shall coordinate with DCH and its Agent as necessary for all Enrollment and Disenrollment functions. Individuals that are no longer Medicaid eligible must be disenrolled from the Contractor's plan.

4.1.1.2 DCH or its Agent will make every effort to ensure that individuals who are ineligible for Enrollment are not enrolled in GF. However, to ensure that such individuals are not enrolled in GF, the Contractor shall assist DCH or its Agent in the identification of individuals who are ineligible for Enrollment in GF, as set forth Section 1.2.3, should such individuals inadvertently become enrolled in GF.

4.1.1.3 DCH or its Agent will make every effort to ensure that individuals ineligible for Enrollment in the Demonstration are not enrolled in GF as P4HB Participants. However, to ensure that such individuals are not enrolled in the Demonstration, the Contractor shall assist DCH or its Agent in the identification of P4HB Participants that are ineligible for enrollment in the Demonstration but have been inadvertently enrolled in GF as P4HB Participants.

4.1.1.4 The Contractor shall assist DCH or its Agent in the identification of individuals that become ineligible for Medicaid and PeachCare for Kids® (for example, those who have died, been incarcerated, or moved out-of-state, or no longer meet P4HB eligibility criteria due to sterilization).

4.1.1.5 The Contractor shall accept all eligible individuals for Enrollment as identified by DCH or its Agent without restrictions. The Contractor shall accept new enrollment from individuals in the order in which they apply without restriction, unless authorized by CMS, up to the limits set under the contract. The Contractor shall not discriminate against individuals on any basis, including but not limited to religion, gender, race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on any basis, including but not limited to religion, gender, race, color, national origin, sex, sexual orientation, gender identity, or disability or on the basis of health, health status, pre-existing Condition, or need for Health Care services.

4.1.2 Selection of a Primary Care Provider (PCP)

4.1.2.1 The Contractor shall provide all Members access to a Primary Care Provider (PCP), also referred to as a Medical Home, that serves as the single point of accountability and coordination—primarily for primary care. A PCP Model/Medical Home:

4.1.2.1.1 Is essentially a person-centered approach to providing comprehensive primary care that facilitates partnerships between individuals and their providers and, when appropriate, the individual's family and other supports.

4.1.2.1.2 Serves as a focal point for information sharing and Referral to specialists and sub-specialists, as well as communication, evaluation and interpretation of specialist recommendations.

4.1.2.1.3 Typically relies on advanced health information systems to support evidence-based care and includes resources to support the Coordination of Care.

4.1.2.1.4 Will allow better access to health care, increased satisfaction with the care process and improved health and health outcomes.

4.1.2.2. The Contractor shall ensure an adequate number of PCPs are available within its network. Assignment of a PCP should be based on a Member's identified needs and preference as well as Provider agreement and accessibility. The PCP's role is to:

4.1.2.2.1 Provide preventive care and teach healthy lifestyle choices

4.1.2.2.2 Identify and treat common medical Conditions

4.1.2.2.3 Assess the urgency of the Member's medical problems and direct them to the most appropriate place for that care

4.1.2.2.4 Make referrals to specialists when necessary

4.1.2.3 The Contractor shall work with DCH and Providers to decrease potentially preventable admissions and Re-admissions and avoidable use of the emergency department. The Contractor shall send PCPs a monthly list of Members with potentially preventable admissions or Re-admissions and avoidable use of the emergency department. PCPs shall work with Providers and the Contractor to identify and address gaps and implement innovative solutions to decreasing potentially preventable admissions or Re-admissions as well as avoidable use of the emergency department. The Contractor will report to DCH each provider-preventable condition. Contractor will not pay providers for the treatment of provider-preventable conditions.

4.1.2.4 The Contractor shall offer its Members the freedom of selecting a PCP to serve as a Medical Home. DCH or its Agent will encourage self-selection of a PCP and continuation of any existing satisfactory Provider relationship with the current PCP if the PCP participates in the Contractor's Network. Upon request from a Member, DCH or its

Agent will provide counseling or assistance in selecting a PCP. If a Member fails to select a PCP, or if the Member has been Auto-Assigned to the CMO, the Contractor shall Auto-Assign Members to a PCP based on the following Algorithm:

4.1.2.4.1 Auto-assign Member to a Provider with whom, based on FFS Claims history, the Member has a Historical Provider Relationship, provided that the geographic access requirements are met.

4.1.2.4.2 If no Historical Provider Relationship exists, Auto-Assign Member to the assigned PCP of an immediate family member enrolled in the CMO, if the Provider is an appropriate Provider based on the age and gender of the Member.

4.1.2.4.3 If other immediate family members do not have an assigned PCP, Auto-Assign Member to a Provider with whom a family member has a Historical Provider Relationship if the Provider is an appropriate Provider based on the age and gender of the Member.

4.1.2.4.4 If no Member or family member has a relationship with a Provider Auto-Assign Member to a PCP, using an algorithm developed by the Contractor and approved by DCH, based on the age and sex of the Member, and geographic proximity.

4.1.2.4.5 Pregnant Members may also select an obstetrician as their assigned PCP. If a pregnant Member fails to select an obstetrician, the Contractor may Auto-Assign the Member to an obstetrician, using an algorithm developed by the Contractor and approved by DCH, based on geographic proximity.

4.1.2.5 PCP assignment shall be effective immediately. The Contractor shall notify the Member via surface mail of their Auto-Assigned PCP within ten (10) Calendar Days of Auto-Assignment.

4.1.2.6 The Contractor shall submit its PCP Auto-Assignment Policies and Procedures during the Readiness Review at a date designated by DCH to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter.

4.1.2.7 The Contractor shall require that Members are assigned to the same PCP for a period of up to six (6) months, except for the following exceptions:

4.1.2.7.1 Members shall be allowed to change PCPs without cause during the first ninety (90) Calendar Days following PCP selection

4.1.2.7.2 Members shall be allowed to change PCPs with cause at any time. The following constitute cause for change:

4.1.2.7.2.1 The PCP no longer meets the geographic access standards as defined in this Contract;

4.1.2.7.2.2 The PCP does not, because of moral or religious objections, provide the Covered Service(s) the Member seeks; and

4.1.2.7.2.3 The Member requests to be assigned to the same PCP as other family members.

4.1.2.7.3 Members shall be allowed to change PCPs every six (6) months.

4.1.2.8 Primary Care services are not Covered Services under the Demonstration for Family Planning Only P4HB participants. However, Contractor shall encourage Family Planning Only P4HB participants to choose a Primary Care Provider. The Contractor shall maintain an up-to-date list of available Providers affiliated with the Georgia Association for Primary Health Care and other Providers serving the uninsured and underinsured populations who are available to provide primary care services. The Contractor must not use Demonstration funds to reimburse for primary care services delivered to Family Planning Only P4HB participants.

4.1.3 Dental Home

4.1.3.1 All Members under age twenty-one (21) shall have access to Dentists within thirty (30) minutes or thirty (30) miles of the Member's home address for urban areas and within forty-five (45) minutes or forty-five (45) miles for rural areas who will serve as the Members' Dental Home. The Dental Home is inclusive of all aspects of oral health and involves parents, the patient, dentists, dental professionals, and non-dental professionals. The Dental Home is the Primary Dental Provider who has

accepted the responsibility for providing or coordinating the provision of all dental care services covered under the Medicaid State Plan.

4.1.3.2 Upon request from a Member, DCH or its Agent will provide counseling or assistance in selecting a Dental Home. DCH or its Agent will encourage self-selection of a Dentist and continuation of any existing satisfactory relationship with their current Dentist if the Dentist participates in the Contractor's network. If the Member does not make a selection with DCH or its Agent at time of CMO selection, fails to select a Dentist, or has been Auto-Assigned to the CMO, the Contractor shall Auto-Assign Members to a Dental Home using an algorithm developed by the Contractor and approved by DCH, based on geographic proximity.

4.1.3.3 Dental Home assignment shall be effective immediately. The Contractor shall notify the Member via surface mail of their Dental Home Assignment within ten (10) Calendar Days of Auto-Assignment.

4.1.3.4 The Contractor shall submit its Dental Home Auto-Assignment Policies and Procedures to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.

4.1.3.5 IPC P4HB Members are not eligible for a Dental Home. IPC P4HB members are eligible for limited dental services which include emergency dental services.

4.1.4 Newborn Enrollment

4.1.4.1 All newborns shall be Auto-Assigned by DCH or its Agent to the mother's CMO. The Contractor shall notify DCH or its Agent of newborns born to enrolled Members who do not appear on the monthly roster.

4.1.4.2 The Contractor shall provide assistance to any Member who is an expectant mother who contacts them wishing to make a PCP selection for her newborn and record that selection.

4.1.4.3 If the mother has not made a PCP selection, the Contractor shall Auto-Assign the newborn to a PCP within thirty (30) Calendar Days of the birth. Auto-Assignment shall be made using the algorithm described in Section 4.1.2.4. Notice of the PCP Auto-Assignment shall be mailed to the mother within twenty-four (24) hours of assignment.

4.1.5 Assignment after Re-Enrollment

4.1.5.1 When a Member who selects a new CMO during annual Enrollment subsequently loses Medicaid or CHIP eligibility and is disenrolled for

more than sixty (60) Calendar Days, the Member is not automatically assigned to the same CMO if re-determined as eligible and reenrolled in GF. Instead, the Member is permitted a new open Enrollment CMO selection. When a Member loses Medicaid or CHIP eligibility and is re-determined to be Medicaid or CHIP eligible and reenrolled in GF within sixty (60) days, the Member shall be automatically assigned to the same CMO.

4.1.6 Reporting Requirements

4.1.6.1 The Contractor shall submit to DCH monthly Member Data Conflict Reports as described in the Requirements Analysis Documents (RADs), as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.1.6.2 The Contractor shall submit to DCH monthly Eligibility and Enrollment Reconciliation Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.2 DISENROLLMENT

4.2.1 Disenrollment Initiated by the Member

4.2.1.1 A Member may request Disenrollment or a change in CMO enrollment without cause during the ninety (90) Calendar Days following the date of the Member's initial Enrollment with the CMO or the date DCH or its Agent sends the Member notice of the Enrollment, whichever is later. A Member may request a change in CMO Enrollment without cause at least once every twelve (12) months thereafter and upon automatic reenrollment if the Member experiences a temporary loss of Medicaid eligibility and misses the annual disenrollment opportunity.

4.2.1.2 A Member may request Disenrollment or a change in CMO Enrollment for cause at any time. The following constitutes cause for requesting Disenrollment:

4.2.1.2.1 The Member moves out of the CMO's Service Region;

4.2.1.2.2 The CMO does not, because of moral or religious objections, provide the Covered Service the Member seeks;

4.2.1.2.3 The Member needs related services to be performed and not all related services are available within the Network. The Member's or Participant's Provider or another Provider have determined that receiving related services

from In-Network and Out-Of-Network Providers would subject the Member to unnecessary risk;

4.2.1.2.4 The Member requests to be assigned to the same CMO as family member(s); and

4.2.1.2.5 The Member's Medicaid Category of Eligibility changes to a category ineligible for GF, and/or the Member otherwise becomes ineligible to participate in GF.

4.2.1.3 Other reasons for Disenrollment initiated by the Member, pursuant to 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of Providers experienced in addressing the Member's Health Care needs. (DCH or its Agent shall make determination of these reasons).

4.2.1.4 The Contractor shall provide assistance to Members seeking to disenroll. This assistance shall consist of providing Disenrollment forms to the Member and referring the Member to DCH or its Agent who will make Disenrollment determinations.

4.2.2 Disenrollment Initiated by the Contractor

4.2.2.1 The Contractor shall complete all Disenrollment paperwork for Members it is seeking to disenroll.

4.2.2.2 The Contractor shall notify DCH or its Agent upon identification of a Member who it knows or believes meets the criteria for Disenrollment.

4.2.2.3 The Contractor may request Disenrollment if:

4.2.2.3.1 The Member's Utilization of services is Fraudulent or abusive.

4.2.2.3.2 The Member is placed in a long-term care nursing facility, State institution, or intermediate care facility for individuals with intellectual disabilities.

4.2.2.3.3 The Member's Medicaid eligibility category changes to a category ineligible for Georgia Families, and/or the Member otherwise becomes ineligible to participate in Georgia Families. Disenrollments due to Member eligibility will follow the normal monthly process as described in Section 4.2. Disenrollments will be processed as of the date that the Member eligibility category actually changes and will not be made retroactive, regardless of the effective date of the new

eligibility category. Note exception when Members become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization.

4.2.2.3.4 The Member has died, been incarcerated, or moved out of State, thereby making them ineligible for Medicaid.

4.2.2.3.5 The P4HB participant no longer meets the eligibility criteria for the Demonstration.

4.2.2.3.6 The IPC P4HB participant has reached the end of the twenty-four (24) months of eligibility for the IPC component of the Demonstration.

4.2.2.3.7 The P4HB participant becomes pregnant while enrolled in the Demonstration.

4.2.2.3.8 The P4HB participant becomes infertile through a sterilization procedure.

4.2.2.4 Prior to requesting Disenrollment of a Member, the Contractor shall document at least three (3) interventions over a period of ninety (90) Calendar Days that occurred through treatment, Case Management, and Care Coordination to resolve any difficulty leading to the request. The Contractor shall provide at least one (1) written warning to the Member, certified return receipt requested, regarding implications of his or her actions. This notice must be delivered within ten (10) Business Days of the Member's action.

4.2.2.5 The Contractor shall cite to DCH or its Agent at least one (1) acceptable reason for Disenrollment before requesting Disenrollment of the Member.

4.2.2.6 The Contractor shall submit Disenrollment requests to DCH or its Agent and the Contractor shall honor all Disenrollment determinations made by DCH or its Agent. DCH's decision on the matter shall be final, conclusive and not subject to appeal.

4.2.3 Unacceptable Reasons for Disenrollment Requests by Contractor

4.2.3.1 The Contractor shall not request Disenrollment of a Member for discriminating reasons, including but not limited to:

4.2.3.1.1 Adverse changes in a Member's health status;

4.2.3.1.2 Missed appointments;

4.2.3.1.3 Utilization of medical services;

4.2.3.1.4 Diminished mental capacity;

4.2.3.1.5 Pre-existing medical condition;

4.2.3.1.6 Uncooperative or disruptive behavior resulting from his or her special needs; or

4.2.3.1.7 Lack of compliance with the treating physician's plan of care.

4.2.3.2 The Contractor shall not request Disenrollment because of the Member's attempt to exercise his or her rights under the Grievance System.

4.2.3.3 The request of one PCP to have a Member assigned to a different Provider shall not be sufficient cause for the Contractor to request that the Member be disenrolled from the plan. Rather the Contractor shall utilize its PCP assignment process to assign the Member to a different and available PCP.

4.3 GEORGIA FAMILIES MEMBER SERVICES

4.3.1 General Provisions

4.3.1.1 The Contractor shall ensure that Members are aware of the following:

4.3.1.1.1 Member rights and responsibilities

4.3.1.1.2 The role of PCPs and Dental Home

4.3.1.1.3 The role of the Family Planning Provider and PCP (for IPC P4HB Participants only)

4.3.1.1.4 How to obtain care

4.3.1.1.5 What to do in an emergency or urgent medical situation (for P4HB participants information must address what to do in an emergency or urgent medical situation arising from the receipt of Demonstration related Services)

4.3.1.1.6 How to request a Grievance, Appeal, or Administrative Law Hearings

4.3.1.1.7 How to report suspected Fraud and Abuse

4.3.1.1.8 Providers who have been terminated from the Contractor's network

4.3.1.2 The Contractor must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting; and email that allow Members to submit questions and receive responses from the Contractor while protecting the confidentiality and PHI of the Members in all instances. The Contractor shall attempt to collect/obtain Member email addresses from Members. Upon request, the Contractor must provide materials in the format preferred by the Member.

4.3.2 Requirements for Written Materials

4.3.2.1 The Contractor shall make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. The Contractor shall notify all Members that information is available in alternative formats and how to access those formats. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print (in a font size no smaller than 18 point).

4.3.2.2 The Contractor shall make all written information available in English, Spanish and all other prevalent non-English languages, as defined by DCH. For the purposes of this Contract, prevalent means a non-English language spoken by a significant number or percentage of Members, Potential Members, or P4HB participants who are Limited-English-Proficient.

4.3.2.3 All written materials distributed to Members shall include a language block, printed in Spanish and all other prevalent non-English languages, that informs the Member that the document contains important information and directs the Member to call the Contractor to request the document in an alternative language or to have it orally translated. Oral interpretation requirements apply to all non-English languages, not just those that DCH identifies as prevalent. Written materials must also contain the toll-free and TTY/TDY telephone number of Contractor's member/customer service unit.

4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5^{th}) grade level. Suggested reference materials to determine whether this requirement is being met are:

4.3.2.4.1 Fry Readability Index;

4.3.2.4.2 PROSE The Readability Analyst (software developed by Education Activities, Inc.);

4.3.2.4.3 Gunning FOG Index;

4.3.2.4.4 McLaughlin SMOG Index;

4.3.2.4.5 The Flesch-Kincaid Index; or

4.3.2.4.6 Other word processing software approved by DCH.

4.3.2.5 The Contractor shall provide written notice to DCH of any changes to any written materials provided to the Members. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.

4.3.2.6 The Contractor must submit all written materials, including information for the Contractor's Web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the Member materials within thirty (30) Calendar Days of submission. DCH reserves the right to require the discontinuation of any Member materials that violate the terms of this Contract.

4.3.3 Member Handbook Information Requirements

4.3.3.1 The Contractor shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Contractor shall make the Member and P4HB participant Handbook available to Members through the Contractor's web site. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant information packet to P4HB participant households.

4.3.3.2 The Member Handbook shall include all requirements set forth in 42 CFR 438.10, and the Member Handbook shall include, but not be limited to:

4.3.3.2.1 A table of contents;

4.3.3.2.2 Information about the roles and responsibilities of the Member (this information to be supplied by DCH);

4.3.3.2.3 Information about the role of the PCP including services provided and the role of the Medical Home;

4.3.3.2.4 Information about choosing a PCP;

4.3.3.2.5 Information about the Dental Home including services provided and how a Member can select a Dental Home;

4.3.3.2.6 Information about what to do when family size changes;

4.3.3.2.7 Appointment procedures;

4.3.3.2.8 Information on the benefits and services including a description of all available Georgia Families Benefits and Services;

4.3.3.2.9 Information on how to access services including a description of all available Georgia Family Benefits and Services;

4.3.3.2.10 Information on how to access services, including EPSDT services, non-emergency transportation (NET) services, and maternity and family planning services;

4.3.3.2.11 Information about the GaHIN including how information will be used by the CMOs and DCH to opt out of the GaHIN;

4.3.3.2.12 An explanation of any service limitations or exclusions from coverage;

4.3.3.2.13 Information about services that can be obtained through telemedicine;

4.3.3.2.14 A notice stating that the Contractor shall be liable only for those services authorized by the Contractor;

4.3.3.2.15 Information on where and how Members may access Benefits not available from or not covered by the Contractor;

4.3.3.2.16 The Medical Necessity definition used in determining whether services will be covered;

4.3.3.2.17 A description of Utilization Review policies and procedures used by the Contractor;

4.3.3.2.18 A description of all Pre-Certification, Prior Authorization or other requirements for treatments and services;

4.3.3.2.19 The policy on Referrals for specialty care and for other Covered Services not furnished by the Member's PCP;

4.3.3.2.20 Information on how to obtain services when the Member is out of the Service Region and for After-Hours coverage;

4.3.3.2.21 Cost-Sharing;

4.3.3.2.22 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including the Contractor's toll-free telephone line and Web site;

4.3.3.2.23 A description of Member rights and responsibilities;

4.3.3.2.24 The policies and procedures for Disenrollment;

4.3.3.2.25 Information on Advance Directives;

4.3.3.2.26 A statement that additional information, including information on the structure and operation of the CMO and physician incentive plans, shall be made available upon request;

4.3.3.2.27 Information on the extent to which, and how, After-Hours and emergency coverage are provided, including the following:

4.3.3.2.27.1 What constitutes an Urgent and Emergency Medical Condition, Emergency Services, and Post-Stabilization Services;

4.3.3.2.27.2 The fact that Prior Authorization is not required for Emergency Services;

4.3.3.2.27.3 The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent;

4.3.3.2.27.4 The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and

Post-Stabilization Services covered herein; and

4.3.3.2.27.5 The fact that a Member has a right to use any hospital or other setting for Emergency Services.

4.3.3.2.28 Information about the Grievance and Appeals Systems policies and procedures, as set forth in Section 4.14, which must include the following:

4.3.3.2.28.1 The right to file a Grievance and request an Appeal and/or Administrative Law Hearing with the Contractor;

4.3.3.2.28.2 The requirements and timeframes for filing a Grievance, Appeal, or Administrative Law Hearing with the Contractor;

4.3.3.2.28.3 The availability of assistance in filing a Grievance, Appeal, or Administrative Law Hearing with the Contractor;

4.3.3.2.28.4 The toll-free numbers Members can use to file a Grievance, Appeal, or Administrative Law Hearing request with the Contractor by phone;

4.3.3.2.28.5 The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing; and

4.3.3.2.28.6 Notice that if a Member files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the Member may be required to pay the cost of services furnished while the Appeal in pending, if the final decision is adverse to the Member.

4.3.3.2.29 Information on how to report suspected fraud or abuse.

4.3.3.2.30 Information on any restrictions on the member's freedom of choice among network providers.

4.3.3.2.31 Information on the extent to which, and how, members may obtain benefits, including family planning services and supplies from out of network providers. This includes an explanation that the Contractor cannot require an enrollee to obtain a referral before choosing a family planning provider.

4.3.3.3 The following information must be available to P4HB participants on the Contractor's web site and mailed to P4HB participants upon request including but not limited to the following:

4.3.3.3.1 General Information pertaining to the Demonstration (eligibility, enrollment and Disenrollment criteria, and information pertaining to the Demonstration's program components – family planning only, IPC, Resource Mothers Outreach);

4.3.3.3.2 A list of Benefits and services available under each Demonstration component;

4.3.3.3.3 A list of service exclusions or limitations under each Demonstration component;

4.3.3.3.4 Information about the role of the Family Planning Provider;

4.3.3.3.5 Information about the role of a PCP for the IPC P4HB participant only;

4.3.3.3.6 Information about providers affiliated with the Georgia Association for Primary Health Care who are available to provide Primary care services and whose services are not covered under the Demonstration for Family Planning Only P4HB participants;

4.3.3.3.7 Information on where and how P4HB participants may access other benefits and services not available from or not covered by the Contractor under the Demonstration;

4.3.3.3.8 Information about appointment procedures;

4.3.3.3.9 Information on how to access Demonstration services, including non-emergency transportation (NET) available to the IPC P4HB participants only;

4.3.3.3.10 A notice stating that the Contractor shall be liable only for those Demonstration services authorized by CMS under the Demonstration;

4.3.3.3.11 A description of all pre-certification, prior authorization or other requirements for Demonstration related Services and treatments;

4.3.3.3.12 The geographic boundaries of the Service Regions;

4.3.3.3.13 Information on the availability of telemedicine services;

4.3.3.3.14 Notice of all appropriate mailing addresses and telephone numbers to be utilized by P4HB participants seeking information or authorization, including the Contractor's toll-free telephone line and web site;

4.3.3.3.15 A description of the P4HB participant's rights and responsibilities;

4.3.3.3.16 The policies and procedures for Disenrollment from the Demonstration;

4.3.3.3.17 Information on Advance Directives;

4.3.3.3.18 A statement that additional information, including information on the structure and operation of the CMO and physician incentive plans, shall be made available upon request;

4.3.3.3.19 Information on the extent to which, and how, After-Hours and emergency coverage are provided, including the following:

4.3.3.3.19.1 What constitutes an Urgent and Emergency Demonstration related Medical Condition, Demonstration related Emergency Services, and Demonstration related Post Stabilization Services;

4.3.3.3.19.2 The fact that Prior Authorization is not required for Demonstration related Emergency Services;

4.3.3.3.19.3 The process and procedures for obtaining Demonstration related Emergency

Services, including the use of the 911 telephone systems or its local equivalent;

4.3.3.3.19.4 The location of any emergency settings and other locations at which Demonstration Providers and hospitals furnish Demonstration related Emergency and Post Stabilization Services; and

4.3.3.3.19.5 The fact that a P4HB participant has a right to use any hospital or other setting for Demonstration related Emergency Services.

4.3.3.3.20 Information on the Grievance Systems policies and procedures, as described in Section 4.14 of the Contract. This description must include the following:

4.3.3.3.20.1 The right to file a Grievance, Appeal, and Administrative Law Hearing with the Contractor;

4.3.3.3.20.2 The requirements and timeframes for filing a Grievance, Appeal, or Administrative Law Hearing with the Contractor;

4.3.3.3.20.3 The availability of assistance in filing a Grievance, Appeal, or Administrative Law Hearing with the Contractor;

4.3.3.3.20.4 The toll-free numbers P4HB participants can use to file a Grievance or an Appeal with the Contractor by phone;

4.3.3.3.20.5 The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;

4.3.3.3.20.6 Notice that if the P4HB participant files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the P4HB participant may be required to pay the cost of services furnished while the Appeal is

pending, if the final decision is adverse to the P4HB participant; and

4.3.3.3.20.7 Any Appeal rights that the State chooses to make available to Providers to challenge the failure of the Contractor to cover the Demonstration related Service.

4.3.3.4 The Contractor shall submit to DCH for review and approval, initial versions, any changes and edits to the Member Handbook (including P4HB), and all other Member materials the Contractor plans to distribute at least sixty (60) Calendar Days before the effective date of change.

4.3.3.5 The Contractor shall provide each Member notice of any significant change at least thirty (30) days before the intended effective date of the change.

4.3.4 Member Rights

4.3.4.1 The Contractor shall have written policies and procedures regarding the rights of Members and shall comply with any applicable federal and State laws and regulations that pertain to Member rights. These rights shall be included in the Member Handbook and the P4HB Handbook. At a minimum, said policies and procedures shall specify the Member's right to:

4.3.4.1.1 Receive information pursuant to 42 CFR 438.10;

4.3.4.1.2 Be treated with respect and with due consideration for the Member's dignity and privacy;

4.3.4.1.3 Have all records and medical and personal information remain confidential;

4.3.4.1.4 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's Condition and ability to understand;

4.3.4.1.5 Participate in decisions regarding his or her Health Care, including the right to refuse treatment;

4.3.4.1.6 Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;

4.3.4.1.7 Request and receive a copy of his or her Medical Records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the records as specified in 45 CFR 164.524 and 164.526;

4.3.4.1.8 Be furnished Health Care services in accordance with 42 CFR 438.206 through 438.210 and 42 CFR 438.100;

4.3.4.1.9 Freely exercise his or her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the Member is treated;

4.3.4.1.10 Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the Covered Services provided to the Member for which DCH does not pay the Contractor; not be held liable for Covered Services provided to the Member for which DCH or the CMO does not pay the Health Care Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, Referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the services directly; and

4.3.4.1.11 Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 42 CFR 447.56 and **Attachment J** of this Contract.

4.3.4.1.12 Choose a network provider.

4.3.5 Provider Directory

4.3.5.1 The Contractor shall provide a Provider Directory to Members. The Contractor shall make the Provider Directory available to Members through the Contractor's web site in a machine-readable file and format as specified by the Secretary. Upon request, the Contractor shall mail via surface mail a hard copy of the Provider Directory to enrolled Member households within three (3) Business Days of receipt of the request whether verbally or in writing. Hard copy paper Provider Directories shall include a statement indicating that changes to the Provider Network will occur and that Members are encouraged to review the online Provider Directory or contact the Contractor for current information as needed. Provider network information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30

Calendar Days after the Contractor receives updated provider information.

4.3.5.2 The electronic Provider Directory, at a minimum, shall be searchable by Provider name, Provider type/specialty and location (to include city, zip code, physical address, and county).

4.3.5.3 The Provider Directory shall include current names as well as any group affiliation, locations including street address(es), office hours, telephone number(s), website URL, as appropriate, and non-English language(s) spoken by, contracted Providers. This includes, at a minimum, information on PCPs, specialists, Family Planning Providers, dentists, pharmacies, vision providers, FQHCs and RHCs, mental health and substance abuse Providers, physical therapists, occupational therapists, speech therapists, and hospitals. The Provider Directory shall provide information on whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment. The Provider Directory shall identify Providers that are not accepting new patients for any provided services and/or Providers that are only accepting specialty populations. The Provider Directory shall also identify if the location is a telemedicine presentation site. The online Provider Directory shall be updated within five (5) Business Days upon any change in the Provider Network, open and closed panels and Provider service offerings.

4.3.5.4 The Contractor shall submit an updated version to DCH of the Provider Network Listing spreadsheet for all requested Provider types upon request. DCH may require the Contractor to include in the submission executed Signature Pages of Provider Contracts and written acknowledgements from all Providers who are part of a Preferred Health Organization (PHO), IPA, or other Network stating that they know they are in the CMO's Network, know they are accepting Medicaid Members, any restrictions on which Members the Provider is seeing, and that they are accepting the terms and conditions of the Provider Contract.

4.3.5.5 The Contractor must submit the Provider Directory template and specifications for the Directory that will be provided on the web site to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated, thereafter. The Contractor shall not use the new template until notification of approval from DCH.

4.3.6 Member Identification (ID) Card

4.3.6.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes:

4.3.6.1.1 Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP.

4.3.6.2 The Member ID Card must, at a minimum, include the following information:

4.3.6.2.1 The Member's name;

4.3.6.2.2 The Member's Medicaid or PeachCare for Kids® identification number;

4.3.6.2.3 The PCP's name, address, and telephone numbers (including After-Hours number if different from business hours number);

4.3.6.2.4 Dental Home name, address and telephone number (if the Member is eligible to receive Dental Home);

4.3.6.2.5 The name and telephone number(s) of the Contractor;

4.3.6.2.6 The Contractor's twenty-four (24) hour, seven (7) day a week toll-free Member services telephone number;

4.3.6.2.7 Instructions for emergencies;

4.3.6.2.8 Minimum instructions to facilitate the submission of a Claim by a Provider;

4.3.6.2.9 Processor Control Number and Bank Identification Number (BIN) Number for pharmacy Claims submission; and

4.3.6.2.10 Toll free phone numbers for provider call centers to assist providers with Claims adjudication questions or issues.

4.3.6.3 The Contractor shall reissue the Member ID Card within seven (7) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.

4.3.6.4 The Contractor shall submit a front and back sample Member ID Card to DCH for initial review and approval, within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.

4.3.6.5 The Contractor shall mail via surface mail a P4HB participant ID Card to all new P4HB participants in the Demonstration within Seven (7) Calendar Days of receiving the notice of Enrollment from DCH or its Agent. The P4HB participant's ID Card will meet the requirements set forth for Member ID Cards in Sections 4.3.6.2 (excluding Section 4.3.6.2.4), 4.3.6.3 and 4.3.6.4, and will identify the Demonstration component in which the P4HB participant is enrolled:

4.3.6.5.1 A Pink color will signify the P4HB participants as eligible for Family Planning Services Only.

4.3.6.5.2 A Purple color will signify the P4HB participants as eligible for Interpregnancy Care Services and Family Planning Services.

4.3.6.5.3 A Yellow color will signify the P4HB participant as eligible for Case Management – Resource Mothers Outreach Only.

4.3.6.6 Each time the P4HB participant's ID card is issued or re-issued to a P4HB participant, the Contractor shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.

4.3.7 Toll-free Member Call Center

4.3.7.1 The Contractor shall operate a toll-free telephone line to respond to Member questions and comments.

4.3.7.2 The Contractor shall develop call center 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.

4.3.7.3 The Contractor shall submit these call center policies and procedures, including performance standards, to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.

4.3.7.4 The call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.

4.3.7.5 The Contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State

holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, the Contractor shall have an automated system available between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.

4.3.7.6 The Contractor shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities The Contractor 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 Call Center. The Contractor shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for review and approval annually. At a minimum, the standards shall require that, on a Calendar month basis:

4.3.7.6.1 Average Speed of Answer: At a minimum, the standards shall require that, on a monthly basis, eighty percent (80%) of calls are answered by a person within thirty (30) seconds. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative.

4.3.7.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.

4.3.7.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).

4.3.7.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a Call Center Representative.

4.3.7.6.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock

hours. DCH will provide the definition of "closed" for this performance measure.

4.3.7.6.6 Accurate Response to Call Center Phone Inquiries: Call center representatives accuracy rate must be ninety percent (90%) or higher.

4.3.7.7 The Contractor shall establish remote phone monitoring capabilities for at least five (5) DCH staff. DCH or its Agent shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress and to identify the number of call center staff answering calls and the identity of the individual call center staff answering the calls.

4.3.8 Georgia Families Member Web Site

4.3.8.1 The Contractor shall develop and maintain a Program web site on which the Contractor will provide Member and P4HB webpages that provide general and up-to-date information about the CMO's program, including but not limited to the following:

4.3.8.1.1 A searchable Member Handbook.

4.3.8.1.2 All Member Information materials.

4.3.8.1.3 A portal that allows Members to access a searchable Provider Directory.

4.3.8.1.4 Information about how limited English speaking persons as well as those who are hearing impaired can access interpreter services.

4.3.8.1.5 Pharmacy Preferred Drug List.

4.3.8.1.6 Pharmacy Conditions for Coverage and Utilization Limits.

4.3.8.1.7 What's New items.

4.3.8.1.8 Frequently asked questions and answers.

4.3.8.1.9 Reminder information about Medicaid eligibility redeterminations.

4.3.8.1.10 Link to the DCH Medicaid web site and to the DCH P4HB web site.

4.3.8.1.11 General and up to date information about the Demonstration that incorporates DCH's messaging regarding the Demonstration.

4.3.8.1.12 Link to the DCH Enrollment Broker website.

4.3.8.2 The Web site must have the capability for Members to submit questions and comments to the Contractor and for Members to receive responses. The Contractor shall respond to Member inquiries within one (1) Business Day of receipt and resolve the issue within seventy-two (72) Clock Hours of receipt. The Contractor shall refer any inquiries to DCH that are not within the Contractor's scope of services (e.g., inquiries about the Fee-for-Service delivery system).

4.3.8.3 The Web site must comply with the marketing policies and procedures and with requirements for written materials described in this Contract and must be consistent with applicable State and federal laws. Information provided on the Member webpages must be written at no higher than a 5th grade reading level.

4.3.8.4 The Contractor must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Contractor must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades which support the ordinary operation, administration, and maintenance of the web site, the Contractor shall not modify the web site prior to receipt of DCH approval.

4.3.8.5 The web site must comply with DCH's requirements for information systems and webpage development, including but not limited to security controls that meet the requirements of this Contract. The Contractor's web site shall also be functionally equivalent, with respect to functions described in this Contract, to the web site maintained by the State's Medicaid Fiscal Agent. See https://www.mmis.georgia.gov/portal/.

4.3.9 Cultural Competency

4.3.9.1 In accordance with 42 CFR 438.206, the Contractor shall have a comprehensive written Cultural Competency Plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Members, including those with Limited-English-Proficiency, hearing impairment, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The Cultural

Competency Plan must describe how the Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each. The cultural Competency Plan must include:

4.3.9.1.1 Training to Member services staff and Contract Providers, including PCPs and Contractor staff at all levels, to receive ongoing education and training in culturally and linguistically appropriate service delivery;

4.3.9.1.2 Plan for interpretive services and written materials, consistent with Section 4.3.10 to meet the needs of Members whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member oriented materials, including the posting of signage in the languages of the commonly encountered group and/or groups represented in the service area;

4.3.9.1.3 Identify community advocates and agencies that could assist Limited-English-Proficiency and/or that provide other Culturally Competent services, which include methods of Outreach and referral;

4.3.9.1.4 Incorporate Cultural Competence into Utilization Management, quality improvement and planning for the course of treatment;

4.3.9.1.5 Identify and employ resources and interventions for high-risk health conditions found in certain cultural groups;

4.3.9.16 Recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State.

4.3.9.2 The Contractor shall submit the Cultural Competency Plan to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter.

4.3.9.3 The Contractor may distribute a summary of the Cultural Competency Plan to the In-Network Providers if the summary includes information on how the Provider may access the full Cultural Competency Plan on

the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.

4.3.10 Interpretation Services

4.3.10.1 The Contractor shall provide oral interpretation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor shall notify its Members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member for interpretation services.

4.3.11 Translation Services

4.3.11.1 The Contractor shall provide translation services to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor shall notify its Members of the availability of oral translation services and to inform them of how to access oral translation services. There shall be no charge to the Member for translation services.

4.3.12 Reporting Requirements

4.3.12.1 The Contractor shall submit monthly Telephone and Internet Activity Reports to DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.4 MARKETING

4.4.1 Prohibited Activities

4.4.1.1 The Contractor is prohibited from engaging in the following activities:

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

4.4.1.1.2 Offering any favors, inducements or gifts, promotions, and/or other insurance products worth more than $15.00 at one time and not more than $50 annually per Member;

4.4.1.1.3 Providing meals for Potential Members, regardless of value;

4.4.1.1.4 Distributing plans and materials that contain statements that DCH determines are inaccurate, false or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in the Contractor's plan in order to obtain Benefits or in order to not lose Benefits, or that the Contractor's plan is endorsed by CMS, the federal or State government, or similar entity; and

4.4.1.1.5 Distributing information or materials that, according to DCH, mislead or falsely describe the Contractor's or other CMO's Provider network, the participation or availability of Network Providers, the qualifications and skills of Network Providers (including their bilingual skills); or the hours and location of Network services.

4.4.1.1.6 Influencing enrollment in conjunction with the sale or offering of any private insurance.

4.4.1.1.7 Distributing any marketing materials without first obtaining State approval.

4.4.1.1.8 Distributing marketing materials to a limited portion of Contractor's service area. Contractor must distribute marketing materials to its entire service area.

4.4.2 Allowable Activities

4.4.2.1 The Contractor shall be permitted to perform the following marketing activities:

4.4.2.1.1 Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);

4.4.2.1.2 Distribute general information through the use of social media platforms to contact a greater proportion of the Members or Potential Members served by the Contractor. Content intended for use on social media platforms must be approved by DCH prior to publication;

4.4.2.1.3 Make telephone calls, mailings and home visits only to Members currently enrolled in the Contractor's plan, for

the sole purpose of educating the Member about services offered by or available through the Contractor.

4.4.2.1.4 Reach out to former Members via telephone calls, mailings, and home visits for a period of up to forty-five (45) Calendar Days from the date the Member is disenrolled from the Contractor's plan for the sole purpose of surveying the former Member about services received while the Member was enrolled with the Contractor.

4.4.2.1.5 Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the CMO's Provider network, provided that all CMOs in which the Provider participates have an equal opportunity to be represented; and

4.4.2.1.6 Attend activities that benefit the entire community such as health fairs or other health education and promotion activities.

4.4.2.2 If the Contractor performs an allowable activity, the Contractor shall conduct these activities statewide.

4.4.2.3 All marketing materials shall comply with the information requirements in 42 CFR 438.10 and detailed in Section 4.3.2 of this Contract to ensure that before enrolling, the Member receives accurate oral and written information he or she needs to make an informed decision on whether or not to enroll.

4.4.3 State Approval of Materials

4.4.3.1 The Contractor shall submit to DCH for initial review within sixty (60) Calendar Days and approval, and as updated thereafter a detailed description of its Marketing Plan and copies of all Marketing Materials (written and oral) it or its Subcontractors plan to distribute.

4.4.3.2 This requirement includes, but is not limited to posters, brochures, Web sites, and any materials that contain statements regarding the benefit package and Provider network-related materials. Neither the Contractor nor its Subcontractors shall distribute any marketing materials without prior, written approval from DCH.

4.4.3.3 The Contractor shall submit any changes to previously approved Marketing Materials and receive approval from DCH of the changes sixty (60) Calendar Days before distribution.

4.5 GEORGIA FAMILIES COVERED BENEFITS AND SERVICES

4.5.1 Included Services

4.5.1.1 The Contractor shall at a minimum provide Medically Necessary services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals. This includes covered outpatient drugs. Such Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition. Contractor must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

4.5.1.2 Contractor must allow each Member to choose his or her network provider to the extent possible and appropriate.

4.5.1.3 The Contractor must cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K. Any additional services deemed necessary for compliance will be identified in the contract by type, amount, duration and scope, consistent with the analysis of parity compliance.

4.5.1.4 Dental Preventive Services that carry a limitation per year shall be limited to a 12-rolling month period.

4.5.1.5 Contractor may cover services provided in an Institution for Mental Disease (IMD) for individuals ages 21-64 for a short-term period not to exceed 15 days. Contractor may not require a Member to receive services in an IMD if an appropriate alternative setting is available.

4.5.1.6 Contractor may not avoid costs for services covered under this contract by referring Members to publicly supported health care resources.

4.5.2 Individuals with Disabilities Education Act (IDEA) Services

4.5.2.1 For Members up to and including age two (2), the Contractor shall be responsible for Medically Necessary IDEA Part C services provided pursuant to an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).

4.5.2.2 For Members ages three (3) to twenty-one (21), the Contractor shall not be responsible for Medically Necessary IDEA Part B services provided pursuant to an IEP or IFSP. Such services shall remain in FFS Medicaid. The Contractor shall be responsible for all other Medically Necessary covered services.

4.5.3 Enhanced Services

4.5.3.1 In addition to the Covered Services provided above, the Contractor shall provide enhanced services to educate Members. The Contractor shall provide such services in a manner that will increase a Member's understanding of the availability of Covered Services, the importance of seeking and receiving such services and how doing so may help to improve outcomes. For example, the Contractor shall do the following:

4.5.3.1.1 Place strong emphasis on programs to enhance the general health and well-being of Members;

4.5.3.1.2 Make health promotion materials available to Members;

4.5.3.1.3 Participate in Medicaid fairs and community-sponsored health fairs;

4.5.3.1.4 Coordinate with community resources to facilitate a holistic approach to Member care; and

4.5.3.1.5 Provide education to Members, families and other Health Care Providers about early intervention and management strategies for various illnesses.

4.5.3.2 The Contractor shall not charge a Member for participating in health education services that are defined as either enhanced or Covered Services.

4.5.4 Timely access

4.5.4.1 The Contractor shall do the following:

4.5.4.1.1 Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

4.5.4.1.2 Ensure that the network providers offer hours of operation 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.

4.5.4.1.3 Establish mechanisms to ensure compliance by network providers.

4.5.4.1.4 Monitor network providers regularly to determine compliance.

4.5.4.1.5 Take corrective action if there is a failure to comply by a network provider.

4.5.5 Medical Necessity

4.5.5.1 Contractor must ensure Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services available through the Georgia Medicaid State Plan. Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:

4.5.5.1.1 Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;

4.5.5.1.2 Compatible with the standards of acceptable medical practice in the community;

4.5.5.1.3 Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;

4.5.5.1.4 Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and

4.5.5.1.5 Not primarily custodial care unless custodial care is a Covered Service or benefit under the Members evidence of coverage.

4.5.5.2 There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

4.5.5.3 For Medicaid children under twenty-one (21) years of age, the Contractor is required to provide Medically Necessary Services to

correct or ameliorate physical and Behavioral Health disorders, a defect, or a condition identified during an EPSDT screening or preventive visit regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

4.5.6 Experimental, Investigational or Cosmetic Procedures, Drugs, Services, or Devices

4.5.6.1 Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manuals, in no instance shall the Contractor cover experimental, investigational or cosmetic procedures, drugs, services or devices or those not recognized by the Federal Food and Drug Administration, the United States Public Health Service, Medicaid and/or the Department's contracted peer review organization as universally accepted treatment.

4.5.7 Moral or Religious Objections

4.5.7.1 The Contractor is required to provide and reimburse for all Covered Services. If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, reimburse for, or provide coverage of a counseling or Referral service because of an objection on moral or religious grounds, the Contractor shall notify:

4.5.7.1.1 DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;

4.5.7.1.2 Members within sixty (60) Calendar Days before adopting the policy with respect to any service; and

4.5.7.1.3 Members before and during Enrollment.

4.5.7.2 The Contractor shall provide to the DCH Enrollment Broker for use in Member CMO selection counseling information with respect to any service the Contractor elects not to provide, reimburse for or provide coverage for a counseling or Referral service because of an objection on moral or religious ground.

4.5.7.3 The Contractor acknowledges that such objection will be grounds for recalculation of rates paid to the Contractor by DCH.

4.5.8 Parity in Mental Health and Substance Use Disorder Benefits

4.5.8.4 The Contractor 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 Members (whether or not the benefits are furnished by the same MCO).

4.5.8.5 If a Contractor's Member 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 Contractor's Member in every classification in which medical/surgical benefits are provided.

4.5.8.6 The Contractor 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.

4.5.8.7 The Contractor may not impose Nonquantitative Treatment Limitations (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to 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.

4.5.8.8 The Contractor shall use processes, strategies, evidentiary standards, or other factors 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 determining access to out-of-network providers for medical/surgical benefits in the same classification.

4.5.8.9 Upon notice from DCH, Contractor must provide documentation and reporting required to establish and demonstrate compliance with 42 CFR 438, subpart K. regarding parity in MH/SUD benefits.

4.6 SPECIAL COVERAGE PROVISIONS

4.6.1 Emergency Services

4.6.1.1 Emergency Services shall be available without Prior Authorization or approval twenty-four (24) hours a day, seven (7) Days a week to treat an Emergency Medical Condition.

4.6.1.2 An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health 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:

4.6.1.2.1 Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

4.6.1.2.2 Serious impairment to bodily functions;

4.6.1.2.3 Serious dysfunction of any bodily organ or part;

4.6.1.2.4 Serious harm to self or others due to an alcohol or drug abuse emergency;

4.6.1.2.5 Injury to self or bodily harm to others; or

4.6.1.2.6 With respect to a pregnant woman having contractions: i. That there is inadequate time to effect a safe transfer to another hospital before delivery, or ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

4.6.1.3 The Contractor shall provide payment for Emergency Services when furnished to a Member by a qualified Provider, regardless of whether that Provider is in the Contractor's Provider Network. These services shall not be subject to Prior Authorization requirements. The Contractor shall be required to pay for all Emergency Services that are Medically Necessary until the Member is stabilized. The Contractor shall also pay for any screening examination services conducted on a Member to determine whether an Emergency Medical Condition exists.

4.6.1.4 The Contractor shall provide payment for Demonstration related Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network.

These services shall not be subject to prior authorization requirements. The Contractor shall be required to pay all Demonstration related Emergency Services that are Medically Necessary until the P4HB Participant is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether a Demonstration related Emergency Medical Condition exists.

4.6.1.5 The Contractor may not deny or inappropriately reduce payment to a Provider of Emergency Services for any evaluation, diagnostic testing, or treatment provided to a Member for an emergency condition or make payment for Emergency Services contingent on the Member or Provider of emergency health care services providing any notification, either before or after receiving Emergency Services.

4.6.1.6 In processing Claims for Emergency Services, the Contractor shall consider, at the time that a Claim is submitted, at least the following criteria:

4.6.1.6.1 The age of the patient;

4.6.1.6.2 The time and day of the week the patient presented for services;

4.6.1.6.3 The severity and nature of the presenting symptoms;

4.6.1.6.4 The patient's initial and final diagnosis; and

4.6.1.6.5 Any other criteria prescribed by the Department, including criteria specific to patients under eighteen (18) years of age.

4.6.1.7 The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a Prudent Layperson.

4.6.1.8 The attending emergency room physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or Discharge, and that determination is binding on the Contractor, who shall be responsible for coverage and payment.

4.6.1.9 The Contractor shall not retroactively deny a Claim for an emergency screening examination or a Demonstration related emergency screening examination because the Condition, which appeared to be an

Emergency Medical Condition or Demonstration related emergency screening examination under the Prudent Layperson standard, turned out to be non-emergency in nature. Likewise, the Contractor shall not routinely or arbitrarily employ the practice of paying a triage rate that reduces reimbursement and places an administrative burden on the Provider to appeal such a payment. If an emergency screening examination or a Demonstration related emergency screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition or Demonstration related Emergency does not exist, then the determining factor for payment liability shall be whether the Member had acute symptoms of sufficient severity at the time of presentation. In this case, the Contractor shall pay for all screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid program.

4.6.1.10 The Contractor may establish guidelines and timelines for submittal of notification regarding provision of Emergency Services and Demonstration related Emergency Services, but, the Contractor shall not refuse to cover an Emergency Service or Demonstration related Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, Contractor's representative, or DCH of the Member's screening and treatment within said timeframes.

4.6.1.11 When a representative of the Contractor instructs the Member to seek Emergency Services the Contractor shall be responsible for payment for the Medical Screening examination and for other Medically Necessary Emergency Services, without regard to whether the Condition meets the Prudent Layperson standard.

4.6.1.12 When a representative of the Contractor instructs the P4HB Participant to seek Demonstration related Emergency Services, the Contractor shall be responsible for payment for the Demonstration related Medical Screening examination without regard to whether the Condition meets the Prudent Layperson standard.

4.6.1.13 The Member who has an Emergency Medical Condition or Demonstration related Emergency Service shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific Condition or stabilize the patient.

4.6.1.14 Once the Member's Condition is stabilized, the Contractor may require Pre-Certification for hospital admission or Prior Authorization for follow-up care.

4.6.2 Post-Stabilization Services

4.6.2.1 The Contractor shall be responsible for providing access to and payment for Post-Stabilization care services and Demonstration related Post Stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to an Emergency Medical Condition or Demonstration related Emergency medical conditions, that are provided after a Member is stabilized in order to maintain the stabilized Condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the Member's Condition.

4.6.2.2 The Contractor shall be responsible for payment for Post-Stabilization Services and Demonstration related Post Stabilization Services that are Prior Authorized or Pre-Certified by a Provider or organization representative, regardless of whether they are provided within or outside the Contractor's Network of Providers.

4.6.2.3 The Contractor is financially responsible for Post-Stabilization Services and Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider Network that are administered to maintain the Member's stabilized Condition for one (1) hour while awaiting response on a Pre-Certification or Prior Authorization request.

4.6.2.4 The Contractor is financially responsible for Post-Stabilization Services and Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network, that are not prior authorized by the Contractor or Contractor's representative but are administered to maintain, improve or resolve the Member's stabilized Condition if:

4.6.2.4.1 The Contractor does not respond to the Provider's request for Pre-certification or Prior Authorization within one (1) hour;

4.6.2.4.2 The Contractor cannot be contacted; or

4.6.2.4.3 The Contractor's Representative and the attending physician cannot reach an agreement concerning the Member's care and the Contractor's physician (i.e., a Chief Medical Officer or Medical Director) is not available for consultation. In this situation the Contractor shall give the treating physician the opportunity to consult with the Contractor's physician and the treating

physician may continue with care of the Member until the Contractor's physician is reached or one of the criteria below in Section 4.6.2.5 is met.

4.6.2.5 The Contractor's financial responsibility for Post-Stabilization Services and Demonstration related Post Stabilization Services it has not approved will end when:

4.6.2.5.1 An In-Network Provider with privileges at the treating hospital assumes responsibility for the Member's care;

4.6.2.5.2 An In-Network Provider assumes responsibility for the Member's care through transfer;

4.6.2.5.3 The Contractor's Representative and the treating physician reach an agreement concerning the Member's care; or

4.6.2.5.4 The Member is discharged.

4.6.2.6 In the event the Member receives Post-Stabilization Services or Demonstration related Post Stabilization Services from a Provider outside the Contractor's network, the Contractor shall reimburse the non-contracted Provider for the Post-Stabilization services at a rate equal to the rate paid by the Department for Claims that it reimburses directly. The Contractor is prohibited from billing the Member for Post-Stabilization services.

4.6.3 Urgent Care Services

The Contractor shall provide Urgent Care Services and Demonstration related Urgent Care Services to Members as necessary. Such services shall not be subject to Prior Authorization or Pre-Certification.

4.6.4 Family Planning Services

4.6.4.1 The Contractor shall provide access to Family Planning Services within the network to Members and P4HB Participants. In meeting this obligation, the Contractor shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act, for the provision of Family Planning Services. The Contractor shall verify its efforts and Documented Attempts to contract with Title X Clinics by maintaining records of communication. The Contractor shall not limit Members' or P4HB Participants' freedom of choice for family planning services to In-Network Providers and the Contractor shall cover services provided by any qualified Provider regardless of whether the Provider is In-

Network. The Contractor shall not require a Referral if a Member or P4HB Participant chooses to receive Family Planning services and supplies from outside of the network.

4.6.4.2 The Contractor shall inform Members and P4HB Participants of the availability of family planning services and must provide services to Members and P4HB Participants wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy.

4.6.4.3 Family Planning Services and supplies for Members and P4HB Participants include at a minimum:

4.6.4.3.1 Education and counseling necessary to make informed choices and understand contraceptive methods;

4.6.4.3.2 Initial and annual complete physical examinations including a pelvic examination and Pap test;

4.6.4.3.3 Follow-up, brief and comprehensive visits;

4.6.4.3.4 Pregnancy testing;

4.6.4.3.5 Contraceptive supplies and follow-up care;

4.6.4.3.6 Diagnosis and treatment of sexually transmitted infections with the following exceptions: P4HB participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration;

4.6.4.3.7 For P4HB participants: Drugs, supplies, or devices related to the women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirement; (subject to the national drug rebate program requirements); and

4.6.4.3.8 Infertility assessments with the following exception – P4HB participants are excluded from receiving this benefit.

4.6.4.4 The Contractor shall furnish all services on a voluntary and confidential basis, even if the Member is less than eighteen (18) years of age.

4.6.4.5 Family Planning Services must be provided in a manner that protects and enables the individual's freedom to choose the method of family planning to be used consistent with federal law.

4.6.5 Sterilizations, Hysterectomies and Abortions

4.6.5.1 In compliance with 42 C.F.R. § § 441.251 through 441.258, the Contractor shall cover sterilizations and hysterectomies, only if all of the following requirements are met:

4.6.5.1.1 The Member is at least twenty-one (21) years of age at the time consent is obtained;

4.6.5.1.2 The Member is mentally competent;

4.6.5.1.3 The Member voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Services. This includes the completion of all applicable documentation;

4.6.5.1.4 At least thirty (30) Calendar Days, but not more than one hundred and eighty (180) Calendar Days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. A Member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least seventy-two (72) hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty (30) Calendar Days before the expected date of delivery (the expected date of delivery must be provided on the consent form);

4.6.5.1.5 An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a Member who is visually impaired, hearing impaired or otherwise disabled; and

4.6.5.1.6 The Member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

4.6.5.2 A hysterectomy shall be considered a Covered Service only if the following additional requirements are met:

4.6.5.2.1 The Member must be informed orally and in writing that the hysterectomy will render the individual permanently

incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and

4.6.5.2.2 The Member must sign and date the Georgia Families Sterilization Request Consent form prior to the Hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

4.6.5.3 A hysterectomy shall not be considered a Covered Service for P4HB Members.

4.6.5.4 Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

4.6.5.4.1 If it is performed solely for the purpose of rendering a Member permanently incapable of reproducing;

4.6.5.4.2 If there is more than one (1) purpose for performing the hysterectomy, but the primary purpose was to render the Member permanently incapable of reproducing; or

4.6.5.4.3 If it is performed for the purpose of cancer prophylaxis.

4.6.5.5 Abortions or abortion-related services performed for family planning purposes are not Covered Services. Abortions are Covered Services if a Provider certifies that the abortion is Medically Necessary to save the life of the mother or if pregnancy is the result of rape or incest. The Contractor shall cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies.

4.6.5.6 The Contractor shall maintain documentation of all sterilizations, hysterectomies and abortions consistent with requirements in 42 CFR 441.206 and 42 CFR 441.256. The Contractor shall not accept documentation for informed consent completed or altered after the service was rendered. All documentation pertaining to sterilizations, hysterectomies, and abortions must be provided to DCH upon request.

4.6.6 Pharmacy

4.6.6.1 The Contractor is permitted to establish a Maximum Allowable Cost (MAC) schedule. However, the Contractor must ensure the MAC pricing schedule is evaluated for pricing appropriateness and updated as appropriate no less frequently than every two (2) weeks.

4.6.6.1.1 The MAC must be reviewed no less frequently than every two (2) weeks to ensure:

4.6.6.1.1.1 Appropriateness of pricing;

4.6.6.1.1.2 MAC pricing schedule does not create a barrier to access to the medication;

4.6.6.1.1.3 Each medication represented on the MAC schedule has at least two (2) A-rated generic equivalents available in the Georgia marketplace;

4.6.6.1.2 The MAC pricing schedule must be posted on the Contractor's website; and

4.6.6.1.3 The Contractor must make available an inquiry and appeal process for Provider disputes over the MAC schedule or individual drugs subject to the MAC pricing with all inquiries and appeals being addressed within five (5) Calendar Days of the receipt of the Provider inquiry or appeal.

4.6.6.2 The Contractor shall provide pharmacy services either directly or through a Pharmacy Benefits Manager (PBM). The Contractor or its PBM may establish a preferred drug list if the following minimum requirements are met:

4.6.6.2.1 Appropriate selection of drugs from therapeutic drug classes are accessible and are sufficient in amount, duration, and scope to meet Members' medical needs;

4.6.6.2.2 The only excluded drug categories are those permitted under Section 1927(d) of the Social Security Act;

4.6.6.2.3 A Pharmacy & Therapeutics Committee that advises and/or recommends preferred drug list decisions is established and maintained; and

4.6.6.2.4 Over the counter medications specified in the Georgia State Medicaid Plan are included in the formulary.

4.6.6.3 The Contractor shall make available to P4HB participants folic acid and/or a multivitamin with folic acid.

4.6.6.4 The Contractor shall make the preferred drug list, utilization limits and conditions for coverage for prior authorized drugs available through its website and provide such documentation to DCH upon request.

4.6.6.5 The Contractor shall conduct a Prior Authorization program that complies with the requirements of section 1927(d)(5) of the Social Security Act, as if such requirements applied to Contractor instead of DCH. The Contractor shall have an automated electronic Prior Authorization portal for the submission of Prior Authorization requests and encourage adoption by Providers. Regardless of whether Providers submit prior authorization requests manually or through the portal, the Contractor shall:

4.6.6.5.1 Provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization.

4.6.6.5.2 Provide for the dispensing of at least a seventy-two (72)-hour supply of a covered outpatient prescription drug in an emergency situation.

4.6.6.5.3 Resolve all pharmacy prior authorization requests within twenty-four (24) hours unless additional information is required from the prescriber. If additional information is needed from the prescriber, documented telephonic or other telecommunication contact with the prescriber must be made every twenty-four (24) hours up to a final disposition within seventy-two (72) hours of receipt of the request.

4.6.6.6 If the Contractor chooses to implement a mail-order pharmacy program, any such program must be established and maintained in accordance with State and federal law. The Contractor shall not require Members to use a mail-order pharmacy to receive covered pharmacy Benefits, but may allow Members to use a mail-order pharmacy if:

4.6.6.6.1 Mail-order delivery is clinically appropriate;

4.6.6.6.2 The pharmacy is willing to accept payments and terms as described in this Contract;

4.6.6.6.3 Cost sharing is no more than it is for Members utilizing services by retail pharmacy;

4.6.6.6.4 The Member expressed desire to receive pharmacy services by mail-order; and

4.6.6.6.5 The Member is allowed to cease mail-order pharmacy services and utilize retail pharmacies at any time.

4.6.6.7 Contractor shall operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 CFR part 456, subpart K, as if such requirements applied to Contractor instead of DCH. Contractor shall provide a detailed description of its drug utilization program review activities to DCH on an annual basis.

Contractor shall report to DCH the drug utilization data that is necessary for DCH to bill manufacturers for rebates in accordance with Section 1927(b)(1)(A) of the Social Security Act no later than 45 (forty-five) days after the end of each quarterly rebate period. Such utilization information shall include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code for each covered outpatient drug dispensed or covered by Contractor.

Contractor must ensure that entities which are a part of the 340B Drug Pricing Program are identified for the purposes required under federal statute regarding drug rebates. Any arrangements that are made (e.g. 340B provider agrees to use or not use 340B drugs when providing services for the GF/GF 360 program, Contractor pays a reduced rate for 340B products, etc.) are at the discretion of Contractor and the providers. However, any time 340B product is used under the GF/GF 360 program, it will have to be identified within the encounter data on the claim pursuant to Section 4.16.3.17.5 to ensure that DCH does not include those claims in any drug rebate invoices, as required by federal statute.

4.6.6.8 Contractor shall ensure that entities which are a part of the 340B Drug Pricing Program are identified for the purposes required under federal statute regarding drug rebates. Any arrangements that are made (e.g. 340B provider agrees to use or not use 340B drugs when providing services for Members, Contractor pays a reduced rate for 340B products, etc.) are at the discretion of Contractor and the providers. However, any time 340B product is used under the Georgia Families program, it will have to be identified within the encounter data on the claim pursuant to Section 4.16.3.17.5 and the drug utilization data required pursuant to Section 4.6.6.7 to ensure that DCH does not include those claims in any drug rebate invoices, as required by federal statute.

4.6.6.9 In providing coverage for outpatient drugs as defined in section 1927(k)(2) of the Social Security Act, Contractor shall meet the standards for such coverage imposed by section 1927 of the Act as if such standards applied directly to Contractor.

4.6.6.10 The Contractor shall comply with the Section 1004 provisions of the SUPPORT for Patient and Communities Act and ensure the following protocols are in place:

4.6.6.10.1 Safety edit on days' supply, early refills, duplicate fills, and quantity limitations on opioids and a claims review automated process that indicates fills of opioids in excess of limitations identified by the State;

4.6.6.10.2 Safety edits on the maximum daily morphine equivalent for treatment of pain and a claims review automated process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State;

4.6.6.10.3 A claims review automated process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics;

4.6.6.10.4 A program to monitor and manage the appropriate use of antipsychotic medications by all children including foster children enrolled under the State plan;

4.6.6.10.5 Fraud and abuse identification processes that identifies potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies;

4.6.6.11 No later than December 31st of each year, the Contractor shall provide the Department of Community Health the following data from the previous plan year:

4.6.6.11.1 Claim level detail for all pharmacy claims, the FINAL amount paid to the pharmacy including but not limited to the amount of drug reimbursement; dispensing fees; copayments; and any direct and indirect renumeration (DIR) clawbacks.

4.6.6.11.2 The amount paid by the Contractor to the PBM for each claim inclusive of any other fees that may be paid by the Contractor to the PBM will also be provided.

4.6.6.11.3 At the claim level detail, the Contractor shall provide an accounting of any difference between the final paid amount to the pharmacy (inclusive of DIR clawbacks) and the amount paid for the claim by the Contractor to the PBM to reflect and account for any administrative fee, rebate, processing charges or DIR fees.

4.6.6.12 Contractor must make available in electronic or paper form, the following information about its formulary:

4.6.6.12.1 Which medications are covered (both generic and name brand)

4.6.6.12.2 Which tier each medication is on.

4.6.7 Immunizations

4.6.7.1 The Contractor shall provide all Members less than twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
See: http://www.cdc.gov/vaccines/schedules/hcp/index.html.

4.6.7.2 The Contractor shall provide P4HB participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the ACIP guidelines as needed.

4.6.7.3 The Contractor shall collaborate with the Department of Public Health to ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccines for Children (VFC) program for Members eighteen (18) years of age and younger. Immunizations shall be given in conjunction with Well-Child/preventive care. See http://dph.georgia.gov/vaccines-children-program for additional information.

4.6.7.4 The Contractor shall develop a policy for collaborating with DPH. The Contractor shall work with DCH to address challenges in providing vaccines under the VFC program.

4.6.7.5 The Contractor shall ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccines for Children (VFC) program for P4HB Participants eighteen (18) years of age.

4.6.7.6 The Contractor shall provide all adult immunizations specified in the Georgia Medicaid Policies and Procedures Manuals.

4.6.7.7 The Contractor shall report all immunizations to the DPH Georgia Registry of Immunization Transactions and Services (GRITS) in a format to be determined by DCH.

4.6.7.8 The Contractor shall enter into an agreement with the Georgia Department of Public Health recognizing a Member of PeachCare for Kids® as a "State Vaccine Eligible Child" as permitted under Section 1928(b)(3) of the Social Security Act. At a minimum, this agreement shall permit the State to enjoy the discounted purchasing of vaccines for children covered under PeachCare for Kids® permitted under said Section and provide appropriate reimbursement to DPH for such vaccines utilized by the CMO's membership.

4.6.8 Transportation

4.6.8.1 The Contractor shall provide emergency transportation and shall not retroactively deny a Claim for emergency transportation to an emergency Provider because the Condition, which appeared to be an Emergency Medical Condition under the Prudent Layperson standard, turned out to be non-emergency in nature.

4.6.8.2 The Contractor is not responsible for providing non-emergency transportation (NET) for its Members. Eligible Medicaid Members are to contact the assigned NET Broker for the county they live in to arrange for transportation. The Contractor is encouraged to collaborate with the NET Brokers and assist both the NET brokers and assigned Members with the coordination of NET services for assigned Members.

4.6.8.3 The Contractor may, however, coordinate other transportation for those Medicaid Members not eligible for transportation under the NET Broker contract. In the event Contractor performs such coordination, DCH shall not be responsible for any payment resulting from such services. The following Categories of Aid are not eligible for Non-Emergency Transportation:

4.6.8.3.1 177 – Family Planning Waiver

4.6.8.3.2 181 - P4HB Family Planning (only)

4.6.8.3.3 460 – SSI Qualified Medicare Beneficiary

4.6.8.3.4 466 - Specified Low Income Medicare Beneficiary

4.6.8.3.5 660 – Qualified Medicare Beneficiary

4.6.8.3.6 661 – Specified Low Income Medicare Beneficiary

4.6.8.3.7 662 – Q11 Beneficiary

4.6.8.3.8 664 – Qualified Working Disabled individuals

4.6.8.3.9 790 – Peachcare 101-150% FPL

4.6.8.3.10 791 – Peachcare 151-200% FPL

4.6.8.3.11 792 – 201-235% FPL

4.6.8.3.12 793 – Peachcare > 235% FPL

4.6.8.3.13 815 – Aged Inmate

4.6.8.3.14 817- Disabled Inmate

4.6.8.3.15 870 – Emergency Alien – Adult

4.6.8.3.16 873 – Emergency Alien - Child

4.6.9 Perinatal Services

4.6.9.1 The Contractor shall ensure that appropriate perinatal care is provided to women and newborn Members. The Contractor shall have adequate capacity such that any new Member who is pregnant is able to have an initial visit with her Obstetric Provider within fourteen (14) Calendar Days of Enrollment. The Contractor shall have in place a system that provides, at a minimum, the following services:

4.6.9.1.1 Pregnancy planning and perinatal health promotion and education for reproductive-age women;

4.6.9.1.2 Perinatal risk assessment of non-pregnant women, pregnant and post-partum women, and newborns and children up to five (5) months of age. The Contractor must have the capacity to electronically accept, in a timely manner, Perinatal Case Management Initial Assessments from local public health departments completing these assessments following the presumptive eligibility determination;

4.6.9.1.3 Childbirth education classes to all pregnant Members and their chosen partner. Through these classes, expectant parents shall be encouraged to prepare themselves physically, emotionally, and intellectually for the

childbirth experience. The classes shall be offered at times convenient to the population served, in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation and translation services if necessary pursuant to Sections 4.3.10 and 4.3.11 of this Contract;

4.6.9.1.4 Access to appropriate levels of care based on risk assessment, including emergency care;

4.6.9.1.5 Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;

4.6.9.1.6 Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and

4.6.9.1.7 Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery.

4.6.10 Parenting Education

4.6.10.1 In addition to individual parent education and anticipatory guidance to parents and guardians at EPSDT preventive visits, the Contractor shall offer or arrange for parenting skills education to expectant and new parents, at no cost to the Member.

4.6.10.2 The Contractor shall create effective ways to deliver this education, whether through classes, as a component of post-partum home visiting, or other such means. The educational efforts shall include topics such as bathing, feeding (including breast feeding), injury prevention, sleeping, illness, when to call the doctor, when to use the emergency room, etc. DCH shall approve education content, class schedule and locations. Classes shall be offered in languages spoken by the Members, including on-site oral interpretation services if necessary pursuant to Section 4.3.11 of this Contract.

4.6.11 Mental Health and Substance Abuse

4.6.11.1 The Contractor shall provide integrated behavioral and physical health care for Members with mental illness including for those with dual-diagnoses. Integrated health care for Members with mental illness shall be focused equally on prevention and intervention utilizing predictive modeling to identify Members at risk as well as innovative and best-practice methods to encourage Member engagement in self-care behaviors. The Contractor shall provide a full range of recovery-based services and engage non-medical services and supports as indicated to provide holistic care focused on whole-health wellness, long-term independence, and skills building. This includes access to Certified Peer Supports for youth, adults and parents of youth with mental illness.

4.6.11.2 The Contractor shall have written Mental Health and Substance Abuse Policies and Procedures that explain how they will arrange or provide for covered mental health and substance abuse services. Such policies and procedures shall include Advance Directives. The Contractor shall assure timely delivery of mental health and substance abuse services and coordination with other acute care services.

4.6.11.3 Mental Health and Substance Abuse Policies and Procedures shall be submitted to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.

4.6.11.4 The Contractor shall permit Members to self-refer to an In-Network Provider for an initial mental health or substance abuse assessment.

4.6.11.5 The Contractor shall permit P4HB IPC Participants to receive Detoxification and Intensive Outpatient Rehabilitation Services as specified in the Special Terms and Conditions. (See Attachment L).

4.6.11.6 The Contractor shall permit all initial outpatient Behavioral Health (mental health and substance abuse) evaluation, diagnostic testing, and assessment services to be provided without Prior Authorization. The Contractor shall permit up to three (3) initial evaluations per year for Members younger than twenty-two (22) years of age without requiring additional Prior Authorization.

4.6.11.7 Following an initial evaluation, the Contractor shall permit up to twelve (12) outpatient counseling/therapy visits to be provided without Prior Authorization.

4.6.11.8 The Contractor shall promote the delivery of Behavioral Health services in the most integrated and person-centered setting including in the home, school or community, for example, when identified through care planning as the preferred setting by the Member. The delivery of home

and community based Behavioral Health services may be incentivized by the Contractor for Providers who engage in this person-centered service delivery.

4.6.11.9 The Contractor shall provide emergency services diversion techniques and interventions (including but not limited to SBIRT-Screening, Brief Intervention and Referral to Treatment) for Members with mental illness and/or substance use.

4.6.11.10 The Contractor shall provide scalable intensity of case management, disease management, Care Coordination, and complex Care Coordination based on the intensity of the Member's need. Refer to Section 4.11.8 for more details.

4.6.12 Advance Directives

4.6.12.1 In compliance with 42 CFR 438.3(j) and 42 CFR 422.128, the Contractor shall maintain written policies and procedures for Advance Directives, including mental health advance directives. Such Advance Directives shall be included in each Member's medical record. The Contractor shall provide these policies to all Members eighteen (18) years of age and older and shall advise Members of:

4.6.12.1.1 Their rights under the law of the State of Georgia, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; and

4.6.12.1.2 The Contractor's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience. At a minimum, this statement must do the following:

- Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians;
- Identify the state legal authority permitting such objection;
- Describe the range of medical conditions or procedures affected by the conscience objection;

4.6.12.2 The information must include a description of State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) Calendar Days after the effective change.

4.6.12.3 The Contractor's information must inform Members that complaints may be filed with the Healthcare Facility Regulation Division, the State's Survey and Certification Agency.

4.6.12.4 The Contractor shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Members, and their responsibility to educate Members about this tool and assist them to make use of it.

4.6.12.5 The Contractor shall educate Members about their ability to direct their care using this mechanism and shall specifically designate which staff Members and/or network Providers are responsible for providing this education.

4.6.13 Member Cost-Sharing

4.6.13.1 The Contractor shall ensure that Providers assess Member co-payments consistent with those specified in **Attachment J**.

4.6.13.2 The Contractor shall ensure that Providers do not refuse to render services based on a Member's inability to pay the Member cost-share.

4.6.13.3 The Contractor shall ensure that Providers do not utilize other methods post-delivery of services (such as but not limited to collection agency) to fulfill Member cost-sharing responsibility.

4.6.14 Value Added Services

4.6.14.1 The Contractor is permitted to provide value added services to Members that address the needs of Members and improve health outcomes. Value added services exceed Georgia State Plan benefits and are designed to improve Members' wellbeing, encourage prudent use of health care benefits, and enhance the cost effectiveness of the Georgia Families program. DCH encourages the Contractor to consider the challenges in improving Member health outcomes in developing Value Added services.

4.6.14.2 The Contractor must submit any proposed value added services to DCH for review and approval prior to implementation. Additional value added services can be added at any time with DCH approval. The Contractor must provide a detailed list of value added services to the DCH Enrollment Broker.

4.6.14.3 Value added services cannot be discontinued once implemented without prior approval from DCH. Should DCH approve the Contractor's request for discontinuation of value added services, DCH reserves the

right to initiate an open enrollment period for the Members assigned to the Contractor if value added benefits are discontinued.

4.6.14.4 Value added services are not considered during the Capitation Rate development process.

4.6.14.5 Contractor may cover services or settings that are in lieu of services covered under the State Plan, if:

4.6.14.5.1 DCH determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting,

4.6.14.5.2 The Member is not required by the Contractor to use the alternative service or setting,

4.6.14.5.3 The approved "in lieu of" services are authorized and identified in the Contract and will be offered to Members at the option of the Contractor, and

4.6.14.5.4 The utilization and actual cost of the "in lieu of" services is taken into account in developing the component of the capitation rates that represents the covered State Plan services.

4.7 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) BENEFIT

4.7.1 General Provisions

4.7.1.1 The Contractor must ensure that Medicaid and PeachCare for Kids® children younger than twenty-one (21) years of age receive the services available under the federal EPSDT benefit.

4.7.1.2 The Contractor shall comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, diagnostic and treatment services. The Contractor shall comply with all EPSDT Program requirements pursuant to the Georgia Medicaid Policies and Procedures Manuals.

4.7.1.3 The Contractor shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the EPSDT Program. The EPSDT Plan shall emphasize outreach and compliance monitoring for

children and adolescents (young adults), taking into account the multi-lingual, multi-cultural nature of the Georgia Families population, as well as other unique characteristics of this population. The EPSDT Plan shall include procedures for ensuring compliance with DCH's EPSDT periodicity schedule, follow-up of missed appointments, including missed Referral appointments for problems identified through preventive screens and exams. The EPSDT Plan shall also include procedures for referral, tracking and follow up for annual dental examinations and visits. The Contractor shall submit its initial EPSDT Plan to DCH for review and approval no later than within one hundred twenty (120) Calendar Days prior to the Operational Start Date and shall submit proposed updated drafts of the EPSDT Plan thereafter. The Contractor shall submit to DCH annually a report and evaluation of its EPSDT Plan according to DCH specifications.

4.7.1.4 The Contractor shall ensure Providers perform all components of the EPSDT preventive health visit according to the requirements documented in the DCH approved periodicity schedule. The visit must include a (i) comprehensive health and developmental history (including assessment of both physical and mental health development), (ii) comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam), (iii) appropriate immunizations (according to the schedules established by the ACIP for individuals 0 – 18 years of age and nineteen (19) and older), (iv) laboratory tests (including blood lead level assessment appropriate to age and risk), and (v) health education (including anticipatory guidance.) All five (5) components must be performed for the visit to be considered an EPSDT preventive health visit.

4.7.2 Outreach and Informing

4.7.2.1 The Contractor's EPSDT outreach and informing process shall include:

4.7.2.1.1 The importance of preventive care;

4.7.2.1.2 The periodicity schedule and the depth and breadth of services;

4.7.2.1.3 How and where to access services, including necessary transportation and scheduling services; and

4.7.2.1.4 A statement that services are provided without cost.

4.7.2.2 The Contractor shall inform its newly enrolled families with EPSDT eligible children about the EPSDT benefit within thirty (30) Calendar Days of Enrollment with the EPSDT Plan. This requirement includes

informing pregnant women and new mothers, either before or within seven (7) days after the birth of their children, that Health Check services are available.

4.7.2.3 The Contractor shall provide to each PCP, on a monthly basis, a list of the PCP's EPSDT eligible Members who appear not to have had an encounter during the initial ninety (90) Calendar Days of CMO enrollment, and/or who are not in compliance with the EPSDT periodicity schedule. The Contractor shall require its Providers to contact the Members' parents or guardians to schedule an appointment for those screens and services that appear not to be in compliance with the EPSDT periodicity schedule. If the PCP has medical record evidence that appropriate screens have occurred for the Member, the Contractor must incorporate these visits into its tracking system and remove the Member from the PCP's list of Members who are non-compliant with the EPSDT periodicity schedule.

4.7.2.4 Informing of the Health Check Program may be oral (on the telephone, face-to-face, or via films/tapes) or written and may be done by Contractor personnel or Health Care Providers. At a minimum, the Contractor shall provide written notification to its families with Health Check eligible children when appropriate periodic assessments or needed services are due. The Contractor shall conduct all outreach and informing in non-technical language at or below a fifth (5th) grade reading level. The Contractor shall use accepted methods for informing persons who are blind or deaf, or who cannot read or understand the English language, in accordance with requirements for written material as described in Section 4.3.2. The Contractor shall document all outreach efforts it makes to inform Members (or their parents/guardians) regarding Health Check services.

4.7.2.5 The Contractor may provide incentives to Members and/or Providers to encourage compliance with the periodicity schedules, as described in Section 4.12.5.

4.7.3 Early and Periodic Screenings – the Preventive Health Visit

4.7.3.1 PCPs within the Contractor's network are responsible for providing, at the time of the Member's preventive visit, all of the EPSDT required components along with those identified in the State's periodicity schedule. The required EPSDT components include:

4.7.3.1.1 A comprehensive health and developmental history (including assessment of both physical and mental health development);

4.7.3.1.2 A comprehensive unclothed physical examination (unclothed means to the extent necessary to conduct a full, age-appropriate exam);

4.7.3.1.3 Appropriate immunizations (according to the schedule established by ACIP for individuals eighteen (18) years of age and younger and individuals nineteen (19) years of age and older;

4.7.3.1.4 Certain laboratory tests (including the federally required blood lead level assessment appropriate to age and risk screening);

4.7.3.1.5 Health Education (including anticipatory guidance);

4.7.3.1.6 Measurements (including head circumference for infants and body mass index);

4.7.3.1.7 Sensory screening (vision and hearing);

4.7.3.1.8 Oral health assessment; and

4.7.3.1.9 Sexually Transmitted Infection/ Human Immunodeficiency Virus (STI/HIV) screening.

4.7.3.2 The Contractor's contracts with its network hospitals/birthing centers shall ensure the EPSDT initial newborn preventive visit occurs in the hospital/birthing center. The newborn preventive visit should be completed within twenty-four (24) hours after birth and prior to discharge of the infant.

4.7.3.3 The Contractor shall provide for a blood lead screening test for all EPSDT eligible children at twelve (12) and twenty-four (24) months of age. Children between thirty-six (36) months of age and seventy-two (72) months of age should receive a blood lead screening test if there is no record of a previous test.

4.7.3.4 The Contractor shall have a lead Case Management program for EPSDT eligible children and their households when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter. The lead Case Management program shall include education, a written Case Management plan that includes all necessary referrals, coordination with other specific agencies, environmental lead assessments, and aggressive pursuit of non-compliance with follow-up tests and appointments. The Contractor must ensure reporting of all blood lead levels to the Department of Public Health.

4.7.3.5 The Contractor shall have procedures for Referral of those eligible for the Health Check Program and follow up with oral health professionals, including annual dental examinations and services by an oral health professional. Dental visits must be performed by a dentist, or other licensed dental professionals working under the supervision of a dentist according to the provisions of Georgia's scope of practice laws, and can occur in settings other than dentist's office, such as a clinic or a school. The Contractor's oral health providers must follow the American Academy of Pediatric Dentistry's (AAPDs) Periodicity Schedule. Dental preventive services that carry a limitation per year shall be limited to a 12-rolling month period.

4.7.3.6 The Contractor shall provide inter-periodic screens, which are screens that occur between the complete periodic screens and are Medically Necessary to determine the existence of suspected physical or mental illnesses or conditions. This includes at a minimum vision and hearing services. An inter-periodic visit may be performed only for vision or hearing services.

4.7.3.7 The Contractor shall allow Referrals for further diagnostic and/or treatment services to correct or ameliorate defects, and physical and mental illnesses and Conditions discovered during the Health Check EPSDT preventive health visit. The PCP may make such Referrals and follow up pursuant to the PCP's contract with the Contractor, as appropriate.

4.7.3.8 The Contractor shall ensure an initial health and screening visit is performed, as appropriate, for all newly enrolled GF EPSDT eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth for all newborns. If the Member's PCP provides medical record evidence to the Contractor that the initial health and screening visit have already taken place, this evidence will meet this Contract requirement. The Contractor should incorporate this evidence for this Member in its tracking system. The Contractor shall share EPSDT health check screening results with PCPs.

4.7.3.9 Minimum Contractor compliance with the Health Check screening requirements is an eighty percent (80%) screening ratio for the periodic preventive health visits, using the methodology prescribed by CMS to determine the screening ratio. This requirement and screening percentage is related to the CMS-416 Report requirements.

4.7.4 Diagnostic and Treatment Services

4.7.4.1 If a suspected problem is detected by a preventive health screening examination as described above, the Member shall be evaluated as necessary for further diagnosis. This diagnosis will be used to determine treatment needs.

4.7.4.2 EPSDT requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a physical or mental illness or condition discovered or shown to have increased in severity during an EPSDT preventive health visit. Such Medically Necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-Covered Services as defined in Title XIX of the Social Security Act. The Contractor shall provide Medically Necessary, Medicaid-covered diagnostic and treatment services.

4.7.4.3 When a preventive health screening examination indicates the need for further evaluation of a Member's health, the Referral for diagnosis must be made without delay. Follow-up is required to ensure that the Member receives a complete diagnostic evaluation. If the Member is receiving care from a Continuing Care Provider, diagnosis may be part of the screening and examination process.

4.7.4.4 Continuing Care Providers may have to arrange for certain specialty services that are beyond the scope of their practice (e.g. cardiology or ophthalmology); and may agree, at their option, to make direct dental Referrals.

4.7.4.5 The Contractor must provide for EPSDT Diagnostic and Treatment Services, which must include:

4.7.4.5.1 Vision Services: At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses.

4.7.4.5.2 Dental Services: At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health, at as early an age as necessary. Also included are emergency dental services, such as those services necessary to control bleeding, relieve pain, eliminate acute infection, etc. Dental services may not be limited to emergency services.

4.7.4.5.3 Hearing Services: At a minimum, include diagnosis and treatment for defects in hearing, and include hearing aids.

4.7.4.5.4 Developmental Assessment: Include structured tests and instruments administered by the professional to whom the Member has been referred after potential problems have been identified by the screening process.

4.7.4.5.5 Diagnosis, Treatment, and Follow-Up for Lead Toxicity: If a child is found to have blood lead levels equal to or greater than 10 ug/dL, Providers are to use their professional judgment regarding patient management and treatment.

4.7.4.5.6 Other Necessary Health Care: Provide other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

4.7.5 Tracking

4.7.5.1 The Contractor shall establish a tracking system that provides information on compliance with EPSDT requirements. This system shall track, at a minimum, the following areas:

4.7.5.1.1 Initial newborn EPSDT visit occurring in the hospital;

4.7.5.1.2 Periodic and preventive/well child screens and visits as prescribed by the periodicity schedule;

4.7.5.1.3 Diagnosis and treatment services, including Referrals;

4.7.5.1.4 Immunizations, lead, tuberculosis and dental services;

4.7.5.1.5 Missed periodic and preventive/visits and Notification to Members of missed visits; and

4.7.5.1.6 Activities listed in the CMS-416 Report. The Contractor must submit to DCH a report, using the CMS 416 Report's template that is specific to its Member population on a quarterly basis.

4.7.5.2 The Contractor shall establish a reminder/notification system that must be integrated with its tracking system allowing timely notifications of preventive visits coming due and missed appointments. The system must also interface with the Providers' notifications to the Contractor of the Members' missed appointments.

4.7.5.3 All information generated and maintained in the tracking system shall be consistent with Encounter Claims requirements as specified elsewhere herein.

4.7.6 Reporting Requirements

4.7.6.1 The Contractor shall submit all required EPSDT-related reports as described in the CMO Report Schedule. The Contractor must utilize the templates and specifications provided by DCH when submitting reports to DCH. From time to time, DCH may modify the reports' specifications and templates in response to federal and state needs. The reports' specifications and templates must not be altered by the CMO prior to submission to DCH. Each EPSDT report must include an analysis of the report's findings along with planned interventions to drive further improvements in the outcomes documented in the report. The report template along with the quality analysis report must be reviewed, approved, and signed by the Contractor's Chief Medical Officer prior to submission to DCH.

4.8 GEORGIA FAMILIES PROVIDER NETWORK

4.8.1 General Provisions

4.8.1.1 The Contractor shall develop, maintain, and monitor a network of appropriate Providers and facilities, supported by written agreements, and adequate to deliver Covered Services as described in the RFP and this Contract. Contractor must ensure the adequate and appropriate provision of services to Members in rural areas, which may include the use of telemedicine when appropriate to the condition and needs of the Member. Contractor must ensure its provider network covers those Members with Limited-English-Proficiency or physical or mental disabilities. The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other health care Providers through whom it provides the items and services included in Covered Services. Contractor shall provide to DCH quarterly, and upon any significant change in Contractor's operations, a report documenting:

4.8.1.1.1 That it offers an appropriate range of preventive, primary care, specialty services, that is adequate for the anticipated number of enrollees in the service area, and

4.8.1.1.2 That it maintains a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated numbers of enrollees in the service area.

For purposes of this report, a significant change in Contractor's operations shall include changes in the Contractor's services, benefits, geographic service area, composition of payments to its Provider network, or enrollment of a new population by the Contractor.

4.8.1.2 Contractor shall ensure that its policies and procedures provide for a second opinion from a network provider, or arranges for the Member to obtain one outside the network, at no cost to the Member.

4.8.1.3 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent, that maintain current license(s), and that have appropriate locations to provide the Covered Services.

4.8.1.4 The Contractor's Provider Network shall reflect, to the extent possible, the delivery of services in a culturally competent manner to all enrollees, including those with Limited-English-Proficiency and diverse cultural and ethnic backgrounds, and regardless of disability, gender, sexual orientation or gender identity.

4.8.1.5 The Contractor shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network enrollment for new Provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.

4.8.1.6 The Contractor shall not include any Providers who have been excluded from participation by the United States Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor shall check the exclusions list on a monthly basis and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.

4.8.2 Provider Selection and Retention Policies and Procedures

4.8.2.1 The Contractor shall have written Provider Selection and Retention Policies and Procedures to DCH for initial review within sixty (60) Calendar Days of the Contract Effective Date and approval, and as updated thereafter. In selecting and retaining Providers in its network the Contractor shall consider the following:

4.8.2.1.1 The anticipated GF Enrollment;

4.8.2.1.2 The expected Utilization of services, taking into consideration the characteristics and Health Care needs of its Members;

4.8.2.1.3 The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the Covered Services;

4.8.2.1.4 The numbers of network Providers who are not accepting new GF patients; and

4.8.2.1.5 The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

4.8.2.1.6 The ability of network providers to communicate with Limited-English-Proficient Members in their preferred language.

4.8.2.1.7 The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid Members with physical or mental disabilities.

4.8.2.1.8 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

4.8.2.2 If the Contractor declines to include individual Providers or groups of Providers in its network, the Contractor shall give the affected Providers written notice of the reason(s) for the decision. These provisions shall not be construed to:

4.8.2.2.1 Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members; and

4.8.2.2.2 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs that are consistent with its responsibilities to Members.

4.8.2.3 The Contractor shall ensure that all network Providers have knowingly and willfully agreed to participate in the Contractor's network. The Contractor shall not acquire established networks without contacting each individual Provider to ensure knowledge of the requirements of this Contract and the Provider's complete understanding and agreement to fulfill all terms of the Provider Contract, as outlined in Section 4.10. DCH reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and on-site visits to network Providers, the existence of a direct relationship between the Contractor and the network Providers.

4.8.2.4 The Contractor shall send all newly contracted Providers a written network participation welcome letter that includes a contract effective date for which Providers are approved to begin providing medical services to Georgia Families Members.

4.8.2.5 The Contractor shall survey all Providers who chose to exit the network and use the results of Provider exit surveys to improve Provider retention and recruitment. The Contractor shall provide DCH with the Provider exit survey template initially and when updated thereafter. The Contractor shall provide DCH with results of the Provider exit surveys upon request.

4.8.2.6 In addition to the minimum provider selection requirements in 42 CFR 438.214, the Contractor shall comply with any additional provider selection requirements established by the State that are incorporated into this contract.

4.8.3 Provider Network Compositions

4.8.3.1 The Contractor shall maintain an online Provider Directory and Network Listing.

4.8.3.2 The Contractor shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted Providers which shall include the use of access and availability audits described in Section 4.8.19.6. Failure to conduct quarterly Validation and provide a clean file after determining errors through Validation may result in liquidated damages up to $5,000 per day against the Contractor.

4.8.3.3 The Contractor shall ensure that all Provider network data files are tested and validated for accuracy prior to Contractor deliverable submissions, which shall include the use of access and availability audits described in Section 4.8.19.6. The Contractor shall scrub data to identify inconsistencies such as duplicate addresses; mismatched cities,

counties, and regions; and incorrect assigned specialties. The Contractor shall be responsible for submission of attestations for each network report. All reports are to be submitted in the established DCH format with all required data elements. Failure to submit all attestations and complete reports in the established DCH format with all required data elements may result in liquidated damages up to $5,000 per day against the Contractor.

4.8.3.4 The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented in record. The Contractor will emphasize to Providers the need for a unique GA Medicaid number for each practice location unless DCH changes this requirement at a future date.

4.8.4 Primary Care Providers (PCPs)

4.8.4.1 The Contractor shall allow for PCPs to include not only traditional provider types that have historically served as PCPs but also alternative provider types such as specialists and patient-centered medical homes (PCMHs) with documented physician oversight and meaningful physician engagement.

4.8.4.2 The Contractor shall include in its network as PCPs the following:

4.8.4.2.1 Physicians who routinely provide Primary Care services in the areas of:

4.8.4.2.1.1 Family Practice;

4.8.4.2.1.2 General Practice;

4.8.4.2.1.3 Pediatrics;

4.8.4.2.1.4 Internal Medicine; or

4.8.4.2.1.5 Obstetrics and Gynecology.

4.8.4.2.2 Nurse Practitioners Certified (NP-C) specializing in:

4.8.4.2.2.1 Family Practice; or

4.8.4.2.2.2 Pediatrics.

4.8.4.2.2.3 NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who is a network

Provider, who has hospital admitting privileges and oversees the provision of services furnished by NP-Cs.

4.8.4.2.3 Psychiatrists who agree to serve as PCPs for Members who have a primary diagnosis of a Severe Persistent Mental Illness.

4.8.4.2.4 Physicians who provide medical services at FQHCs and RHCs. The Contractor shall maintain an accurate list of all Providers rendering care at these facilities.

4.8.4.2.5 Providers who practice at Public Health Department clinics and Hospital Outpatient clinics may be included as PCPs if they agree to the requirements of the PCP role, including the following conditions:

4.8.4.2.5.1 The practice must routinely deliver Primary Care as defined by the majority of the practice devoted to providing continuing comprehensive and coordinated medical care to a population undifferentiated by disease or organ system. If deemed necessary, a Medical Record audit of the practice will be performed by the Contractor. Any exceptions to this requirement will be considered by DCH on a case-by-case basis.

4.8.4.2.5.2 Any Referrals for specialty care to other Providers of the same practice may be reviewed for appropriateness.

4.8.4.2.5.3 Members who have a primary diagnosis of a Severe Persistent Mental Illness may be permitted to have any physician including a psychiatrist as their PCP assuming the physician or psychiatrist agrees to serve in this role.

4.8.4.2.6 Physician's assistants (PAs); however, the physician should be listed as the Member's PCP.

4.8.4.3 The Contractor may allow Members with Chronic Conditions to select a specialist with whom he or she has an on-going relationship to serve as a PCP.

4.8.4.4 The Contractor is encouraged to promote and facilitate the capacity of all PCP practices to meet the recognition requirements of a NCQA PCMH™ as jointly defined by NCQA. The Contractor shall report to DCH those PCP practices that achieve recognition or meet the requirements of the NCQA for PCMH™ or The Joint Commission (TJC) PCH Accreditation. The Contractor shall collaborate with other CMOs to coordinate efforts when PCPs are contracted with one or more plans so that efforts are not duplicated.

4.8.4.5 The Contractor will include Behavioral Health Homes in its Medical Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated. The number of Behavioral Health Homes proposed in the network should be responsive to the prevalence of members with severe and persistent mental illness or chronic behavioral health conditions. The proposed algorithm along with assignment of Behavioral Health Homes shall be included in a Medical Home implementation plan.

4.8.4.6 The Contractor shall provide a Medical Home implementation plan within ninety (90) days of the Operational Start Date for DCH review and approval that identifies the methodology for promoting and facilitating NCQA PCMH recognition and/or TJC PCH accreditation. The implementation plan shall include, but not be limited to:

4.8.4.6.1 Payment methodology for payment to primary care practices;

4.8.4.6.2 Provision of technical support, to assist in their transformation to PPC®-PCMH recognition or TJC PCH accreditation (e.g., education, training, tools, and provision of data relevant to patient clinical care management);

4.8.4.6.3 Facilitation of specialty Provider Network access and coordination to support the PCMH; and

4.8.4.6.4 Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other Providers.

4.8.5 Direct Access

4.8.5.1 The Contractor shall provide female Members with direct In-Network access to a women's health specialist for covered care necessary to

provide her routine and preventive Health Care services. This access is in addition to the Member's designated source of Primary Care if that Provider is not a women's health specialist.

4.8.5.2 The Contractor shall have a process in place that ensures that Members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the Member's condition and identified needs. The Contractor's Medical Director shall be responsible for overseeing this process.

4.8.6 Pharmacies

4.8.6.1 The Contractor shall maintain a comprehensive Provider network of pharmacies that ensures pharmacies are available and geographically accessible to all Members.

4.8.7 Hospitals

4.8.7.1 The Contractor shall have a comprehensive Provider network of hospitals such that they are available and geographically accessible to all Members. This includes, but is not limited to tertiary care facilities and facilities with neo-natal, intensive care, burn, and trauma units.

4.8.7.2 The Contractor shall include in its network all Critical Access Hospitals (CAHs).

4.8.7.2.1 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include CAHs in its network. This documentation shall be provided to DCH upon request.

4.8.8 Laboratories

4.8.8.1 The Contractor shall maintain a comprehensive Provider network of laboratories that ensures laboratories are accessible to all Members. The Contractor shall ensure that all laboratory testing sites providing services under this contract have either a clinical laboratory (CLIA) certificate or a waiver of a certificate of registration, along with a CLIA number, pursuant to 42 CFR 493.3.

4.8.9 Behavioral Health (Mental Health/Substance Abuse)

4.8.9.1 The Contractor shall include in its network the three tiers of community Behavioral Health Providers listed below that meet the requirements of the Department of Behavioral Health and Developmental Disabilities, provided they have been credentialed to participate in Medicaid for that provider type and agree to the Contractor's terms and conditions as well

as rates. Additional information about these provider types and related policies and standards are available at https://gadbhdd.policystat.com/policy/1038203/latest/.

4.8.9.1.1 Tier 1: Comprehensive Community Providers (CCP)

4.8.9.1.1.1 CCPs function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The standards and requirements for CCPs are found in CCP Standards for Georgia's Tier 1 Behavioral Health Safety Net, 01-200.

4.8.9.1.2 Tier 2: Community Medicaid Providers (CMPs)

4.8.9.1.2.1 CMPs provide Behavioral Health services and supports identified in the Medicaid State Plan for Serious Emotional Disturbance (SED) youth, young adults, Serious and Persistent Mental Illness (SPMI) Adults, and individuals with Substance Use Disorders (SUDs). CMPs must competently serve children, adolescents, emerging adults, and/or adults and have the capacity and infrastructure to provide all of the services in the core benefit package:

4.8.9.1.3 Tier 3: Specialty Providers (SPs)

4.8.9.1.3.1 SPs offer an array of specialty services including but not limited to:

4.8.9.1.3.1.1 Intensive Family Intervention providers for children who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.

4.8.9.1.3.1.2 Certified Peer Specialists (CPS) with lived experience for both young adults and adults to include CPS-Parents who are associated

with a Family Support Organization (i.e. Federation of Families), CPS-Addiction and CPS Whole Health and Wellness.

4.8.9.1.3.1.3 Care Management Entities to provide intensive, customized, complex Care Coordination for children, youth, and young adults who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.

4.8.9.1.3.1.4 Assertive Community Treatment for adults with SPMI.

4.8.9.2 Additionally, the Contractor shall include in its Provider network Providers who are enrolled as psychologists under the State Plan.

4.8.9.3 The Contractor shall maintain copies of all letters and other correspondence related to the inclusion of Community Behavioral Health Providers in its network. This documentation shall be provided to DCH upon request.

4.8.10 Federally Qualified Health Centers (FQHCs)

4.8.10.1 The Contractor shall include in its Provider network all FQHCs and utilize the PPS rates for reimbursement.

4.8.10.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include FQHCs in its network. This documentation shall be provided to DCH upon request.

4.8.10.3 The FQHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for FQHC (the Manual). Services and supplies deemed necessary for the provision of a Core service as described in §901.2 of the Manual are considered part of the FQHC service. In addition, an FQHC can provide other ambulatory services

of the following state Medicaid Program, once enrolled in the programs:

4.8.10.3.1 EPSDT [Health Check (COS 600)];

4.8.10.3.2 Mental Health (COS 440);

4.8.10.3.3 Dental Services (COS 450 and 460);

4.8.10.3.4 Refractive Vision Care services (COS 470); and

4.8.10.3.5 Podiatry (COS 550).

4.8.11 Rural Health Clinics (RHCs)

4.8.11.1 The Contractor shall include in its Provider network all RHCs in its Service Region based on PPS rates.

4.8.11.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include RHCs in its network. This documentation shall be provided to DCH upon request.

4.8.11.3 The RHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for RHC (the Manual). Services and supplies deemed necessary for the provision of a Core service as described in §901.2 of the Manual are considered part of the RHC service. In addition, an RHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:

4.8.11.3.1 EPSDT [Health Check (COS 600)]

4.8.11.3.2 Mental Health (COS 440);

4.8.11.3.3 Dental Services (COS 450 and 460);

4.8.11.3.4 Refractive Vision Care services (COS 470); and,

4.8.11.3.5 Podiatry (COS 550).

4.8.12 Telemedicine

4.8.12.1 Telemedicine allows Provider-to-Provider and Provider-to-Member live interactions, and is especially useful in situations where Members do not have easy access to a Provider, such as for Members in rural areas. Providers also use telemedicine to consult with each other and share their expertise for the benefit of treating Members. DCH does not

currently recognize provider-to-provider live interactions without a Member present. DCH reserves the right to modify this policy decision in the future, acknowledging that such a change would require a review of the appropriateness of the Capitation Rates. However, nothing in this Contract prevents Contractor from offering Store-and-Forward use of telemedicine or Provider-to-Provider interactions without a Member present as an additional service not subject to consideration in the Capitation Rate setting process.

4.8.12.2 The Contractor shall provide telemedicine services to increase access to primary and specialty care as appropriate. Telemedicine presentation sites shall receive a telemedicine presentation site facility fee consistent with the Georgia Medicaid FFS program unless otherwise negotiated. The Contractor must include in its Provider Directory information on Providers with telemedicine capabilities and telemedicine presentation sites. The Contractor must:

4.8.12.2.1 Promote and employ broad-based utilization for access to HIPAA-compliant Telemedicine service systems.

4.8.12.2.2 Follow accepted HIPAA and 42 C.F.R. Part 2 regulations that affect Telemedicine transmission, including but not limited to staff and Provider training, room setup, security of transmission lines, etc. The Contractor shall have and implement policies and procedures that follow all federal and State security and procedure guidelines.

4.8.12.2.3 Identify, develop, and implement training for accepted Telemedicine practices.

4.8.12.2.4 Participate in the needs assessment of the organizational, developmental, and programmatic requirements of Telemedicine programs.

4.8.12.3 A health care facility that receives reimbursement under this Section for consultations provided by a Medicaid-participating provider who practices in that facility and a health professional who obtains a consultation under this section shall establish quality-of-care protocols and patient confidentiality guidelines to ensure that telehealth consultations meet all requirements and patient care standards as required by law.

4.8.12.4 The Contractor shall determine the exact number and locations of all telemedicine presentation sites and the number of Providers who will commit to providing telemedicine consultations.

4.8.13 Family Planning Clinics

4.8.13.1 The Contractor shall ensure that its provider network includes sufficient family planning providers, including those funded by Title X of the Public Health Services Act, so that its Members may access services in a timely manner.

4.8.13.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include Title X Clinics in its network. This documentation shall be provided to DCH upon request.

4.8.14 Nurse Practitioners Certified (NP-Cs) and Certified Nurse Midwives (CNMs)

4.8.14.1 The Contractor shall ensure that Members have appropriate access to NP-Cs and CNMs, through either Provider contracts or Referrals. This provision shall in no way be interpreted as requiring the Contractor to provide any services that are not Covered Services.

4.8.15 Dental Practitioners

4.8.15.1 The Contractor shall not deny any dentist from participating in the Medicaid and PeachCare for Kids® dental program administered by the Contractor if the dentist meets the below criteria:

4.8.15.1.1 Such dentist has obtained a license to practice in this State and is an enrolled Provider who has met all of the requirements of DCH for participation in the Medicaid and PeachCare for Kids® program;

4.8.15.1.2 Licensed dentist will provide dental services to Members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, the Contractor shall be required to offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the service region who participate in the Contractor's Medicaid and PeachCare for Kids® dental programs; and

4.8.15.1.3 The geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by DCH, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services.

4.8.15.2 The Contractor must establish a sufficient number of general dentists and specialists as specified by Geographic Access Requirements, specified in Section 4.8.17, to provide covered dental services to Members. The Contractor may cover certain dental services provided by a dental hygienist in a Public Health setting in accordance with all applicable laws and rules. The Contractor may also provide for services in a school environment by mobile dentistry providers.

4.8.15.3 Should the Contractor find that the Provider does not meet these provisions set forth in Section 4.8.15.1 and elects to deny participation, the Contractor's denial letter of a credentialed provider's request to contract must include specific information regarding the basis for denial and how to file an appeal.

4.8.15.4 The Contractor must report to DCH the number of dental application appeals, and appeal outcomes on a calendar month basis.

4.8.16 Dental Home

4.8.16.1 The Contractor shall provide all Members under age twenty-one (21) a Dentist who will serve as the Members' Dental Home. The Contractor shall have written Selection Policies and Procedures describing how Members select or are assigned to a Dental Home.

4.8.16.2 P4HB members are not eligible for a dental home.

4.8.17 Geographic Access Requirements

4.8.17.1 In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the following geographic access standards for all Members as outlined in Figure 1. The Contractor shall utilize the most recent Geo Access program versions available and update periodically as appropriate. The Contractor shall use GeoCoder software along with the Geo Access application package.

4.8.17.2 Beginning on the Operational Start Date, the Contractor's Geographic Access analysis must include the below data standards and reporting specifications. However, DCH reserves the right to modify the data standards and report specifications at any time in its discretion. The Contractor can submit recommendations for differing data standards and report specifications for DCH consideration and approval. With this submission, the Contractor must include its rationale for requesting the change. DCH's prior written approval of the change is required.

4.8.17.2.1 Data Standards:

4.8.17.2.1.1 The Contractor shall use the most recent eligibility files provided by DCH.

4.8.17.2.1.2 The Contractor shall use the most recent Member data to geocode each Member by street address. Identifying Members at zip code centroids or randomly within zip codes is not acceptable.

4.8.17.2.1.3 All Contractor's network Provider street addresses should be exactly geocoded. For any address that cannot be exactly geocoded, the address should be geocoded using a technique that takes into account population density. Placing Providers at zip code centroids or randomly within zip codes is not acceptable.

4.8.17.2.1.4 If more than one Provider is located at the same address, all Providers at that address should have the same geographic coordinates.

4.8.17.2.1.5 Physicians should be classified based on their primary specialty only. For example, a pediatric cardiologist should be classified as cardiologist, not a pediatrician. The Provider file must include the capacity for each PCP and general dentist.

4.8.17.2.1.6 The Contractor shall only include in its Geographic Access data reports those Providers that operate a Full-Time Provider location. For purposes of this requirement, a Full-Time Provider location is defined as a location operating for sixteen (16) or more hours in an office location each week. For Providers who have more than one (1) office location, the Contractor must indicate each location by a separate record in the Provider file and divide the capacity of the Provider by the number of locations. For example, if the Provider capacity is one hundred fifty (150), and the Provider has two (2) offices,

each office would have a capacity of seventy-five (75). The "individual capacity" option should be used when reporting PCPs.

4.8.17.2.1.7 For calculating distance (miles) the Contractor must use the maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider. DCH recognizes that transportation with NET vendors may not always follow direct routes due to multiple passengers.

4.8.17.2.2 Report Specifications

4.8.17.2.2.1 The Contractor must prepare separate Geographical Access reports for each county, addressing all Provider types included in Figure 1. Additionally, the Contractor shall prepare separate analyses for the following:

4.8.17.2.2.1.1 Adult PCPs for ages twenty-one (21) and over

4.8.17.2.2.1.2 Pediatric PCPs for children under the age of twenty-one (21)

4.8.17.2.2.1.3 General Dentist

4.8.17.2.2.1.4 Telemedicine Presentation Sites

4.8.17.2.2.1.5 Provider specialist shortages as identified by DCH or the Contractor including but not limited to OB Providers

4.8.17.2.2.2 The Contractor must prepare separate Geographical Access reports showing Providers with open panels only and showing all open and closed panels.

Figure 1. Geographic Access Standards by Provider Type

Provider Type	Urban	Rural
PCPs*	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
OB/GYN	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialist -Adult	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Specialist-Pediatric	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers - Adult	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Pediatric Dental	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Behavioral Health - Adult (mental health and SUD)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Behavioral Health-Pediatric (mental health and SUD)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

Provider Type	Urban	Rural
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles
Therapy : (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

*PCPs not including practitioners listed below in Table.

4.8.18 Other Reports

4.8.18.1 In addition to the Geographic Access data reports, the Contractor shall submit the following separate reports:

4.8.18.1.1 Providers and associated locations with closed panels (any Provider which the Contractor recognizes as no longer accepting new Members) and those Providers and associated locations with less than Full-Time Provider hours. The separate reports must include a listing of the Providers by name and location, Provider type and an analysis of the total number of Providers with closed panels or less than Full-Time Provider hours expressed as a percentage of the Contractor's total contracted Providers for the state and then for each Service Region.

4.8.18.1.2 The percent of Members who do not have Provider access as defined by Figure 1.

4.8.18.1.3 Plans or corrective actions to enhance access of the Providers included in these separate reports. If enhanced access is not possible (i.e., no Providers available for contracting or available Providers only practice part-time) the Contractor must describe the limitations to enhancing

access. The Contractor may indicate whether a Provider's office is a primary, secondary, tertiary, etc. location.

4.8.18.1.4 Report monthly the total number of Provider requests to contract received, the total number of Providers referred to DCH or its Agent for credentialing, the total number of contracts pending a determination, and the total of each of the approved and denied contract requests by Provider type and in aggregate.

4.8.18.2 The Contractor shall ensure that all executed Provider contracts are processed and loaded into all systems including but not limited to the Contractor's Claims processing system, within thirty (30) Calendar Days of receipt by the Contractor or its designated subcontracted vendor.

4.8.19 Waiting Maximums and Appointment Requirements

4.8.19.1 The Contractor shall require that all network Providers offer hours of operation that are no less than the hours of operation offered to commercial and Fee-for-Service patients. The Contractor shall encourage its PCPs to offer After-Hours office care in the evenings and on weekends.

4.8.19.2 The Contractor shall have in its network the capacity to ensure that waiting times for appointments do not exceed those outlined in Figure 2.

Figure 2. Waiting Times by Provider Type

Provider Type	Waiting Time
PCPs (routine visits)	Not to exceed fourteen (14) Calendar Days
PCP (adult sick visit)	Not to exceed twenty-four (24) clock hours
PCP (pediatric sick visit)	Not to exceed twenty-four (24) clock hours

Provider Type	Waiting Time
Maternity Care	First Trimester – Not to exceed fourteen (14) Calendar Days Second Trimester – Not to exceed seven (7) Calendar Days Third Trimester – Not to exceed three (3) Business Days
Specialists	Not to exceed thirty (30) Calendar Days
Therapy: Physical Therapists, Occupational Therapists, Speech Therapists, Aquatic Therapists	Not to exceed thirty (30) Calendar Days
Vision Providers	Not to exceed thirty (30) Calendar Days
Dental Providers (routine visits)	Not to exceed twenty-one (21) Calendar Days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) Calendar Days
Behavioral Health Providers	Fourteen (14) Calendar Days
Urgent Care Providers	Not to exceed twenty-four (24) clock hours
Emergency Providers	Immediately (twenty-four (24) clock hours a day, seven (7) days a week) and without prior authorization

4.8.19.3 The Contractor shall have in its network the capacity to ensure that waiting times in the Provider office does not exceed those outlined in Figure 3 for pediatrics and adults.

Figure 3. Waiting Times by Appointment Type

Appointment Type	Waiting Time
Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed ninety (90) minutes. After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

4.8.19.4 Providers shall track waiting times by appointment to be reviewed by DCH upon request.

4.8.19.5 The Contractor shall ensure that Provider response times for returning calls After-Hours do not exceed those outlined in Figure 4:

Figure 4. Returned Call Response Times

Call Type	Response Time
Urgent Calls	Shall not exceed twenty (20) minutes
Other Calls	Shall not exceed one (1) hour

4.8.19.6 The Contractor shall at least quarterly conduct access and availability audits to validate Provider network access (outreach phone calls, emails) of individual Providers within the Contractor's primary care, specialty, dental, pediatric and obstetrical Provider Network. The Contractor may coordinate with other CMOs to conduct these audits to avoid duplicate contacts to Providers. The Contractor shall conduct a review of twenty-five percent (25%) of the combined network. Reviews shall include the use of "secret shopper" calls during which the caller pretends to be a Member to confirm specific information including but not limited to the following:

4.8.19.6.1 Contact information, such as address, phone, email, web site and fax numbers.

4.8.19.6.2 Provider is participating in the Network.

4.8.19.6.3 Open/Closed panel status.

4.8.19.6.4 Appointment availability and how far in advance the Member can schedule an appointment.

4.8.19.7 The Contractor shall provide DCH with results of all access and availability audits upon request. The Contractor shall take corrective action to remediate instances of identified non-compliance with the standards above and report all non-compliance to DCH within thirty (30) Calendar Days of the audit. Should DCH identify and notify the Contractor of non-compliance with the standards listed above, the Contractor shall provide to DCH a corrective action plan within thirty (30) Calendar Days of receipt of such notice.

4.8.20 Mainstreaming

4.8.20.1 The Contractor shall encourage that all In-Network Providers accept Members for treatment, unless they have a full panel and are accepting no new Georgia Families or commercial patients. The Contractor shall ensure that In-Network Providers do not intentionally segregate Members in any way from other persons receiving services.

4.8.20.2 The Contractor shall ensure that Members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.

4.8.21 Provider Credentialing

4.8.21.1 DCH is contracting with a single Credentialing Verification Organization (CVO) to conduct credentialing and re-credentialing of Providers for Medicaid and the contracted CMOs. Providers must enroll with Medicaid and/or Georgia Families or Georgia Families 360˚ by submitting an electronic application and supporting documentation through the CVO's web-based Provider Credentialing Portal. The Contractor will not conduct its own Credentialing processes and shall accept the CVO's credentialing and recredentialing determinations. The Contractor cannot appeal the CVO credentialing decision. The Contractor cannot require Providers to submit supplemental or additional information for purposes of conducting a second credentialing process by the Contractor. See **Attachment V**, ***Provider Credentialing Process***.

4.8.21.2 The Contractor shall coordinate with DCH's contracted CVO to confirm the status of Providers who are requesting to enroll with the Contractor and to confirm recredentialing status. The Contractor shall

report to DCH any instances of which it is informed a determination has not been made by the CVO within thirty (30) Calendar Days of application. See **Attachment W**, **Provider Credentialing Timelines**. DCH reserves the right to modify the credentialing timelines as needed.

4.8.21.3 The Contractor shall refer providers to the CVO website to complete the credentialing process prior to enrolling with a CMO. The Contractor shall also provide information about the re-credentialing process to all network Providers. The Contractor will refer all Providers to the CVO who are not Medicaid providers and requesting to enroll.

4.8.21.4 The CVO updates the Provider Credentialing Portal and notifies DCH of the Credentialing status. If Credentialing is successful, the application is sent to DCH for final disposition. For approved applications, the CVO sends a file with all of the Provider's enrollment data to the Fiscal Agent to update the MMIS to include the necessary Provider information. The Fiscal Agent will send the Provider a welcome letter, and notify any CMO in which the Provider has requested to also enroll.

4.8.21.5 In the event the State decides not to contract with a single CVO, the Contractor shall be responsible for all credentialing and re-credentialing of its network providers. The Contractor would be required to submit a credentialing and re-credentialing plan to DCH for review and approval prior to beginning these processes, and updates thereto.

4.8.21.5.1 During the PHE, DCH will take steps to limit the demands on providers during the credentialing and recredentialing processes, which will proceed based on information available to DCH, but no adverse action will be taken against the provider applicant for supplying incomplete information to the CVO. Specifically, the credentialing and recredentialing processes and provider enrollment shall proceed as follows:

<u>Initial Credentialing Process</u>

(1) **Submission of Enrollment Application:** The provider shall apply through GAMMIS.
(2) **Verification:** The CVO shall verify provider licensure/accreditation and check appropriate federal databases.
(3) **Enrollment:** DCH shall enroll and issue a Provider ID number after the CVO verifies the

provider's licensure/accreditation and determines that the provider has successfully passed the federal databases check. Providers who do not possess the requisite license/accreditation will not be enrolled.

(4) **Credentialing:** After the provider is enrolled and has been issued a Provider ID number, the CVO shall continue its standard credentialing activities if there is no missing information in the provider's application. Providers whose credentialing applications are incomplete will not be credentialed.

Recredentialing Process

Currently enrolled providers will be recredentialed by the CVO in accordance with the 60-day extension allowed by NCQA. Providers whose recredentialing applications are incomplete will not be recredentialed.

Provider Enrollment

With respect to provider enrollment, DCH will waive or suspend the following requirements:

(a) Application fees will be waived for all provider types.

(b) Criminal background checks will be waived for the temporary enrollment of providers.

(c) Site visits will be waived for the temporary enrollment of providers.

(d) Revalidation will be postponed for Georgia providers or those providers otherwise impacted by the PHE.

(e) Out-of-state licensed providers will be allowed to render services if the provider is properly licensed (out-of-state) and meets the PHE provider enrollment requirements referenced above.

(f) Providers located out of state will be allowed to render services if the provider is properly licensed and meets the PHE provider enrollment requirements referenced above.

(g) Pending applications submitted on or after March 1, 2020 will follow the

PHE provider enrollment process referenced above.

4.8.21.5.2 After the conclusion of the PHE, the following actions shall be taken:

Initial Credentialing and Recredentialing

For those providers whose credentialing or recredentialing applications are incomplete and have not been credentialed or recredentialed during the PHE, the CVO shall contact those providers in order to obtain the missing information to complete the process. Providers who fail to complete the necessary credentialing or recredentialing activities after the conclusion of the PHE will be subject to adverse action, including, but not limited to, termination.

Provider Enrollment

For those providers who did not complete the standard enrollment process during the PHE, DCH shall work with those providers to complete, where possible, the standard enrollment process.

Sections 4.8.21.5.1 and 4.8.21.5.2 shall be effective as of the declaration of the PHE on January 31, 2020. Section 4.8.21.5.1 shall terminate upon the termination of the PHE, and Section 4.8.21.5.2 shall terminate ninety (90) Calendar Days thereafter. Upon termination of these sections as set forth in this paragraph, these subsections shall be deleted from the Contract in their entirety and have no further force or effect.

4.8.21.6 Contractor may execute network provider agreements once the provider has been screened, enrolled, and credentialed by DCH. Contractor must terminate a network provider immediately upon notification from DCH that the network provider cannot be enrolled. Contractor must notify affected members of the provider's termination.

4.8.22 Network Changes

4.8.22.1 The Contractor shall notify DCH within seven (7) Business Days of any significant changes to the Provider network or, if applicable, to any Subcontractors' Provider network. A significant change is defined as:

4.8.22.1.1 A decrease in the total number of PCPs by more than five percent (5%);

4.8.22.1.2 A loss of all Providers in a specific specialty where another Provider in that specialty is not available within the geographic access standards as defined in Section 4.8.17;

4.8.22.1.3 A loss of specialty Providers in a Health Professional Shortage Area including but not limited to Obstetric Providers;

4.8.22.1.4 A loss of a hospital in an area where another contracted hospital of equal service ability is not available the geographic access standards as defined in Section 4.8.17; or

4.8.22.1.5 Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to In-Network Providers including closed Provider panel.

4.8.22.2 The Contractor shall have procedures to address changes in the Contractor's Provider network that negatively affect the ability of Members to access services, including access to a culturally diverse Provider network. Failure to adequately address significant changes in network composition that negatively impact Member access to services may be grounds for Contract termination or State determined remedies.

4.8.22.3 If a PCP ceases participation in the Contractor's Provider network the Contractor shall send written notice to the Members who have chosen the Provider as their PCP. The notice shall encourage the Member to select a new PCP as soon as possible to limit disruption in care, and explain that the DCH Enrollment Broker will assign a new PCP if the Member does not choose a new PCP within thirty (30) Calendar Days. This notice must contain contact information to assist the Member in selecting a new PCP. This notice shall be issued no less than thirty (30) Calendar Days prior to the effective date of the termination and no more than ten (10) Calendar Days after receipt or issuance of the termination notice.

4.8.22.4 If a Member is in a prior authorized ongoing course of treatment with any other participating Provider who becomes unavailable to continue to provide services, the Contractor shall notify the Member in writing within ten (10) Calendar Days from the date the Contractor becomes aware of such unavailability.

4.8.22.5 These requirements to provide notice to the Member prior to the effective dates of Provider termination shall be waived in instances where a Provider becomes physically unable to care for Members due to illness, a Provider dies, the Provider moves from the Service Region and fails to notify the Contractor, or when a Provider fails Credentialing. Under these circumstances, notice shall be issued immediately upon the Contractor becoming aware of the circumstances, along with contact information to assist the Member in selecting a new PCP.

4.8.22.6 The Contractor shall submit a Continuity of Care plan to DCH sixty (60) Calendar Days prior to the anticipated mass Network changes, as defined in this section that will impact membership. DCH may require the Continuity of Care Plan drill down to the individually affected member level depending upon the situation.

4.8.23 Out-of-Network Providers

4.8.23.1 If the Contractor's network is unable to provide Medically Necessary Covered Services to a particular Member, the Contractor shall adequately and timely cover these services Out-of-Network for the Member. The Contractor must inform the Out-of Network Provider that the Member cannot be balance billed.

4.8.23.2 The Contractor shall coordinate with Out-of-Network Providers regarding payment. For payment to Out-of-Network, or non-participating Providers, the following guidelines apply:

4.8.23.2.1 If the Contractor offers the service through an In-Network Provider(s), and the Member chooses to access the service (i.e., it is not an emergency) from an Out-of-Network Provider, the Contractor is not responsible for payment.

4.8.23.2.2 If the service is not available from an In-Network Provider and the Member requires the service and is referred for treatment to an Out-of-Network Provider, the payment amount is a matter between the CMO and the Out-of-Network Provider.

4.8.23.2.3 If the service is not available from an In-Network Provider, but the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).

4.8.23.2.4 If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition standard, and the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).

4.8.23.2.5 When paying out of state Providers in an emergency situation, the Contractor shall not allow a Member to be held accountable for payment.

4.8.23.3 In the event that needed services are not available from an In-Network Provider and the Member must receive services from an Out-of-Network Provider, the Contractor must reimburse the Provider. In this instance, Contractor is prohibited from billing the Member.

4.8.24 Shriners Hospitals for Children

4.8.24.1 The Contractor shall comply with the responsibilities outlined in the "Memorandum of Understanding for the PeachCare Partnership Program" executed on February 18, 2008, as amended from time to time, and attached to this Contract as **Attachment T** and expressly incorporated into this Contract as if completely restated herein.

4.8.24.2 The Contractor shall cooperate with DCH in making any updates or revisions to the Memorandum, as necessary.

4.8.25 Reporting Requirements

4.8.25.1 The Contractor shall submit to DCH quarterly Provider Network Adequacy and Capacity Reports (including Policies and Procedures) as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.8.25.2 The Contractor shall submit to DCH quarterly Timely Access Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.9 PROVIDER SERVICES

The Contractor shall establish and maintain a Provider services function to act as the point of contact for its Providers. As such, the Contractor will provide educational material, operate a Provider services line, facilitate Provider complaints and timely address Provider contract and payment issues. The Contractor must staff its provider

services department with personnel qualified to fulfill the requirements as described in this Section.

4.9.1 General Provisions

4.9.1.1 The Contractor shall provide information to all Providers about Georgia Families in order to operate in full compliance with the GF Contract and all applicable federal and State regulations.

4.9.1.2 The Contractor shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.

4.9.1.3 Within sixty (60) Calendar Days of the Contract Effective Date, the Contractor shall submit to DCH for initial review and approval all materials and information to be distributed and/or made available to Providers about Georgia Families. Any proposed revisions to such materials and information thereafter shall also be submitted to DCH for prior review and approval. DCH will attempt to complete its review of such materials within thirty (30) Calendar Days of its receipt of such materials.

4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.

4.9.1.5 Contractor must seek DCH's written approval of the Contractor's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider contracts or communications. DCH's review and response will be completed within sixty (60) Calendar Days of the Contractor's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Contractor misinterprets a Medicaid policy which is communicated to Providers, the Contractor must submit a written corrective action plan to DCH within three (3) Business Days of notice from DCH. Contractor will be required to retroactively correct and adjust any previously adjudicated Claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) Calendar Days of approval of the corrective action plan.

4.9.2 Provider Handbooks

4.9.2.1 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding GF Covered Services, policies and procedures, statutes, regulations,

telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information:

4.9.2.1.1 Georgia Families Covered Services;

4.9.2.1.2 Member eligibility categories;

4.9.2.1.3 Medical Necessity standards and practice guidelines;

4.9.2.1.4 Role of the PCP;

4.9.2.1.5 Link to the NCQA and Joint Commission web sites;

4.9.2.1.5 Role of the Dental Home;

4.9.2.1.6 Emergency Service responsibilities;

4.9.2.1.7 Health Check/EPSDT Benefit;

4.9.2.1.8 Prior Authorization, Pre-Certification, and Referral procedures;

4.9.2.1.9 Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

4.9.2.1.10 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers;

4.9.2.1.11 Provider Complaint System Policies and Procedures, including, but not be limited to, specific instructions for contacting the Contractor's Provider services to file a complaint and which individual(s) have the authority to review a complaint;

4.9.2.1.12 Policies and procedures for the Provider Grievance and Appeals process;

4.9.2.1.13 Information on the Member Grievance System, including the Member's right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the right to request continuation of Benefits while utilizing the Grievance System;

4.9.2.1.14 The role of the CVO and link to the CVO web site;

4.9.2.1.15 Information about the GaHIN including how information will be used by the CMOs and DCH and an explanation of any service limitations or exclusions from coverage;

4.9.2.1.16 Link to the DCH web site;

4.9.2.1.17 Role of the DCH fiscal agent and link to the fiscal Agent's web site;

4.9.2.1.18 Information about the Georgia Families Value-based Purchasing;

4.9.2.1.19 Transition of Care Planning;

4.9.2.1.20 Care Coordination Policies;

4.9.2.1.21 Protocol for Encounter Claims element reporting/records;

4.9.2.1.22 Medical Records standards;

4.9.2.1.23 Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;

4.9.2.1.24 Payment policies;

4.9.2.1.25 The Contractor's Cultural Competency Plan;

4.9.2.1.26 Member rights and responsibilities;

4.9.2.1.27 Other Provider or Subcontractor responsibilities; and

4.9.2.1.28 Information about the 1115 Demonstration, Planning for Healthy Babies, including:

4.9.2.1.28.1 Demonstration description;

4.9.2.1.28.2 Covered Demonstration Services;

4.9.2.1.28.3 Practice protocols;

4.9.2.1.28.4 Other Provider responsibilities;

4.9.2.1.28.5 Coding requirements;

4.9.2.1.28.6 Prior Authorization, Pre-Certification, and Referral procedures; and

4.9.2.1.28.7 P4HB participants' rights and responsibilities.

4.9.2.2 The Contractor shall disseminate bulletins as needed to incorporate any needed changes to the Provider Handbook. These bulletins can be mailed hard copy or can be disseminated via email, provided hard copies are available and Providers are informed of how to request in hard copy.

4.9.2.3 The Contractor shall submit the Provider Handbook to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date and as updated thereafter. Any updates or revisions shall be submitted to DCH for review and approval at least thirty (30) Calendar Days prior to distribution.

4.9.3 Education and Training

4.9.3.1 The Contractor shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Contractor shall conduct initial training within thirty (30) Calendar Days of executing a contract with a newly contracted Provider. The Contractor shall also conduct ongoing training which may include webinars and web-based tutorials, as deemed necessary by the Contractor or DCH in order to ensure compliance with program standards and the GF Contract and meet the needs of Providers.

4.9.3.2 The Contractor shall also provide Provider workshops, data, trainings and technical assistance, webinars and web-based tutorials about the emergence and ongoing operations of Medical Homes and other service delivery innovations, evidence-based and emergency best practices, delivering a person-centered approach to care and the System of Care approach to care delivery.

4.9.3.3 The Contractor shall provide training to all Demonstration Family Planning and IPC service Providers and their staffs regarding the requirements of the Demonstration and the Contract provisions related to the Demonstration and special needs of the P4HB participants. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by

the Contractor or DCH in order to ensure compliance with the Demonstration's standards and the Contract.

4.9.3.4 The Contractor's Demonstration Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling available at http://fpm.emory.edu/preventive/research/projects/index.html.

4.9.3.5 The Contractor shall develop and submit the Provider Training Manual and Training Plan, including topics, schedule and languages spoken, to DCH for initial review and approval at least thirty (30) Calendar Days prior to any scheduled trainings and as updated thereafter.

4.9.3.6 DCH may attend any training sessions specific to this Contract at its discretion.

4.9.4 Provider Relations

4.9.4.1 The Contractor shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. The Contractor shall implement policies addressing the compliance of Providers with the requirements included in this RFP and institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.

4.9.4.2 The Contractor shall provide for at least one (1) Provider Relations Liaison per Service Region to Conduct the Provider Relations functions.

4.9.5 Provider Services Call Center

4.9.5.1 The Contractor shall operate a toll-free call center to respond to Provider questions, comments and concerns.

4.9.5.2 The Contractor shall develop call center 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.

4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.

4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment K.

4.9.5.5 Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays. The Contractor shall ensure that after regular business hours the non-Prior Authorization/ Pre-certification line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition. The call center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Contractor shall provide information to Providers on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.

4.9.5.6 The Contractor 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 Call Center. The Contractor shall submit the call center Quality Criteria and Protocols to DCH Provider Services for initial review and approval and as updated thereafter. At a minimum, the standards shall require that, on a Calendar month basis:

4.9.5.6.1 Average Speed of Answer: At a minimum, the standards shall require that, on a monthly basis, eighty percent (80%) of calls are answered by a person within thirty (30) seconds. “Answer” shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative.

4.9.5.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.

4.9.5.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).

4.9.5.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the

average length of time callers are placed on hold by a live Call Center Representative.

4.9.5.6.5 Timely Response to call center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.

4.9.5.6.6 Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.

4.9.5.7 The Contractor shall set up remote phone monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer or phone, to monitor call Center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Contractor will facilitate bi-annual calibration sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.

4.9.6 Georgia Families Provider Web Site

4.9.6.1 The Contractor shall dedicate a section of its Web Site to Provider services and provide general up-to date information about the Contractor's program. At a minimum, the website must have the capability for Providers to make inquiries and receive responses through the Medicaid fiscal agent Web Site (**Error! Hyperlink reference not valid.**www.mmis.georgia.gov) and must:

4.9.6.1.1 Include a searchable Provider Handbook.

4.9.6.1.2 Include a searchable Provider Directory that the Contractor updates within five (5) Business Days of a change.

4.9.6.1.3 Include Customer services, including the capability for Providers to submit questions and comments to the Contractor and receive responses. The Contractor shall respond to Provider inquiries within one (1) Business Day of receipt. The Contractor shall refer any inquiries to DCH that are not within the Contractor's scope of services (e.g., inquiries about the Fee-for-Service delivery system).

4.9.6.1.4 Include the capability for Providers to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate Claims electronically and consistent with the Contractor's policies and procedures for Provider Claims activities. To the extent a Provider has the capability; the Contractor shall submit payments to Providers electronically and submit remittance advices to Providers electronically within one (1) Business Day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.

4.9.6.1.5 Provide information about the following:

4.9.6.1.5.1 Grievance and Appeals System

4.9.6.1.5.2 Pharmacy Preferred Drug List

4.9.6.1.5.3 Pharmacy Conditions for Coverage and Utilization Limits

4.9.6.1.5.4 Member rights and responsibilities

4.9.6.1.5.5 DCH's Value-based Purchasing

4.9.6.1.5.6 Information about the HIE/GaHIN including how information will be used by the CMOs and DCH and procedures to opt out of the GaHIN

4.9.6.1.5.7 PCP/Medical Home responsibilities;

4.9.6.1.5.8 Dental Home responsibilities

4.9.6.1.5.9 Planning for Healthy Babies 1115 Demonstration;

4.9.6.1.6 Link to the DCH CVO web site;

4.9.6.1.7 Link to the DCH Fiscal Agent web site;

4.9.6.1.8 Link to the NCQA accreditation recognition web site;

4.9.6.1.9 Include What's New items;

4.9.6.1.10 Include frequently asked questions and answers; and

4.9.6.1.11 Links to the DCH Medicaid web site, DCH P4HB web site and the Enrollment Broker web site.

4.9.6.2 The Contractor must review and update the web site monthly or more frequently as needed to ensure information is accurate and up to date. The Contractor must submit to DCH for prior approval all materials that it will post on its web site as well as screenshots for any webpage changes. Excluding upgrades which support the ordinary operation, administration, and maintenance of the web site, the Contractor shall not modify the web site prior to receipt of DCH approval.

4.9.6.3 The Contractor's Web Site shall be functionally equivalent, with respect to functions described in this Contract, to the Web Site maintained by the State's Medicaid fiscal agent (https://www.mmis.georgia.gov/portal/default.aspx/) and consistent with the standards established by the Georgia Technology Authority (GTA) as published at http://gta.georgia.gov/psg/ and amended periodically.

4.9.7 Provider Complaint System

4.9.7.1 The Contractor shall establish a Provider Complaint system that permits a Provider to dispute the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.

4.9.7.2 The Contractor shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and annually and as updated thereafter. The Contractor shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor's Provider services to file a Provider complaint and which individual(s) have the authority to review a Provider complaint.

4.9.7.3 The Contractor shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers. The Contractor may distribute a summary of these Policies and Procedures if the summary includes information on how the Provider may access the full Policies and Procedures on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.

4.9.7.4 As a part of the Provider Complaint System, the Contractor shall:

4.9.7.4.1 Allow Providers thirty (30) Calendar Days from the date of issue or incident to file a written complaint;

4.9.7.4.2 Allow Providers to consolidate complaints that involve the same or similar issues, regardless of the number of issues included in the bundled complaint;

4.9.7.4.3 Require that Providers' complaints are clearly documented;

4.9.7.4.4 Allow a Provider that has exhausted the Contractor's internal appeals process related to a denied or underpaid Claim or group of Claims bundled for appeal the option either to pursue the administrative appeals process described in O.C.G.A. § 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A. § 33-21A-7. If the Contractor and the 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 Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties;

4.9.7.4.5 For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from fifteen (15) Calendar Days after the date the Claim was submitted. The Contractor shall pay all interest required to be paid under this provision or Code Section O.C.G.A. 33-21A-7 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment;

4.9.7.4.6 Accurately identify all interest payments on the associated remittance advice submitted by the Contractor to the Provider;

4.9.7.4.7 Require that Providers exhaust the Contractor's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);

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

4.9.7.4.9 Identify a staff person specifically designated to receive and process Provider Complaints;

4.9.7.4.10 Thoroughly investigate each GF Provider Complaint using applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and

4.9.7.4.11 Ensure that Contractor executives with the authority to require corrective action are involved in the Provider Complaint process.

4.9.7.5 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Determination to the Provider. The Notice of Adverse Determination shall state that Providers may request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.

4.9.7.6 The Contractor shall notify the Providers that a request for an Administrative Law Hearing must include the following information:

4.9.7.6.1 A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;

4.9.7.6.2 Identification of the Action being appealed and the issues that will be addressed at the hearing;

4.9.7.6.3 A specific statement of why the Provider believes the Contractor's Action is wrong; and

4.9.7.6.4 A statement of the relief sought.

4.9.7.7 DCH has delegated its statutory authority to receive hearing requests to the Contractor. The Contractor shall include with the Notice of Adverse Benefit Determination the Contractor's address where a Provider's request for an Administrative Law Hearing should be sent in accordance with O.C.G.A. § 49-4-153(e).

4.9.8 Claims Adjustment Requests/Claim Payment Disputes

4.9.8.1 If the amount reimbursed by the Contractor to an enrolled Provider is not correct, a positive or negative adjustment may be necessary. Such request for Claims adjustment shall be included in the Contractor's internal appeals process and shall not negate a Provider's right to appeal pursuant to O.C.G.A. §49-4-153(e). The Contractor shall develop a procedure to address Claims adjustment requests that meet the following minimum requirements:

4.9.8.1.1 Contractor Positive Adjustments

4.9.8.1.1.1 When a Provider can substantiate that additional reimbursement is appropriate, the Provider may adjust and resubmit a Claim. Provider shall be given the option to submit the written request, Explanation of Payment and all Claims related documentation either electronically or by U.S. mail. All documentation must be received within three (3) months from the end of the month of payment. The adjustment request must include sufficient documentation to identify each Claim identified in the request. The Contractor may return incomplete requests without further action provided it notifies the Provider of the basis for the incomplete status and allows the Provider ten (10) Calendar Days to resubmit the adjustment request. The Provider shall be required to submit documentation that supports the requested Claims adjustment. If a positive adjustment is warranted, the Contractor shall make additional reimbursement upon processing of the request. If an adjustment is not warranted, the Provider will be notified via written correspondence from the Contractor.

4.9.8.1.2 Contractor Negative Adjustments

4.9.8.1.2.1 When a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim. Provider shall be given the option to submit the written request, Explanation of Payment and all claims related documentation either electronically or by U.S. mail. If a negative adjustment is warranted, Contractor may either deduct the payment from future reimbursement or request reimbursement from the Provider as required by the Provider's contract with the Contractor.

4.9.8.2 The Contractor shall respond to all adjustment requests within fifteen (15) Calendar Days of receipt.

4.9.8.3 Contractor shall maintain a website that allows Providers to submit, process, edit, rebill, and adjudicate claims electronically.

4.9.8.4 Contractor shall include recoupment information to be combined within the remittance where the recoupment occurs.

4.9.9 Reporting Requirements

4.9.9.1 The Contractor shall submit to DCH monthly Telephone and Internet Activity Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.9.9.2 The Contractor shall submit to DCH monthly Provider Complaints Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.10 PROVIDER CONTRACTS AND PAYMENTS

4.10.1 Provider Contracts

4.10.1.1 The Contractor shall submit to DCH for initial review and approval and as updated thereafter a model for each type of Provider Contract and shall comply with all DCH procedures for contract review and approval submission. Memoranda of Agreement (MOA) shall not be permitted. No payment shall be made to any network Provider other than by

Contractor for services provided under this Contract, except when payments are specifically required to be made by DCH or when DCH makes direct payments to network Providers.

4.10.1.2 Any significant changes to the model Provider Contract shall be submitted to DCH for review and approval no later than thirty (30) Calendar Days prior to use of the revised Provider Contract.

4.10.1.3 Upon request, the Contractor shall provide DCH with copies of all executed Provider Contracts at no cost.

4.10.1.4 In addition to addressing the CMO licensure requirements, the Contractor's Provider Contracts shall:

4.10.1.4.1 Not require Providers to participate or accept other plans or products offered by the Contractor unrelated to providing Covered Services to Members. The Contractor shall be subject to a penalty of $1,000.00 per violation if this prohibition is violated;

4.10.1.4.2 Prohibit the Contractor from entering into any exclusive contracts agreements with providers that exclude other health care providers from contract agreements for network participation;

4.10.1.4.3 Prohibit the Contractor from entering into a contract with or without the Provider's consent that prohibits the provider from Contracting with another Georgia Families CMO as a condition of the Contract;

4.10.1.4.4 Prohibit the health care provider from, as a condition of contracting with the Contractor, requiring the Contractor to contract with or not contract with another health care provider;

4.10.1.4.5 Prohibit the Provider from seeking payment from the Member for any Covered Services provided to the Member within the terms of the Contract and require the Provider to look solely to the Contractor for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Georgia Medicaid or CHIP State Plans, the Georgia State Medicaid Policies and Procedures Manuals, and this Contract;

4.10.1.4.6 Require the Provider to cooperate with the Contractor's quality improvement and Utilization Review and management activities;

4.10.1.4.7 Include provisions for the immediate transfer to another PCP or Contractor if the Member or P4HB participant's health or safety is in jeopardy;

4.10.1.4.8 Not prohibit a Provider from discussing treatment or non-treatment options with Members that may not reflect the Contractor's position or may not be covered by the Contractor;

4.10.1.4.9 Not prohibit a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;

4.10.1.4.10 Not prohibit a Provider from advocating on behalf of the Member in any Grievance System or Utilization Review process, or individual authorization process to obtain necessary Health Care services;

4.10.1.4.11 Require Providers to meet appointment waiting time standards pursuant to Section 4.8.19.2;

4.10.1.4.12 Provide for continuity of treatment in the event a Provider's participation terminates during the course of a Member's treatment by that Provider;

4.10.1.4.13 Prohibit discrimination with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely based on such license or certification. This provision should not be construed as any willing provider law, as it does not prohibit Contractors from limiting Provider participation to the extent necessary to meet the needs of the Members. Additionally, this provision shall not preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. This provision also does not interfere with measures established by the Contractor that are designed to maintain Quality and control costs;

4.10.1.4.14 Prohibit discrimination against Providers serving high-risk populations or those that specialize in Conditions requiring costly treatments;

4.10.1.4.15 Specify that CMS and DCH or its Agent will have the right to inspect, evaluate, and audit any pertinent books, financial records, documents, papers, and records of any Provider involving financial transactions related to this Contract for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later;

4.10.1.4.16 Specify Covered Services and populations;

4.10.1.4.17 Require Provider submission of timely, complete and accurate Encounter Claims;

4.10.1.4.18 Include the definition and standards for Medical Necessity, pursuant to the definition in Sections 1.4 and 4.5.5;

4.10.1.4.19 Specify rates of payment. The Contractor ensures that Providers will accept such payment as payment in full for Covered Services provided to Members less any applicable Member cost sharing pursuant to this Contract;

4.10.1.4.20 Provide for timely payment to all Providers for Covered Services to Members. Pursuant to O.C.G.A. 33-24-59.5(b) (1) once a Clean Claim has been received, the CMO(s) will have fifteen (15) Business Days within which to process and either transmit funds for payment electronically for the Claim or mail a letter or notice denying it, in whole or in part giving the reasons for such denial;

4.10.1.4.21 Specify acceptable billing and coding requirements;

4.10.1.4.22 Require that Providers comply with the Contractor's Cultural Competency plan;

4.10.1.4.23 Require that any marketing materials developed and distributed by Providers to Members be submitted to the Contractor to submit to DCH for prior approval;

4.10.1.4.24 Specify that in the case of newborns the Contractor shall be responsible for any payment owed to Providers for

services rendered prior to the newborn's Enrollment with the Contractor;

4.10.1.4.25 Specify that the Contractor shall not be responsible for any payments owed to Providers for services rendered prior to a Member's Enrollment with the Contractor, even if the services fell within the established period of retroactive eligibility;

4.10.1.4.26 Comply with 42 CFR 434 and 42 CFR 438.6;

4.10.1.4.27 Require Providers to attempt to collect Member Co-payments;

4.10.1.4.28 Prohibit Providers from refusing to treat a Member on the basis of inability to pay Co-payments;

4.10.1.4.29 Not employ or subcontract with individuals on the State or Federal Exclusions list;

4.10.1.4.30 Prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a member of the Provider's family has a Financial Relationship;

4.10.1.4.31 Require Providers of transitioning Members to cooperate in all respects with Providers of other CMOs to assure maximum health outcomes for Members;

4.10.1.4.32 Contain a provision stating that in the event DCH is due funds from a Provider who has exhausted or waived the Administrative Review process, if applicable, the Contractor shall reduce payment by one hundred percent (100%) to that Provider until such time as the amount owed to DCH is recovered;

4.10.1.4.33 Contain a provision giving notice that the Contractor's negotiated rates with Providers shall be adjusted in the event the Commissioner of DCH directs the Contractor to make such adjustments in order to reflect budgetary changes to the Medical Assistance program;

4.10.1.4.34 Require the Contractor to notify the Provider in writing no less than thirty (30) Calendar Days prior to any adjustments to the Provider's contracted reimbursement

rates and receive written notification from the Provider of acceptance of the new reimbursement rates;

4.10.1.4.35 Allow for the Contractor to recoup or withhold reimbursement made or due to a Provider, as required by and upon receipt of notice by DCH that the Provider has an outstanding balance that is owed to DCH as the result of an identified overpayment for Fee-for-Service Claims. Contractor must transfer all funds withheld or recouped to DCH;

4.10.1.4.36 Prohibit Providers from requiring a pre-service consultation prior to providing care; and

4.10.1.4.37 Require that Providers participate in all DCH and CMO driven Quality improvement, performance measurement activities and Program Integrity operations.

4.10.1.4.38 Inform providers and subcontractors, at the time they enter into a contract, about the Member's right to file grievances and appeals and the requirements and timeframes for filing.

4.10.1.4.39 Inform providers and subcontractors, at the time they enter into a contract, about the availability of assistance to the Member with filing grievances and appeals.

4.10.1.4.40 Inform providers and subcontractors, at the time they enter into a contract, about the Member's right to request a state fair hearing after the Contractor has made a determination on a Member's appeal, which is adverse to the Member.

4.10.1.4.41 Inform providers and subcontractors at the time they enter into the contract about the Member's right to request continuation of benefits, that the Contractor seeks to reduce or terminate, during an appeal or state fair hearing filing, if filed within the allowable timeframes, although the Member may be liable for the cost of any continued benefits while the appeal or state fair hearing is pending if the final decision is adverse to the Member.

4.10.2 Provider Termination

4.10.2.1 The Contractor shall comply with all State and federal laws regarding Provider termination. In its Provider Contracts the Contractor shall:

4.10.2.1.1 Specify that in addition to any other right to terminate the Provider Contract, and notwithstanding any other provision of this Contract, DCH may require Provider termination immediately, or the Contractor may immediately terminate on its own, a Provider's participation under the Provider Contract if a Provider fails to abide by the terms and conditions of the Provider Contract, as determined by DCH, or, in the sole discretion of DCH, fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from the Contractor specifying such failure and requesting such Provider to abide by the terms and conditions hereof; and

4.10.2.1.2 Specify that any Provider whose participation is terminated under the Provider Contract for any reason shall utilize the applicable appeals procedures outlined in the Provider Contract. No additional or separate right of appeal to DCH or the Contractor is created as a result of the Contractor's act of terminating, or decision to terminate any Provider under this Contract. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, this Contract shall remain in full force and effect with respect to all other Providers.

4.10.2.2 The Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network. If the termination was "for cause", the Contractor may terminate, suspend, or withdraw the Provider immediately and shall notify DCH in writing within one (1) Business Day of the termination with the reasons for termination. If a Member is receiving ongoing care, the Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal.

4.10.3 Provider Insurance

4.10.3.1 The Contractor shall require each Provider (with the exception of Section 4.10.3.2, and FQHCs that are section 330 grantees) to maintain, throughout the terms of the Contract, at its own expense, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written Contract with the Provider. Such

professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) annual aggregate. Providers may be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve. DCH reserves the right to waive the insurance requirement if necessary for business need.

4.10.3.2 The Contractor shall require allied mental health professionals to maintain, throughout the terms of the Contract, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written Contract with Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars ($1,000,000) per occurrence, and one million dollars ($1,000,000) annual aggregate. These Providers may also be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve.

4.10.3.3 In the event any such insurance is proposed to be reduced, terminated or canceled for any reason, the Contractor shall provide to DCH and Department of Insurance (DOI) at least thirty (30) Calendar Days prior written notice of such reduction, termination or cancellation. Prior to the reduction, expiration and/or cancellation of any insurance policy required hereunder, the Contractor shall require the Provider to secure replacement coverage upon the same terms and provisions so as to ensure no lapse in coverage, and shall furnish DCH and DOI with a Certificate of Insurance indicating the receipt of the required coverage at the request of DCH or DOI.

4.10.3.4 The Contractor shall require Providers to maintain insurance coverage (including, if necessary, extended coverage or tail insurance) sufficient to insure against claims arising at any time during the term of this Contract, even though asserted after the termination of this Contract. DCH or DOI, at its discretion, may request that the Contractor immediately terminate the Provider from participation in the program upon the Provider's failure to abide by these provisions. The provisions of this Section shall survive the expiration or termination of this Contract for any reason.

4.10.4 Provider Payment

4.10.4.1 With the exceptions noted below, the Contractor shall negotiate rates with Providers and such rates shall be specified in the Provider Contract. The Contractor shall also develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive

payments it receives from DCH for achieving targets. The Contractor is required to submit to DCH timely, complete and accurate Encounter Claims for all services, including Claims from those Providers that may be paid a Capitation Payment by the Contractor. The Contractor must require all Providers to submit detailed Encounter data.

4.10.4.2 For services rendered within seventy-two (72) hours after the Provider verifies the eligibility of the patient with the Contractor, the Contractor shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Contractor made payment for a patient for whom it was not responsible, then the Contractor may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.

4.10.4.3 The Contractor shall be responsible for issuing an IRS Form (1099) in accordance with all federal laws, regulations and guidelines.

4.10.4.4 When the Contractor negotiates a contract with a Critical Access Hospital (CAH), the Contractor shall pay the CAH a payment rate based on one hundred and one percent (101%) allowable costs incurred by the CAH. DCH may require the Contractor to adjust the rate paid to CAHs if so directed by the State of Georgia's Appropriations Act.

4.10.4.4.1 A CAH must provide notice to the Contractor and DCH of any alleged breaches in its contract by the Contractor.

4.10.4.4.2 If a CAH satisfies the requirement of Title 33 of the Official Code of Georgia Annotated (Medicaid Care Management Organizations Act), and if DCH concludes, after notice and hearing, that the Contractor has substantively and repeatedly breached a term of its contract with a CAH, the DCH is authorized to require the Contractor to pay damages to the CAH in an amount not to exceed three (3) times the amount owed. Notwithstanding the foregoing, nothing in said Act shall be interpreted to limit the authority of DCH to establish additional penalties or fines against a CMO for failure to comply with the contract between the Contractor and DCH.

4.10.4.5 When the Contractor negotiates a contract with a FQHC and/or a RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the

Social Security Act, the Contractor shall pay the PPS rates for Core Services and other ambulatory services per Encounter. The rates are established as described in §1001.1 of the Manual. At Contractor's discretion, it may pay more than the PPS rates for these services. Payment Reports must consist of all covered service claim types each month, inclusive of all services provided by the Contractor.

4.10.4.6 Upon receipt of notice from DCH that it is due funds from a Provider, who has exhausted or waived the Administrative Review process, if applicable, the Contractor shall reduce payment to the Provider for all claims submitted by that Provider by one hundred percent (100%), or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered. The Contractor shall promptly remit any such funds recovered to DCH in the manner specified by DCH. To that end, the Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to DCH.

4.10.4.7 The Contractor shall adjust its negotiated rates with Providers to reflect budgetary changes to the Medical Assistance program, as directed by the Commissioner of DCH, to the extent such adjustments can be made within funds appropriated to DCH and available for payment to the Contractor. The Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to DCH. Change in the terms of the Provider's reimbursement rate methodology must be agreed to by the Provider. Contractors are not permitted to simply send a notice advising as to a reimbursement rate methodology change. This does not prevent routine and necessary adjustments to Maximum Allowable Charge rates.

4.10.4.8 The Contractor shall recognize and honor for payment consideration any Provider's claims with dates of service on or after the Provider credentialing date or the Provider contract effective date, whichever is later, irrespective of the date the Contractor loads the Provider into its claims processing system.

4.10.4.9 As a condition of payment, the provider shall identify all provider-preventable conditions. Contractor is prohibited from making payment to a provider for provider-preventable conditions that meet the following criteria:

(a) A provider-preventable condition that is identified in the State Plan;

(b) A provider-preventable condition that has been found by DCH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
(c) A provider-preventable condition that has a negative consequence for the beneficiary.
(d) A provider-preventable condition that is auditable.
(e) A provider-preventable condition that includes, at a minimum, wrong surgical or other invasive procedure performed on a Member; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong Member.

4.10.5 Special Payment Arrangements

4.10.5.1 The Contractor shall fully participate in, and faithfully execute, all special payment arrangements established by DCH under 42 CFR 438.6(c). These special payment arrangements will be defined by DCH. DCH will establish criteria for each arrangement, including, but not limited to:

4.10.5.2 The time frame for the payment;

4.10.5.3 The providers who will participate in the special payment arrangement;

4.10.5.4 The mechanism for the calculation of the payment; and

4.10.5.5 The methodology for delivering the amount(s) to be paid to the selected providers.

4.10.5.6 The CMO will collect and provide to DCH such information and data as is required to support all such special payment arrangements.

4.10.5.7 Incentive arrangements must be made available to both public and private contractors under the same terms of performance.

4.10.6 Administrative Review Process/Law Hearing

4.10.6.1 The Contractor shall offer the opportunity for Administrative Review to any Provider against whom it proposes to take an adverse benefit determination or denial of payment unless otherwise authorized to by law to take such action without Administrative Review. The Contractor shall develop policies and procedures which outline the Administrative Review process.

4.10.6.2 For a Provider to obtain an Administrative Review, a written request must be received at the address identified by the Contractor within thirty (30) Calendar Days of the date of the notification of the denial or reduction in payment, initial determination, or other adverse benefit determination. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation.

4.10.6.3 The Contractor shall issue an Administrative Review Response within thirty (30) Calendar Days of receipt of the request for Administrative Review. If the Contractor upholds the Proposed Action, the Contractor shall issue a Notice of Adverse Benefit Determination which informs the Provider of their right to a hearing before an Administrative Law Judge at the Office of State Administrative Hearings (OSAH).

4.10.6.4 The Contractor shall offer Provider the opportunity for an Administrative Hearing after the Administrative Review has been completed and upon receipt of a written request from the Provider. The Request for an Administrative Hearing must be submitted within thirty (30) Calendar Days of the date of the Administrative Review response. The Request for Hearing must be accompanied by a copy of the Administrative Review Response.

4.10.6.5 All Provider Administrative Appeals shall be transmitted to the Office of State Administrative Hearings.

4.10.7 Reporting Requirements

4.10.7.1 The Contractor shall submit to DCH monthly FQHC and RHC Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.10.8 Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)).

4.10.8.1 The Contractor shall increase benefit payments to Providers in an amount consistent with the Provider rate increases included in the State of Georgia’s fiscal year budget. This enhanced rate shall be effective for all dates of service for which the Hospital Medicaid Financing Program Act is in place or until or modified by legislative action or DCH policy changes.

4.10.8.2 The Contractor will provide reports as requested by DCH to enable DCH to determine the amount of the increase in benefit payments to Providers as referenced in Section 4.10.8.1. The report will include, but not be limited to monthly reports, by hospital, that provide the following data for each claim paid:

4.10.8.2.1 Claim Number;

4.10.8.2.2 Date of Service;

4.10.8.2.3 Date of Payment;

4.10.8.2.4 Base Paid Amount;

4.10.8.2.5 Add-on Paid Amount;

4.10.8.2.6 Interest Paid Amount; and

4.10.8.2.7 Total Paid Amount.

4.10.9 Prohibited Payments

4.10.9.1 The Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for the following:

4.10.9.1.1 Funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

4.10.9.1.2 Roads, bridges, stadiums, or any other item or service not covered under the MSP.

4.11 UTILIZATION MANAGEMENT AND COORDINATION AND CONTINUITY OF CARE RESPONSIBILITIES

4.11.1 Utilization Management

4.11.1.1 The Contractor shall implement innovative and effective Utilization Management processes to ensure a high quality, clinically appropriate yet highly efficient and cost-effective delivery system. The Contractor shall continually evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Contractor must apply objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account

when determining the medical appropriateness of Health Care services.

4.11.1.2 The Contractor shall enable Pre-Certification of service requests when required and direct providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Contractor must evaluate all review requests for Medical Necessity and make recommendations that are more appropriate and more cost-effective. The Contractor should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.

4.11.1.3 The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:

4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.

4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.

4.11.1.3.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.

4.11.1.3.4 Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Sections 1.4 and 4.5.5.

4.11.1.3.5 Provide for the appeal by Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.

4.11.1.4 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval annually and as changed. Nothing in this Section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures insofar as that decision is accompanied by the clinical rationale for such a decision.

4.11.1.5 Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.

4.11.1.5.1 Utilization Management Committee

4.11.1.5.1.1 The Contractor shall establish a Utilization Management Committee. The Utilization Management Committee is accountable to the Medical Director and governing body of the Contractor. The Utilization Management Committee shall meet no less frequently than a quarterly basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.

4.11.1.5.2 Emergency Room (ER) Diversion Pilot

4.11.1.5.2.1 The Contractor shall develop and implement an ER diversion pilot program with hospital(s) that agree to participate to reduce inappropriate utilization of ERs for non-emergent conditions. The Contractor shall submit to DCH ninety (90) Calendar Days prior to beginning the ER Diversion Pilot program a detailed plan describing how the Contractor will work with providers to reduce inappropriate utilization of ERs for non-emergent conditions. The diversion pilot shall not prohibit or delay a Member's access to ER services.

4.11.1.6 The Contractor, and any delegated Utilization Review agent, shall not permit or provide compensation or anything of value to its employees, agents, contractors, or subcontractors so as to provide for incentives

for the individual or entity to deny, limit, or discontinue medically necessary services to any Member. The Contractor or its delegated subcontractor may not allow:

4.11.1.6.1 Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or

4.11.1.6.2 Any other method that encourages the rendering of a Proposed Action.

4.11.2 Prior Authorization and Pre-Certification

4.11.2.1 The Contractor shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services, as described in Section 4.6.1, 4.6.2, and 4.6.3, Special Coverage Provisions.

4.11.2.2 The Contractor shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.

4.11.2.3 The Contractor may require Prior Authorization and/or Pre-Certification for all non-emergent, Out-of-Network services.

4.11.2.4 Prior Authorization and Pre-Certification shall be conducted by a currently Georgia licensed or eNLC multi-state licensed, registered or certified Health Care Professional who is appropriately trained in the principles, procedures and standards of Utilization Review.

4.11.2.5 The Contractor and its network Providers (except Pharmacy Providers) shall use DCH's central Prior Authorization Portal for communicating Prior Authorization and Pre-Certification requests and their disposition. The Contractor shall establish an interface with the Prior Authorization Portal that allows the Contractor to receive and submit required data. The Prior Authorization and Pre-Certification process shall be one hundred percent (100%) paperless. The Contractor shall conduct outreach to and educate network Providers about use of the Portal and submission of all required documentation through the Portal.

4.11.2.6 The Contractor will retain authority for reviewing requests and making Prior Authorization and Pre-Certification determinations. The Contractor shall implement policies and procedures that incorporate how the Contractor will conduct the following activities:

4.11.2.6.1 Accept Prior Authorization and Pre-Certification requests that Providers submit on a standardized form developed by DCH through the Prior Authorization Portal.

4.11.2.6.2 Communicate requests for additional information from the Provider through the Prior Authorization Portal. The Contractor may directly contact the Provider with questions, but the Contractor shall communicate the same information through the Prior Authorization Portal.

4.11.2.6.3 Review requests when a Member has an outstanding Prior Authorization and transitions enrollment to the Contractor. The Contractor may not require the requesting Provider to re-submit the Prior Authorization request. The Contractor may make its own determination regarding approval of the request.

4.11.2.7 The Contractor shall notify the Provider of Prior Authorization determinations via the Prior Authorization Portal in accordance with the following timeframes.

4.11.2.7.1 Standard Authorizations. Prior Authorization decisions for non-urgent services shall be made within three (3) Business Days, or other established timeframe, of the request (generally submitted one week prior to the service or procedure). An extension may be granted for an additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's best interest.

4.11.2.7.2 Expedited Authorizations. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision with twenty-four (24) clock hours and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for service. The Contractor may extend the twenty-four (24) clock hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's best interest.

4.11.2.7.3 Authorization for Services that have been Delivered. Determinations for authorization involving health care services that have been delivered shall be made within thirty (30) Calendar Days of receipt of the necessary information.

4.11.2.7.4 Contractor must notify the requesting provider, and Member notice of any decision by Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the Member must meet the requirements of 42 CFR § 438.404.

4.11.2.8 The Contractor's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.

4.11.2.9 The Contractor's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits as required in 42 CFR 438.910(d).

4.11.3 Referral Requirements

4.11.3.1 The Contractor may require that Members obtain a Referral from their PCP prior to accessing non-emergency specialized services.

4.11.3.2 In the Utilization Management Policies and Procedures discussed in Section 4.11.1, the Contractor shall address:

4.11.3.2.1 When a Referral from the Member's PCP is required;

4.11.3.2.2 How a Member obtains a Referral to an In-Network Provider or an Out-of-Network Provider when there is no Provider within the Contractor's network that has the appropriate training or expertise to meet the particular health needs of the Member;

4.11.3.2.3 How a Member with a Condition which requires on-going care from a specialist may request a standing Referral; and

4.11.3.2.4 How a Member with a life-threatening Condition or disease, which requires specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.

4.11.3.3 The Contractor shall prohibit Providers from making Referrals for designated health services to Health Care entities with which the

Provider or a member of the Provider's family has a Financial Relationship.

4.11.3.4 The Contractor shall develop electronic, web-based Referral processes and systems. In the event a Referral is made via the telephone, the Contractor shall ensure that the Contractor, the Provider and DCH maintain Referral data, including the final decision, in a data file that can be accessed electronically.

4.11.3.5 In conjunction with the other Utilization Management policies, the Contractor shall submit the Referral processes to DCH for review and approval.

4.11.4 Relinquishment of Members

4.11.4.1 When relinquishing Members, the Contractor shall cooperate with the receiving CMO, Fee-for Service Medicaid or private insurance regarding the course of ongoing care with a specialist or other Provider. Contractor must identify and facilitate Coordination of Care for all Members during changes or transitions between Contractors, as well as transitions to Fee-for-Service Medicaid or private insurance. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations. Special circumstances include Members designated as having "special Health Care needs", as well as Members who have medical conditions or circumstances such as:

4.11.4.1.1 Pregnancy (especially women who are high risk and in third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date)

4.11.4.1.2 Major organ or tissue transplantation services which are in process, or have been authorized

4.11.4.1.3 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing or other facilities

4.11.4.1.4 Significant medical conditions, (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments

4.11.4.1.5 Members who are in treatment such as:

4.11.4.1.5.1 Chemotherapy, and/or radiation therapy; or

4.11.4.1.5.2 Dialysis.

4.11.4.1.6 Members with ongoing needs such as:

4.11.4.1.6.1 Durable medical equipment including ventilators and other respiratory assistance equipment;

4.11.4.1.6.2 Home health services;

4.11.4.1.6.3 Medically Necessary transportation on a scheduled basis; or

4.11.4.1.6.4 Prescription medications.

4.11.4.1.7 Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible Members

4.11.4.1.8 Members who are currently hospitalized.

4.11.5 Long-Term Care Coverage Responsibility

4.11.5.1 Members enrolled in a CMO that are receiving services in a long-term care facility will remain the responsibility of the admitting CMO until disenrolled from the CMO by DCH.

4.11.5.2 For the purposes of this requirement, long-term care facilities include Nursing Homes, Skilled Nursing Facilities, Psychiatric Residential Treatment Facilities and other facilities that provide long-term non-acute care.

4.11.5.3 Upon disenrollment from the CMO, the financial responsibility for services provided to the Member transitions to the Member's new CMO or Fee for Service Medicaid.

4.11.5.4 Members that are in ongoing non acute treatment in an inpatient facility that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary Transition of Care. The CMO will not be obligated to cover services beyond thirty (30) Calendar Days, even if the DCH authorization was for a period greater than thirty (30) Calendar Days.

4.11.6 Back Transfers

4.11.6.1 The Contractor shall permit transfers from a higher level of care, back to a lower level (referred to as a back transfer). The transfer is subject to Medical Necessity review and the payment policies outlined in the contract with the payer.

4.11.6.2 Each request will be reviewed on an individual basis to determine if the transfer is appropriate. The length of stay for the transferring hospital and for the return to the originating hospital will also be evaluated to determine if the transfer is appropriate.

4.11.6.3 If a transfer back to a hospital that provides a lower level of care does occur, the facility receiving the back-transfer will be eligible for reimbursement if Prior Authorization is obtained from the applicable payer and according to the payment agreement of that payer.

4.11.6.4 The Contractor shall make available Provider education and clear policies regarding the "back transfer" Pre-Certification requirements along with the billing procedures.

4.11.7 Court-Ordered Evaluations and Services

4.11.7.1 In the event a Member requires Medicaid-Covered Services ordered by a State or federal court, the Contractor shall fully comply with all court orders while maintaining appropriate Utilization Management practices.

4.11.8 Second Opinions

4.11.8.1 The Contractor shall provide for a second opinion in any situation when there is a question concerning a diagnosis or the options for surgery or other treatment of a health Condition when requested by any Member of the Health Care team, a Member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility.

4.11.8.2 The second opinion must be provided by a qualified Health Care Professional within the network, or the Contractor shall arrange for the Member to obtain one outside the Provider network, if an appropriate Provider is unavailable in the Contractor's network.

4.11.8.3 The second opinion shall be provided at no cost to the Member.

4.11.9 Coordination and Continuity of Care Responsibilities

4.11.9.1 The Contractor is responsible for employing a System of Care approach to Care Coordination and Continuity of Care. Care Coordination is a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely, and cost effective manner. Care Coordination includes Case Management, Disease Management, Transition of Care and Discharge Planning.

4.11.9.2 The Contractor must develop and implement Care Coordination and Continuity of Care policies and procedures that are designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and include, at a minimum, the following elements:

4.11.9.2.1 The provision of an individual needs assessment and diagnostic assessment within the first ninety (90) days following Enrollment; the development of an individualized treatment plan, as necessary, based on the needs assessment; the establishment of treatment objectives; the monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary. Subsequent attempts to complete the individual needs assessments and diagnostic assessments must be made if the initial attempt to contact the Member is unsuccessful;

4.11.9.2.2 Includes a patient-centered approach to meet the needs of Members, addressing both developmental and chronic conditions including the formal designation of a person or entity as primarily responsible for coordinating the services accessed by the Member, with appropriate information to enable the Member to contact that person or entity when coordination assistance is needed;

4.11.9.2.3 Ensure that Members who are determined to need a course of treatment or regular care monitoring have a treatment plan. This treatment plan shall be developed by the Member's PCP with Member participation, and in consultation with any specialists caring for the Member. The Contractor will develop a care plan for all members with a treatment plan who are actively enrolled in case management. The Contractor's medical officer responsible for oversight of the care management function shall follow up with the treating physician when the actively case managed member is not achieving his/her care plan goals that align with the treating physician's treatment plan;

4.11.9.2.4 A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning or regular care management;

4.11.9.2.5 A strategy to ensure the timely provision of services;

4.11.9.2.6 A strategy to ensure that the Contractor works with Members and Providers to implement an integrated approach to meeting physical health and Behavioral Health needs of the Member;

4.11.9.2.7 Use of data analytics to identify patterns of care. DCH encourages the use of predictive modeling to identify high risk Members;

4.11.9.2.8 Procedures and criteria for making Referrals to specialists and sub-specialists;

4.11.9.2.9 Procedures and criteria for maintaining treatment plans and Referral Services when the Member changes PCPs;

4.11.9.2.10 Capacity to implement, when indicated, Case Management functions such as individual needs assessment, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plan;

4.11.9.2.11 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions;

4.11.9.2.12 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP; and

4.11.9.2.13 Includes the coordination of services between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.

4.11.9.3 The Contractor shall submit Care Coordination and Continuity of Care Policies and Procedures to DCH for review and approval within ninety (90) Calendar Days of Contract Award and as updated thereafter.

4.11.9.4 The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities. This includes: Transition of Care, Discharge Planning; Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management.

4.11.9.5 Transition of Care for Members Moving Between CMOs and FFS

4.11.9.5.1 The Contractor shall coordinate the transfer of information, to include historical utilization data, when Members transition from one CMO to another, to the fee-for-service system, or to private insurance.

4.11.9.5.2 The Contractor will implement a transition of care policy that is consistent with 42 CFR 438.62(b)(1) and at least meets the state defined transition of care policy. Contractors shall identify and facilitate transitions for Members that are moving from one CMO to another or from a CMO to a Fee-for-Service provider or to private insurance and require additional or distinctive assistance during a period of transition. When relinquishing or receiving Members, the Contractor shall cooperate with the CMO or FFS Medicaid regarding the course of on-going care with a specialist or other Provider. Priority will be given to Members who have medical conditions or circumstances such as:

4.11.9.5.2.1 Members who are currently hospitalized;

4.11.9.5.2.2 Pregnant women who are high risk and in their third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date;

4.11.9.5.2.3 Major organ or tissue transplantation services which are in process, or have been authorized;

4.11.9.5.2.4 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities;

4.11.9.5.2.5 Members who are in treatment such as Chemotherapy, radiation therapy, or Dialysis;

4.11.9.5.2.6 Members with ongoing needs such as Specialized Durable medical equipment, including ventilators and other respiratory assistance equipment;

4.11.9.5.2.7 Current Home health services;

4.11.9.5.2.8 Medically Necessary transportation on a scheduled basis;

4.11.9.5.2.9 Prescription medications requiring Prior Authorizations;

4.11.9.5.2.10 The Contractor will monitor Providers to ensure Transition of Care from one entity to another to include Discharge Planning as appropriate. Members with procedures that are scheduled to occur after their new CMO effective date, but that have been authorized by either DCH or the Member's original CMO prior to their new CMO effective date will be covered by the Member's new CMO for thirty (30) Calendar Days; and

4.11.9.5.2.11 Contractor's new Members that are in ongoing outpatient treatment or that are receiving medication that has been covered by FFS Medicaid or another CMO prior to their new CMO effective date with Contractor shall be covered by the new Contractor for at least thirty (30) Calendar Days to allow time for clinical review, and if necessary Transition of Care. The Contractor will not be obligated to cover services beyond thirty (30) Calendar Days, even if the FFS Medicaid or prior CMO authorization was for a period greater than thirty (30) Calendar Days, unless necessary to prevent serious detriment to the enrollee's health or to reduce the risk of hospitalization or institutionalization.

4.11.9.6 Transition of Care assistance by Contractor shall include:

4.11.9.6.1 Continuing access by Member to Member's prior

PCP for at least thirty (30) Calendar Days, even if that Provider is not in the Contractor's network;

4.11.9.6.2 Full and timely compliance with requests from Contractor for Member's historical utilization data;

4.11.9.6.3 Assistance for Member's new Providers to obtain Member's medical records.

4.11.9.7 Inpatient Acute Coverage Responsibility

4.11.9.7.1 Members enrolled in a CMO that are hospitalized in an acute

inpatient hospital facility will remain the responsibility of that CMO until they are discharged from the facility, even if they change to a different CMO, or they become eligible for coverage under FFS Medicaid during their inpatient stay. Members enrolled in a CMO that are hospitalized in an acute inpatient hospital facility and are placed in Foster Care during the inpatient stay will be disenrolled from the CMO and enrolled in the Georgia Families 360˚ Program on the date the Member's 834 file is transferred to the Georgia Families 360˚ CMO. The CMO is not required to cover services for an individual that has no Medicaid eligibility, if the individual remains an acute inpatient and loses Medicaid eligibility during the stay; the CMO is only responsible for payment until the last day of Medicaid eligibility.

4.11.9.7.2 A P4HB Participant that is hospitalized in an acute inpatient hospital facility will remain the responsibility of that P4HB Participant's original CMO until she is discharged from the facility, even if she changes to a different CMO or becomes eligible for other coverage during her inpatient stay. The CMO is not required to cover Demonstration related Services for a P4HB Participant that has no Demonstration eligibility. If the P4HB Participant remains an acute inpatient and loses Demonstration eligibility during the stay, the CMO is only

responsible for payment until the last day of Demonstration eligibility.

4.11.9.7.3 Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned CMO.

4.11.9.7.4 The Contractor shall remain responsible for Members that become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization until they are discharged from inpatient acute hospital care. These Members will remain the responsibility of the Contractor for all Covered Services, even if the start date for SSI eligibility is made retroactive to a date prior to the inpatient acute hospitalization.

4.11.9.7.5 Upon notification that a hospitalized Member will be transitioning to a new CMO, or to Fee-for-Service Medicaid, the current CMO will work with the new CMO or Fee-for-Service Medicaid or private insurance to ensure that Coordination of Care and appropriate Discharge Planning occurs.

4.11.9.8 Discharge Planning

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

4.11.9.8.2 The Contractor shall implement a Discharge Planning pilot program with hospital(s) that agree to participate to improve coordination for Members when being discharged from the hospital. The intent of this program is to improve Quality of care and outcomes, as well as to reduce readmissions. The Contractor will place a nurse onsite in the hospital to serve as an onsite resource for Members and to provide support to Members, such as patient education and care planning, reviewing medications and how to take those medications, identifying community resources that may be beneficial to the

Member, assuring follow-up care is arranged for when Members leave the hospital and regularly contacting Members after Discharge to confirm they have received follow up care.

4.11.9.8.3 The Contractor shall submit its plan for a Discharge Planning pilot program to DCH for initial review and approval prior to implementation and any updates thereto. The plan shall include, for example, information about the hospital(s) that will participate, Member eligibility for the program, services that will be provided, and approach to coordinating with hospital staff to supplement the care and education they are providing. The Contractor shall submit monthly reports to DCH that provide information that will track results to help identify initiatives that improve quality of care and outcomes.

4.11.9.9 Care Coordination

4.11.9.9.1 The Contractor shall provide Care Coordination services which shall:

4.11.9.9.1.1 Be comprehensive: All services a Member receives are to be coordinated;

4.11.9.9.1.2 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and

4.11.9.9.1.3 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP.

4.11.9.10 Coordination with Other Entities

4.11.9.10.1 The Contractor shall coordinate and work collaboratively with all divisions within DCH, as well as with other State agencies, and with other CMOs for administration of the Georgia Families program.

4.11.9.10.2 The Contractor shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children's Intervention School Services provided by the LEAs to ensure Medical Necessity and prevent duplication of services.

4.11.9.10.3 The Contractor shall coordinate the services furnished to its Members with the service the Member receives outside the CMO, including services received through any other managed care entity.

4.11.9.10.4 The Contractor shall coordinate with all DCH-contracted entities involved in providing care to the Member or administering program services that also impact the CMO's services. Coordination with other contracted-entities includes, but is not limited to, the following:

4.11.9.10.4.1 NET vendors to ensure Members are able to access Medically Necessary services in a timely manner.

4.11.9.10.4.2 DCH's Pharmacy Rebate Services Vendor for the purposes of processing pharmacy rebates. The Contractor shall regularly submit data, such as Omnibus Budget Reconciliation Act (OBRA) and J-Code claims feed to the Fee-for-Service Pharmacy Rebate Services Vendor. Prior to program launch, the Contractor will accept the Fee-for-Service Pharmacy Rebate Services Vendor's file format for data feeds and for testing interface capabilities. The Contractor shall respond to and resolve all inquiries and requests from the Pharmacy

Rebate Vendor within thirty (30) Calendar Days of receipt of such inquiry or request.

4.11.9.10.4.3 DCH's CVO as set forth in Section 4.8.21.

4.11.9.10.4.4 DCH's Fiscal Agent Contractor.

4.11.9.1.4.5 The State Health Benefit Plan

4.11.9.1.4.6 Vendors identified by DCH to complete DCH required audits, reviews and special projects.

4.11.9.1.4.7 Other DCH vendors, including other Georgia Families CMOs to complete statewide initiatives.

4.11.9.1.4.8 Private insurance and Fee-for-Service providers

4.11.9.10.5 The Contractor shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 45 CFR 164.

4.11.9.11 Integration of Physical and Behavioral Health Services

4.11.9.11.1 The Contractor shall develop an innovative approach to encourage PCPs, Behavioral Health Providers, and dental Providers to effectively and efficiently share behavioral and physical health clinical Member information, including how the Contractor will notify Behavioral Health Providers and PCPs after an inpatient mental health stay.

4.11.9.11.2 The Contractor must require Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks.

4.11.9.11.3 The Contractor shall submit an annual Health Coordination and Integration Report to the Department due June 30th of each calendar year for the prior calendar

year beginning 2017. This report is subject to approval by the Department. At a minimum, this report shall include:

4.11.9.11.3.1 Program Goals and Objectives

4.11.9.11.3.2 Summary of activities and efforts to integrate and coordinate behavioral and physical health;

4.11.9.11.3.3 Successes (e.g., exceeding performance targets) and opportunities for improvement;

4.11.9.11.3.4 Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and

4.11.9.11.3.5 Roadmap of activities planned for the next reporting

4.11.10 Disease Management

4.11.10.1 The Contractor shall develop a minimum of three (3) disease management programs for Members with Chronic Conditions. These programs must target the prevalent chronic diseases within the Contractor's population, as specified by DCH.

4.11.10.2 Disease Management functions include, but are not limited to:

4.11.10.2.1 Incorporating evidence-based guidelines or standards of care in program development.

4.11.10.2.2 Utilizing clinical data to stratify Members for Enrollment based on levels of service intensity.

4.11.10.2.3 Encouraging the Member's active participation and adherence to interventions.

4.11.10.2.4 Educating the Member on their disease or condition to facilitate self-management.

4.11.10.2.5 Consistently informing the Member on progress in the achievement of goals and about the areas that require further improvement.

4.11.10.2.6 Promoting Coordination of Care by collaborating and communicating with Providers and other health care resources to improve Member outcomes.

4.11.10.3 The Contractor must notify DCH of the disease management programs it initiates and terminates and provide evidence, on an annual basis of the effectiveness of such programs for its enrolled Members. The Contractor is encouraged to align disease management programs with quality initiatives.

4.11.10.4 The Contractor must submit Quarterly status reports to DCH which include specified Disease Management Program data as listed in Section 5.7.1 in addition to the annual report.

4.11.11 Case Management

4.11.11.1 The Contractor's Case Management program shall emphasize prevention, Continuity of Care, and Coordination of Care and integration of care. The program shall link Members to services.

4.11.11.2 Case Management functions include, but are not limited to:

4.11.11.2.1 Early identification of Members who have or may potentially have special needs by receiving referrals, reviewing medical records, claims and/or administrative data, or by conducting interviews, while gaining consent when appropriate. An Initial Assessment of pregnant women may be performed by a local public health agency at the time of the presumptive eligibility determination. This completed assessment will be forwarded to the woman's selected CMO;

4.11.11.2.2 Assessment of a Member's risk factors such as an over- or under-utilization of services, inappropriate use of services, non-adherence to established plan of care or lack thereof, lack of education or understanding of current condition, lack of support system, financial barriers that impede adherence to plan of care, compromised patient safety, cultural or linguistic challenges, and physical, mental, or cognitive disabilities;

4.11.11.2.3 Development of a personalized, patient-centered plan of care which is consistent with evidence-based guidelines and includes established goals that are specific and measurable, with emphasis on Member education of

disease or condition to facilitate shared decision making and self-management;

4.11.11.2.4 Coordination of Care, as previously described;

4.11.11.2.5 Monitoring to ensure the plan of care and interventions continue to be appropriate or revised as needed based on changes in the Member's condition or lack of positive response to the plan of care;

4.11.11.2.6 Continuity of care which includes collaboration and communication with other Providers involved in the Member's transition to another level of care to optimize outcomes and resources while eliminating fragmentation of care;

4.11.11.2.7 Follow up which includes assessing the achievement of established goals and identifying the overall impact of the plan of care;

4.11.11.2.8 Documentation which includes adherence to Member privacy and confidentiality standards, evidence of Member's progress and effectiveness of the plan of care, evaluation of Member satisfaction ; and

4.11.11.2.9 When appropriate, Disenrollment from Case Management when the goals have been achieved and the Member is able to self-manage, or the needs and desires of the Member change.

4.11.11.3 Case Management functions for the IPC component of the P4HB Demonstration include:

4.11.11.3.1 Early identification of P4HB IPC Participants who have or may have special needs;

4.11.11.3.2 Assessment of a P4HB IPC Participant's risk factors;

4.11.11.3.3 Development of a plan of care;

4.11.11.3.4 Referrals and assistance to ensure timely access to Providers included and external to the Contractor's network;

4.11.11.3.5 Coordination of Care actively linking the P4HB IPC Participant to In-Network and Out of Network Providers,

physical and Behavioral Health Services, residential social and other support services where needed;

4.11.11.3.6 Resource Mothers Outreach;

4.11.11.3.7 Monitoring;

4.11.11.3.8 Continuity of care;

4.11.11.3.9 Follow up; and

4.11.11.3.10 Documentation

4.11.11.4 Details pertaining to Resource Mothers Outreach are incorporated in **Attachment N** to this Contract. The Contractor must utilize the Resource Mothers Training Manual specified by DCH as the training manual for the Resource Mothers Outreach.

4.11.11.5 The Contractor must monitor the effectiveness of the Resource Mothers Outreach and ensure such Outreach activities comply with the Resource Mothers Training Manual.

4.11.11.6 Levels of Case Management for the GF Program include:

4.11.11.6.1 Level I – Services that ensure Members have received area specific information about public assistance programs for health and social services to which they may be entitled, have received an assessment related to their health problem, and a plan of care that has been developed which provides for health and social problem follow-up as indicated.

4.11.11.6.2 Level II - Services that ensure necessary Member services are available. Case managers will arrange for appointments and transportation to the Member's appointments and referrals and verify that the referral site is available and appropriate for the Member's needs.

4.11.11.6.3 Level III - Services defined in Level I and Level II plus assisting the Member to complete forms, accompanying the Member to their appointments to provide introductions and support as well as contacting the Member to schedule additional appointments. Visits to the Member's residence are included in Level III Case Management. This level of Case Management services ensures the Member successfully negotiates any

transitions in care. Level III Case Management may be reserved for certain high risk Members who require special assistance to negotiate complex or highly structured health or social systems.

4.11.11.7 The Contractor shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have catastrophic or other high-cost or high-risk Conditions including pregnant women under twenty-one (21) years of age, high risk pregnancies and infants and toddlers with established risk for developmental delays.

4.11.11.8 The Contractor must notify DCH of the specific Case Management programs it initiates (i.e. OB Case Management, Behavioral Health case management, etc.) and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members.

4.11.11.9 The Contractor will submit quarterly reports to DCH which include specified Case Management Program data as listed in Section 5.7.1 in addition to the annual report.

4.11.12 Reporting Requirements

4.11.12.1 The Contractor shall submit to DCH quarterly Case Management and Disease Management Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.1.1.12.2 The Contractor shall submit to DCH quarterly Prior Authorization and Pre-Certification Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.11.12.3 The Contractor shall submit to DCH all reports as outlined in the Demonstration Quality Strategy identified in **Attachment M** of this Contract in addition to the annual report.

4.12 QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

4.12.1 General Provisions

4.12.1.1 The Contractor shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent

any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).

4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers, community resources and agencies to actively improve the Quality of care provided to Members.

4.12.1.3 National Committee for Quality Assurance (NCQA) Accreditation

4.12.1.3.1 The Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date. Contractors shall apply for NCQA accreditation, or at other times as required by DCH as follows:

4.12.1.3.1.1 July 1, 2016: Apply for NCQA Interim Status

4.12.1.3.1.2 July 1, 2017: Apply for provisional status (first survey)

4.12.1.3.1.3 December 31, 2017: Notify NCQA of intent to submit data

4.12.1.3.1.4 June 15, 2018: Submit CY 2017 data

4.12.1.3.2 The Contractor shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.

4.12.1.4 Quality Oversight Committee

4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following:

4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director;

4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization;

4.12.1.4.1.3 A senior executive who is responsible for program implementation;

4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and

4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

4.12.1.4.2 The Quality Management Committee must:

4.12.1.4.2.1 Maintain Records that document the committee's activities, findings, recommendations, actions, and results; and

4.12.1.4.2.2 Obtain DCH's approval of membership of the Quality Oversight Committee.

4.12.2 DCH Quality Strategic Plan Requirements

4.12.2.1 The Contractor shall support and comply with the Georgia Families DCH Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to Georgia Families and Georgia Families 360 Members (as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).

4.12.2.2 The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to enrolled Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit is responsible for oversight of the Contractor's Quality program including:

4.12.2.2.1 Monitoring and evaluating the Contractor's service delivery system and Provider network, as well as its own

processes for Quality management and performance improvement;

4.12.2.2.2 Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members;

4.12.2.2.3 Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, Provider profiling, Utilization Management reviews, etc.;

4.12.2.2.4 Monitoring compliance with Federal, State and DCH requirements;

4.12.2.2.5 Ensuring the Contractor's coordination with State registries;

4.12.2.2.6 Ensuring Contractor executive and management staff participation in the quality management and performance improvement processes;

4.12.2.2.7 Ensuring that the development and implementation of Quality management and performance improvement activities include Provider participation and information provided by Members, their families and guardians; and

4.12.2.2.8 Identifying the Contractor's best practices, lessons learned and other findings for performance and Quality improvement.

4.12.3 Performance Measures

4.12.3.1 The Contractor shall comply with the GF DCH Quality Strategic Plan requirements to improve the health outcomes for all GF Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measure and incent Contractor improvement through the Value-based Purchasing program.

4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS® measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirement for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure.

4.12.3.3 DCH establishes Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at http://dch.georgia.gov/medicaid-quality-reporting. Performance targets are based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH.

4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.

4.12.3.5 The performance measures apply to the Member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.

4.12.3.6 The Contractor must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.

4.12.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

4.12.4.1 The Contractor shall deliver to DCH the results of CAHPS Surveys conducted by an NCQA certified CAHPS survey vendor. The survey report must include but not limited be to the following items:

4.12.4.1.1 An Executive Summary with the description of the survey process conducted according to the CAHPS Health Plan Survey guidelines of the HEDIS protocol;

4.12.4.1.2 Protocols for the administration of the survey via mail, telephone or mixed mode;

4.12.4.1.3 Definition of the sample size, number of completed surveys and response rates achieved. Response rates should, at a minimum, be no less than the NCQA average Medicaid response rates for the period; and

4.12.4.1.4 Detailed survey results and trend analysis.

4.12.4.2 The Contractor shall submit, on an annual basis to DCH, Adult and Child CAHPS Survey reports as stated in Section 4.12.16.

4.12.5 Member and Provider Incentives

4.12.5.1 The Contractor shall implement Member and Provider incentives to increase Member and Provider participation in reaching program goals. The Contractor may provide:

4.12.5.1.1 Incentives to Members and/or Providers to encourage compliance with periodicity schedules. Such incentives shall be established in accordance with all applicable State and federal laws, rules and regulations. Member incentives must be of nominal value ($10.00 or less per item and $50.00 in the aggregate on an annual basis per Member) and may include gift cards so long as such gift cards are not redeemable for cash or Co-payments. The Contractor shall submit the proposed incentive methods to DCH for review and receive DCH approval prior to implementation. Upon request by DCH, the Contractor shall provide DCH with reports detailing incentives provided to Members and/or Providers and illustrating efficacy of incentive programs. In accordance with 42 CFR 1003.101, the Nominal Value requirement stated herein is not applicable where the incentive is offered to promote the delivery of preventive care services, provided:

4.12.5.1.1.1 The delivery of the preventive services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or Medicaid;

4.12.5.1.1.2 The incentive is not cash or an instrument convertible to cash; and

4.12.5.1.1.3 The value of the incentive is not disproportionally large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care).

4.12.5.1.2 Provider incentives for the specific purpose of supporting necessary costs to transform and sustain NCQA PCMH recognition or TJC PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters.

4.12.5.1.3 Provider incentive strategies to improve Provider compliance with clinical practice guidelines and ensure consistent application of the guidelines.

4.12.6 Quality Assessment Performance Improvement (QAPI) Program

4.12.6.1 The Contractor shall have in place an ongoing QAPI program consistent with 42 CFR 438.330. The program must be established utilizing strategic planning principles with defined goals, objectives, strategies and measures of effectiveness for the strategies implemented to achieve the defined goals. The Contractor's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include:

4.12.6.1.1 A method of monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over Utilization of services), including those with special Health Care needs;

4.12.6.1.2 Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy;

4.12.6.1.3 A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data;

4.12.6.1.4 Designated staff with expertise in Quality assessment, Utilization Management and Care Coordination;

4.12.6.1.5 Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to Providers and Members;

4.12.6.1.6 A methodology and process for conducting and maintaining Provider profiling;

4.12.6.1.7 Ad-Hoc Reports to the Contractor's multi-disciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations and implemented system changes; and annual Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas;

4.12.6.1.8 Integration of the results from annual Performance Improvement Projects (PIPs), performance measure rate monitoring, and compliance with federal and state standards;

4.12.6.1.9 The impact of the Contractor's Member demographics on their ability to improve health outcomes; and

4.12.6.1.10 A process for evaluation of the impact and assessment of the Contractor's QAPI program.

4.12.6.2 The Contractor shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCPs or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.

4.12.6.3 The Contractor's QAPI Program Plan must be submitted to DCH for initial review and approval and as updated thereafter.

4.12.6.4 The Contractor shall submit any changes to its QAPI Program Plan to DCH for review and prior approval sixty (60) Calendar Days prior to implementation of the change.

4.12.6.5 Upon the request of DCH, the Contractor shall provide any information and documents related to the implementation of the QAPI program.

4.12.6.6 Annually, the Contractor shall submit to DCH a comprehensive QAPI Report, utilizing the report template that integrates all aspects of the QAPI Plan and tells the story of the effectiveness of the Contractor's QAPI Plan in meeting defined goals and objectives and achieving improved health outcomes for the Contractor's Members. DCH may

require interim reports more frequently than annually to demonstrate progress.

4.12.7 Performance Improvement Projects

4.12.7.1 As part of its QAPI program, the Contractor shall conduct clinical and non-clinical Performance Improvement Projects in accordance with DCH and federal protocols. In designing its performance improvement projects, the Contractor shall:

4.12.7.1.1 Show that the selected area of study is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale);

4.12.7.1.2 Establish clear, defined and measurable goals and objectives that the Contractor shall achieve in each year of the project;

4.12.7.1.3 Utilize Rapid Cycle Process Improvement and Plan Do Study Act (PDSA) processes;

4.12.7.1.4 Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;

4.12.7.1.5 Implement interventions designed to achieve Quality improvements;

4.12.7.1.6 Evaluate the effectiveness of the interventions;

4.12.7.1.7 Establish standardized performance measures (such as HEDIS® or another similarly standardized product);

4.12.7.1.8 Plan and initiate activities for increasing or sustaining improvement; and

4.12.7.1.9 Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.

4.12.7.2 Each performance improvement project must be completed in a period determined by DCH, to allow information on the success of the project in the aggregate to produce new information on Quality of care each year.

4.12.7.3 The Contractor shall perform the required performance improvement projects (PIPs), as specified by DCH and agreed upon by the

Parties, on an annual basis. Plan Do Study Act cycles must be incorporated into each PIP process.

4.12.7.4 Each PIP will use a study period approved by DCH.

4.12.7.5 Each PIP must include AIM statements and Driver Diagrams and align with the EQRO prepared PIP template. PIP components will be included as agreed upon by DCH and the CMOs.

4.12.7.6 The Contractor shall submit the designated PIPs to the EQRO Contractor using the DCH specified template and format as defined in the PIP protocol approved by DCH.

4.12.7.7 The EQRO will evaluate the CMOs' PIPs performance, using CMS approved Rapid Cycle PIP and/or other EQRO protocols. DCH reserves the right to request modification of the PIPs based on this evaluation. Modifications will be discussed with each CMO prior to implementation.

4.12.7.8 The Contractor shall submit PIP documentation to DCH and/or the EQRO using the DCH specified template and format as specified in the CMS approved Rapid Cycle PIP and/or other EQRO protocols.

4.12.7.9 The Contractor shall submit a PIP Annual Improvement Strategy Plan to DCH and/or the EQRO using the DCH specified template and format by October 31st of each contract year. This Plan will describe the improvement strategies to be implemented in the upcoming plan year (January 1st – December 31st).

4.12.8 Clinical Practice Guidelines (CPGs)

4.12.8.1 The Contractor shall adopt a minimum of three (3) evidence-based clinical practice guidelines. Such guidelines shall:

4.12.8.1.1 Be based on the health needs and opportunities for improvement identified as part of the QAPI program;

4.12.8.1.2 Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;

4.12.8.1.3 Consider the needs of the Members;

4.12.8.1.4 Be adopted in consultation with network Providers; and

4.12.8.1.5 Be reviewed and updated periodically as appropriate.

4.12.8.2 The Contractor shall submit to DCH for review and prior approval and as updated thereafter all Clinical Practice Guidelines in use, which shall include a methodology for measuring and assessing compliance as part of the QAPI program plan.

4.12.8.3 The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members.

4.12.8.4 The Contractor shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

4.12.8.5 To ensure consistent application of the guidelines, the Contractor shall require Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Contractor will conduct this review on a quarterly basis. The Contractor may use Provider incentive strategies to improve Provider compliance with guidelines.

4.12.8.6 To further ensure consistent application of the Clinical Practice Guidelines, the Contractor shall perform a review of a minimum random sample of fifty (50) Members' medical records per evidence-based CPG, each quarter.

4.12.9 Focused Studies

4.12.9.1 Focused Studies examine a specific aspect of health care (such as prenatal care) for a defined point in time. These studies are usually based on information extracted from medical records or Contractor administrative data such as Enrollment files and Encounter/claims data. Steps that may be taken by the Contractor when conducting focused studies are:

4.12.9.1.1 Selecting the Study Topic(s)

4.12.9.1.2 Defining the Study Questions or Aim Statement

4.12.9.1.3 Selecting the Study Indicator(s)

4.12.9.1.4 Identifying a representative and generalizable study population

4.12.9.1.5 Documenting sound sampling techniques utilized (if applicable)

4.12.9.1.6 Collecting reliable data

4.12.9.1.7 Analyzing data and interpreting study results

4.12.9.2 The Contractor may perform, at DCH discretion, a Focused Study to examine a specific aspect of health care (such as prenatal care) for a defined point in time. The Focused Study will have a calendar year study period and the results will be reported to DCH by June 30th following the year of the study. DCH shall retain the right to approve or disapprove all proposed Focus Studies.

4.12.10 Patient Safety Plan

4.12.10.1 The Contractor shall have a structured Patient Safety Plan, Report, and Analysis to address incidents and concerns regarding clinical care. This plan must include written policies and procedures for processing Member complaints regarding the care received and addressing incidents and concerns with clinical care. Such policies and procedures shall include:

4.12.10.1.1 A system of classifying incidents, concerns, and complaints according to severity;

4.12.10.1.2 A review by the Medical Director and a mechanism for determining which incidents will be forwarded to Peer Review; and

4.12.10.1.3 A summary of incident(s), including the final disposition, included in the Provider profile.

4.12.10.2 At a minimum, the Patient Safety Program process shall:

4.12.10.2.4.1 Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals;

4.12.10.2.4.2 Report and analyze Medication recalls;

4.12.10.2.4.3 Report and analyze Medication errors;

4.12.10.2.4.4 Describe the results of site Inspections; and

4.12.10.2.4.5 Report and analyze Patient Quality of Care Concerns, including those arising from patient grievances.

4.12.10.3 The Contractor shall submit the Patient Safety Plan to DCH for initial review and approval and as updated and submit to DCH on an annual basis no later than June 30 of the Contract year a Patient Safety Program Report inclusive of the program components described in 4.12.10.1 and 4.12.10.2.

4.12.11 External Quality Review

4.12.11.1 DCH will contract with an External Quality Review Organization (EQRO) to conduct independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Contractor shall collaborate with DCH and its EQRO to develop studies, surveys and other analytic activities to assess the Quality of care and services provided to Members and to identify opportunities for CMO improvement. To facilitate this process the Contractor shall supply data, as requested by DCH or its EQRO, to the EQRO.

4.12.12 Value-Based Purchasing (VBP) Program

4.12.12.1 The Contractor shall collaborate with DCH to implement a Value-Based Purchasing (VBP) model. A VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for Members, Providers, Contractors and the State to achieve the program's overarching goals. The impact of initiatives is measured in terms of access, outcomes, quality of care and savings.

4.12.12.2 Prior to the Operational Start Date, DCH will establish a VBP performance management team ("VBP Performance Management Team"). The VBP Performance Management Team will have responsibility for planning, implementing, and executing the VBP initiative. The Team will work collaboratively with the Contractor to review the Contractor's progress on a monthly, quarterly and/or annual basis, determine incentive payments, and determine the need to modify priority areas, measures and targets.

4.12.12.3 In addition to DCH staff, key leadership from the Contractor such as the Medical Director, Chief Operating Officer, or other designee approved by DCH will provide input and feedback on planned priorities and initiatives. As appropriate, DCH will engage operational-level Contractor staff.

4.12.12.4 Through the VBP Performance Management Team, the Contractor and DCH shall meet at least quarterly to discuss progress on initiatives. Rapid cycle feedback is key to the success of a VBP model. The Contractor shall regularly review and provide real-time information

focused on the initiatives it is undertaking to achieve required targets on a monthly and quarterly basis to DCH. The Contractor shall provide ongoing and ad hoc reports to DCH to highlight status and progress of initiatives, as well as successes and challenges. Regularly reviewing data is necessary for DCH and the Contractor to identify where initiatives are not resulting in improvements necessitating adjustments to the implemented approach. When adjustments are necessary, the Contractor shall report to DCH changes the Contractor will make to continually work towards improvements.

4.12.12.5 **Attachment U** outlines the performance measures and related targets that the Contractor must achieve under the VBP model. The Contractor must establish in collaboration with DCH initiatives that it will undertake to achieve the specified targets. Such initiatives may differ from or include other required initiatives, such as Performance Improvement Projects (PIPs) and Focused Studies. Beginning in Calendar Year (CY) 2019, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold") as further described in Section 7.2.1. The withholding arrangement will be renewed in DCH's discretion and will not be renewed automatically. Contractor's participation is not conditioned on entering into or adhering to intergovernmental transfer agreements. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle. Therefore, the first incentive payments, if any, will be made in CY 2018.

4.12.12.6 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the fourteen (14) performance measures. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold.

Contractor Payout Amount = (Number of Performance Targets Achieved/Total Number of Performance Targets) x Total VBP Withhold

4.12.12.7 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to a methodology for quantifying the Contractor's success in achieving targets and payments for each measure. VBP will not be renewed

automatically, but will be reviewed by Contractor and DCH to ensure continued feasibility.

4.12.12.8 The Contractor shall incentivize Providers to participate in VBP and may also incentivize Members. The Contractor shall develop a plan for distributing to Providers fifty (50) percent of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize Providers on a more frequent schedule than DCH's schedule for payment to the Contractor). Contractors are encouraged to collaborate to develop and implement interventions and solutions. The Contractor shall submit the plan to DCH for prior approval. The Contractor shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date. The plan shall include details of how the Contractor will collaborate with Providers to determine the frequency of incentive payments to Providers and how the Contractor will encourage participation in the program.

4.12.12.9 The Contractor shall comply with the requirements set forth in the VBP Operations Manual.

4.12.13 Monitoring and Oversight Committee

4.12.13.1 The Contractor shall participate in the Georgia Families Monitoring and Oversight Committee ("GFMOC") and associated subcommittees as requested by DCH. The GFMOC and associated subcommittees will assist DCH in assessing the performance of the Contractor and developing improvements and new initiatives specific to the Georgia Families program. The GFMOC will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration between State agencies, the Contractor and external stakeholders. Members of the GFMOC will be appointed by the DCH Commissioner or his designee. The GFMOC meetings must be attended by Contractor decision makers defined as one or more of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position; and Chief Medical Officer.

4.12.14 Member Advisory Committee

4.12.14.1 The Contractor shall establish and maintain a Member Advisory Committee consisting of persons served by the Contractor including current and past Members and/or Authorized Representatives, and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-

being of Members. The Committee shall meet at least quarterly, and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct on-site reviews of the membership of the Committee to ensure:

4.12.14.1.1 The Committee is discussing issues pertinent to the Member population;

4.12.14.1.2 The Committee is meeting as scheduled; and

4.12.14.1.3 The Committee members are in attendance.

4.12.15 Provider Advisory Committee

4.12.15.1 The Contractor shall establish and maintain a Provider Advisory Committee consisting of Providers contracted with the Contractor to serve Members. At least two (2) Providers on the Committee shall maintain health care practices that predominantly serve Medicaid beneficiaries. The Committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor Quality management activities and policy and operational changes. The Contractor must provide meeting schedules and minutes to DCH upon request. DCH may conduct onsite reviews of the Committee meetings to ensure:

4.12.15.1.1 The Committee is discussing issues pertinent to the Member population;

4.12.15.1.2 The Committee is meeting as scheduled; and

4.12.15.1.3 The Committee members are in attendance.

4.12.16 Reporting Requirements

4.12.16.1 Contractors must submit the following data reports as indicated.

REPORT	DUE DATE	REPORTS DIRECTED TO:
Performance Improvement Project Proposal(s)	Annually October 31	DCH PQO Unit
Quality Assurance Performance Improvement Plan	Annually June 30	DCH PQO Unit
Quality Assessment Performance Improvement Program Evaluation	Annually June 30	DCH PQO Unit

Performance Improvement Project Report	Annually June 30	EQRO vendor
Performance Measures Report	Annually June 30	DCH PQO Unit
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys	Annually July 31	DCH PQO Unit

4.12.16.2 If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the DCH PQO Unit.

4.12.16.3 The Contractor's Quality Oversight Committee shall submit to DCH Quality Oversight Committee Reports - Ad Hoc as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.12.16.4 The Contractor shall submit to DCH Performance Improvement Project Reports no later than June 30 of the Contract year or per protocol described in Section 4.12.7.

4.12.16.5 The Contractor shall submit to DCH Focused Studies Reports no later than June 30 of the Contract year as described in Section 4.12.9.

4.12.16.6 The Contractor shall submit to DCH annual Patient Safety Plan Reports no later than June 30 of the Contract year as described in Section 4.12.10.

4.13 FRAUD, WASTE AND ABUSE

4.13.1 Program Integrity

4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to detect and prevent fraud, waste, and abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud, waste and abuse in the administration and delivery of services under this Contract. The Contractor shall establish policies and procedures governing program integrity in order to reduce the incidence of fraud, waste, and abuse and shall comply with all state and federal program integrity requirements.

4.13.1.2 The Contractor shall have adequate Program Integrity staff located in Georgia that are solely dedicated to the Georgia Families contract. Contractor's Program Integrity staff shall investigate indicia of fraud,

waste, and abuse and develop and implement corrective action plans relating to fraud, waste, abuse, and overpayment.

4.13.1.3 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan, and pharmacy lock-in program described below. The Contractor's written fraud, waste, and abuse prevention program shall have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, investigate, correct and report known or suspected fraud, abuse, and waste activities. This shall include reporting instances of fraud, waste, and abuse pursuant to 42 CFR 438.608 *et seq.*

4.13.1.4 Contractor shall ensure that its subcontracts, for which Contractor has delegated duties related to the provision of services under this contract, contain provisions requiring internal controls designed to prevent, reduce, detect, investigate, correct, and report known or suspected fraud, abuse, and waste activities.

4.13.1.5 In accordance with §6032 of the federal Deficit Reduction Act of 2005, the Contractor shall make available fraud, waste, and abuse policies to all employees. The Contractor's employee handbook shall include, specific information about § 6032, the Contractor's policies and the rights of employees to be protected as whistleblowers.

4.13.1.6 The Contractor shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and Provider type within seven (7) Business Days of the settlement.

4.13.2 Compliance Plan

4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following:

4.13.2.1.1 The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this contract and who reports directly to the Chief Executive Officer and the Board of Directors. The Compliance Officer shall promote, implement, and oversee the compliance program. The Compliance Officer shall have unrestricted access to the Contractor's governing body for compliance reporting, including fraud, waste, abuse, and overpayment.

4.13.2.1.2 The Compliance Officer shall be a designated, full-time employee, qualified by knowledge, training, and experience in health care or risk management. The Compliance Officer shall also exhibit knowledge of relevant regulations, provide expertise in compliance processes, and be qualified to design, implement, and oversee a fraud, waste, and abuse program designed to ensure program integrity through fraud, waste, and abuse prevention and detection, which identifies and addresses emerging trends of fraud, abuse, and waste pursuant to this Contract and state and federal law.

4.13.2.1.3 A written description or chart outlining the organizational arrangement of the Contractor's personnel who are responsible for the investigation and reporting of possible overpayment, fraud, waste, and abuse; their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols. Such internal investigational methodology and reporting protocols shall ensure the unit's primary purpose is for the investigation (or supervision of the investigation) of suspected insurance/Medicaid fraud and fraudulent claims.

4.13.2.1.4 Written policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements and standards under this contract and all applicable Federal and State requirements.

4.13.2.1.5 The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under the contract.

4.13.2.1.6 A system for training and education of the Compliance Officer, the Contractor's senior management, and the Contractor's employees for the Federal and State standards and requirements under the contract.

4.13.2.1.7 Effective lines of communication between the Compliance Officer and the Contractor's employees.

4.13.2.1.8 Enforcement of standards through well-publicized disciplinary guidelines.

4.13.2.1.9 Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.

4.13.3 Timelines for Compliance Plan

4.13.3.1 The Contractor shall submit its compliance plan by September 1st of each contract year, including its fraud, waste, and abuse policies and procedures. Any changes to these items must be submitted to DCH OIG for written approval at least forty-five (45) days before those plans and procedures are implemented. The Contractor shall submit these documents via a secure file transfer protocol (SFTP) site.

4.13.4 Additional Program Integrity Requirements:

4.13.4.1 Contractor shall develop and submit its policies and procedures for educating and training personnel on how to detect and prevent fraud, waste, abuse, and overpayment as follows:

4.13.4.1.1 At a minimum, training shall be conducted within thirty (30) days of new hire and annually thereafter;

4.13.4.1.2 The Contractor shall have a methodology to verify that training occurs as required; and

4.13.4.1.3 The Contractor shall also include Deficit Reduction Act requirements in the training curriculum.

4.13.4.2 Contractor shall develop and maintain Policies and Procedures requiring prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud.

4.13.4.3 Contractor shall develop and maintain Policies and Procedures requiring prompt notification to DCH when it

receives information about changes in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence and the death of a Member.

4.13.4.4 Contractor shall develop and maintain Policies and Procedures requiring notification to DCH when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the Georgia Families program, including termination of the provider agreement with the Contractor.

4.13.4.5 Contractor shall develop a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Members. This verification process shall occur on a quarterly basis. Such methods must be either the use of electronic verification or biometric technology but may also include sending enrollee explanations of Medicaid benefits (EOMB), contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses;

4.13.4.6 Contractor shall develop and maintain written policies for all employees of the Contractor, and any agents, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

4.13.4.7 Contractor shall develop policies and procedures requiring the prompt referral of any potential fraud, waste, or abuse that Contractor identifies to DCH's Program Integrity Unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

4.13.4.8 Contractor shall develop policies and procedures requiring the suspension of payments to a network provider for which DCH and/or MFCU determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23.

4.13.4.9 Contractor shall implement pre-payment and post-payment review processes, including but not limited to data analysis, claims and other system edits, and auditing of participating

providers. The pre-payment process and post-payment review process should be based on DCH's policies and procedures.

4.13.4.10 Contractor shall analyze payment trends for its providers to identify questionable claim patterns indicative of fraud, waste, or abuse, and determine if corrective action should be taken.

4.13.4.11 Upon notice from DCH, Contractor shall conduct a risk assessment of identified providers who have been investigated by DCH or another CMO, or identified as a risk for improper billing patterns, to determine if further actions including, but not limited to, investigation, prepayment review, post payment review, suspension, or termination should be taken.

4.13.4.12 Contractor shall report all proposed provider terminations, which involve issues related to fraud, waste, abuse, quality, or other program integrity concerns, prior to terminating with cause or without cause.

4.13.4.13 Contractor shall meet all required standards and goals established by DCH/OIG. DCH shall provide notice to Contractor of the standards and goals.

4.13.4.14 Contractor shall report to DCH within sixty (60) Calendar Days of discovery, when it has identified capitation payments or other payments in excess of amounts specified in this contract.

4.13.4.15 If Contractor provides telemedicine, the Contractor shall include procedures specific to prevention and detection of potential or suspected fraud, waste, and abuse of telemedicine in its fraud, waste, and abuse detection activities.

4.13.4.16 Contractor shall provide a report summarizing the results of the investigations of fraud, waste, abuse, or overpayment which were conducted by the Contractor's fraud investigative unit. The report frequency shall be as follows:

- Monthly: Monthly reports are due by the 5th day of each month.
- Quarterly: Quarterly reports are due on the 10th day of the month.

- Annually: Annual reports are due on September 1st of each year. Annual reports represent a summary of all activities for the previous state fiscal year.

For purposes of this summary, a case includes any action, whether an investigation, audit, provider payment review, provider on-site review, or other provider-specific evaluation. This summary shall include information pertaining to the state fiscal year that concluded immediately prior to the submission of this report. This summary shall include: Total number of cases opened; Total number of cases closed; Total number of cases that remain open as of the last day of the previous month, quarter, or fiscal year; Total amount of overpayments identified for recovery which were identified as waste; Total amount of overpayments identified for recovery which were identified as fraud or abuse; Total amount of overpayments identified as waste which were actually recovered; and Total amount of overpayments identified as fraud or abuse which were actually recovered. The report should summarize how the case was adjudicated and include the last look back date for audit and recovery. Total cases referred to DCH for a referral to MFCU for fraud, waste, and abuse. Total number of suspended providers, terminated providers and a summary of pharmacy lock in members.

4.13.4.17 Contractor and all providers and subcontractors, upon request and as required by state or federal law, shall: (a) Make available to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Attorney General, and any and all administrative, financial and medical/case records and data relating to the delivery of items or services for which Medicaid monies are expended (42 CFR 438.3(h)); and (b) Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Attorney General, and to any place of business and all medical/case records and data, as required by state or federal law. The right to audit exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. Access shall be during Normal Business Hours, except under special circumstances. The Agency and the Attorney General shall determine the need for special circumstances.

4.13.4.18 Contractor shall cooperate fully in any investigation by federal and state oversight agencies and any subsequent legal action that may result from such an investigation;

4.13.4.19 Contractor shall provide details and educate employees, subcontractors and providers about the following as required by § 6032 of the federal Deficit Reduction Act of 2005: (a) The Federal False Claim Act; (b) Georgia False Claims Act (O.C.G.A. §49-4-168); (c) The penalties and administrative remedies for submitting false claims and statements; (d) Whistleblower protections under federal and state law; (e) The entity's role in preventing and detecting fraud, waste and abuse; (f) Each person's responsibility relating to detection and prevention; and (g) The toll-free state telephone numbers for reporting fraud, waste, and abuse.

4.13.4.20 On at least a monthly basis check current staff, subcontractors, and providers that provide health services against the federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System (EPLS) or their equivalent, to identify excluded parties. The Contractor shall also check monthly, Georgia's Inspector General's exclusion listing of suspended and terminated providers (https://dch.georgia.gov/georgia-oig-exclusions-list) to ensure the Contractor does not include any non-Medicaid eligible providers in its network. The Contractor shall also conduct these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Contractor shall not engage or employ the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under Sections 1128 and 1128A of the Social Security Act;

4.13.4.21 Contractor shall conduct provider profiling, and ongoing provider monitoring including a review process for claims, prior authorization requests, and encounters that shall include providers who:

a. Demonstrate a pattern of submitting falsified claims data or service reports;
b. Demonstrate a pattern of overstated reports or up-coded levels of service;

c. Alter, falsify or destroy clinical record documentation;
d. Make false statements relating to credentials;
e. Misrepresent medical information to justify Member referrals;
f. Fail to render medically necessary covered services they are obligated to provide according to their provider contracts;
g. Charge enrollees for covered services; or
h. Bill for services not rendered;

4.13.4.22 Contractor shall ensure that its policies and procedures contain provisions for the confidential reporting of violations to DCH and other agencies as required by law;

4.13.4.23 Contractor's policies and procedures shall include provisions for the investigation and follow-up of any reports;

4.13.4.24 Contractor shall ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud, waste, and abuse;

4.13.4.25 Require all suspected or confirmed instances of internal and external fraud, waste, and abuse relating to the provision of, and payment for, Medicaid services including but not limited to Contractor employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under state or federal law be reported to DCH OIG within fifteen (15) days of detection. Additionally, any final resolution reached by the Contractor shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State nor precludes the State from taking further action for the circumstances that brought rise to the matter;

4.13.4.26 Contractor or its vendors must not retaliate against any individual who reports violations of fraud, waste, and abuse policies and procedures or suspected fraud, waste, and abuse;

4.13.4.27 Contractor shall not knowingly have affiliations or relationships with individuals or entities debarred or excluded from participation in any federal health care program under § 1128 and 1128A of the Social Security Act, nor with an individual or entity who is an affiliate, as

defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610 (a)(1); or subcontractors on the discriminatory vendor list maintained by the Department of Administrative Services;

4.13.5 Disclosures

4.13.5.1 Contractor and its subcontractors shall provide written disclosure of any prohibited affiliation under 42 C.F.R. §438.610.

4.13.5.2 Contractor and its subcontractors shall provide written disclosures of information on ownership and control required under 42 C.F.R. §455.104.

4.13.6 Treatment of recoveries of overpayments

4.13.6.1 Contractor may retain recoveries of overpayments from a provider, due to fraud, waste, and abuse, if recovered within twelve months from the date of service.

4.13.6.2 Contractor may retain recoveries of all overpayments from a provider, not related to fraud, waste, or abuse, if recovered within twelve months from the date of service.

4.13.6.3 Contractor must report all recoveries within sixty (60) days of recovery, utilizing the method and process outlined by DCH's OIG.

4.13.6.4 In those instances wherein Contractor has exceeded the period in which to retain the overpayment, Contractor must remit the identified amount to DCH's OIG unit utilizing the method and process outlined by DCH's OIG.

4.13.6.5 Contractor must have a process for a provider to notify Contractor when the provider has received an overpayment and the method for which the provider will return the overpayment to Contractor within sixty (60) Calendar Days after the date on which the overpayment was identified.

4.13.6.6 Contractor must report monthly, quarterly, and annually to DCH its recoveries of overpayments.

4.13.6.7 Where the recoveries are time barred and the Contractor has not properly reported the suspected waste, abuse or fraud, recoveries made by DCH or its vendors shall be

retained by DCH. However, DCH may identify overpayments that are not time barred, and after notice to the Contractor, if the Contractor does not engage in recovery efforts and DCH recovers the overpayments, DCH shall retain the recoveries. DCH will collect the identified overpayment from the Contractor. Contractor's subcontracts shall ensure that providers are obligated to cooperate with recovery effort, including participation in audits and repayment of overpayments.

4.13.6.8 The Contractor shall ensure that all participating providers are required to cooperate with recovery efforts, including participation in audits and repayment of overpayments, whether such efforts are taken by the Contractor, DCH, MFCU or other authorized entity.

4.13.7 Pharmacy Lock In Program

4.13.7.1 As part of the Program Integrity Program, the Contractor must implement a pharmacy lock-in program. The contractor should designate a Pharmacist, reporting to the Compliance Officer, to manage the pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH/OIG for review and approval as part of the Program Integrity Policies and Procedures described in Section 4.13.1. The pharmacy lock-in program shall:

4.13.7.2 Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;

4.13.7.3 Provide Case Management and education reinforcement of appropriate medication use;

4.13.7.4 Annually assess the need for lock in for each Member;

4.13.7.5 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH/OIG; and

4.13.7.6 Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.

4.13.8 Coordination with DCH and Other Agencies

4.13.8.1 The Contractor shall cooperate with and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.

4.13.8.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.

4.13.8.3 The Contractor shall inform DCH immediately about known or suspected fraud cases and it shall not investigate or resolve the suspicion without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.

4.13.8.4 Contractor's Special Investigation Unit shall conduct both announced and unannounced on site reviews of providers.

4.13.9 Reporting Requirements

4.13.9.1 The Contractor shall submit to DCH a quarterly Fraud and Abuse Report, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. This Report shall include information on the pharmacy lock-in program described in Section 4.13.7. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.21.

4.13.9.2 The Contractor shall comply with all reporting requirements as set forth below and in 42 CFR 438.608 and state statute.

4.13.9.3 The Contractor shall report on a quarterly basis a comprehensive fraud, waste, and abuse prevention activity report regarding its investigative, preventive and detective activity efforts.

4.13.9.4 In accordance with 42 CFR 455.106, the Contractor shall disclose to DCH OIG within ten (10) business days after discovery, the identity of any person who: (1) Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

4.13.9.5 The Contractor shall submit the written notification referenced above to DCH OIG as instructed by the Agency. Document information examples include, but are not limited to, court records such as indictments, plea agreements, judgments and conviction/sentencing documents.

4.13.9.6 The Contractor shall notify DCH OIG and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) days after execution of such agreements.

4.13.9.7 The Contractor shall notify DCH and provide a copy of any corrective action plans required by the DCH OIG or federal governmental entities, within thirty (30) days after execution of such plans.

4.13.9.8 The Contractor shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify DCH OIG.

4.13.9.9 If the Contractor fails to timely report, or report all required information for all suspected or confirmed instances of provider or recipient fraud or abuse within fifteen (15) days after detection to DCH OIG, a sanction of up to $1,000 per day will be imposed under this Contract, until DCH OIG deems the Contractor to be in compliance.

4.13.10 Credible Allegation Of Fraud

4.13.10.1 The Contractor shall comply with 42 C.F.R. §455.23 by suspending all payments to a provider after DCH, Office of Inspector General, Program Integrity Unit determines that there is a credible allegation of fraud unless the Contractor has a good cause exemption to not suspend payments.

4.13.10.2 The Contractor may suspend payments without first notifying the provider of its intentions to suspend such payments.

4.13.10.3 A provider may request, and must be granted, administrative review where State law so requires.

4.13.10.4 The Contractor must send notice of its suspension of program payments to the provider within the following timeframes:

1) Five (5) days of taking such action unless requested in writing by the MFCU or other law enforcement agency to temporarily withhold such notice.

2) Thirty (30) days if requested by the MFCU or other law enforcement agency in writing to delay sending such notice, which request for delay may be renewed twice in writing, and in no circumstances, may exceed 90 days. The notice must include or address all the following:

a) State that payments are being suspended in accordance with this provision.

b) Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation.

c) State that the suspension is for a temporary period and cite the circumstances under which the suspension will be terminated.

d) Specify, when applicable, to which type or types of Medicaid claims or business units of a provider suspension is effective.

e) Inform the provider of the right to submit written evidence for consideration to the Contractor.

f) Set forth the applicable State administrative appeals process and corresponding citations to State law.

4.13.11 Duration of suspension:

1) All suspension of payment actions under this section will be temporary and will not continue after either of the following:

1) The Contractor or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

2) Legal proceedings related to the provider's alleged fraud are completed.

3) Contractor must document in writing the termination of a suspension including, where applicable and appropriate, any appeal rights available to a provider. (42 C.F.R. 455.23).

4.14 GRIEVANCE AND APPEALS SYSTEM FOR MEMBERS

4.14.1 General Requirements

4.14.1.1 Contractor must have a Grievance and Appeals System in place. The Grievance and Appeals System is a process utilized to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the

processes to collect, track, and report information about them. Contractor must give the member the right to file a Grievance and request an Appeal. The member may request an Administrative Law Hearing after receiving notice that the Adverse Benefit Determination has been upheld. The Contractor's Grievance and Appeals process shall include access to the State's Administrative Law Hearing (State Fair Hearing) system for Appeals. Grievances may not progress to the level of a State Administrative Law Hearing. The Contractor's Grievance and Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing. See O.C.G.A. §49-4-153. The Contractor may have only one level of appeals for Members.

4.14.1.2 Contractor must provide information specified in 42 CFR § 438.10(g)(2)(xi) about the Grievance and Appeal system to all providers and subcontractors at the time they enter into a contract.

4.14.1.3 The Contractor shall develop written Grievance and Appeals System Policies and Procedures that detail the operation of the Grievance and Appeals System. The Contractor's policies and procedures shall be available in the Member's primary language. The Grievance and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.

4.14.1.4 The Contractor shall process each Grievance, Appeal, and Administrative Law Hearing using applicable State and federal laws and regulations, the provisions of this Contract, and the Contractor's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

4.14.1.5 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for Grievances, Appeals, and Administrative Law Hearings. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

4.14.1.6 The Contractor shall acknowledge receipt of each filed Grievance and Appeal in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.

4.14.1.7 The Contractor shall ensure that the individuals who make decisions on Grievances and Appeals were not involved in any previous level of review or decision-making or a subordinate of any such individual (438.406(b)(2)(i)) and are Health Care Professionals who have the

appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:

4.14.1.7.1 An Appeal of a denial that is based on lack of Medical Necessity;

4.14.1.7.2 A Grievance regarding denial of expedited resolution of an Appeal; and

4.14.1.7.3 Any Grievance or Appeal that involves clinical issues.

4.14.1.8 Contractor shall have a process for expedited appeals when Contractor determines or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

4.14.1.9 Contractor must maintain records of grievances and appeals. The record of each grievance or appeal must contain, at a minimum, all of the following 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.

(6) Name of the covered person for whom the appeal or grievance was filed.

4.14.1.10 The Contractor and its subcontractors shall retain enrollee grievance and appeal records and the data, information, and documentation specified in 42 CFR § 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

4.14.2 Grievance Process

4.14.2.1 A member may file a Grievance at any time. A Grievance is an expression of dissatisfaction about any matter *other than* an adverse benefit determination. A Member or Member's Authorized Representative may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter *other than* an Adverse Benefit Determination. If allowed under Georgia law, and with

the written consent of the Member, a provider or an authorized representative may file a Grievance on behalf of a Member. A Grievance may not progress to the level of a State Administrative Law Hearing

4.14.2.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.

4.14.2.4 The Contractor shall issue written disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days from the date the Contractor receives the grievance.

4.14.2.5 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director, who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making nor a subordinate of any such individual. (438.406(b)(2)(i)). Such individuals must take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

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4.14.3 Notice Requirements for Adverse Benefit Determinations

4.14.3.1 Contractor must give timely and adequate notice of an Adverse Benefit Determination in writing, to the Member or the Member's Authorized Representative and the Provider, in accordance with federal requirements, consistent with the following requirements:

All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member's Condition or disease.

The Adverse Benefit Determination the Contractor intends to take, including the service or procedure that is subject to the Adverse Benefit Determination.
The reasons for the Adverse Benefit Determination, including the right of the Member to be provided with reasonable access to and copies of all documents, records, and other relevant information.

The Member's right to request an Appeal of the Adverse Benefit Determination and the right to request a State Administrative Law

Hearing, including the Member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Benefit Determination.

The Member's right to have Benefits continue pending resolution of the Appeal with the Contractor, instructions on how to request that Benefits continue, and the circumstances under which the Member may be required to pay the costs of these services.

The procedures for exercising this right and the procedure for requesting an expedited appeal.

4.14.4. The Contractor shall mail the notice of Adverse Benefit Determination within the following timeframes:

4.14.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of action or not later than the date of action in the event of one of the following exceptions:

4.14.4.1.1 The Contractor has factual information confirming the death of a Member.

4.14.4.1.2 The Contractor receives a clear written statement signed by the Member that

4.14.4.1.2.1 he or she no longer wishes to receive services; or

4.14.4.1.2.2 gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.

4.14.4.1.3 The Contractor establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

4.14.4.1.4 The Member has been admitted to an institution where he is ineligible under the plan for further services.

4.14.4.1.5 The post office returns Contractor mail directed to the Member indicating no forwarding address and the Member's whereabouts are unknown (refer to 42 CFR 431.231(d) for procedures if the Member's whereabouts become known).

4.14.4.1.6 The Member's Provider prescribes an immediate change in the level of medical care.

4.14.4.1.7 The date of action will occur in less than ten (10) Calendar days, in accordance with 42 C.F.R. §483.12(a) (5) (ii), which provides exceptions to the thirty (30) Calendar days' notice requirements of 42 C.F.R. § 483.12(a) (5) (i).

4.14.4.2 For an Adverse Benefit Determination with regard to preadmission screening requirements, not later than the date of action in accordance with 42 CFR 431.213.

4.14.4.3 For Standard Service Authorization decisions that deny or limit services, within the timeframes required in the sections above.

4.14.4.4 If the Contractor extends the timeframe for the decision and issuance of notice of Adverse Benefit Determination, the Contractor shall give the Member written notice of the reasons for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.

4.14.4.5 For authorization decisions not reached within the required timeframes for either standard or expedited Service Authorizations (which constitutes a denial and is thus an adverse benefit determination), notice of action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus an Adverse Benefit Determination.

4.14.4.6 Notice in Case of Probable Fraud

4.14.4.6.1 The Contractor may shorten the period of advance notice to five (5) Calendar Days before date of action if the Contractor has facts indicating that the action should be taken because of probable Member Fraud and the facts have been verified, if possible, through secondary sources.

4.14.5 Appeal of Adverse Benefit Determination

4.14.5.1 Following receipt of a notification of an Adverse Benefit Determination from Contractor, member has sixty (60) Calendar Days from the date on the Adverse Benefit Determination notice in which to file a request for an appeal to Contractor or its designee.

4.14.5.2 The Member may request an appeal either orally or in writing. Based upon Georgia law, and with the written consent of the Member, a provider or an authorized representative may request an Appeal on behalf of a Member. Providers cannot request continuation of benefits as noted in 42 CFR § 438.420(b)(5).

4.14.5.3 The Contractor shall acknowledge receipt of each filed Appeal in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Appeals resolution.

4.14.5.4 Unless the Member requests an expedited resolution, an oral appeal must be followed by a written, signed request.

4.14.5.5 Contractor may have only one level of appeal.

4.14.5.6 The parties to the Appeal shall include the Contractor as well as the Member, Member's Authorized Representative, or Authorized Representative of a deceased Member's estate. DCH reserves the right to intervene on behalf of the interest of either party.

4.14.5.7 The Contractor shall ensure that the individuals who make decisions on Appeals that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director, who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making nor a subordinate of any such individual. [438.406(b)(2)(i)]. Such individuals must take into account all comments,

documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

4.14.5.8 Contractor must give Member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Contractor must give the Member an opportunity to examine their case file, in person and in writing, including Medical Records and any other documentation available. This information must be provided to the Member free of charge and sufficiently in advance of the resolution of the Appeal. Contractor must inform the Member of this opportunity in advance of the resolution timeframe for appeals.

4.14.5.9 For standard resolution of an appeal, Contractor has thirty (30) Calendar days from the date of receipt of the Appeal to issue a decision or sooner if the Member's physical or mental health condition warrants a faster resolution.

4.14.5.10 For expedited resolution of an appeal, Contractor has seventy-two (72) hours from the date of receipt of the Appeal to issue a decision. If Contractor denies the request for an expedited Appeal, Contractor must utilize the timeframe for a standard resolution. In this instance, Contractor must provide prompt notice to the Member that the request for an expedited Appeal has been denied.

4.14.5.11 Contractor may extend the timeframe for resolving an Appeal, by up to 14 Calendar Days, under the following conditions:

- Member requests the extension;
- Contractor demonstrates to the satisfaction of the State Agency that there is a need for additional information and that the extension is in the Member's best interest;
- Following the extension, Contractor must:
    - Make reasonable efforts to give the enrollee prompt oral notice of the delay;
    - Within 2 Calendar Days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to

file a grievance if he or she disagrees with that decision; and

- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

4.14.5.12 For all appeals, Contractor must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR § 438.10.

4.14.5.13 Content of notice of appeal resolution. The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the Member--

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the Member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

4.14.5.14 For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice.

4.14.6 State Administrative Law Hearing

4.14.6.1 A member may request an Administrative Law Hearing after receiving notice that the Adverse Benefit Determination has been upheld. Based upon Georgia law and with the written consent of the Member, a provider or an authorized representative may request a State Administrative Law Hearing on behalf of a Member. A Member may request a continuation of benefits while the Administrative Law Hearing is pending. Providers **cannot** request continuation of benefits as specified in 42 CFR § 438.420(b)(5).

4.14.6.2 The State will maintain an independent State Administrative Law Hearing process as defined in O.C.G.A. § 49-4-153 and as required by federal law. The State Administrative Law Hearing Process

shall provide Members an opportunity for a hearing before an impartial Administrative Law Judge. The Contractor shall comply with decisions reached as a result of the Administrative Law Hearing process.

4.14.6.3 If Contractor fails to adhere to the notice and timing requirements in 42 C.F.R. § 438.408, the Member is deemed to have exhausted Contractor's appeal process and may initiate an Administrative Law Hearing.

4.14.6.4 The Member must request a State fair hearing no later than 120 Calendar Days from the date of the Contractor's notice of resolution.

4.14.6.5 The parties to the State fair hearing include the Contractor, as well as the Member and his or her representative or the representative of a deceased Member's estate. DCH reserves the right to intervene on behalf of the interest of either party.

4.14.6.6 The Contractor is responsible for providing counsel to represent its interests. DCH is not a party to the case and will only provide counsel to represent its own interests.

4.14.6.7 The Contractor shall make available any records and any witnesses at its own expense in conjunction with a request pursuant to an Administrative Law Hearing.

4.14.7 Continuation of Benefits During State Administrative Law Hearing

4.14.7.1 The Contractor shall continue the Member's Benefits if the Member or the Member's Authorized Representative files the request for a State Administrative Law Hearing in a timely manner; the Administrative Law Hearing involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the Member requests extension of the benefits.

4.14.7.2 Providers **cannot** request continuation of benefits as specified in 42 CFR § 438.420(b)(5).

4.14.7.3 If at the Member's request, the Contractor continues or reinstates the Member's Benefits while the Administrative Law Hearing is pending, the Benefits must be continued until one of the following occurs:

- The Member withdraws the request for an Administrative Law Hearing

- An Administrative Law Judge issues a hearing decision adverse to the Member
- The Member fails to request a state fair hearing and continuation of benefits within 10 Calendar Days after Contractor sends the notice of an adverse resolution to the Member's appeal.

4.14.7.4 If the final resolution of the State Administrative Law Hearing is adverse to the Member, the Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal was pending, to the extent that they were furnished solely because of the requirements of this Section.

4.14.8. Reversed Appeal Decisions

4.14.8.1 If Contractor, or the State Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Contractor must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

4.15 ADMINISTRATION AND MANAGEMENT

4.15.1 General Provisions

4.15.1.1 The Contractor shall be responsible for the administration and management of all requirements of this Contract. All costs related to the administration and management of this Contract shall be the responsibility of the Contractor.

4.15.2 Place of Business and Hours of Operation

4.15.2.1 The Contractor shall maintain a place of business in the metropolitan Atlanta Area within thirty-five (35) miles of 2 Peachtree Street, NW Atlanta, GA 30303. The Contractor must have at least one (1) satellite office serving no less than two (2) contiguous Service Regions. The central business office must be accessible for foot and vehicle traffic. All documentation must reflect the address of the location identified as the legal, duly licensed, central business office. This business office must be open at least between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday with the exception of State holidays. The Contractor shall ensure that the office(s) are adequately staffed to ensure that Members and Providers receive prompt and accurate responses to inquiries.

4.15.2.2 The Contractor shall provide access twenty-four (24) clock hours a day, seven (7) days per week to its web site. The Contractor shall provide seventy-two (72) clock hours advance notice of web site upgrades, servicing and updates.

4.15.3 Training

4.15.3.1 The Contractor shall conduct on-going training for its entire staff, in all departments, to ensure appropriate functioning in all areas and to ensure that staff is aware of all programmatic changes. The Contractor must train its staff using a curriculum specific to their areas of responsibility. The training program must include, for example, training about the Georgia Medicaid program, Medicaid regulations, issues specific to the enrolled populations and managed care operations. Staff must receive training about the functionality of Information Systems so that they are fully capable of using the systems to complete their job functions. The Contractor shall also ensure that staff have the necessary qualifications and education to perform their assigned jobs. The Contractor and its staff shall attest that staff have received required trainings and have necessary qualifications and education.

4.15.3.2 The Contractor shall submit a staff-training plan to DCH for initial review and approval and as updated thereafter.

4.15.3.3 The Contractor designated staff are required to attend DCH in-service training on an ad-hoc basis. DCH will determine the type and scope of the training.

4.15.3.4 DCH may attend any training sessions conducted by or on behalf of the Contractor specific to this Contract at its discretion.

4.15.4 Data and Report Certification

4.15.4.1 The Contractor shall certify all data pursuant to 42 CFR 438.606. The data that must be certified include, but are not limited to, Enrollment information, Encounter Data, Contractual Reports, inclusive of all Quality management reports, and other information required by the State and contained in Contracts, proposals and related documents. The data must be certified by one of the following: the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for and who Reports directly to the Contractor's Chief Executive Officer or Chief Financial Officer. Specific to the Quality management reports, the Chief Medical Officer or other delegated physician must review and attest to the accuracy of all Quality management reports submitted to DCH.

The signature of the Chief Medical Officer or other delegated physician is required on all Quality management reports.

4.15.4.1.1 By virtue of submission, the Contractor attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.

4.15.4.1.2 Inaccurate data, reports, and other documents provided to the State by the Contractor are subject to applicable Liquidated Damages.

4.15.4.2 The Contractor shall submit the certification concurrently with the certified data.

4.15.5 Transition Planning

4.15.5.1 The Contractor must include a transition plan as part of its implementation CMO Project Plan. The transition plan must outline specific goals and objectives that articulate how the Contractor will coordinate with DCH and DCH sister agencies to assume responsibility for Members transitioning from another CMO and other scope of work activities. An impact statement should be produced outlining the potential impact of the transition of Members, the existing infrastructure and operations and support staff. Specifically, the Contractor must:

4.15.5.1.1 Work to ensure Members will be served in a timely and appropriate manner to maintain continuity of care for the Members;

4.15.5.1.2 Detail how activities will differ for existing Medicaid Members upon the Operational Start Date versus new Members coming into the program after the Operational Start Date; and

4.15.5.1.3 Accept and recognize existing Pre-Certifications and Prior Authorizations.

4.15.5.2 The transition plan must also identify the tools, techniques, and methodologies that are needed to perform an efficient and effective transition.

4.15.6 Turnover Planning

4.15.6.1 No later than thirty (30) Calendar Days after the Contract Effective Date, the Contractor must submit a detailed turnover plan ("Turnover Plan") to DCH. The Turnover Plan must:

4.15.6.1.1 Specify how the Contractor will turn over any and all records, files, methodologies, data and any supplemental documentation which DCH would require for DCH or another contractor to take over operation of the Georgia Families programs in the event of Contract expiration or termination for any reason;

4.15.6.1.2 Include all elements of turnover phases, including specific schedule;

4.15.6.1.3 Include a statement of resources and training that would be necessary to facilitate and efficiently turnover the Georgia Families programs to the State or another contractor;

4.15.6.1.4 Include a statement commitment to maintain the level of resources dedicated to full-program operations through the contract termination; and

4.15.6.1.5 Any Turnover Plan revisions required by DCH must be finalized within five (5) Calendar Days of DCH's feedback.

4.16 CLAIMS MANAGEMENT

The Contractor shall have adequate systems and staff in place to ensure that the provision of Health Care services under this Contract is properly documented, accounted for, and reported.

4.16.1 General Provisions

4.16.1.1 The Contractor shall adhere to the time frames and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid Claims outlined in the DCH Policy Manuals. The Contractor shall administer an effective, accurate and efficient claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by DCH (see Part I. Policy and Procedures for Medicaid/PeachCare for Kids® Manual) and in compliance with all applicable State and federal laws, rules and regulations. Any claims processing issues caused by the Contractor will be resolved within a forty-five (45) Calendar Day limit. The Contractor shall contact Providers within fifteen (15) Calendar Days to resolve claims processing issues. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in

addition to the amount determined to be owed, interest of twenty percent (20%) per annum, calculated from fifteen (15) Calendar Days after the date the Claim was submitted.

4.16.1.2 The Contractor shall maintain a Claims management system that can identify date of receipt (the date the Contractor receives the Claim as indicated by the date-stamp), real-time-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, Appealed, etc.), and date of payment (the date of the check or other form of payment).

4.16.1.3 At a minimum, the Contractor shall run one (1) Provider payment cycle per week, on the same day each week, as determined by DCH.

4.16.1.4 The Contractor shall support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of Claims payments.

4.16.1.5 The Contractor 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), i.e. electronic Claims. Electronic Claims must be processed in adherence to information exchange and data management requirements specified in the Information Management and Systems section of this Contract, Section 4.17. As part of this Electronic Claims Management (ECM) function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status information.

4.16.1.6 The Contractor shall generate explanation of Benefits and remittance advices in accordance with State standards for formatting, content and timeliness and will verify that Members have received the services indicated on the explanation of Benefits and the remittance advices.

4.16.1.7 The Contractor shall issue a formal tracking number for claims inquiries and shall tie any recoupment to the original payment on the remittance advice. The Contractor shall provide the ability to separate provider remittance advice by location identified through the location-specific provider number.

4.16.1.8 The Contractor shall not pay any Claim submitted by a Provider who is excluded or suspended from the Medicare, Medicaid or CHIP programs for Fraud, Waste or Abuse or otherwise included on the U.S. Department of Health and Human Services Office of Inspector General exclusions list, or who employs someone on this list. The Contractor shall not pay any Claim submitted by a Provider that is on payment hold under the authority of DCH or its Agent(s).

4.16.1.9 Not later than the fifteenth (15) Business Day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO web site/Provider Portal or an interim explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO shall complete processing of the Claim within fifteen (15) Business Days.

4.16.1.10 For services rendered within seventy-two (72) hours after the Provider verifies the eligibility of the patient with the Contractor, the Contractor shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the Contractor made payment for a patient for whom it was not responsible, then the Contractor may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.

4.16.1.11 The Contractor shall not apply any penalty for failure to file Claims in a timely manner, for failure to obtain Prior Authorization, or for the Provider not being a participating Provider in the Contractor's network. The amount of reimbursement shall be that Provider's applicable rate for the service provided by an In Network or Out of Network Provider. Providers that file claims untimely or do not obtain Prior Authorization may receive a denial, which is not classified as a "penalty."

4.16.1.12 The Contractor shall inform all network Providers about the information required to submit a Clean Claim as a provision within the Contractor/Provider Contract. The Contractor shall make available to network Providers Claims coding and processing guidelines for the applicable Provider type. The Contractor shall notify Providers ninety (90) Calendar Days before implementing significant changes to Claims coding and processing guidelines. DCH's definition of 'significant' shall be binding.

4.16.1.13 The Contractor shall perform and submit to DCH Quarterly scheduled Global Claims Analyses to ensure an effective, accurate, and efficient claims processing function that adjudicates and settles Provider Claims. In addition, the Contractor shall assume all costs associated with Claims processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor's Span of

Control. If, based on its review of such analysis, DCH finds the Contractor's claims management system and/or processes to be insufficient, DCH may require from the Contractor a Corrective Action Plan outlining how it will address the identified issues.

4.16.1.14 The Contractor's web site shall be functionally equivalent to the web site maintained by the State's Medicaid Fiscal Agent Contractor.

4.16.2 Other Considerations

4.16.2.1 An adjustment to a paid Claim shall not be counted as a Claim for the purposes of reporting.

4.16.2.2 Electronic Claims shall be treated as identical to paper-based Claims for the purposes of reporting.

4.16.3 Encounter Claims Submission Requirements

4.16.3.1 The GF program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor and its subcontractors to provide timely, complete, and accurate information. Encounter data from the Contractor and its subcontractors also allows DCH to budget available resources, set Contractor Capitation Rates, monitor Utilization, follow public health trends, and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes.

4.16.3.2 Encounter data collection and submission is required from the Contractor and its subcontractors for all services, including expanded benefits and benefits administered by a third party or subcontractor, rendered to its Members. The Contractor and its subcontractors shall submit encounter data that meets established data quality standards as defined herein. These standards are defined by CMS and DCH to ensure receipt of complete and accurate data for program administration and are closely monitored and enforced.

4.16.3.3 If the Contractor fails to comply with the encounter data reporting requirements of this Contract, DCH will impose sanctions pursuant to the Sanctions or Liquidated Damages of this contract.

4.16.3.4 The Contractor shall retain submitted historical encounter data for a period of not less than ten (10) years per 42 CFR 438.3(u).

4.16.3.5 Within thirty (30) Calendar Days of Contract Award, the Contractor must submit to DCH a data model of the Supplier's reporting repository, the proposed data layout for weekly data file submissions and a corresponding data dictionary. As these documents are part of DCH's advancement in MITA maturity, such information will not be considered final without DCH approval. A sample data dictionary is included in the Supplier's Library. That sample data dictionary is a guide to provide suppliers with an understanding of DCH's expectations as it relates to the elements to be included in a dictionary and the format which will be most useful to the DCH. Alternate dictionaries may be accepted if they, at the least, provide the listed elements in a format with similar functionality.

4.16.3.6 The Contractor shall implement and maintain review procedures to validate the successful loading of encounter files by DCH's fiscal agent's electronic data interface (EDI) clearinghouse. The Contractor shall use the EDI response (acknowledgement) files to determine if files were successfully loaded.

4.16.3.7 The Contractor shall review the encounter claims of its subcontractors to ensure quality and accuracy prior to submission to DCH.

4.16.3.8 The Contractor shall implement and maintain review procedures to validate encounter data submitted by providers.

4.16.3.9 The Contractor shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on its behalf.

4.16.3.10 The Contractor shall designate sufficient information technology (IT) and staffing resources to perform these encounter functions as determined by generally accepted best industry practices.

4.16.3.11 The Contractor shall assist DCH in reconciliation of the Cash Disbursement check amount totals to Contractor Paid Amount totals for submitted claims.

4.16.3.12 The Contractor shall participate in DCH sponsored workgroups directed at continuous improvements in encounter data quality and operations.

4.16.3.13 The Contractor and its subcontractors shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with CMS' and DCH's data quality standards as originally defined or subsequently amended. The Contractor and its subcontractors must be capable of sending and receiving any claims

information directly to DCH in standards and timeframes specified by DCH.

4.16.3.14 The Contractor and its subcontractors shall follow the instructions in the User Guide and Report Guide regarding the reporting of encounter data.

4.16.3.15 The Contractor and its subcontractors shall work with all contracted providers to implement standardized billing requirements to enhance the Quality and accuracy of the billing data submitted to the health plan.

4.16.3.16 The Contractor shall have the capacity to identify encounter data anomalies and shall provide a description of that process to DCH for review and approval.

4.16.3.17 Encounter submissions shall include all paid claims, denied claims, voided claims, and adjusted claims, including any iterations of such claims. The Contractor shall submit complete, accurate, and timely encounter data to DCH as defined below:

4.16.3.17.1 The Contractor, subcontractors, and delegated vendors shall submit ninety-nine percent (99%) of Encounter Claims (including resubmitted encounter claims) within twenty-one (21) Calendar Days from the Claims payment date or the Claims adjudication date, whichever is later, for both the original claim and any adjustments. DCH will validate Encounter Claims submissions according to the cash disbursement journal of the Contractor and any of its applicable subcontractors.

4.16.3.17.2 The Contractor and its subcontractors shall maintain an Encounter Error Rate of less than five percent weekly as monitored by DCH's fiscal agent and DCH. The Encounter Error Rate is the occurrence of a single error in any ICN or Encounter Claim regardless of how many other errors are detected in the ICN.

4.16.3.17.3 All Contractor encounters (including Contractor subcontractor's encounters) shall be submitted to DCH in the standard HIPAA transaction formats including the standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. The Contractor shall also submit all encounters in accordance to the Companion Guides for NCPDP, Professional, Institutional, and Dental claims as outlined by DCH's Fiscal Agent.

4.16.3.17.4 All Encounter data elements shall be submitted to DCH in the same order as originally submitted to the Contractor (e.g., diagnosis codes, modifiers, etc.).

4.16.3.17.5 Encounter submissions shall include all information that DCH is required to produce under 42 CFR 438.818. This information includes, but is not limited to the following elements which will be monitored for data completeness and accuracy:

- Rendering provider information (e.g., NPI number)
- Ordering, Prescribing, Referring provider information (e.g., NPI number)
- Tax identification number
- Facility code
- Member information (e.g., Member name, date of birth)
- Place of service
- Date of service
- Type of service
- Procedure and diagnosis codes (in the same order as originally submitted to Contractor),
- Units of service
- Diagnostic related groupings (DRGs)
- DRG version
- Allowed claim amounts
- Paid claim amounts
- Voided claim amounts
- Denied claim amounts
- Adjusted claim amounts
- Member cost share
- Third party liability amounts
- Adjudication, claim submission and payment dates
- A unique Transaction Code Number
- CMS 1500 or UB 04 codes
- Mandatory identification of any claim that is a 340B claim

DCH reserves the right to request additional information as needed.

4.16.3.17.6 For encounter data acceptance purposes the Contractor must ensure the provider information it supplies to DCH matches the data in MMIS as either actively enrolled

Medicaid providers or as Contractor registered providers. The Contractor is responsible for ensuring information is an accurate identification of participating network providers and non-participating providers who render services to Contractor's Members. Critical data elements such as the State Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, Member Name and DOB must match the State's eligibility and provider file.

4.16.3.17.7 For each Encounter submission, Contractor must provide via DCH's required electronic format the following Cash Disbursements data elements:

- Provider/Payee Number
- Name
- Address
- City
- State
- Zip
- Check date
- Check number
- Check amount
- Check code (e.g., EFT, paper check, etc.)

4.16.3.17.8 The Contractor shall instruct its contracted providers that the State of Georgia Medicaid ID number is mandatory, until such time as otherwise determined by DCH. The Contractor will emphasize to its providers the need for a unique state of Georgia Medicaid ID number for each practice location unless otherwise determined by DCH.

4.16.3.17.9 The Contractor shall submit weekly cycles of data files to DCH's Fiscal Agent. Contractor shall also have the ability to submit weekly cycle data files to DCH's data warehouse vendor. All identified errors shall be submitted to the Contractor from the Fiscal Agency each week. The Contractor shall address identified issues and resubmit the corrected file to the Fiscal Agent. Data files to the DCH Data Warehouse vendor may lag a week based on corrected file re-submissions identified by DCH's Fiscal Agent.

4.16.3.17.10 The Contractor shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.

4.16.3.17.11 For any services in which a Contractor has entered into capitation reimbursement arrangements with providers, the Contractor shall comply with all encounter data submission requirements in this section. The Contractor shall require timely submissions from its providers as a condition of the capitation payment.

4.16.4 Encounter Resubmission – Adjustments, Reversals, Resubmissions

4.16.4.1 Within thirty (30) days after notice from DCH or its fiscal agent of encounters getting a denied or rejected payment status (failing fiscal agent edits), the Contractor and its subcontractors shall correct and accurately resubmit one hundred percent (100%) of all encounters for which errors can be remedied.

4.16.4.2 The Contractor and its subcontractors shall correct and resubmit one hundred percent (100%) of previously submitted encounter data to reflect the most current and accurate payment adjustments or reversals.

4.16.5 Pharmacy Encounters (NCPDP)

4.16.5.1 In addition to the requirements in sections 4.16.3 and 4.16.4, the Contractor shall comply with the following:

4.16.5.1.1 Contractor shall follow the instructions in the User Guide and Report Guide regarding the reporting of pharmacy encounter data using the National Council for Prescription Drug Program (NCPDP) standard D. 0. format and field definitions. Additionally, the Contractor shall submit all denied pharmacy claims data and the reason code(s) for denial.

4.16.5.1.2 Contractor shall submit encounters for one hundred percent (100%) of the covered services provided by participating and non-participating providers.

4.16.5.1.3 For each encounter data submission, ninety-nine percent (99%) of the Contractor’s encounter lines submissions shall pass NCPDP edits and the pharmacy benefits system edits as specified by DCH. The NCPDP edits are described in the

National Council for Prescription Drug Programs Telecommunications Standard Guides.

4.16.5.1.4 No less than ninety-nine percent (99%) of the Contractor's encounter lines submission shall pass MMIS system edits as specified by the Agency.

4.16.5.1.5 Within thirty (30) days after encounters fail NCPDP edits, X12 (EDI) edits or MMIS system edits, the Contractor shall correct and resubmit all encounters for which errors can be remedied.

4.16.5.1.6 The Contractor shall correct and resubmit one hundred percent (100%) of previously submitted X12 and NCPDP encounter data transactions to reflect the most current and accurate payment adjustments or reversals that resulted in a recoupment or additional payment within thirty (30) days of the respective action.

4.16.6 The Contractor must certify all data to the extent required in 42 CFR 438.606. Such certification must be submitted to the Agency with the certified data and must be based on the knowledge, information and belief of the Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Medical Officer (CMO) or an individual who has written delegated authority to sign for, and directly reports to the CEO or CFO that all data submitted in conjunction with the encounter data and all documents requested by the Agency are accurate, truthful, and complete. The Contractor shall provide the certification at the same time it submits the certified data, information, and documentation specified in 42 CFR 438.604.

4.16.7 Emergency Services

4.16.7.1 The Contractor shall not deny or inappropriately reduce payment to a Provider of Emergency Services for any evaluation, diagnostic testing, or treatment provided to a Member for an emergency condition.

4.16.7.2 The Contractor shall not make payment for Emergency Services contingent on the Member or Provider of Emergency Services providing any notification, either before or after receiving Emergency Services.

4.16.7.3 In processing claims for Emergency Services, the Contractor shall consider, at the time that a claim is submitted, at least the following criteria:

4.16.7.3.1 The age of the patient;

4.16.7.3.2 The time and day of the week the patient presented for services;

4.16.7.3.3 The severity and nature of the presenting symptoms;

4.16.7.3.4 The patient's initial and final diagnosis; and

4.16.7.3.5 Any other criteria prescribed by DCH, including criteria specific to patient less than eighteen (18) years of age.

4.16.7.4 The Contractor shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for Claims presented for Emergency Services.

4.16.7.5 If a provider that has not entered into a contract with the Contractor provides Emergency Services or post-stabilization services to the Contractor's Member, the Contractor shall reimburse the non-contracted provider for such Emergency Services and post-stabilization services at a rate equal to the rate paid by DCH for Medicaid claims that it reimburses directly.

4.16.8 Reporting Requirements

4.16.8.1 The Contractor shall submit to DCH monthly Claims Processing Reports as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.17 INFORMATION MANAGEMENT AND SYSTEMS

The Contractor shall develop, maintain and update, at no cost to DCH or Providers, an information management system for the purpose of integrating all components of the delivery of care to its Members. The system shall have the capability to collect, analyze, and integrate data. Additionally, the information system must securely store and transmit information, interface with other relevant systems and report data in a format specified by DCH. The Contractor shall ensure the system is available and accessible to users at times and in a format that encourages meaningful use by stakeholders.

4.17.1 General Provisions

4.17.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GF requirements, State and federal reporting requirements, all

other Contract requirements and any other applicable State and federal laws, rules and regulations, as amended, including HIPAA.

4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.

4.17.1.2 The Contractor is responsible for maintaining Systems that shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.

4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.

4.17.1.4 The Contractor shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its Agents and every Contractor.

4.17.1.5 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with the State. This system shall be:

4.17.1.5.1 Available from the workstations of the designated Contractor contacts; and

4.17.1.5.2 Capable of attaching and sending documents created using software products other than Contractor systems, including the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

4.17.1.6 By no later than the 30th of April of each year, the Contractor will provide DCH with an annual progress/status report of the Contractor's Systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Contractor's Span of Control will be systematically assessed to determine the need to modify, upgrade

and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The Systems refresh plan will also indicate how the Contractor will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the Systems' components.

4.17.1.7 The Contractor is responsible for all costs associated with the Contractor's Systems refresh plan.

4.17.1.8 Contractor's Health Information System must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.

4.17.1.9 Contractor's Health Information System must comply with Section 6504(a) of the Affordable Care Act.

4.17.2 Health Information Technology and Exchange

4.17.2.1 The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased information on cost and Quality of care through health information technology.

4.17.2.2 The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the Quality and cost of health care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Contractor shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers.

4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).

4.17.2.3.1 If not already participating in the GaHIN, the Contractor shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Contract Effective Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such

application process shall include successful completion of the GaHIN accreditation process;

4.17.2.3.2 The Contractor shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;

4.17.2.3.3 DCH and/or its designee shall provide detailed on-boarding information for use by the Contractor to establish interoperability with the GaHIN; and

4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.

4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.

4.17.2.4.1 Through their system and interoperability with the GaHIN, the Contractor shall provide the following types of patient health information on Members including, but not limited to:

4.17.2.4.1.1 Member-specific information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic information, as appropriate;

4.17.2.4.1.2 Name and address of each Member's PCP;

4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;

4.17.2.4.1.4 Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;

4.17.2.4.1.5 Record of each service event with a physician or other Provider, including routine checkups conducted in accordance

with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnoses, and treatment given, including drugs prescribed;

4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;

4.17.2.4.1.7 Complete record of all immunizations;

4.17.2.4.1.8 Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the claims or "visits" module of the VHR; and

4.17.2.4.1.9 Any utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description.

4.17.2.5 The Contractor shall access the GaHIN to display Member health information within their system for the purpose of Care Coordination and management of the Members.

4.17.2.6 The Contractor shall provide DCH with a list of Authorized Users who may access patient health data from the Contractor's Systems. DCH shall review and approve the list, including revisions thereto, of the Contractor's Authorized Users who may access patient health data from the Contractor's systems. The Contractor shall be permitted to access the GaHIN for purposes associated with this Contract only.

4.17.2.7 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.

4.17.3 Global System Architecture and Design Requirements

4.17.3.1 The Contractor shall comply with federal and State policies, standards and regulations in the design, development and/or modification of the Systems it will employ to meet the aforementioned requirements and in the management of Information contained in those Systems. Additionally, the Contractor shall adhere to DCH and State-specific system and data architecture preferences as indicated in this Contract.

4.17.3.2 The Contractor's Systems shall:

4.17.3.2.1 Employ a relational data model in the architecture of its databases and relational database management system (RDBMS) to operate and maintain them;

4.17.3.2.2 Be SQL and ODBC compliant;

4.17.3.2.3 Adhere to Internet Engineering Task Force/Internet Engineering Standards Group standards for data communications, including TCP and IP for data transport;

4.17.3.2.4 Conform to standard code sets detailed in Attachment K;

4.17.3.2.5 Contain industry standard controls to maintain information integrity applicable to privacy and security, especially PHI. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly and mutually agreed upon by the Contractor and DCH; and

4.17.3.2.6 Partner with the State in the development of future standard code sets, not specific to HIPAA or other federal effort and will conform to such standards as stipulated by DCH.

4.17.3.3 Where Web services are used in the engineering of applications, the Contractor's Systems shall conform to World Wide Web Consortium (W3C) standards such as XML, UDDI, WSDL and SOAP so as to facilitate integration of these Systems with DCH and other State systems that adhere to a service-oriented architecture.

4.17.3.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the Information is finally recorded. The audit trails shall:

4.17.3.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

4.17.3.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

4.17.3.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

4.17.3.4.4 Be supported by listings, transaction Reports, update Reports, transaction logs, or error logs;

4.17.3.4.5 Facilitate auditing of individual Claim records as well as batch audits; and

4.17.3.4.6 Be maintained for ten (10) years in either live and/or archival Systems, as applicable. The right to audit exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. The duration of the retention period may be extended at the discretion of and as indicated to the Contractor by the State as needed for ongoing audits or other purposes.

4.17.3.5 The Contractor shall house indexed images of documents used by Members and Providers to transact with the Contractor in the appropriate database(s) and document management systems to maintain the logical relationships between certain documents and certain data.

4.17.3.6 The Contractor shall institute processes to ensure the validity and completeness of the data it submits to DCH. At its discretion, DCH will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Member ID, date of service, Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of Claim processing, and date of Claim payment.

4.17.3.7 Where Systems are herein required to, or otherwise supports, the applicable batch or on-line transaction type, the Systems shall comply with HIPAA-standard transaction code sets as specified in **Attachment K**, and as updated thereafter.

4.17.3.8 The Contractor System(s) shall conform to HIPAA standards for information exchange, and as updated thereafter.

4.17.3.9 The layout and other applicable characteristics of the pages of Contractor Web sites shall be compliant with Federal “section 508 standards” and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.

4.17.3.10 Contractor Systems shall conform to any applicable Application, Information and Data, Middleware and Integration, Computing Environment and Platform, Network and Transport, and Security and Privacy policy and standard issued by GTA as stipulated in the appropriate policy/standard, and as updated thereafter. These policies and standards can be accessed at: http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.html

4.17.4 Data and Document Management Requirements By Major Information Type

4.17.4.1 In order to meet programmatic, reporting and management requirements, the Contractor's Systems shall serve as either the Authoritative Host of key data and documents or the host of valid, replicated data and documents from other systems. **Attachment K** lays out the requirements for managing (capturing, storing and maintaining) data and documents for the major information types and subtypes associated with the aforementioned programmatic, reporting and management requirements.

4.17.5 System and Data Integration Requirements

4.17.5.1 All of the Contractor's applications, operating software, middleware, and networking hardware and software shall be able to interface with the State's systems DCH vendors systems and will conform to standards and specifications set by the Georgia Technology Authority and the agency that owns the systems. These standards and specifications are detailed in **Attachment K**.

4.17.5.2 The Contractor's System(s) shall be able to transmit and receive transaction data to and from the MMIS as required for the appropriate processing of Claims and any other transaction that may be performed by either system.

4.17.5.3 The Contractor shall generate Encounter data files no less than weekly (or at a frequency defined by DCH) from its claims management system(s) and/or other sources. The files will contain settled Claims and Claim adjustments and encounters from Providers with whom the Contractor has a capitation arrangement for the most recent month for which all such transactions were completed. The Contractor will provide these files electronically to DCH and/or its designated Agent in adherence to the procedure and format indicated in **Attachment K**, and as updated thereafter. File reports shall comply with the requirements of HIPAA security and privacy standards, and shall be submitted in the format required by the Medicaid Statistical Information System or any successor thereto.

4.17.5.4 The Contractor's System(s) shall be capable of generating all required files in the prescribed formats (as referenced in **Attachment K**, including any updates thereto) for upload into state systems used specifically for program integrity and compliance purposes.

4.17.5.5 The Contractor's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

4.17.6 Systems Access Management and Information Accessibility Requirements

4.17.6.1 The Contractor's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and Information. The access management function shall:

4.17.6.1.1 Restrict access to Information on a "need to know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;

4.17.6.1.2 Restrict access to specific Systems' functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by DCH and the Contractor;

4.17.6.1.3 Restrict attempts to access Systems' functions (both internal and external) to three (3), with a system function that automatically prevents further access attempts and records these occurrences; and

4.17.6.1.4 At a minimum, follow the GTA Security Standard and Access Management protocols, and updates thereto.

4.17.6.2 The Contractor shall make System Information available to duly Authorized Representatives of DCH and other State and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

4.17.6.3 The Contractor shall have procedures to provide for prompt electronic transfer of System Information upon request to In-Network or Out-of-Network Providers for the medical management of the Member in adherence to HIPAA and other applicable requirements.

4.17.7 Systems Availability and Performance Requirements

4.17.7.1 The Contractor will ensure that Member and Provider portal and/or phone-based functions and information, such as confirmation of CMO Enrollment (CCE) and electronic claims management (ECM), Member services and Provider services, are available to the applicable System users twenty-four (24) hours a day, seven (7) Days a week, except during periods of scheduled System Unavailability agreed upon by DCH and the Contractor. Unavailability caused by events outside of a Contractor's Span of Control is outside of the scope of this requirement.

4.17.7.2 The Contractor shall ensure that at a minimum, all other Systems' functions and Information are available to the applicable Systems' users between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday with the exception of State holidays.

4.17.7.3 The Contractor shall ensure that the average response time that is controllable by the Contractor is no greater than the requirements set forth below, between 7:00 am and 7:00 pm EST, Monday through Friday for all applicable system functions except: a) during periods of scheduled downtime, b) during periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Contractor's Span of Control, or c) for Member and Provider portal and phone-based functions such as CCE and ECM that are expected to be available twenty-four (24) hours a day**, seven (7) days a week:**

4.17.7.3.1 Record Search Time – The response time shall be within three (3) seconds for ninety-eight percent (98%) of the record searches as measured from a representative sample of DCH System Access Devices, as monitored by the Contractor;

4.17.7.3.2 Record Retrieval Time – The response time will be within three (3) seconds for ninety-eight percent (98%) of the records retrieved as measured from a representative sample of DCH System Access Devices;

4.17.7.3.3 On-line Adjudication Response Time – The response time will be within five (5) seconds ninety-nine percent (99%) of the time as measured from a representative sample of user System Access Devices.

4.17.7.3.4 Screen Display Time – The system Screen Display Time must be within 2 seconds for 95% of the time. Screen Display Time is the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor;

4.17.7.3.5 New Screen Page Time – must be within 2 seconds for 95% of the time. New Screen/Page Time is the time elapsed from the time a new screen is requested until the data from the screen appears or loads to completion on the monitor; and

4.17.7.3.6 Print Initiation Time – must be within 2 seconds for 95% of the time. Print Initiation Time is the time elapsed from the command to print a screen or report until it appears in the appropriate queue.

4.17.7.4 The Contractor shall develop an automated method of monitoring the CCE and ECM functions on at least a thirty (30) minute basis twenty-four (24) hours a day, seven (7) Days per week. The monitoring method shall separately monitor for availability and performance/response time each component of the CCE and ECM systems, such as the voice response system, the PC software response, direct line use, the swipe box method and ECM on-line pharmacy system.

4.17.7.5 Upon discovery of any problem within its Span of Control that may jeopardize System availability and performance as defined in this Section of the Contract, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, in person, via phone and electronic mail, followed by surface mail notification.

4.17.7.6 The Contractor shall deliver notification as soon as possible but no later than 7:00 pm EST if the problem occurs during the Business Day and no later than 9:00 am EST the following Business Day if the problem occurs after 7:00 pm.

4.17.7.7 Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on System Unavailability protocols.

4.17.7.8 The Contractor shall provide to the DCH Director, Contract Compliance and Resolution, information on System Unavailability events, as well as status updates on problem resolution. These up-dates shall be provided on an hourly basis and made available via electronic mail, telephone and the Contractor's Web Site/DCH Portal.

4.17.7.9 Unscheduled System Unavailability of CCE and ECM functions, caused by the failure of systems and telecommunications technologies

within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the Contractor's discovery of System Unavailability. Unscheduled System Unavailability to all other Contractor System functions caused by systems and telecommunications technologies within the Contractor's Span of Control shall be resolved, and the restoration of services implemented, within four (4) hours of the Contractor's discovery of System Unavailability.

4.17.7.10 Cumulative System Unavailability caused by systems and telecommunications technologies within the Contractor's Span of Control shall not exceed one (1) hour during any continuous five (5) Calendar Day period.

4.17.7.11 The Contractor shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Contractor's Span of Control. The Contractor is obligated to work with identified vendors to resolve and report system availability and performance issues.

4.17.7.12 Full written documentation that includes a Corrective Action or Remedial Action response that describes what caused the problem, how the problem will be prevented from occurring again, and within a set time frame for resolution must be submitted to DCH within the DCH required timeframe of the problem's occurrence.

4.17.7.13 Regardless of the architecture of its Systems, the Contractor shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that at a minimum addresses the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, and (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e. causes unscheduled System Unavailability.

4.17.7.14 The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore System functions per the standards outlined elsewhere in this Contract. The Contractor

will prepare a report of the results of these tests and present to DCH staff within five (5) business days of test completion. DCH or its designee, federal auditors, or the State Auditor, reserves the right to conduct a site visit of the Contractor's disaster recovery location with one (1) day prior notice.

4.17.7.15 In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall be required to submit to the State a CAPA that describes how the failure will be resolved. The CAPA will be delivered within five (5) Business Days of the conclusion of the test.

4.17.7.16 The Contractor shall submit monthly System Availability and Performance Reports to DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.17.8 System User and Technical Support Requirements

4.17.8.1 The Contractor shall provide Systems Help Desk (SHD) services to all DCH staff and the other agencies that may have direct access to Contractor Systems.

4.17.8.2 The SHD shall be available via local and toll free telephone service and via e-mail from 7:00 a.m. to 7:00 p.m. EST Monday through Friday, with the exception of State holidays. Upon State request, the Contractor shall staff the SHD on a State holiday, Saturday, or Sunday at the Contractor's expense.

4.17.8.3 SHD staff shall answer user questions regarding Contractor Systems' functions and capabilities; report recurring programmatic and operational problems to appropriate Contractor or DCH staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate State login account administrator.

4.17.8.4 The Contractor shall submit to DCH for review and approval its SHD Standards. At a minimum, these standards shall require that between the hours of 7:00 a.m. and 7:00 p.m. EST ninety percent (90%) of calls are answered by the fourth (4th) ring, the call abandonment rate is five percent (5%) or less, the average hold time is two (2) minutes or less, and the Blocked Call rate does not exceed one percent (1%).

4.17.8.5 Individuals who place calls to the SHD between the hours of 7:00 p.m. and 7:00 a.m. EST shall be able to leave a message. The Contractor's SHD shall respond to messages by noon EST the following Business Day.

4.17.8.6 Recurring problems not specific to System Unavailability identified by the SHD shall be documented and reported to Contractor management within one (1) Business Day of recognition so that deficiencies are promptly corrected in accordance with this Contract.

4.17.8.7 Additionally, the Contractor shall have an IT service management system that provides an automated method to record, track, and report on all questions and/or problems reported to the SHD. The service management system shall:

4.17.8.7.1 Assign a unique number to each recorded incident;

4.17.8.7.2 Create State defined extract files that contain summary information on all problems/issues received during a specified time frame;

4.17.8.7.3 Escalate problems based on their priority and the length of time they have been outstanding;

4.17.8.7.4 Perform key word searches that are not limited to certain fields and allow for searches on all fields in the database;

4.17.8.7.5 Notify support personnel when a problem is assigned to them and re-notify support personnel when an assigned problem has escalated to a higher priority;

4.17.8.7.6 Generate a list of all problems assigned to a support person or group;

4.17.8.7.7 Perform searches for duplicate problems when a new problem is entered;

4.17.8.7.8 Allow for entry of at least five hundred (500) characters of free form text to describe problems and resolutions; and

4.17.8.7.9 Generate Reports that identify categories of problems encountered, length of time for resolution, and any other State-defined criteria.

4.17.8.8 The Contractor's call center systems shall have the capability to track call management metrics identified in **Attachment K** and updates thereto.

4.17.9 System Change Management Requirements

4.17.9.1 The Contractor shall absorb the cost of routine maintenance, inclusive of defect correction, Systems changes required to effect changes in State and federal statute and regulations, and production control activities, of all Systems within its Span of Control.

4.17.9.2 The Contractor shall provide DCH prior written notice of non-routine System changes excluding changes prompted by events described in the Systems Access management and Information Accessibility Requirements section above and including proposed corrections to known system defects, within ten (10) Calendar Days of the projected date of the change. As directed by the State, the Contractor shall discuss the proposed change in the Systems Work Group.

4.17.9.3 The Contractor shall respond to State reports of System problems not resulting in Systems Unavailability and shall perform the needed changes according to the following timeframes:

4.17.9.3.1 Within five (5) Calendar Days of receipt, the Contractor shall respond via phone and in writing via email to notices of system problems.

4.17.9.3.2 Within fifteen (15) Calendar Days, the correction will be made and confirmed to the State or a Requirements Analysis and Specifications document will be due.

4.17.9.4 The Contractor will correct the deficiency by an effective date to be determined by DCH.

4.17.9.5 Contractor Systems will have a system-inherent mechanism for recording any change to a software module or subsystem.

4.17.9.6 The Contractor shall put in place procedures and measures for safeguarding the State from unauthorized modifications to Contractor Systems.

4.17.9.7 Unless otherwise agreed to in advance by DCH as part of the activities described in the System User and Technical Support Requirements section above, scheduled System Unavailability to perform System maintenance, repair and/or upgrade activities shall take place between

11:00 p.m. EST on a Saturday and 6:00 a.m. EST on the following Sunday.

4.17.10 System Security and Information Confidentiality and Privacy Requirements

4.17.10.1 The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide DCH with access to data facilities upon DCH request. The physical security provisions shall be in effect for the life of this Contract and thereafter.

4.17.10.2 The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

4.17.10.3 The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

4.17.10.4 The Contractor shall ensure that the operation of all of its Systems is performed in accordance with State and federal regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations.

4.17.10.5 The Contractor will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a Contractor's Span of Control.

4.17.10.6 The Contractor shall ensure compliance with:

4.17.10.6.1 42 CFR Part 431 Subpart F (confidentiality of information concerning applicants and Members of public medical assistance programs);

4.17.10.6.2 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and

4.17.10.6.3 Special confidentiality provisions related to people with HIV/AIDS and mental illness.

4.17.10.7 The Contractor shall provide its Members with a privacy notice as required by HIPAA. The Contractor shall provide the State with a copy of its Privacy Notice for its filing.

4.17.11 Information Management Process and Information Systems Documentation Requirements

4.17.11.1 The Contractor shall ensure that written System Process and Procedure Manuals, and updates thereto, document and describe all manual and automated system procedures for its information management processes and information systems in accordance to CMS seven conditions and standards, and amendments thereto. Available at: http://www.acs-inc.com/wp_state_self_assessment.aspx

4.17.11.2 The Contractor shall develop, prepare, print, maintain, produce, and distribute distinct System Design and Management Manuals, User Manuals and Quick/Reference Guides, and any updates thereafter, for DCH and other agency staff that use the DCH Portal.

4.17.11.3 The Systems User Manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system's data.

4.17.11.4 When Systems change are subject to State approval, the Contractor shall draft revisions to all appropriate manuals impacted by the system change, i.e. user manuals, technical specifications etc., prior to State approval of the change.

4.17.11.5 All of the aforementioned manuals and reference guides shall be available in printed form and on-line via the DCH Portal. The manuals will be published in accordance to the applicable DCH and/or Georgia Technology Authority (GTA) standard.

4.17.11.6 Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) Business Days of the update taking effect.

4.17.12 Reporting Requirements

4.17.12.1 The Contractor shall submit to DCH a monthly Systems Availability and Performance Report as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein.

4.18 MONITORING AND REPORTING

4.18.1 General Procedures

4.18.1.1 The Contractor shall support DCH in its program monitoring and reporting efforts for program performance and trending analyses

through submission of ongoing, dashboard and ad hoc reports to DCH for all activities described in the Contract. The Contractor shall provide ad hoc reports to DCH upon request and within timeframes agreed to by DCH and the Contractor.

4.18.1.2 The Contractor shall meet with DCH Business Owners during implementation to discuss all data requirements and the Contractor's recommended reports. The Contractor shall accommodate DCH's requests for data and reporting based on implementation decisions as well as for ongoing requests during operations.

4.18.2 Ongoing Reporting

4.18.2.1 The Contractor shall collect, validate and report required program data to DCH in an accurate and timely manner. The Contractor's Chief Executive or Financial Officer, or a designee vested with their authority, shall attest to the accuracy and completeness of all submitted reports, in accordance with 42 CFR §438.604. In addition, the Contractor shall comply with all state and federal requirements set forth in this Section and throughout this Contract.

4.18.2.2 The Contractor shall comply with all the reporting requirements established by this Contract and shall submit all Reports included in this Contract. The Contractor shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. **DCH may modify reports, specifications, templates, or timetables as necessary during the Contract year.** Contractor changes to the format must be approved by DCH prior to implementation. The Contractor shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 23.2. The Contractor's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 25.0.

4.18.2.2.1 The Contractor shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, **unless otherwise indicated**.

4.18.2.2.1.1 Weekly Reports shall be submitted on the same day of each week as determined by DCH;

4.18.2.2.1.2 Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month;

4.18.2.2.1.3 Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;

4.18.2.2.1.4 Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12^{th}) month of the contract year ending June 30^{th};

4.18.2.2.1.5 Ad-Hoc, as determined by DCH; and

4.18.2.2.1.6 Other Reports (bi-annual, according to the due date of the respective report).

4.18.2.2.2 For reports required by DOI and DCH, the Contractor shall submit such reports according to the DOI schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in this Contract, should the DOI schedule of due dates be amended at a future date, the due dates in this Contract shall automatically change to the new DOI due dates.

4.18.2.2.3 The Contractor shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Contractor's responsibility shall be limited to data in its possession.

4.18.2.3 Medical Loss Ratio Reporting Requirements:

4.18.2.3.1 Contractor shall calculate and report its Medical Loss Ratios (MLR) for each MLR reporting year, consistent with the MLR standards set forth in 42 CFR § 438.8 with adjustments for Directed Payments as noted below. Contractor shall calculate and report its MLR for the previous state fiscal year on a template specified by the Department by January 15 of each year, starting with a deadline of January 15, 2019 for SFY 2018.

4.18.2.3.2 The CMO must submit an annual combined MLR report that will be used for rebating purposes, as well as other purposes. The report must have separate detail broken out for:

- Aggregated Low Income Medicaid (LIM) eligible members, Breast and Cervical Cancer (BCC) eligible

members, and Delivery Kick payments,
- Planning for Healthy Babies (P4HB) members
- PeachCare for Kids (PCK) eligible members in accordance with Attachment X.

4.18.2.3.3 The template shall include, at a minimum, the following elements:

- Total Incurred Claims;
- Expenditures on quality improvement activities;
- Payments made under any Directed Payments Program as approved by CMS;
- Expenditures related to activities compliant with program integrity requirements;
- Non-claims costs;
- Premium Revenue;
- Taxes;
- Licensing fees;
- Regulatory fees;
- Methodology(ies) for allocation of expenditures;
- Any credibility adjustment applied;
- The calculated MLR;
- If applicable, any remittance (rebate) owed to or from DCH;
- A comparison of the information reported with the audited financial report;
- A description of the aggregation method used to calculate total incurred claims; and
- The number of member months

4.18.2.3.4 If a Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards. Contractor must aggregate data for all Medical eligibility groups covered under this Contract.

4.18.2.3.5 Reporting Expenses

4.18.2.3.5.1 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 prorated between types of expenses.

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

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

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

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

4.18.2.3.6 Credibility Adjustments

4.18.2.3.6.1 Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible.

4.18.2.3.6.2 Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

4.18.2.3.6.3 Contractor shall determine whether its experience is fully credible or partially credible utilizing the annual MLR Credibility Adjustment guidance published by CMS.

4.18.2.3.7 Pursuant to 42 CFR 438.8(k)(3), Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days of the end of the state fiscal year or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

4.18.2.3.8 In any instance in which the Department makes a retroactive change to Capitation Payments for a MLR reporting year and the MLR report has already been submitted to the Department, Contractor must (1)

recalculate the MLR for all reporting years affected by the change and (2) submit a new MLR report meeting the requirements of section 4.18.2.3 of this Contract to the Department for each affected reporting year.

4.18.2.3.9 Contractor must attest to the accuracy of the calculation of the MLR in accordance with the requirements of 42 CFR § 438.8(n) and 42 CFR § 438.606.

4.18.2.4 Medical Loss Ratio and Risk Corridor

The Contractor is required to report its medical loss ratio (MLR) consistent with the provisions of the sections above. Contractor and the State shall remit amounts pursuant to the risk corridor provisions outlined below:

4.18.2.4.1 Risk Corridor - Contractor's Remittance to the State

4.18.2.4.1.1 PeachCare for Kids

Effective July 1, 2019 through June 30, 2022, a remittance of capitation payments related to the PeachCare for Kids MLR from the CMO to the State shall occur if the MLR is equal to or less than eighty-five and a half percent (85.5%). The remittance amount shall be calculated as follows:

4.18.2.4.1.1.1 If the CMO has an MLR less than or equal to eighty-five percent (85%), the CMO shall submit a remittance to the State for one hundred percent (100%) of the difference between the dollar amount corresponding to the actual MLR and the dollar amount corresponding to an eighty-five percent (85%) MLR plus fifty percent (50%) of the difference between the dollar amount corresponding to an eighty-five percent (85%) MLR and the dollar amount corresponding to an eighty-five and a half percent (85.5%) MLR.

4.18.2.4.1.1.2 If the CMO has an MLR of less than or equal to eighty-five and a half percent (85.5%), but greater than eighty-five percent (85%), the CMO shall submit a remittance to the State for fifty (50%) of the difference between the

dollar amount corresponding to the actual MLR and the dollar amount corresponding to an eighty-five and a half percent (85.5%) MLR.

Effective July 1, 2022 through the life of this Contract, the remittance amount shall be calculated as follows: If the CMO has an MLR less than or equal to eighty-six percent (86%), the CMO shall submit a remittance to the State for one hundred percent (100%) of the difference between the dollar amount corresponding to the actual MLR and the dollar amount corresponding to an eighty-six percent (86%) MLR.

4.18.2.4.1.2 Georgia Families, excluding PeachCare for Kids

Effective July 1, 2019 through June 30, 2022, a remittance of capitation payments related to the Georgia Families program, excluding PeachCare for Kids, MLR from the CMO to the State shall occur if the MLR is equal to or less than eighty-seven percent (87%). The remittance amount shall be calculated as follows:

4.18.2.4.1.2.1 If the CMO has an MLR less than or equal to eighty-five percent (85%), the CMO shall submit a remittance to the State for one hundred percent (100%) of the difference between the dollar amount corresponding to the actual MLR and the dollar amount corresponding to an eighty-five percent (85%) MLR plus fifty percent (50%) of the difference between the dollar amount corresponding to an eighty-five percent (85%) MLR and the dollar amount corresponding to an eighty-seven percent (87%) MLR.

4.18.2.4.1.2.2 If the CMO has an MLR of less than or equal to eighty-seven percent (87%), but greater than eighty-five percent (85%), the CMO shall submit a remittance to the State for fifty (50%) of the difference between the dollar amount corresponding to actual MLR and the dollar amount corresponding to an

eighty-seven percent (87%) MLR.

Effective July 1, 2022 through the life of this Contract, the remittance amount shall be calculated as follows: If the CMO has an MLR less than or equal to eighty-six percent (87%), the CMO shall submit a remittance to the State for one hundred percent (100%) of the difference between the dollar amount corresponding to the actual MLR and the dollar amount corresponding to an eighty-seven percent (87%) MLR.

4.18.2.4.2 Risk Corridor - State's Remittance to the Contractor

4.18.2.4.2.1 PeachCare for Kids

Effective July 1, 2019 through June 30, 2022, a remittance of capitation payments related to the PeachCare for Kids MLR from the State to the CMO shall occur if the MLR is greater than eighty-seven and a half percent (87.5%). The remittance amount shall be calculated as follows:

4.18.2.4.2.1.1 If the CMO has an MLR of greater than eighty-seven and a half percent (87.5%), but equal to or less than eighty-eight percent (88%), the State shall submit a remittance to CMO for fifty percent (50%) of the difference between the dollar amount corresponding to actual MLR and the dollar amount corresponding to an eighty-seven and a half percent (87.5%) MLR.

4.18.2.4.2.1.2 If the CMO has an MLR greater than eighty-eight percent (88%), the State shall submit a remittance to the CMO for eighty percent (80%) of the difference between the dollar amount corresponding to the actual MLR and the dollar amount corresponding to an eighty-eight percent (88%) MLR plus fifty percent (50%) of the difference between the dollar amount corresponding to an eighty-eight percent (88%) MLR and the dollar amount corresponding to an eighty-seven and a half percent (87.5%) MLR.

4.18.2.4.2.2 Georgia Families, excluding PeachCare for Kids

Effective July 1, 2019 through June 30, 2022, a remittance of capitation payments related to the Georgia Families program, excluding PeachCare for Kids, from the State to the CMO shall occur if the MLR is greater than eighty-nine percent (89%). The remittance amount shall be calculated as follows:

4.18.2.4.2.2.1 If the CMO has an MLR of greater than eighty-nine percent (89%), but equal to or less than ninety-one percent (91%), the State shall submit a remittance to CMO for fifty percent (50%) of the difference between the dollar amount corresponding to actual MLR and the dollar amount corresponding to an eighty-nine percent (89%) MLR.

4.18.2.4.2.2.2 If the CMO has an MLR greater than ninety-one percent (91%), the State shall submit a remittance to the CMO for eighty percent (80%) of the difference between the dollar amount corresponding to the actual MLR and the dollar amount corresponding to a ninety-one percent (91%) MLR plus fifty percent (50%) of the difference between the dollar amount corresponding to a ninety-one percent (91.0%) MLR and the dollar amount corresponding to an eighty-nine percent (89.0%) MLR.

4.18.2.5 Calculating MLRs

4.18.2.5.1 The Contractor must calculate its program MLR utilizing the following formula:

4.18.2.5.1.1 The MLR calculation is the ratio of the numerator, as defined by 42 CFR § 438.8(e), to the denominator, as defined by 42 CFR §438.8(f). The Contractor 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 rebates and in accordance with 42 CFR 438.8(h). For

additional information, see Attachment X. Directed Payments are included in the numerator and denominator from July 1, 2019 through June 30, 2022. Effective July 1, 2022 through the life of this Contract, Directed Payments are excluded from the numerator and denominator.

4.18.2.6 Process for Rebating Capitation Payments

4.18.2.6.1 Effective July 1, 2019 through the life of this Contract, for each MLR reporting year, the Contractor must provide a rebate to the State if the Contractor's MLR is less than the remittance to the state MLR threshold established above.

4.18.2.6.2 Effective July 1, 2019 through June 30, 2022, for each MLR reporting year, the State must provide a rebate to the Contractor if the Contractor exceeds the State's remittance to the Contractor's MLR threshold established above.

4.18.2.6.3 The Contractor rebate amounts will be assessed by the State using the MLR calculations provided within the SFY MLR Report submitted to the State by the Contractor. The MLR rebate, if any, is due to the State in full sixty (60) Calendar Days after the State notifies the Contractor in writing of any MLR rebate amount due.

4.18.2.6.4 If the Contractor determines that payment of the MLR rebate by the Contractor will cause the Contractor's risk-based capital to fall below the level required by the State, the Contractor's responsible official must notify the State in writing as soon as administratively possible and prior to making any MLR rebate payments to the State.

4.18.3 Public Reporting

4.18.3.1 DCH will periodically publish information or receive requests from audiences such as legislators that may require data from the Contractor. DCH will provide the Contractor with information about the data DCH would like to publish or must produce, and the Contractor shall produce all reports or summary data for DCH to incorporate into a larger report. The Contractor shall develop these reports considering the audience to be targeted.

4.18.3.2 The Contractor shall not publish reports on its website or any other forum without prior consent from DCH.

4.18.4 Ongoing Reporting and Monitoring Meetings

4.18.4.1 The Contractor must be prepared to participate in regularly scheduled meetings with DCH staff to review decisions, resolve issues and define operational enhancements. These meeting schedules will be determined by DCH.

4.18.4.2 The Contractor and its various levels of staff as determined by DCH must also attend an onsite meeting at DCH to report on all activities, trends, opportunities for improvement and recommendations for programmatic and policy changes at the frequency determined by DCH. Contractors must provide best practices and lessons learned to reach GF program goals.

5.0 DELIVERABLES

5.1 CONFIDENTIALITY

The Contractor shall ensure that any Deliverables that contain information about individuals that is protected by confidentiality and privacy laws shall be prominently marked as "CONFIDENTIAL" and submitted to DCH in a manner that ensures that unauthorized individuals do not have access to the information. The Contractor shall not make public such reports. Failure to ensure confidentiality may result in sanctions and liquidated damages as described in Section 25.

5.2 NOTICE OF APPROVAL/DISAPPROVAL

5.2.1 All Deliverables are subject to approval from DCH.

5.2.2 DCH will provide written notice of disapproval of a Deliverable to the Contractor within fourteen (14) Calendar Days of submission if it is disapproved. DCH may, at its sole discretion, elect to review a deliverable longer than fourteen (14) Calendar Days.

5.2.3 The notice of disapproval shall state the reasons for disapproval as specifically as is reasonably necessary and the nature and extent of the corrections required for meeting the Contract requirements.

5.3 RESUBMISSION WITH CORRECTIONS

Within fourteen (14) Calendar Days of receipt of a notice of disapproval, the Contractor shall make the corrections and resubmit the Deliverable.

5.4 NOTICE OF APPROVAL/DISAPPROVAL OF RESUBMISSION

Within thirty (30) Calendar Days following resubmission of any disapproved Deliverable, DCH will give written notice to the Contractor of approval, Conditional approval or disapproval.

5.5 DCH FAILS TO RESPOND

In the event that DCH fails to respond to a Contractor's submission or resubmission within the applicable time period, the Contractor should notify DCH of the outstanding request. DCH's failure to respond within the applicable time period does not constitute approval of the submission.

5.6 REPRESENTATIONS

5.6.1 By submitting a Deliverable or report, the Contractor represents that to the best of its knowledge, it has performed the associated tasks in a manner that will, in concert with other tasks, meet the objectives stated or referred to in the Contract.

5.6.2 By approving a Deliverable or report, DCH represents only that it has reviewed the Deliverable or report and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the Withholding or denial of payment for the work completed. DCH's acceptance of a Deliverable or report does not discharge any of the Contractor's contractual obligations with respect to that Deliverable or report.

5.7 CONTRACTOR DELIVERABLES

Contractor must consider the timeframes for receiving such DCH approval in meeting the specific deadlines for each deliverable. Any dates that fall on a weekend or State holiday shall have a deliverable date of the next Business Day. All deliverables must be complete and comprehensive.

5.7.1 Reports

Contractor shall deliver the following reports to DCH in the format(s) required by DCH or as set forth in this Contract:

Report	Frequency
Pharmacy Rebate File	Weekly
Claims Processing Report	Monthly
Cost Avoidance Report	Monthly
Dental Participation Denial Report	Monthly
Disenrollment Activity Notification Report	Monthly
Eligibility and Enrollment Reconciliation Report	Monthly

FQHC and RHC Report	Monthly
Medical Loss Ratio Report	Monthly
Member Data Conflict Report	Monthly
Provider Complaints Report	Monthly
System Availability and Performance Report	Monthly
Telephone and Internet Activity Report	Monthly
Third Party Liability and Coordination of Benefits Report	Monthly
Case Management Report	Quarterly
CMS 416 Report	Quarterly
Clinical Practice Guidelines (CPGs)	Quarterly
Contractor Notification	Quarterly
Dental Utilization Report	Quarterly
Disease Management Report	Quarterly
DUR Program Annual Report	Annually
EPSDT Informing Activity Report	Quarterly
EPSDT Initial Screening Report	Quarterly
EPSDT Medical Health Check Record Review Report	Quarterly
EPSDT Referrals Report	Quarterly
Fraud and Abuse Report	Quarterly
Grievance System Report	Quarterly
Hospital Statistical and Reimbursement Report	Quarterly
Neonatal Intensive Care Supplement Payment Report	Quarterly
Performance Improvement Projects (PIPs) Reports	Quarterly
Pharmacy Audit Reports	Quarterly
Pharmacy Cost Reports	
Pharmacy Benefit Manager Report	Quarterly
Prior Authorization and Pre-Certification Report	Quarterly
Provider Network Adequacy and Capacity Report	Quarterly
Provider Preventable Conditions Report	Monthly
Timely Access Report	Quarterly
Utilization Management Report	Quarterly
Disclosure of Information on Annual Business Transactions	Annually
EPSDT Reports	Annually

Independent Audit and Income Statement	Annually
Patient Safety Reports and Analysis	Annually
Performance Improvement Projects Reports	Annually
Performance Measures	Annually
Quality Assessment Performance Improvement (QAPI)	Annually
Systems Refresh Plan	Annually
"SSAE 16" Reports	Annually
Unclaimed Payments Report	Annually
Unclaimed Property Report	Annually
72 Hour Eligibility Rule Report	Ad Hoc
Focused Studies Report	Ad Hoc
Provider Rep Field Visit Report	Ad Hoc
Quality Oversight Committee Report	Ad Hoc
State Quality Monitoring Reports	Ad Hoc
Subcontractor Agreement and Monitoring Information Report	B-Annually

5.7.2 Other Miscellaneous Deliverables

Contractor shall deliver the following deliverables to DCH in the format(s) required by DCH or as set forth in this Contract:

Deliverable	**Contract Section**
PCP Auto assignment Policies	2.3.3
Member Handbook	4.3.3
Provider Directory	4.3.5
Sample Member ID card	4.3.6
Telephone Hotline Policies and Procedures (Member and Provider)	4.3.7 4.9.5
Call Center Quality Criteria and Protocols	4.3.7.6 4.9.5.6
Web site Screenshots	4.3.8 4.9.6
Cultural Competency Plan	4.3.9.3
Marketing Plan and Materials	4.4
Provider Marketing Materials	4.4.3
MH/SA Policies and Procedures	4.6.11
EPSDT Policies and Procedures	4.7
Provider Selection and Retention Policies and Procedures	4.8.2

Provider Network Listing spreadsheet for all requested Provider types and Provider Letters of Intent or executed Signature Pages of Provider Contracts not previously submitted as part of the RFP response	4.8
Final Provider Network Listing spreadsheet for all requested Provider types, Signature Pages for all Providers, and written acknowledgements from all Providers part of a PHO, IPA, or other network stating they know they are in the Contractor's network, know they are accepting Medicaid patients, and are accepting the terms and conditions of the Provider Contract	4.3.5.4
PCP Selection Policies and Procedures	4.1.2
Provider Handbook	4.9.2
Provider Training Manuals	4.9.3.2
Provider Complaint System Policies and Procedures	4.9.7
Utilization Management Policies and Procedures	4.11
Care Coordination and Case Management Policies and Procedures	4.11
Quality Assessment and Performance Improvement Program	4.12.6 4.12.7
Focused Studies	4.12.9
Patient Safety Plan	4.12.10
Program Integrity Policies and Procedures	4.13
Grievance System Policies and Procedures	4.14
Staff Training Plan	4.15.3
Claims Management	4.16
Business Continuity Plan	4.17.7.13
System Users Manuals and Guides	4.17.11
Information Management Policies and Procedures	4.17
Subcontractor Agreements	18.0

6.0 TERM OF CONTRACT

6.1 This Contract shall begin on the Contract Effective Date and shall continue until June 30, 2017 unless terminated earlier pursuant to **Section 24**, ***Termination of Contract***. The Parties agree that DCH has five (5) options to renew this Contract for additional terms of up to one (1) State fiscal year each, which shall begin on July 1, and end at midnight on June 30 of the following year as follows:

Initial Term:	Contract Effective Date - June 30, 2017*****
Renewal Option 1:	July 1, 2017 - June 30, 2018
Renewal Option 2:	July 1, 2018 - June 30, 2019
Renewal Option 3:	July 1, 2019 - June 30, 2020
Renewal Option 4:	July 1, 2020 - June 30, 2021
Renewal Option 5:	July 1, 2021 - June 30, 2022
Renewal Option 6:	July 1, 2022 - June 30, 2023
Renewal Option 7:	July 1, 2023 - June 30, 2024

****The period from August 4, 2016 when DCH signed the Contract through June 30, 2017 was an uncompensated implementation period during which the Contractor was not serving members under this Contract.***

6.2 Pursuant to O.C.G.A. § 50-5-64(a)(2), each renewal option shall be exercisable solely and exclusively by DCH. The terms, conditions and pricing in effect at the time of renewal shall apply for each renewal option term. DCH will send Contractor written notice of its intent to exercise a renewal option under this Contract. As to each term, the Contract shall be terminated absolutely at the close of the then current state fiscal year without further obligation by DCH. Notwithstanding any language to the contrary, DCH reserves the right to terminate this Contract prior to the close of the fiscal year pursuant to Section 24 of this Contract.

7.0 PAYMENT FOR SERVICES

7.1 GENERAL PROVISIONS

7.1.1 DCH will compensate the Contractor on a Per Member/Participant Per Month basis, respectively, for each Member and Participant enrolled in the Contractor's plan as detailed in Attachment G ("Capitation Rates") which is incorporated by this reference as if fully written herein. Upon CMS approval of any Capitation Rates added or revised via amendments to the Contract, such approved rates shall be effective for the time period noted in the amendment. Payments made prior to the CMS approval date shall be reprocessed utilizing the latest approved rates. Capitation payments may only be made by DCH and retained by Contractor for

Medicaid/CHIP-eligible Members and Participants. Capitation payments may not be made for deceased Members or Participants.

For the first partial month of a Member/Participant's enrollment in the Contractor's plan, DCH will prorate the Member/Participant's Capitation Payment on a per Calendar Day basis for the remainder of the calendar month. The Capitation Payment will be prorated on a per Calendar Day basis for any partial month of a Member/Participant's enrollment in the CMO. The number of enrolled Members and Participants will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's Fiscal Agent Contractor. The monthly compensation will be the final negotiated rate for each rate cell multiplied by the number of enrolled Members or Participants in each rate cell category. The Contractor must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, and notwithstanding any other withheld amounts allowed under this Contract, such amount shall be withheld from the prepaid, monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

7.1.2 DCH will only compensate the Contractor on a Per Member Per Month basis for each Member aged 21-64 receiving inpatient treatment in an Institution for Mental Diseases, as defined in 42 CFR §435.1010 ("IMD"), so long as 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) days during the period of the monthly Capitation Payment. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services at § 438.3(e)(2)(i) through (iv).

7.1.3 The relevant Deliverables concerning payment under this Contract shall be mailed to the Project Leader named in the Notice provision of this Contract.

7.1.4 The total of all payments made by DCH to Contractor under this Contract shall not exceed the amount allowed based on the Per Member Per Month Capitation Rates agreed to under **Attachment G** (hereinafter the "Maximum Funds"), which has been provided for through the use of State or federal grants or other funds. It is expressly understood that the total amount of payment to the Contractor will not exceed the maximum funds provided above, unless Contractor has obtained prior written approval, in the form of a Contract amendment, authorizing an increase in the total payment. Additionally, the Contractor agrees that DCH will not pay or otherwise compensate the Contractor for any work that it performs in excess of the Maximum Funds.

7.1.5 Pursuant to the provisions of 42 CFR 438.608(c)(3), Contractor will report to DCH within 60 Calendar Days when it has identified any capitation payments or

other payments from DCH (including but not limited to Performance Incentives under Section 7.2) in excess of amounts specified in the Contract. Contractor shall require any Subcontractor to comply with this provision, with respect to payments by Contractor to any Subcontractor, by the addition of similar language to all contracts with its Subcontractors.

7.1.6 The Georgia Families program shall be risk adjusted starting in State Fiscal Year 2018 consistent with the requirements outlined in 42 CFR § 438.5. Risk adjustment shall be budget-neutral to the State and compliant with generally accepted actuarial principles and practices. The State shall reduce rates to CMOs that have healthier-than-average members and increase rates to CMOs that have sicker-than-average members. The risk adjustment methodology for each state fiscal year shall be implemented as described in the corresponding actuarial rate certification document. Risk adjusted rates shall be amended into the contract and implemented as they become available under the methodology described in the actuarial rate certification document.

7.1.7 The final capitation rates for Contractor must be identified and developed, and payment must be made in accordance with 42 CFR 438.3(c).

7.1.8 DCH must use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined in 42 CFR 457.10.

7.2 PERFORMANCE INCENTIVES

7.2.1 Beginning in Calendar Year (CY) 2019, DCH will withhold five percent (5%) of the Contractor's Capitation Rates ("VBP withhold") from which incentive payments will be made to the Contractor for achieving identified VBP targets. DCH will make incentive payments for achieving performance targets based on the HEDIS reporting and validation cycle.

7.2.2 The Contractor will only receive incentive payments when meeting or exceeding specified targets (e.g., if one target is achieved, but others are not, the Contractor will only receive agreed upon incentive payment for the target achieved). The withhold amount will be allotted equally to each of the performance targets. The total amount of the incentive payments will be based on the Contractor's performance relative to the targets for the fourteen (14) performance measures outlined in **Attachment U**. The maximum incentive payment to the Contractor will be the full five percent (5%) withhold.

7.2.2.1 While the current performance measures are HEDIS measures, DCH reserves the right to change the measures over the term of this Contract. Should DCH identify performance measures that are not HEDIS measures, DCH shall develop and the Contractor shall agree to

a methodology for quantifying the Contractor's success in achieving targets and payments for each measure.

7.2.3 The Contractor shall develop a plan for distributing to Providers fifty percent (50%) of the Value-Based Purchasing incentive payments it receives from DCH for achieving targets. The frequency of incentive payments to the Providers is at the discretion of the Contractor (e.g., the Contractor may elect to incentivize providers on a more frequent schedule than DCH's schedule for payment to the Contractor). The Contractor shall submit the plan to DCH for prior approval. The Contractor shall submit such plan for Provider incentives to DCH for review and approval within ninety (90) Calendar Days of the Contract Effective Date.

8.0 FINANCIAL MANAGEMENT

8.1 GENERAL PROVISIONS

8.1.1 The Contractor shall be responsible for the sound financial management of the CMO.

8.2 SOLVENCY AND RESERVES STANDARDS

8.2.1 The Contractor shall establish and maintain such net worth, working capital and financial reserves as required pursuant to O.C.G.A. § 33-21-1 *et seq*.

8.2.2 The Contractor shall provide assurances to the State that its provision against the risk of insolvency is adequate such that its Members shall never be liable for its debts in the event of insolvency.

8.2.3 As part of its accounting and budgeting function, the Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. As part of its reserving process, the Contractor shall conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

8.3 REINSURANCE

8.3.1 DCH will not administer a Reinsurance program funded from capitation payment withholding.

8.3.2 In addition to basic financial measures required by State law and discussed in section 8.2.1 and Section 28, the Contractor shall meet financial viability standards. The Contractor shall maintain net equity (assets minus liability) equal to at least one (1) month's capitation payments under this Contract. In addition, the Contractor shall maintain a current ratio (current assets/current liabilities) of greater than or equal to 1.0.

8.3.3 In the event the Contractor does not meet the minimum financial viability standards outlined in 8.3.2, the Contractor shall obtain Reinsurance that meets all

DOI requirements. While commercial Reinsurance is not required, DCH recommends that Contractors obtain commercial Reinsurance rather than self-insuring. The Contractor may not obtain a reinsurance policy from an offshore company; the insurance carrier, the insurance carrier's agents and the insurance carrier's subsidiaries must be domestic.

8.4 THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.

8.4.1.1 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Contractor as its Agent to identify and cost avoid Claims for all CMO Members, including PeachCare for Kids® Members.

8.4.1.2 The Contractor shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO Members. To the extent permitted by State and federal law, the Contractor shall use Cost Avoidance processes to ensure that primary payments from the liable third party are identified, as specified below in Section 8.4.2.

8.4.1.3 If the Contractor is unsuccessful in obtaining necessary cooperation from a Member to identify potential Third Party Resources after sixty (60) Calendar Days of such efforts, the Contractor may inform DCH, in a format to be determined by DCH, that efforts have been unsuccessful.

8.4.1.4 For situations other than Medicare payments where payment is already made to the Provider by the CMO, the CMO shall coordinate with the other responsible payer and shall not recoup funds directly from the Provider and cause the Provider to have to resubmit claims to the other responsible payer.

8.4.2 Cost Avoidance

8.4.2.1 The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier, and may deny a service to a Member if the Contractor is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below in Section 8.4.2.2. However, if a third party health insurance carrier requires the Member to pay any cost-sharing amounts (e.g., co-payment, coinsurance, deductible), the

Contractor shall pay the cost sharing amounts. The Contractor's liability for such cost sharing amounts shall not exceed the amount the Contractor would have paid under the Contractor's payment schedule for the service.

8.4.2.2 Further, the Contractor shall not withhold payment for services provided to a Member if third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) Calendar Days.

8.4.2.3 The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services, the Contractor shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Contractor shall then coordinate with DCH or its Agent to enable DCH to recover payment from the potentially liable third party.

8.4.2.4 If the Contractor determines that third party liability exists for part or all of the services rendered, the Contractor may:

8.4.2.4.1 Pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider; and

8.4.2.4.2 Pay the Provider only the amount, if any, by which the Provider's allowable Claim exceeds the amount of third party liability.

8.4.2.5 If the provider determines that a person other than the Contractor to which it has submitted a Claim is responsible for coverage of the Member at the time the service was rendered, the provider may submit the claim to the person that is responsible and that person shall reimburse all Medically Necessary Services without application of any penalty for failure to file claims in a time manner, for failure to obtain Prior Authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by the DCH for the same type of claim that it pays directly if the provider is not under contract with that person.

8.4.3 Compliance

8.4.3.1 DCH may determine whether the Contractor complies with this Section by inspecting source documents for timeliness of billing and accounting for third party payments.

8.5 PHYSICIAN INCENTIVE PLAN

8.5.1 The Contractor may establish physician incentive plans pursuant to federal and State regulations, including 42 CFR 422.208 and 422.210, and 42 CFR 438.6.

8.5.2 The Contractor shall disclose any and all such arrangements to DCH, and upon request, to Members. Such disclosure shall include:

8.5.2.1 Whether services not furnished by the physician or group are covered by the incentive plan;

8.5.2.2 The type of Incentive Arrangement;

8.5.2.3 The percent of withhold or bonus; and

8.5.2.4 The panel size and if patients are pooled, the method used.

8.5.2.5 Whether stop-loss protection is provided.

8.5.3 Upon request, the Contractor shall report adequate information specified by the regulations to DCH in order that DCH will adequately monitor the CMO.

8.5.4 If the Contractor's physician incentive plan includes services not furnished by the physician/group, the Contractor shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to DCH proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual Member surveys, with results disclosed to DCH, and to Members, upon request.

8.5.5 Such physician incentive plans may not provide for payment, directly or indirectly, to either a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.

8.5.6 If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself the Contractor must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with section 42 CFR § 422.208.

8.6 REPORTING REQUIREMENTS

8.6.1 The Contractor shall submit to DCH the Cost Avoidance Reports within twenty (20) Calendar Days of a written request from DCH as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein

8.6.2 The Contractor shall submit to DCH audited financial reports specific to this Contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

8.6.3 The Contractor shall submit to DCH monthly Medical Loss Ratio Reports that detail direct medical expenditures for Members and premiums paid by the Contractor, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. In addition, Contractor must submit an annual report to DCH within twelve (12) months of the end of the MLR reporting year that includes at least the following information:

8.6.3.1 Total incurred claims;
8.6.3.2 Expenditures on quality improvement activities;
8.6.3.3 Expenditures related to activities compliant with the Program Integrity requirements of 42 CFR 438.608(a)(1) through (5), (7), (8), and (b);
8.6.3.4 Non-claims costs;
8.6.3.5 Premium revenue;
8.6.3.6 Taxes, licensing and regulatory fees;
8.6.3.7 Methodologies for allocation of expenditures;
8.6.3.8 Any credibility adjustment applied;
8.6.3.9 The calculated MLR;
8.6.3.10 Any remittance owed to DCH, if applicable;
8.6.3.11 A comparison of the information reported pursuant to 42 CFR 438.8(k) with the audited financial report required under 42 CFR 438.3(m);
8.6.3.12 A description of the aggregation method used under 42 CFR 438.8(i);
8.6.3.13 The number of member months; and
8.6.3.14 Payments made under any Directed Payments Program as approved by CMS (to be included in both the numerator and the denominator.)

Contractor shall attest to the accuracy of the calculations of the MLR when submitting the report.

8.6.4 The Contractor shall submit to DCH Third Party Liability and Coordination of Benefits Reports within ten (10) Business Days of verification of available Third Party Resources to a Member, as described in the RADs, as amended from time to

time, and expressly incorporated by reference into the Contract as if completely restated herein. The Contractor shall report any known changes to such resources in the same manner.

8.6.5 The Contractor, at its sole expense, shall submit by May 15 (or a later date if approved by DCH) of each year a "Reporting on Controls at a Service Organization", meeting all standards and requirements of the American Institute of Certified Public Accountants' (AICPA) SSAE 16 "type 2" report, for the Contractor's operations performed for DCH under this Contract. Such initial report shall cover a period of no less than nine (9) months, ending March 31 of that year. Subsequent reports shall cover 12 months ending on March 31 of that year.

8.6.5.1 Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization, is an attestation standard developed by the AICPA which is required for such auditors' reports for periods ending on or after June 15th of each year.

8.6.5.2 For more information on the AICPA's "Statement on Standards for Attestation Engagements No. 16, Reporting on Controls at a Service Organization," Contractor may refer to this AICPA website: http://www.aicpa.org/News/FeaturedNews/Pages/SASNo70Transformed%E2%80%93ChangesAheadforStandardonServiceOrganizations.aspx.

8.6.5.3 The audit shall be conducted by an independent auditing firm, which has SSAE No. 16 audit experience. The auditor must meet all AICPA standards for independence. The selection of, and contract with, the independent auditor shall be subject to the approval of DCH and the State Auditor. Since such audits are not intended to fully satisfy all auditing requirements of DCH, the State Auditor reserves the right to fully and completely audit at their discretion the Contractor's operations, including all aspects, which will have effect upon the DCH account, either on an interim audit basis or at the end of the State's fiscal year. DCH also reserves the right to designate other auditors or reviewers to examine the Contractor's operations and records for monitoring and/or stewardship purposes.

8.6.5.4 The independent auditing firm shall simultaneously deliver identical reports of its findings and recommendations to the Contractor and DCH within forty-five (45) Calendar Days after the close of each review period. The audit shall be conducted and the report shall be prepared in accordance with generally accepted auditing standards for such audits as defined in the publications of the AICPA, entitled

Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization.

8.6.5.5 The Contractor shall respond to the audit findings and recommendations within thirty (30) Calendar Days of receipt of the audit and shall submit an acceptable proposed corrective action to DCH. The Contractor shall implement the Corrective Action Plan within forty (40) Calendar Days of its approval by DCH. Such response shall address, at minimum, any opinion other than a clean opinion; any testing exception; and any other exception, deficiency, weakness, opportunity for improvement, or recommendation reported by the independent auditor.

8.6.6 The Contractor shall submit to DCH and the US Department of Health and Human Services a "Disclosure of Ownership and Control Interest Statement."

8.6.6.1 The Contractor shall disclose to DCH full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including 42 CFR §455.104.

8.6.6.2 The Contractor (including its Subcontractors) shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The Contractor shall screen their employees and contractors initially and on an ongoing quarterly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to the DCH on a monthly basis. The word "contractors" in this Section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.

8.6.6.3 Definition of A Party in Interest – As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

8.6.6.3.1 Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and

valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or Member of such corporation under applicable State corporation law;

8.6.6.3.2 Any organization in which a person as described in the above Section is a director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;

8.6.6.3.3 Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or

8.6.6.3.4 Any spouse, child, or parent of an individual as described in section 8.6.6.3.1.

8.6.6.4 The Contractor shall disclose the name and address of each person with an ownership or control interest in the disclosing entity or in any Provider, Subcontractor or Contractor's Fiscal Agent in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. In the case of an individual it shall include date of birth and Social Security Number.

8.6.6.5 The Contractor shall disclose the identity including the name, address, date of birth, and Social Security Number of any Provider or Subcontractor with whom the Contractor has had significant business transactions, defined as those totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the Contractor, any wholly owned supplier, or between the Contractor and any Provider or Subcontractor, during the five (5) year period ending on the date of the disclosure.

8.6.6.6 The Contractor shall disclose the identity including the name, address, date of birth, and Social Security Number of any person who has an ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor and who has been convicted of a criminal offense related to that person's involvement in any program

under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs.

8.6.6.7 Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

8.6.6.7.1 Any sale, exchange or lease of any property between the Contractor and a party in interest;

8.6.6.7.2 Any lending of money or other extension of credit between the Contractor and a party in interest; and

8.6.6.7.3 Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

8.6.6.8 The information which must be disclosed in the transactions listed in Section 8.6.6.7 between the Contractor and a party of interest includes:

8.6.6.8.1 The name of the party in interest for each transaction;

8.6.6.8.2 A description of each transaction and the quantity or units involved;

8.6.6.8.3 The accrued dollar value of each transaction during the fiscal year; and

8.6.6.8.4 Justification of the reasonableness of each transaction.

8.6.6.9 All information regarding ownership and financial transactions which must be disclosed by the Contractor pursuant to Section 8.6.6 is due at any of the following times:

8.6.6.9.1 Upon the Contractor submitting the Contractor Proposal in accordance with the State's procurement process;

8.6.6.9.2 Upon the Contractor executing this Contract with the State;

8.6.6.9.3 Upon renewal or extension of this Contract;

8.6.6.9.3 Within thirty (35) Calendar Days after any change in ownership; and

8.6.6.9.4 At least once every quarter, if so requested by DCH.

8.6.7 The Contractor shall submit all necessary reports, documentation, to DOI as required by State law, which may include, but is not limited to the following:

8.6.7.1 Pursuant to State law and regulations, an annual report on the form prescribed by the National Association of Insurance Commissioners (NAIC) for HMOs, on or before March 1 of each calendar year.

8.6.7.2 An annual income statement detailing the Contractor's fourth quarter and year to date earned revenue and incurred expenses as a result of this Contract on or before March 1 of each year. This annual income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and a reconciliation of the Medical Loss Ratio report to the annual NAIC filing on an accrual basis.

8.6.7.3 Pursuant to state law and regulations, a quarterly report on the form prescribed by the NAIC for HMOs filed on or before May 15 for the first quarter of the year, August 15 for the second quarter of the year, and November 15, for the third quarter of the year.

8.6.7.4 A quarterly income statement detailing the Contractor's quarterly and year to date earned revenue and incurred expenses because of this Contract filed on or before May 15, for the first quarter of the year, August 15, for the second quarter of the year, and November 15, for the third quarter of the year. Each quarterly income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and reconciliation of the Medical Loss Ratio report to the quarterly NAIC filing on an accrual basis.

8.6.7.5 An annual independent audit of its business transactions to be performed by a licensed and certified public accountant, in accordance with NAIC Annual Statement Instructions regarding the Annual Audited Financial Report, including but not limited to the financial transactions made under this Contract.

8.6.8 The Contractor shall submit all necessary reports, documentation, to the Department of Revenue as required by State law, which may include, but is not limited to the following for Unclaimed Property Reports:

8.6.8.1 Pursuant to State law and regulations, an annual report on the form prescribed by the Georgia Department of Revenue for Unclaimed Property Reports for all Insurance Companies is due on or before May 1 of each calendar year.

9.0 FUNDING

Notwithstanding any other provision of this Contract, the Parties acknowledge that institutions of the State of Georgia are prohibited from pledging the credit of the State. At the sole discretion of DCH, this Contract shall immediately terminate without further obligation of the State if the source of payment for DCH's obligation, including but not limited to state appropriations and/or federal grant funding, no longer exists or is insufficient. The certification by DCH of the events stated above shall be conclusive and not subject to appeal.

10.0 PAYMENT OF TAXES

10.1 Contractor will forthwith pay all taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. DCH makes no representation whatsoever as to the liability or exemption from liability of Contractor to any tax imposed by any governmental entity.

10.2 Furthermore, Contractor shall be responsible for payment of all expenses related to, based on, or arising from salaries, benefits, employment taxes (whether State or Federal) and insurance (whether health, disability, personal, or retirement) for its employees, designees, or assignees.

11.0 RELATIONSHIP OF PARTIES

Neither Party is an agent, employee, assignee or servant of the other. It is expressly agreed that Contractor and any Subcontractors and agents, officers, and employees of Contractor or Subcontractor, or agent in the performance of this Contract, shall act as independent contractors and not as officers or employees of DCH. DCH shall not be responsible for withholding taxes with respect to the Contractor's compensation hereunder. The Parties acknowledge, and agree, that the Contractor, its agents, Subcontractors, employees, and servants shall in no way hold themselves out as agents, employees, or servants of DCH. The parties also agree that the Contractor, its agents, Subcontractors, employees, and servants shall have no claim against DCH hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and DCH.

12.0 INSPECTION OF WORK

12.1 DCH, the State Department of Audits and Accounts, the U.S. Department of Health and Human Services, the General Accounting Office and the Comptroller General of the United States, if applicable, or their authorized representatives, shall have the right to enter into the premises of Contractor and/or all Subcontractors, or such other places where duties under this Contract are being performed for DCH in order to inspect, monitor or otherwise evaluate the services or any work performed pursuant to this Contract. Contractor shall bear all costs associated with inspections

and evaluations of work. All inspections and evaluations of work being performed shall be conducted with prior notice and during normal business hours and performed in such a manner as will not unduly delay work.

12.2 Contractor agrees to sign and comply with **Attachment C**, ***Non-Profit Organization Disclosure Form***.

13.0 STATE PROPERTY

13.1 Contractor agrees that any materials, reports, analyses, compilations of data or other Deliverables that are furnished to DCH in accordance with the terms of this Contract, shall be the property of DCH upon submission of such materials to DCH, for whatever use that DCH deems appropriate. Contractor further agrees to execute any and all documents, or to take any additional actions that may be necessary in the future to effectuate this provision fully. In particular, if the work product or services include the taking of photographs or videotapes of individuals, Contractor must obtain the written consent from such individuals authorizing the use by DCH of such photographs, videotapes, and names in conjunction with such use. Contractor shall also obtain necessary written releases from such individuals, releasing DCH from any and all damages, claims or demands arising from such use.

13.2 All information received by DCH and prepared or maintained on behalf of DCH, including but not limited to all handwritten and electronic documents, papers, letters, emails, maps, books, tapes, photographs, policies, procedures, notes, computer based or generated information, or similar material, is subject to the Open Records Act of Georgia (O.C.G.A. § 50-18-70 et seq.) (hereinafter "ORA") and open to public inspection. If Contractor claims that any portion of its material submitted to DCH at any time and for any purpose is a proprietary trade secret, Contractor must clearly identify at the time of submission those portions of the material. In addition, Contractor is required to submit an affidavit which meets the requirements of O.C.G.A. § 50-18-72(a)(34) setting forth any and all trade secret claims. Material submitted to DCH that is not designated as a trade secret is subject to disclosure under the ORA. Information that is designated as a trade secret will not be disclosed under the ORA without (1) a determination by DCH's Office of General Counsel that the information is not a trade secret; and (2) prior notification of Contractor that DCH intends to disclose the information, which notification will enable Contractor to seek legal protection of the information. If DCH determines that information submitted by Contractor is a trade secret and must not be disclosed by DCH as required herein, DCH shall use commercially reasonable efforts to hold such information in confidence.

13.3 The Contractor shall be responsible for the proper custody and care of any State-owned property furnished for the Contractor's use in connection with the performance of this Contract. The Contractor will also reimburse DCH for its loss or damage, normal wear and tear excepted, while such property is in the Contractor's custody or use.

14.0 OWNERSHIP AND USE OF DATA; RELATED MATTERS

14.1 OWNERSHIP AND USE OF DATA

14.1.1 All data created from information, documents, messages (verbal or electronic), reports, or meetings involving or arising out of this Contract is owned by DCH (hereafter referred to as "DCH Data"). The Contractor is expressly prohibited from sharing or publishing DCH Data or any information relating to Medicaid, PeachCare for Kids®, or P4HB data without the prior written consent of DCH. In the event of a dispute regarding what is or is not DCH Data, DCH's decision on this matter shall be final and not subject to Appeal.

14.1.2 If DCH consents to the publication of its Data by Contractor, Contractor shall display the following statement within the publication in a clear and conspicuous manner:

"This publication is made possible by the Georgia Department of Community Health (DCH) through a contract managed by (Contractor's name). Neither DCH or (Contractor's name) is responsible for any misuse or copyright infringement with respect to the publication."

14.1.3 The statement shall not be considered clear and conspicuous if it is difficult to read or hear, or if the placement is easily overlooked.

14.2 SOFTWARE AND OTHER UPGRADES

14.2.1 The Parties also understand and agree that any upgrades or enhancements to software programs, hardware, or other equipment, whether electronic or physical, shall be made at the Contractor's expense only, unless the upgrade or enhancement is made at the Department's request and solely for the Department's use exclusive of the deliverables contemplated by this Contract. Any upgrades or enhancements requested by and made for the Department's sole use shall become the Department's property without exception or limitation. The Contractor agrees that it will facilitate the Department's use of such upgrade or enhancement and cooperate in the transfer of ownership, installation, and operation by the Department.

14.3 INFRINGEMENT AND MISAPPROPRIATION

14.3.1 The Contractor warrants that all Deliverables provided by the Contractor do not and will not infringe or misappropriate any right of any third party based on copyright, patent, trade secret, or other intellectual property rights. In case the Deliverables or any one or part thereof is held or alleged to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a

proceeding appears to the Contractor to be likely to be brought, the Contractor will, at its own expense, either:

14.3.1.1 Procure for the Department the right to continue using the Deliverables; or

14.3.1.2 Modify or replace the Deliverables to comply with the Specifications so that no violation of any intellectual property right occurs.

14.3.2 If Contractor fails to comply with the terms and conditions set forth in this Section, DCH shall have the option to terminate the Contract.

14.4 CUSTOMIZATION

14.4.1 If the Department requests specific customization of software programs, hardware, or other equipment, whether electronic or physical after the initial term of this Contract begins, the Contractor shall promptly make the requested change or modification at no cost to the Department.

14.5 SYSTEM CHANGES

14.5.1 All system changes required to comply, enable, and operate data transfers pursuant to this Contract shall be enabled, completed, and operated at no cost to DCH.

14.5.2 The Parties agree that the required system changes are not complete until they are fully implemented, tested and approved by DCH prior to the live date. In any event, DCH's determination on whether the system changes are complete and satisfactory shall be conclusive and final, subject to Section 30.

14.6 BUSINESS CONTINUITY AND DISASTER RECOVERY

14.6.1 Contractor shall provide and maintain for the life of the Contract a detailed Business Continuity and Disaster Recovery (BC-DR) Plan that will be implemented in the event that Contractor's facility experiences a disaster (for example, power outages, computer virus infections, natural disaster, etc.) that impacts fulfilling the requirements of this Contract. The BC-DR Plan shall include the following:

14.6.1.1 Notification process;

14.6.1.2 Identification of the Contractor's disaster recovery location and equipment;

14.6.1.3 Testing frequency of the plan; and

14.6.1.4 Step-by-step explanation of the backup and recovery procedures of services, which must include the number of hours to complete each step within a twelve (12) hour period.

14.6.2 Contractor shall submit an updated BC-DR Plan within thirty (30) Calendar Days of notification of Contract renewal.

14.6.3 DCH, federal auditors, or the State Auditor, reserves the right to conduct a site visit of the Contractor's disaster recovery location with one (1) day prior notice.

14.6.4 Contractor shall conduct an annual Disaster Recovery Plan Review and exercise/drill at the Contractor's own expense. The review must test all components of the Contractor's operation, including services provided by any third parties. A written report of the findings must be delivered to DCH within fifteen (15) Calendar Days of the date that the test is conducted. The Contractor must develop a written CAP for any deficiencies noted in the test and must thoroughly re-test until satisfactory results are achieved and maintained.

14.6.5 This Section shall survive termination of this Contract for any reason.

14.7 DISCHARGE OF LIENS

14.7.1 The Contractor shall immediately discharge or cause to be discharged any lien or right in lien of any kind, other than in favor of DCH, which at any time exists or arises in connection with work done or equipment or other instrumentality furnished under this Contract. If any such lien or right in lien is not immediately discharged, DCH may discharge or cause to be discharged such lien or right at the expense of the Contractor.

15.0 OWNERSHIP AND USE OF INTELLECTUAL PROPERTY

15.1 OWNERSHIP OF INVENTIONS AND WORKS OF AUTHORSHIP

15.1.1 DCH shall own any Inventions or Works of Authorship that may be (i) made by Contractor personnel in the course of performance of this Contract and relate to Contractor's Technology or (ii) made by DCH personnel.

15.2 SOFTWARE AND OWNERSHIP RIGHTS

15.2.1 The Parties specifically agree that the rights to any Proprietary Software licensed or developed by Contractor pursuant to this Contract shall rest and remain with Contractor, subject to the License. During the term of this Contract, Contractor hereby grants DCH a nonexclusive, term license to use any Proprietary Software owned or sublicensed to DCH by Contractor. In the event of termination of this Contract, a nonexclusive and irrevocable license to use any Proprietary Software necessary and appropriate to DCH business continuity shall be issued to DCH by

Contractor at a cost equivalent to the cost paid by DCH during the term of the Contract for the License.

16.0 CONTRACTOR STAFFING

The Contractor shall demonstrate to DCH's satisfaction that it has the necessary staffing, by function and qualifications, to fulfill its obligations as described in this Scope of Work. In addition, the Contractor shall have adequate infrastructure, organization, management and systems in place to carry out the requirements of the GF Program. The Contractor shall provide a detailed listing of contact information for all of its Material Subcontractors, including a description of the Subcontractor's organization and the responsibilities that are delegated to the Subcontractor. The Contractor will not contract with or permit the performance of any work or services by Material Subcontractors without prior written consent of DCH.

16.1 STAFFING ASSIGNMENT AND CREDENTIALS

16.1.1 The Contractor warrants and represents that all persons, including Subcontractors, independent contractors and consultants assigned by it to perform this Contract, shall be employees or formal agents of the Contractor and shall have the credentials necessary (i.e., licensed, and bonded, as required) to perform the work required herein; failure to notify DCH of replacement of Subcontractors will be considered breach of contract. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work hereunder. The Contractor also agrees that DCH may approve or disapprove the Contractor's Subcontractors or its staff assigned to this Contract prior to the proposed staff assignment. DCH's decision on this matter shall not be subject to Appeal.

16.1.2 The Contractor shall ensure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice. On at least an annual basis, the CMO and its Subcontractors will verify that staff has a current license that is in good standing and will provide a list to DCH of licensed staff and current licensure status.

16.1.3 In addition, the Contractor warrants that all persons assigned by it to perform work under this Contract shall be employees or authorized Subcontractors of the Contractor and shall be fully qualified, as required in the RFP and specified in the Contractor's Proposal and in this Contract, to perform the services required herein. Personnel commitments made in the Contractor's Proposal shall not be changed unless approved by DCH in writing. Staffing will include the named individuals at the levels of effort proposed.

16.1.4 The Contractor shall provide and maintain sufficient qualified personnel and staffing to enable the Deliverables to be provided in accordance with the RFP, the Contractor's Proposal and this Contract. The Contractor shall submit to DCH a detailed staffing plan, within thirty (30) Calendar Days of the Contract Effective

Date which includes plans to fill any staffing needs to have a sufficient level of support during the Implementation Phase and after the Operational Start Date. Such staffing plan must include a timetable for filling all staffing position(s) after the Contract Effective Date. The Contractor must provide DCH with resumes of Key Staff, reporting responsibilities, Contractor staff to Member ratios and an organizational chart during the Implementation Phase with updates provided to DCH within two (2) Business Days of any changes or vacancies. The staffing must include the employees and management for all CMO functions.

16.1.5 At a minimum, the Contractor shall provide the following Key Staff:

16.1.5.1 A dedicated project manager to lead program implementation and facilitate ongoing operations. The CMO Project Manager must be stationed at the CMO's metropolitan Atlanta headquarters. The Project Manager must also be onsite at the DCH offices in Atlanta, Georgia at times specified by DCH during the planning, implementation and deployment phases of the Contract.

16.1.5.2 An Executive Administrator who is a full-time administrator with clear authority over the general administration and implementation of the requirements detailed in this Contract.

16.1.5.3 A Medical Director who is a licensed physician in the State of Georgia. The Medical Director shall be actively involved in all major clinical program components of the CMO, shall be responsible for the sufficiency and supervision of the Provider network, and shall ensure compliance with federal, State and local reporting laws on communicable diseases, child abuse, neglect, etc.

16.1.5.4 A Quality Improvement Director with appropriate education, training and licensure, if applicable. The Quality Improvement Director shall possess or obtain within six (6) months of hire, training in one or more of the following areas:

16.1.5.4.1 Strategic planning

16.1.5.4.2 Six Sigma Certification

16.1.5.4.3 Lean Six Sigma Certification

16.1.5.4.4 Plan-Do-Study-Act Cycle

16.1.5.4.5 Rapid Cycle Improvement

16.1.5.5 A Chief Financial Officer who oversees all budget and accounting systems.

16.1.5.6 A Strategic Planner to support clinical quality improvement.

16.1.5.7 Utilization Management Director.

16.1.5.8 An Information Management and Systems Director and a complement of technical analysts and business analysts as needed to maintain the operations of Contractor Systems and to address System issues in accordance with the terms of this Contract.

16.1.5.9 Pharmacist who is licensed in the State of Georgia.

16.1.5.10 A Dental Consultant who is a licensed dentist in the State of Georgia.

16.1.5.11 Mental Health Coordinator who is a licensed mental health professional in the State of Georgia.

16.1.5.12 A Member Services Director.

16.1.5.13 A Provider Services Director.

16.1.5.14 A Provider Relations Liaison.

16.1.5.15 A Grievance/Complaint Coordinator.

16.1.5.16 Compliance Officer.

16.1.5.17 A Prior Authorization/Pre-Certification Coordinator who is a physician, registered nurse, or physician's assistant licensed in the State of Georgia.

16.1.5.18 Sufficient staff in all departments, including but not limited to, Member services, Provider services, and Prior Authorization and concurrent review services to ensure appropriate functioning in all areas.

16.1.5.19 Hospital-based care managers whose responsibilities include visiting with patients and interacting with hospital staff to ensure proper utilization and Discharge Planning.

16.1.5.20 Staff trained in the System of Care approach to service delivery.

16.1.5.21 Ombudsman Staff including Ombudsman Coordinator and Ombudsman Liaison. The Contractor must consider and monitor current Enrollment levels when evaluating the number of Ombudsman Liaisons necessary to meet Member needs. The Ombudsmen staff is responsible for collaborating with DCH's designated staff in the

identification and resolution of issues. Such collaboration includes working with DCH staff on issues of access to health care services, and communication and education Members and Providers.

16.1.6 The Contractor shall comply with all staffing/personnel obligations set out in the RFP and this Contract, including but not limited to those pertaining to security, health, and safety issues.

16.1.7 The Contractor shall provide the DCH Project Leader with a staff roster every ninety (90) days during the Term of the Contract. This roster shall set forth the names, titles, and physical location of all members of Contractor's staff (including Subcontractor and Contractor affiliates), their areas of assignment and the number of hours they are required to work.

16.2 STAFFING CHANGES

16.2.1 DCH may reject any proposed changes in key staff and may require the removal or reassignment of any Contractor employee or Subcontractor employee that the Department deems to be unacceptable in the exercise of its reasonable judgment. The Department's decision on this matter shall be final.

16.2.2 Notwithstanding the above provisions, the Parties acknowledge and agree that the Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law. In the event of Contractor termination of any key staff, Contractor will provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee with a person of equivalent training, experience, and talent within ten (10) Calendar Days of the termination.

16.2.3 The Contractor shall notify DCH within five (5) Business Days, via written communication, prior to any changes to key staff, including the Executive Administrator, Medical Director, Quality Improvement Director, Utilization Management Director, Management Information Systems Director, and Chief Financial Officer. The Contractor shall replace any of the key staff with a person of equivalent experience, knowledge and talent. Within ten (10) Calendar Days of the termination, Contractor shall provide the DCH Project Leader with the resume of the individual that will be acting in the capacity of the vacated position until a permanent replacement is identified and offer the DCH Project Leader, and/or his authorized representatives, the opportunity to interview that person. If the DCH Project Leader is not reasonably satisfied with the apparent skill and qualifications of the acting replacement, he or she shall notify Contractor within ten (10) Calendar Days after receiving the resume or conducting the interview (whichever occurs last). Once that has occurred, the Contractor shall propose another acting replacement and the DCH Project Leader shall have the same right of approval. Such process shall be repeated until a permanent replacement is approved by the DCH Project Leader. If, after sixty (60) Calendar Days from the

notice of termination, a qualified acting replacement is not approved, liquidated damages may be assessed against and imposed on Contractor.

16.2.4 DCH also may require the removal or reassignment of any Contractor employee or Subcontractor employee that DCH deems to be unacceptable. DCH's decision on this matter shall not be subject to Appeal. Notwithstanding the above provisions, the Parties acknowledge and agree that the Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law. In the event of Contractor termination of any key staff the Contractor shall provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee.

16.2.5 The Contractor must submit to DCH quarterly the Contractor Information Report that includes but is not limited to the changes to Contractor's local staff information as well as local and corporate organizational charts.

16.3 CONTRACTOR'S FAILURE TO COMPLY

16.3.1 If DCH, in its sole discretion, determines that the Contractor's services and/or performance under the terms, conditions, and requirements of this Contract are insufficient, unacceptable, or unsatisfactory, the Contractor, after notice from DCH, agrees that it will make every attempt to remedy the deficiency within two (2) Business Days.

16.3.2 Should the Contractor at any time: 1) refuse or neglect to supply adequate and competent supervision; 2) refuse or fail to provide sufficient and properly skilled personnel, equipment, or materials of the proper quality or quantity; 3) fail to provide the services in accordance with the timeframes, schedule or dates set forth in this Contract; 4) fail in the performance of any term or condition contained in this Contract, 5) knowingly or unknowingly accept payment from DCH of an amount in excess of what it is owed at the time of the payment under the terms of this Contract, DCH may (in addition to any other contractual, legal or equitable remedies) proceed to take any one or more of the following actions after five (5) Calendar Days' written notice to the Contractor:

16.3.2.1 Withhold any monies then or next due to the Contractor;

16.3.2.2 Obtain the services or their equivalent from a third party, pay the third party for same, and withhold the amount so paid to third party from any money then or thereafter due to the Contractor;

16.3.2.3 Withhold monies in the amount of any damage caused by any deficiency or delay in the services; or

16.3.2.4 Any combination of the above.

16.3.3 In addition to the consequences indicated above, if it is determined that Contractor knowingly submitted any false statement, invoice or other document to DCH, Contractor shall also be subject to the sanctions imposed by O.C.G.A. §16-10-20.

17.0 CRIMINAL BACKGROUND, EXCLUSIONS, AND DEBARMENT

17.1 The Contractor agrees that it will not permit any of its employees or its Subcontractor's employees, (which in this section includes temporary and contract employees) to perform the services under this Contract unless and until they pass a background check as outlined below.

17.2 Minimum background check requirements

17.2.1 Contractor shall conduct annual criminal background checks on all Contractor and Subcontractor employees who have direct interaction with members. All Key Staff shall receive an annual criminal background check. Any Contractor or Subcontract employee without direct member contact, who utilize PHI to perform their job duties, shall receive a criminal background check prior to being granted access to this PHI.

17.2.2 Contractor shall verify that the individual has a satisfactory criminal record. Satisfactory criminal record means that, at minimum, the individual has no history of convictions for the following crimes in his/her record:

17.2.2.1 Aggravated Assault;
17.2.2.2 Aggravated Battery;
17.2.2.3 Armed Robbery;
17.2.2.4 Arson;
17.2.2.5 Attempted Murder;
17.2.2.6 Financial-related crimes, including but not limited to fraud and identity theft;
17.2.2.7 Forgery;
17.2.2.8 Kidnapping;
17.2.2.9 Murder or Felony Murder;
17.2.2.10 Rape;
17.2.2.11 Sexual Offenses; and
17.2.2.12 Theft by taking, by deception or by conversion.

A conviction shall not include treatment under the Georgia First Offender Act.

17.2.3 The background checks must be conducted prior to the performance of any services under this Contract and on an annual basis.

17.2.4 Contractor shall develop and implement policies and procedures to ensure that employees, at all times during their employment while this Contract is in effect, maintain a satisfactory criminal record as defined in Section 17.2.2.

17.2.5 Contractor shall, on an annual basis, submit to DCH a report which demonstrates compliance with the minimum background check requirements. The report shall include, but need not be limited to, the results of a random sampling of at least 25% of those employees subject to background checks.

17.2.6 Contractor shall have defined oversight procedures to ensure that its subcontractors meet or exceed all minimum background check requirements.

17.2.7 Notwithstanding any language to the contrary, the Parties understand that the requirements set forth in Section 17 are minimum requirements and Contractor may establish additional criteria, as appropriate.

17.3 The Contractor shall not employ or use any company, entity, or individual that is on the Federal Exclusions List or any company, entity, or individual subject to 42 USCS § 1320a-7.

17.4 By signing or executing this Contract, the Contractor states and certifies that it is in compliance with and that it will continue to comply with the Anti-Kickback Act of 1986, 41 USCS § 51-58, and Federal Acquisition Regulation 52.203-7.

17.5 Contractor agrees to sign and comply with **Attachment B**, ***Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters***.

18.0 SUBCONTRACTS

18.1 USE OF SUBCONTRACTORS

18.1.1 The Contractor will not subcontract or permit anyone other than Contractor personnel to perform any of the work, services, or other performance required of the Contractor under this Contract, or assign any of its rights or obligations hereunder, without the prior written consent of DCH. Prior to hiring or entering into an agreement with any Subcontractor, any and all Subcontractors and Subcontracts shall be approved by DCH. DCH must also approve any replacement Subcontractors in the same manner. Upon request from DCH, the Contractor shall provide in writing the names of all proposed or actual Subcontractors. DCH reserves the right to reject any or all Subcontractors that, in the judgment of DCH, lack the skill, experience, or record of satisfactory performance to perform the work specified herein.

18.1.2 Contractor is solely responsible for all work contemplated and required by this Contract, whether Contractor performs the work directly or through a Subcontractor. No subcontract will be approved which would relieve Contractor or its sureties of their responsibilities under this Contract. In addition, DCH reserves the right to terminate this Contract if Contractor fails to notify DCH in accordance with the terms of this paragraph.

18.1.3 All contracts between the Contractor and Subcontractors must be in writing and must specify the activities and responsibilities delegated to the Subcontractor as well as all related reporting responsibilities. The contract must provide that the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's contract obligations. Further, the contracts must also include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. DCH reserves the right to inspect all subcontract agreements at any time during the Contract period.

18.1.4 All contracts entered into between Contractor and any Subcontractor related to this Contract must contain provisions which require Contractor to monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to formal review according to a schedule established by DCH and consistent with industry standards or State laws and regulations. Contractor shall identify any deficiencies or areas for improvement related to any Subcontractor's performance related to this Contract, and upon request from DCH, provide evidence that corrective action has been taken to address the deficiency.

18.1.5 For any subcontract, there must be a designated project manager who is a member of the Subcontractor's staff that is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The subcontract agreement must contain a provision which requires the Contractor and its Subcontractors to seek binding arbitration to resolve any dispute between those parties and to provide DCH with written notice of the dispute.

18.1.6 Contractor shall give DCH immediate notice in writing by registered mail or certified mail of any action or suit filed by any Subcontractor and prompt notice of any Claim made against the Contractor by any Subcontractor or vendor that, in the opinion of Contractor, may result in litigation related in any way to this Contract.

18.1.7 All Subcontractors must fulfill the requirements of 42 CFR 438.3(k) and 438.230 as appropriate.

18.1.8 All Provider contracts shall comply with the requirements and provisions as set forth in Section 4.10 of this Contract.

18.1.9 The Contractor shall submit a Subcontractor Information and Monitoring Report to include, but is not limited to: Subcontractor name, services provided, effective date of the subcontracted agreement.

18.1.10 The Contractor shall submit to DCH a written notification of any subcontractor terminations at least ninety (90) days prior to the effective date of the termination.

18.1.11 The subcontractor must agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

18.1.12 The subcontractor must agree that DCH, CMS, the HHS Inspector General, the Comptroller General or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertains to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with DCH.

18.1.13 The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

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

18.2 COST OR PRICING BY SUBCONTRACTORS

18.2.1 Contractor shall submit, or shall require any Subcontractors hereunder to submit, cost or pricing data for any subcontract to this Contract prior to Contract Award. The Contractor shall also certify that the information submitted by the Subcontractor is, to the best of their knowledge and belief, accurate, complete and current as of the date of agreement, or the date of the negotiated price of the subcontract to the Contract or amendment to the Contract. The Contractor shall insert the substance of this Section in each subcontract hereunder.

18.2.2 If DCH determines that any price, including profit or fee negotiated in connection with this Contract, or any cost reimbursable under this Contract was increased by any significant sum because of the inaccurate cost or pricing data, then such price and cost shall be reduced accordingly and this Contract and the subcontract shall be modified in writing to reflect such reduction.

19.0 LICENSE, CERTIFICATE AND PERMIT REQUIREMENT

19.1 Contractor shall have, obtain, and maintain in good standing any licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits that may be necessary, upon DCH's request.

19.2 The Contractor warrants that it is qualified to do business in the State and is not prohibited by its articles of incorporation, bylaws, or other controlling documents relevant to Contractor's entity type, or any law of the State under which it is incorporated from performing the services under this Contract. The Contractor shall have and maintain a Certificate of Authority pursuant to O.C.G.A. §33-21-1 et seq., and shall obtain and maintain in good standing any Georgia-licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Loss of the licenses, certificates, permits, or Certificate of Authority for health maintenance organizations shall be cause for termination of the Contract pursuant to Section 24 of this Contract. In the event the Certificate of Authority, or any other license or permit is canceled, revoked, suspended or expires during the term of this Contract, the Contractor shall inform the State immediately and cease all activities under this Contract, until further instruction from DCH. The Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits necessary upon request.

19.3 The Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) for MCO, URAC (Health Plan accreditation), Accreditation Association for Ambulatory Health Care (AAAHC) for MCO, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for MCO, or shall be actively seeking and working towards such accreditation. The Contractor shall provide to DCH upon request any and all documents related to achieving such accreditation and DCH shall monitor the Contractor's progress towards accreditation. DCH may require that the Contractor achieve such accreditation by year three of this Contract.

19.4 The Contractor shall notify DCH within fifteen (15) Calendar Days of any accrediting organization noted deficiencies as well as any accreditations that have been rescinded by a recognized accrediting organization.

19.5 The Contractor warrants that there is no claim, legal action, counterclaim, suit, arbitration, governmental investigation or other legal, administrative, or tax proceeding, or any order, decree or judgment of any court, governmental agency, or arbitration tribunal that is in progress, pending, or threatened against or relating to Contractor or the assets of Contractor that would individually or in the aggregate have a material adverse effect on Contractor's ability to perform the obligations contemplated by this Contract. Without limiting the generality of the

representation of the immediately preceding sentence, Contractor is not currently the subject of a voluntary or involuntary petition in bankruptcy, does not presently contemplate filing any such voluntary petition, and is not aware of any intention on the part of any other person, or entity, to file such an involuntary petition against it. Contractor shall authorize each accrediting entity to provide DCH with a copy of its most recent accreditation review of Contractor, including;

19.5.1 Accreditation status, survey type, and level (as applicable);

19.5.2 Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of finding; and

19.5.3 Expiration date of the accreditation.

20.0 RISK OF LOSS AND REPRESENTATIONS

20.1 DCH takes no title to any of the Contractor's goods used in providing the services and/or Deliverables hereunder and the Contractor shall bear all risk of loss for any goods used in performing work pursuant to this Contract.

20.2 The Parties agree that DCH may reasonably rely upon the representations and certifications made by the Contractor, including those made by the Contractor in the Contractor's Proposal in response to the RFP and this Contract, without first making an independent investigation or verification.

20.3 The Parties also agree that DCH may reasonably rely upon any audit report, summary, analysis, certification, review, or work product that the Contractor produces in accordance with its duties under this Contract, without first making an independent investigation or verification.

20.4 By submitting a Deliverable, the Contractor represents that, to the best of its knowledge, it has performed the associated tasks in a manner, which will, in concert with other tasks, meet the objectives states or referred to in the Contract.

20.5 By unconditionally approving a Deliverable, DCH represents only that it has reviewed the Deliverable and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the withholding or denial of payment for the work completed. DCH's approval of a Deliverable does not discharge any of the Contractor's contractual obligations with respect to that Deliverable.

21.0 PROHIBITION OF GRATUITIES AND LOBBYIST DISCLOSURES

21.1 The Contractor, in the performance of this Contract, shall not offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation, or contract for future reward or

compensation at any time during the term of this Contract, and shall comply with the disclosure requirements set forth in O.C.G.A. § 45-1-6.

21.2 The Contractor also states and warrants that it complies with the provisions of the Ethics in Government Act in Article 1, Chapter 5 of Title 21, and if required, complies with the provisions of O.C.G.A. §§ 21-5-70 *et seq.* concerning registration of lobbying activities.

21.3 As required by applicable Federal law, Contractor states and warrants that no federal money has been or will be used for any lobbying of State officials, as required under applicable federal law.

22.0 RECORDS REQUIREMENTS

The Contractor agrees to maintain books, records, documents, invoices, and any other evidence pertaining to the costs and expenses of this Contract and/or any document that is a part of this Contract by reference or inclusion. This includes, but is not limited to, Contractor's balance sheets, income statements and invoices from Subcontractors, Contractor's affiliates or other vendors. The Contractor's accounting procedures and practices shall conform to generally accepted accounting principles, and the costs properly applicable to the Contract shall be readily ascertainable therefrom. This includes, but is not limited to, payment (with respect to salary), overhead and Subcontractors.

22.1 RECORDS RETENTION REQUIREMENTS

22.1.1 The Contractor and its subcontractors shall preserve and make available all of its records pertaining to the performance under this Contract for a period of ten (10) years from the date of final payment under this Contract, and for such period, if any, as is required by applicable statute or by any other section of this Contract. If the Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of ten (10) years from the date of termination or of any resulting final settlement. Records that relate to Appeals, litigation, or the settlements of Claims arising out of the performance of this Contract, or costs and expenses of any such agreements as to which exception has been taken by the Contractor or any of its duly Authorized Representatives, shall be retained by Contractor until such Appeals, litigation, Claims or exceptions have been disposed of. (*Authority*: 42 CFR § 438.230(c)(3)(iii) & 438.3(k)).

22.2 ACCESS TO RECORDS

22.2.1 The State and federal standards for audits of DCH agents, contractors, and programs are applicable to this section and are incorporated by reference into this Contract as though fully set out herein.

22.2.2 Pursuant to the requirements of 42 CFR 434.6(a)(5), the Contractor shall make all of its books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases available for examination and audit by DCH, the State Attorney General, the State Health Care Fraud Control Unit, the State Department of Audits and Accounts, and/or authorized State or federal personnel. Any records requested hereunder shall be produced immediately for review at DCH or sent to the requesting authority by mail within fourteen (14) Calendar Days following a request. All records shall be provided at the sole cost and expense of the Contractor. DCH shall have unlimited rights to access, use, disclose, and duplicate all information and data in any way relating to this Contract in accordance with applicable State and federal laws and regulations. DCH shall not be restricted in the number of times it may audit, visit, inspect, review or otherwise monitor Contractor and any Subcontractors during the term of this Contract. DCH will only conduct audits as determined reasonably necessary by the Department.

22.3 SUBPOENAS FOR RECORDS OR OTHER DOCUMENTS

The Department may issue subpoenas to Contractor, which require the Contractor or its agents (e.g. employees, subcontractors) to: produce and permit inspection and copying of designated books, papers, documents, or other tangible items; and/or attend and give testimony at a deposition or hearing. The Contractor agrees to comply with all subpoenas issued by the Department or parties acting on behalf of the Department. The Contractor understands that it is ultimately responsible for its agents' compliance with the subpoenas described herein.

22.4 FINANCIAL RECORDS

During the entire life of the Contract, the Contractor and all Subcontractors shall provide DCH with copies of its annual report and all disclosure or reporting statements or forms filed with the State of Georgia and/or the Securities and Exchange Commission (SEC) as soon as they are prepared in final form and are otherwise available for distribution or filing. In the event that the Contractor is not required to or does not prepare either an annual report or SEC disclosure or reporting statements or forms by virtue of being a subsidiary of another corporation, it shall fulfill the requirements of this section, with respect to all such documents for any parent corporation, which reflect, report or include any of its operations on any basis. In addition, upon the written request of the Program Manager, the Contractor and all Subcontractors shall furnish DCH with the most recent un-audited and audited copies of its current balance sheet within fourteen (14) Calendar Days of its receipt of such request.

22.5 INDEPENDENT SERVICE AUDITOR'S REPORT

At its discretion, DCH may request a third party be engaged to prepare an Independent Service Auditor's Report. This report would meet the standards articulated by the American Institute of Certified Public Accountants including, but not limited to, the

Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization. Contractor shall bear the cost of obtaining the report. In addition, Contractor shall provide the Auditor with complete access to the records described in this Section.

22.6 MEDICAL RECORD REQUESTS

22.6.1 The Contractor shall ensure a copy of the Member's Medical Record is made available, without charge, upon the written request of the Member or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request.

22.6.2 The Contractor shall ensure that Medical Records are furnished at no cost to a new PCP, Out-of-Network Provider or other specialist, upon Member's request, no later than fourteen (14) Calendar Days following the written request.

23.0 CONFIDENTIALITY REQUIREMENTS

23.1 GENERAL CONFIDENTIALITY REQUIREMENTS

23.1.1 The Contractor shall treat all individually identifiable health information, including PHI and PII, that is obtained or viewed by its employees, agents, or authorized Subcontractors in the performance of this Contract as confidential information and shall not use any information so obtained, in any manner, except as may be necessary for the proper discharge of its obligations. Employees or authorized Subcontractors of the Contractor who have a reasonable need to know such information for purposes of performing their duties under this Contract shall use personal or patient information, provided such employees and/or Subcontractors have first signed an appropriate non-disclosure agreement that has been approved and maintained by DCH. The Contractor shall remove any person from performance of services hereunder upon notice that DCH reasonably believes that such person has failed to comply with the confidentiality obligations of this Contract. In such cases, Contractor shall replace such removed personnel in accordance with the staffing requirements of this Contract. DCH, the State Attorney General, federal officials as authorized by federal law or regulations, or the Authorized Representatives of these parties shall have access to all confidential information in accordance with the requirements of State and federal laws and regulations.

23.2 HIPAA COMPLIANCE

23.2.1 Contractor warrants to DCH that it is familiar with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the HITECH Act, and all implementing regulations (together, the "HIPAA Privacy and Security Rules"). Upon the execution of this Contract and upon any material change in the HIPAA Privacy and Security Rules, Contractor must provide DCH

with a written description of the policies and procedures used by it to achieve and maintain compliance with the HIPAA Privacy and Security Rules. These policies and procedures are subject to DCH approval.

23.2.2 The Contractor also agrees to assist DCH in its efforts to comply with the HIPAA Privacy and Security Rules, as amended from time to time. To that end, the Contractor will abide by any requirements mandated by the HIPAA Privacy and Security Rules or any other applicable laws in the course of this Contract. Contractor warrants that it will cooperate with DCH, including cooperation with DCH privacy officials and other compliance officers required by the HIPAA Privacy and Security Rules and all implementing regulations, in the course of performance of this Contract so that both parties will be in compliance with HIPAA. The Contractor also acknowledges that the HIPAA Privacy and Security Rules may require the Contractor and DCH to sign documents for compliance purposes, including but not limited to a Business Associate Agreement. Contractor further agrees to sign any other documents that may be required for compliance with the HIPAA Privacy and Security Rules and to abide by their terms and conditions. Contractor also agrees to abide by the terms and conditions of current DCH policies and procedures.

23.3 HIPAA PERFORMANCE GUARANTEE

23.3.1 Failure to achieve or maintain compliance with the requirements of the HIPAA Privacy and Security Rules, as amended from time to time, and with the DCH Business Associate Agreement will constitute failure to substantially perform and will result in the assessment of liquidated damages. These liquidated damages will be assessed in the amount of $2,000.00 for each day the Contractor fails to achieve or maintain compliance. If DCH incurs penalties and/or fines as a result of Contractor's non-compliance with the HIPAA Privacy and Security Rules, as amended from time to time, and Contractor indemnifies DCH as required by Section 26 of this Contract with respect to such penalties and/or fines, any liquidated damages due and payable at the time will be offset by the amount that the Contractor paid to indemnify the Department.

23.4 ENHANCED PRIVACY AND SECURITY PROVISIONS OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 ("ARRA")

23.4.1 The Contractor warrants that it will comply with all requirements of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), specifically related to improved privacy and security provisions. Contractor is subject to the provisions in effect as of the signing of the Act, and any provisions made effective during the term of this Contract, including increased penalties for HIPAA violations as contemplated in 42 U.S.C. §1320d et seq.

24.0 TERMINATION OF CONTRACT

24.1 GENERAL PROVISIONS

24.1.1 This Contract may terminate, or may be terminated in whole or in part by DCH for any or all of the following reasons:

24.1.1.1 Default by the Contractor, upon thirty (30) Calendar Days' notice;

24.1.1.2 Convenience of DCH, upon thirty (30) Calendar Days' notice;

24.1.1.3 Immediately, in the event of insolvency, Contract breach, or declaration of bankruptcy by the Contractor;

24.1.1.4 Determination by DCH that the instability of the Contractor's financial condition threatens delivery of services and continued performance of Contractor's responsibilities, upon five (5) Calendar Days' notice; or

24.1.1.5 Immediately, when sufficient appropriated funds no longer exist for the payment of DCH's obligation under this Contract.

24.2 TERMINATION BY DEFAULT

24.2.1 In the event DCH determines that the Contractor has defaulted by failing to carry out the substantive terms of this Contract or failing to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act, DCH may terminate the Contract in addition to or in lieu of any other remedies set out in this Contract or available by law.

24.2.2 Prior to the termination of this Contract, DCH will:

24.2.2.1 Provide written notice of the intent to terminate at least thirty (30) Calendar Days prior to the termination date, the reason for the termination, and the time and place of a hearing to give the Contractor an opportunity to Appeal the determination and/or cure the default;

24.2.2.2 Provide written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of the termination; and

24.2.2.3 For an affirming decision, give Members or the Contractor notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

24.3 TERMINATION FOR CONVENIENCE

DCH may terminate this Contract for convenience and without cause upon thirty (30) Calendar Days written notice. Termination for convenience shall not be a breach of the

Contract by DCH. The Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date Availability of funds shall be determined solely by DCH.

24.4 TERMINATION FOR INSOLVENCY OR BANKRUPTCY

The Contractor's insolvency, or the Contractor's filing of a petition in bankruptcy, shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy, the Contractor shall immediately advise DCH. If DCH reasonably determines that the Contractor's financial condition is not sufficient to allow the Contractor to provide the services as described herein in the manner required by DCH, DCH may terminate this Contract in whole or in part, immediately or in stages. The Contractor's financial condition shall be presumed not sufficient to allow the Contractor to provide the services described herein, in the manner required by DCH if the Contractor cannot demonstrate to DCH's satisfaction that the Contractor has risk reserves and a minimum net worth sufficient to meet the statutory standards for licensed health care plans. The Contractor shall cover continuation of services to Members for the duration of period for which payment has been made, as well as for inpatient admissions up to Discharge.

24.5 TERMINATION FOR INSUFFICIENT FUNDING

In the event that federal and/or State funds to finance this Contract are insufficient or otherwise unavailable, DCH, at its sole discretion, may terminate the Contract immediately. DCH shall provide prompt written notice of such termination. Subject to the availability of funds, the Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the terminate date. The certification by DCH of the events stated above shall be conclusive and not subject to appeal.

24.6 TERMINATION PROCEDURES

24.6.1 DCH will issue a written notice of termination to the Contractor by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall cite the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective. Termination shall be effective at 11:59 p.m. EST on the termination date.

24.6.2 Upon receipt of notice of termination or on the date specified in the notice of termination and as directed by DCH, the Contractor shall:

24.6.2.1 Stop work under the Contract on the date and to the extent specified in the notice of termination;

24.6.2.2 Place no further orders or Subcontract for materials, services, or facilities, except as may be necessary for completion of such portion of the work under the Contract as is not terminated;

24.6.2.3 Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;

24.6.2.4 Assign to DCH, in the manner and to the extent directed by the DCH Contract Administrator, all of the right, title, and interest of Contractor under the orders or subcontracts so terminated, in which case DCH will have the right, at its discretion, to settle or pay any or all Claims arising out of the termination of such orders and Subcontracts;

24.6.2.5 With the approval of the DCH Contract Administrator, settle all outstanding liabilities and all Claims arising out of such termination or orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of the Contract;

24.6.2.6 Complete the performance of such part of the work as shall not have been terminated by the notice of termination;

24.6.2.7 Take such action as may be necessary, or as the DCH Contract Administrator may direct, for the protection and preservation of any and all property or information related to the Contract that is in the possession of Contractor and in which DCH has or may acquire an interest;

24.6.2.8 Promptly make available to DCH, or another CMO acting on behalf of DCH, any and all records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this Contract in the format required by DCH. Such records shall be provided at no expense to DCH;

24.6.2.9 Promptly supply all information necessary to DCH, or another CMO acting on behalf of DCH, for reimbursement of any outstanding Claims at the time of termination; and

24.6.2.10 Submit a termination plan to DCH for review and approval that includes the following terms:

24.6.2.10.1 Maintain Claims processing functions as necessary for ten (10) consecutive months in order to complete adjudication of all Claims;

24.6.2.10.2 Comply with all duties and/or obligations incurred prior to the actual termination date of the Contract, including but

not limited to, the Appeal process as described in Section 4.14;

24.6.2.10.3 File all Reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;

24.6.2.10.4 Ensure the efficient and orderly transition of Members from coverage under this Contract to coverage under any new arrangement developed by DCH in accordance with procedures set forth in Section 4.11.9;

24.6.2.10.5 Maintain the financial requirements, and insurance set forth in this Contract until DCH provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled; and

24.6.2.10.6 Submit Reports to DCH every thirty (30) Calendar Days detailing the Contractor's progress in completing its continuing obligations under this Contract until completion.

24.6.3 Upon completion of these continuing obligations, the Contractor shall submit a final report to DCH describing how the Contractor has completed its continuing obligations. DCH will advise, within twenty (20) Calendar Days of receipt of this report, if all of the Contractor's obligations are discharged. If DCH finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, then DCH will require the Contractor to submit a revised final report to DCH for approval.

24.7 TERMINATION CLAIMS

24.7.1 After receipt of a notice of termination, the Contractor shall submit to the DCH Contract Administrator any termination claim in the form, and with the certification prescribed by, the DCH Contract Administrator. Such claim shall be submitted promptly but in no event later than ten (10) months from the effective date of termination. Upon failure of the Contractor to submit its termination claim within the time allowed, the DCH Contract Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the Contract, determine, on the basis of information available, the amount, if any, due to the Contractor by reason of the termination and shall thereupon cause to be paid to the Contractor the amount so determined.

24.7.2 Upon receipt of notice of termination, the Contractor shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this Contract or any other contract. Upon termination, the Contractor shall be paid in accordance with the following:

24.7.2.1 At the Contract price(s) for completed Deliverables and/or services delivered to and accepted by DCH; and/or

24.7.2.2 At a price mutually agreed upon by the Contractor and DCH for partially completed Deliverables and/or services.

24.7.3 In the event the Contractor and DCH fail to agree in whole or in part as to the amounts with respect to costs to be paid to the Contractor in connection with the total or partial termination of work pursuant to this article, the provisions of Section 30 shall control.

25.0 DAMAGES/PERFORMANCE GUARANTEES

25.1 GENERAL PROVISIONS

25.1.1 The Contractor shall, at all times, comply with all terms, conditions, and performance requirements and expectations specified in the RFP, Contractor's Proposal, and this Contract. In the event that Contractor fails to meet the terms, conditions, or requirements of this Contract and said failure results in damages that can be measured in actual cost, DCH will assess the actual damages warranted by said failure.

25.1.2 Contractor acknowledges that its failure to: complete the tasks, activities, and responsibilities set forth in Sections 25.2, 25.3, 25.4, 25.5, and 25.6, and submit Deliverables specified by the deadlines required therein, will cause the DCH substantial damages of types and in amounts which are difficult or impossible to ascertain exactly. The Parties further acknowledge and agree that the specified liquidated damages in Sections 25.2, 25.3, 25.4, 25.5, and 25.6 are the result of a good faith effort by the Parties to estimate the actual harm caused by the Contractor's failure to meet the Performance Guarantees. Accordingly, Contractor agrees that DCH may assess liquidated damages against the Contractor for its failure to meet the Performance Guarantees outlined in Sections 25.2, 25.3, 25.4, 25.5, and 25.6.

25.1.3 The Parties further acknowledge and agree that the liquidated damages referenced in Sections 25.2, 25.3, 25.4, 25.5, and 25.6 are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of DCH's projected financial loss and damage resulting from: the Contractor's nonperformance, including financial loss as a result of project delays, of the activities and responsibilities described in Sections 25.2, 25.3, 25.4, 25.5 and 25.6; or Contractor's failure to timely submit the deliverables described therein. Accordingly, Contractor agrees that DCH may assess liquidated damages against the Contractor for its failure to meet the Performance Guarantees outlines in Sections 25.2, 25.3, 25.4, 25.5, and 25.6.

25.1.4 Contractor acknowledges, affirms, ratifies, and agrees that the damage provisions set forth herein meet the criteria for enforceable damages that are reasonable, appropriate, and necessary. Liquidated damages shall be in addition to any other remedies that DCH may have. Accordingly, DCH reserves the right to seek all other reasonable and appropriate remedies available at law and in equity.

25.1.5 If the Contractor commits any of the violations or fails to meet the requirements set forth in Sections 25.2, 25.3, 25.4, 25.5, and 25.6, the Contractor shall submit a written CAP to DCH for review and approval prior to implementing the corrective action. All Corrective Action Plans must be submitted within the timeframe outlined in the Contract.

25.1.6 Contractor must agree to or provide evidence acceptable to DCH to challenge the reimbursement to the State for actual damages or the amounts set forth as liquidated damages within thirty (30) Calendar Days as further discussed in Section 25.1.7 below.

25.1.7 DCH will notify Contractor in writing of the proposed damage assessment. The amounts due to DCH as actual or liquidated damages may be deducted from any fees or other compensation payable to the Contractor or DCH may require the Contractor to remit the actual or liquidated damages within thirty (30) Calendar Days following the notice of assessment or resolution of any dispute at DCH's sole discretion. At DCH's option, DCH may obtain payment of assessed actual or liquidated damages through one (1) or more claims upon any irrevocable letter of credit furnished by the Contractor.

25.1.8 The Parties agree that disputes arising under this Section shall be handled through negotiations with DCH Vendor Management. The Contractor shall be allowed to appeal the decision of DCH Vendor Management to the Commissioner of DCH or his or her designee. Pending final determination of any dispute, the Contractor shall proceed diligently with performance of the Contract and in accordance with the direction of DCH.

25.1.9 Imposition of liquidated damages will not relieve the Contractor from submitting the CAP and implementing the associated corrective action as determined by DCH.

25.1.10 Notwithstanding any sanction or liquidated damages imposed upon the Contractor other than
Contract termination, the Contractor shall continue to administer all the provisions of the State's
Medicaid Managed Care Program, Georgia Families and the Section 1115 Family Planning
Waiver, Planning for Healthy Babies Program.

25.1.11 The venue for any formal legal proceedings shall lie in Fulton County, Georgia.

25.2 CATEGORY 1

25.2.1 Liquidated damages up to $100,000.00 per day may be imposed for Category 1 events. For Category 1 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 1 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.2.1.1 Failure to "go live" by the Operational Start Date; and

25.2.1.2 Failure to meet the readiness and/or annual review requirements, as specified in Section 2.13.

25.3 CATEGORY 2

25.3.1 Liquidated damages up to $100,000 per violation may be imposed for Category 2 events. For Category 2 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 2 events are monitored by DCH to determine compliance and shall include and constitute the following:

25.3.1.1 Acts that discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a Member, or any act that would reasonably be expected to discourage enrollment by Members whose medical condition or history indicates probable need for substantial future medical services;

25.3.1.2 Misrepresentation of information or false statements furnished to CMS or the State;

25.3.1.3 Failure to implement requirements stated in the Contractor's Proposal, the RFP, this Contract, or other material failures in the Contractor's duties;

25.3.1.4 Failure to provide an adequate provider network of physicians, pharmacies, hospitals, and other specified health care Providers in order to assure member access to all Covered Services;

25.3.1.5 Failure to achieve the Performance Target for each Quality Performance Measure as described in Section 4.12.3;

25.3.1.6 Failure to comply with the eighty percent (80%) screening ratio for periodic visits on the Contractor's CMS-416 EPSDT as described Section 4.7.3.9;

25.3.1.7 Failure to deliver effective Demonstration services as evidenced by lack of achievement of annual targeted LBW and VLBW reduction targets as identified in **Attachment M**;

25.3.1.8 Failure to achieve annual targeted reductions in the Pregnancy Rate as identified in **Attachment M**; and

25.3.1.9 Failure to fulfill duties to report Member abuse, neglect, or exploitation as a State Mandated Reported as defined by the Official Code of Georgia Annotated, as may be amended from time to time.

25.4 CATEGORY 3

25.4.1 Liquidated damages up to $25,000 per violation may be imposed for Category 3 events. For Category 3 events, the Contractor shall submit a written Corrective Action Plan to DCH for review and approval prior to implementing the corrective action. Category 3 events are monitored by DCH to determine compliance and include the following:

25.4.1.1 Substantial failure to provide Medically Necessary Services that the Contractor is required to provide under law, or under this Contract, to a Member covered under this Contract;

25.4.1.2 Misrepresentation of information or false statements furnished to a Member, Potential Member, or health care Provider;

25.4.1.3 Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;

25.4.1.4 Distribution directly, or indirectly, through any Agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;

25.4.1.5 Violation of any other applicable requirements of Section 1903(m) or 1932 of the Social Security Act and any implementing regulations;

25.4.1.6 Failure of the Contractor to assume full operation of its duties under this Contract in accordance with the transition timeframes specified herein;

25.4.1.7 Imposition of premiums or charges on Members that are in excess of the premiums or charges permitted under the Medicaid program (the State will deduct the amount of the overcharge and return it to the affected Member);

25.4.1.8 Failure to resolve Member Appeals and Grievances within the timeframes specified in this Contract;

25.4.1.9 Failure to ensure client confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of noncompliance will be assessed as per member and/or per HIPAA regulatory violation;

25.4.1.10 Violation of a subcontracting requirement in the Contract; and

25.4.1.11 Failure to provide notice of any known or suspected conflicts of interest, as prescribed in Section 31, **Attachment P**, **Attachment Q** and **Attachment R**.

25.5 CATEGORY 4

25.5.1 Liquidated damages up to $5,000.00 per day may be imposed for Category 4 events. For Category 4 events, a written Corrective Action Plan may be required and corrective action must be taken. In the case of Category 4 events, if corrective action is taken within four (4) Business Days, then liquidated damages may be waived at the discretion of DCH. Category 4 events are monitored by DCH to determine compliance and shall include the following:

25.5.1.1 Failure to submit required Reports and Deliverables in the timeframes prescribed in Section 4.18 and Section 5.7;

25.5.1.2 Submission of incorrect or deficient Deliverables or Reports as determined by DCH, including the submission of Deliverables or Reports in a format unacceptable to DCH;

25.5.1.3 Failure to comply with the Claims processing standards as follows:

25.5.1.3.1 Failure to process and finalize to a paid or denied status ninety-seven percent (97%) of all Clean Claims within fifteen (15) Business Days during a fiscal year; and

25.5.1.3.2 Failure to pay Providers interest at a twelve percent (12%) annual rate, calculated daily for the full period during which a clean, unduplicated Claim is not adjudicated within the claims processing deadlines. For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from 15 Calendar Days after the date the claim

was submitted. A Contractor shall pay all interest required to be paid under this provision or O.C.G.A. Section 33-24-59.5 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the Contractor to the Provider. A Contractor shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic claims, a CMS Form 1500 for non-electronic claims, or any claim prescribed by DCH.

25.5.1.4 Failure to provide an initial visit within fourteen (14) Calendar Days for all newly enrolled women who are pregnant in accordance with Sections 4.6.9.1;

25.5.1.5 Failure to comply with the Notice of Proposed Action and Notice of Adverse Benefit Determination requirements as described in Sections 4.14.3 and 4.14.5;

25.5.1.6 Failure to comply with any Corrective Action Plan as required by DCH;

25.5.1.7 Failure to seek, collect and/or report third party information as described in Section 8.4;

25.5.1.8 Failure to comply with the Contractor staffing requirements and/or any other conditions described in Sections 16.1 and 16.2;

25.5.1.9 Failure of Contractor to issue written notice to Members upon Provider's notice of termination in the Contractor's plan as described in Section 4.3.1.1.8;

25.5.1.10 Failure to comply with federal law regarding sterilizations, hysterectomies, and abortions and as described in Section 4.6.5;

25.5.1.11 Failure to submit acceptable Member and Provider directed materials or documents in a timely manner, i.e., member, handbooks, policies and procedures;

25.5.1.12 Failure to comply with the required Demonstration Reports and Deliverables as prescribed in Attachments L and M;

25.5.1.13 Failure to conduct quarterly Validation of Provider demographic data and provide DCH with current and accurate data for all contracted Providers as described in Section 4.8.3.2; and

25.5.1.14 Failure to submit attestations for each Provider network report in the established DCH format with all required data elements as described in Section 4.8.3.3.

25.6 CATEGORY 5

25.6.1 Liquidated damages as specified below may be imposed for Category 5 events. Imposition of liquidated damages will not relieve the Contractor from submitting and implementing the Corrective Action Plan or corrective action as determined by DCH. Category 5 events are monitored by DCH to determine compliance and include the following:

25.6.1.1 Failure to implement the business continuity-disaster recovery (BC-DR) plan as follows:

25.6.1.1.1 Implementation of the (BC-DR) plan exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2;

25.6.1.1.2 Implementation of the (BC-DR) plan exceeds the proposed time by more than (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per each day beginning with Day 3 and up to Day 5;

25.6.1.1.3 Implementation of the (BC-DR) plan exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days, twenty-five thousand dollars ($25,000) per day beginning with Day 6 and up to Day 10; and

25.6.1.1.4 Implementation of the (BC-DR) plan exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per each day beginning with Day 11.

25.6.1.2 Unscheduled System Unavailability (other than CCE and ECM functions described below) occurring during a continuous five (5) Calendar Day period, may be assessed as follows:

25.6.1.2.1 Greater than or equal to two (2) and less than twelve (12) clock hours cumulative: up to one hundred twenty-five dollars ($125) for each thirty (30) minutes or portions thereof;

25.6.1.2.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof; and

25.6.1.2.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to five hundred dollars ($500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars ($25,000) per occurrence.

25.6.1.3 Confirmation of CMO Enrollment (CCE) or Electronic Claims Management (ECM) system downtime. In any calendar week, penalties may be assessed as follows for downtime outside the State's control of any component of the CCE and ECM systems, such as the voice response system and PC software response system:

25.6.1.3.1 Less than twelve (12) clock hours cumulative: up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof;

25.6.1.3.2 Greater than or equal to twelve (12) and less than twenty-four (24) clock hours cumulative: up to five hundred ($500) for each thirty (30) minutes or portions thereof; and

25.6.1.3.3 Greater than or equal to twenty-four (24) clock hours cumulative: up to one thousand dollars ($1,000) for each thirty (30) minutes or portions thereof up to a maximum of fifty thousand dollars ($50,000) per occurrence.

25.6.1.4 Failure to make available to the State and/or its agent readable, valid extracts of Encounter Information for a specific month within fifteen (15) Calendar Days of the close of the month: five hundred dollars ($500) per day. After fifteen (15) Calendar Days of the close of the month: two thousand dollars ($2000) per day.

25.6.1.5 Failure to correct a system problem not resulting in System Unavailability within the allowed timeframe, where failure to complete was not due to the action or inaction on the part of DCH as documented in writing by the Contractor:

25.6.1.5.1 One (1) to fifteen (15) Calendar Days late: two hundred and fifty dollars ($250) per Calendar Day for Days 1 through 15;

25.6.1.5.2 Sixteen (16) to thirty (30) Calendar Days late: five hundred dollars ($500) per Calendar Day for Days 16 through 30; and

25.6.1.5.3 More than thirty (30) Calendar Days late: one thousand dollars ($1,000) per Calendar Day for Days 31 and beyond.

25.6.1.6 Failure to meet the Telephone Hotline performance standards:

25.6.1.6.1 One thousand dollars ($1,000) for each percentage point that is below the target answer rate of eighty percent (80%) in thirty (30) seconds;

25.6.1.6.2 One thousand ($1,000) for each percentage point that is above the target of a one percent (1%) Blocked Call rate; and

25.6.1.6.3 One thousand ($1,000) for each percentage point that is above the target of a five percent (5%) Abandoned Call rate.

25.6.1.7 Failure to make available to the State and/or its agent readable valid neonatal intensive care supplement payment reports for a specific month within fifteen (15) Calendar Days of the close of the month:

25.6.1.7.1 Five hundred dollars ($500) per Calendar Day; and

25.6.1.7.2 Two thousand dollars ($2,000) per Calendar Day after fifteen (15) Calendar Days of the close of the month.

25.6.1.8 Failure to have office space procured and operational by the Operational Start Date:

25.6.1.8.1 One thousand dollars ($1,000) per Calendar Day

25.6.1.9 Failure to be in full compliance with geographic access standards and submit electronic provider network reporting demonstrating its full compliance with the Provider network requirements within ten (10) Calendar Days after receiving the initial Member file. [The initial Member file will be delivered to the Contractor prior to the Operational Start Date.]

25.6.1.9.1 0.25% of the monthly Capitation Payment for Provider types not meeting the geographic access standards per Service Area until the deficiency is fully corrected.

25.6.1.10 Failure to test and ensure the Information Systems are fully operational and meet all RFP and Contract requirements prior to the Operational Start Date:

25.6.1.10.1 Ten thousand dollars ($10,000) per Calendar Day

25.7 CATEGORY 6

25.7.1 Liquidated Damages Section 6

25.7.1.1 Failure to establish and maintain at least one full time staff member of Contractor's Special Investigator's Unit in the Georgia office of the Contractor shall result in liquidated damages of one hundred dollars ($100.00) a day until the Contractor has proven to Department of Community Health that a permanent employee exists in the Contractor's Georgia office.

25.7.1.2 Failure to have a surveillance and utilization review program will result in liquidated damages being assessed. Liquidated damages shall be assessed at five hundred ($500.00) a day until the Contractor can successfully demonstrate that these programs exist in accordance with the Contract requirements.

25.7.1.3 Failure to submit an annual compliance plan by September 1st of each contract term shall result in liquidated damages being assessed. The damages will be five hundred dollars ($500.00) for missing the deadline and one hundred dollars ($100.00) a day until the plan has been submitted and accepted by DCH.

25.7.1.4 Failure to suspend provider payments for a credible allegation of fraud shall result in liquidated damages being assessed. The damages will be five hundred ($500.00) for each incident.

25.7.1.6 Failure to terminate a provider, employee, owner, or managing employee who has been excluded from participating in any federal health care program as described in Section 4.8.1.6 shall result in liquidated damages being assessed. The damages will be one thousand dollars ($1000.00) for the first incident, five thousand dollars ($5,000.00) for the second incident, ten thousand dollars ($10,000.00) for the third incident. Any other violations of this section will be assessed at twenty-five thousand dollars ($25,000).

25.7.1.7 Failure to cooperate in an investigation as described in Section

4.13.4.18 shall result in liquidated damages being assessed. The damages will be five hundred dollars ($500.00) per incident.

25.7.1.8 Failure to submit the monthly Termination/Suspension report shall result in liquidated damages being assessed. The damages will be five hundred dollars ($500.00) per incident.

25.7.1.9 Failure to submit the reports as described in Section 4.13.4.16 shall result in liquidated damages being assessed. The damages will be five hundred ($500.00) per incident.

25.8 OTHER REMEDIES

25.8.1 In addition to other liquidated damages described above for Category 1-5 events, DCH may impose the following other remedies in addition to other remedies available at law or equity:

25.8.1.1 Appointment of temporary management of the Contractor as provided in 42 CFR 438.706, if DCH finds that the Contractor has repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Social Security Act. Temporary management may be imposed when the state finds, through onsite surveys, Member or other complaints, financial status, or any other source:
(a) There is continued egregious behavior by Contractor;
(b) There is substantial risk to Member's health; or
(c) The sanction is necessary to ensure the health of the Contractor's Members in one of two circumstances:
(i) While improvements are made to remedy violations that require sanctions; or
(ii) Until there is an orderly termination or reorganization of the Contractor.

25.8.1.2 Granting Members the right to terminate Enrollment without cause and notifying the affected Members of their right to disenroll;

25.8.1.3 Suspension of all new Enrollment, including default Enrollment, after the effective date of remedies;

25.8.1.4 Suspension of payment to the Contractor for Members enrolled after the effective date of the remedies and until CMS or DCH is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur;

25.8.1.5 Denial of payment to the Contractor for all new Members when, and for so long as, payment for new Members is denied by CMS based on DCH's recommendation in accordance with 42 CFR 438.730;

25.8.1.6 Termination of the Contract if the Contractor fails to carry out the substantive terms of the Contract or fails to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act;

25.8.1.7 Civil Monetary Fines in accordance with 42 CFR 438.704;

25.8.1.8 Additional remedies allowed under State statute or State regulation that address areas of non-compliance specified in 42 CFR 438.700;

25.8.1.9 Referral to appropriate state licensing agency for investigation; and

25.8.1.10 Referral to the Office of the Attorney General for investigation.

25.8.1.11 Denial of payment to Contractor for all new Members when, and for so long as payment for those Members is denied by CMS, based on DCH's recommendation, when the Contractor acts to discriminate among Members on the basis of their health status or need for health care services.

25.8.1.12 Denial of payment to Contractor for all new Members when, and for so long as payment for those Members is denied by CMS, based on DCH's recommendation, when the Contractor misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider.

25.8.1.13 Denial of payment for Contractor for all new Members when, and for so long as, payment for these Members is denied by CMS based upon DCH's recommendation, when the Contractor fails to comply with the requirements for Performance Improvement Projects.

25.9 NOTICE OF REMEDIES

25.9.1 Prior to the imposition of either liquidated damages or other remedies, DCH will issue a written notice of remedies that will include the following:

25.9.1.1 A citation to the law, regulation or Contract provision that has been violated;

25.9.1.2 The remedies to be applied and the date the remedies will be imposed;

25.9.1.3 The basis for DCH's determination that the remedies should be imposed;

25.9.1.4 Request for a Corrective Action Plan, if applicable; and

25.9.1.5 The time frame and procedure for the Contractor to dispute DCH's determination. A Contractor's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damage or remedies.

26.0 INDEMNIFICATION

26.1 Contractor hereby releases and agrees to indemnify and hold harmless DCH, the State of Georgia, its departments, agencies and instrumentalities (including but not limited to the State Tort Claims Trust Fund, the State Authority Liability Trust Fund, The State Employee Broad Form Liability Funds, the State Insurance and Hazard Reserve Fund, and other self-insured funds, all such funds hereinafter collectively referred to as the "Funds"), and each of its current or former officers, directors, and employees, in individual and official capacities from and against any and all claims, demands, liabilities, losses, costs or expenses, and attorneys' fees , caused by, growing out of, or arising from this Contract, due to any act or omission on the part of Contractor, its agents, employees, customers, invitees, licensees or others working at the direction of Contractor or on its behalf, or due to any breach of this Contract by Contractor, or due to the insolvency or declaration of bankruptcy by Contractor, or due to the application or violation of any pertinent federal, state or local law, rule or regulation. This indemnification extends to the successors and assigns of Contractor, and this indemnification survives the termination of the Contract and the dissolution or, to the extent allowed by law, the bankruptcy of Contractor.

26.2 The Parties who shall be entitled to enforce this indemnity of the Contractor shall be DCH, the State of Georgia, its officials, agents, employees, and representatives, including attorneys or the Office of the Attorney General, other public officials, any successor in office to any of the foregoing individuals, and their respective legal representatives, heirs, and beneficiaries.

27.0 INSURANCE

27.1 Contractor shall, at a minimum, prior to the commencement of work, procure and maintain the insurance policies identified below at Contractor's own cost and expense and shall furnish DCH with an insurance certificate evidencing proof of coverage at least in the amounts indicated, which shall list DCH as certificate holder and as an additional insured. The insurance certificate must document that the Commercial General Liability insurance coverage purchased by Contractor includes contractual liability coverage applicable to this Contract.

27.2 In addition, the insurance certificate must provide the following information: the name and address of the insured; name, address, telephone number and signature of the authorized agent; name of the insurance company (authorized to operate in Georgia); a description of coverage in detailed standard terminology [including policy period, policy number, limits of liability, exclusions, endorsements, and

policy notification requirements for claims (to whom, address and time limits)]; and an acknowledgment of notice of cancellation to DCH.

27.3 It shall be the responsibility of Contractor to require any Subcontractor to secure the same insurance coverage as prescribed herein for Contractor, and to obtain a certificate evidencing that such insurance is in effect. Upon request, Contractor shall provide evidence of such insurance to DCH. In addition, Contractor shall indemnify and hold harmless DCH and the State from any liability arising out of Contractor's or Subcontractor's untimely failure in securing adequate insurance coverage as prescribed herein:

27.3.1 Workers' Compensation Insurance

Contractor shall maintain Workers' Compensation Insurance in accordance with the statutory limits established by the General Assembly of the State of Georgia. The Workers' Compensation Policy must include Coverage B – Employer's Liability Limits of:

Bodily Injury by Accident	$100,000.00 per employee
Bodily Injury by Disease	$100,000.00 per employee
Policy Limits	$500,000.00 policy limits

27.3.2 Commercial General Liability

Contractor shall maintain Commercial General Liability Policy(ies), which shall include, but need not be limited to, coverage for bodily injury and property damage arising from premises and operations liability, personal injury liability and contractual liability. The Commercial General Liability Insurance shall provide at least the following limits (per occurrence) for each type of coverage with a $3,000,000.00 aggregate:

Premises and Operations	$1,000,000.00
Personal Injury	$1,000,000.00
Contractual Liability	$1,000,000.00

27.3.3 Automobile Liability

27.3.3.1 Contractor shall procure and maintain Commercial Automobile Liability Insurance, which shall include coverage for bodily injury and property damage arising from the operation of any owned, non-owned or hired automobile with limits of at least:

Automobile Liability
Combined Singled Limit
$1,000,000.00

27.3.3.2 To achieve the appropriate coverage levels, a combination of a specific policy written with an umbrella policy covering liabilities above stated limits is acceptable.

27.3.4 Professional Liability Insurance

Professional Liability Insurance	$1,000,000.00

27.4 Each of the insurance policies required pursuant to this section shall be issued by a company licensed to transact the business of insurance in the State of Georgia by the Insurance Commissioner for the applicable line of insurance and, unless waived or modified in writing by DCH, shall be an insurer with a Best Policyholders Rating of "A" or better and with a financial size rating of Class IX or larger. Each such policy shall also contain the following provisions, or the substance thereof, made a part of the insurance policy:

27.4.1 The Contractor agrees that this policy shall not be canceled, changed, allowed to lapse, or allowed to expire until thirty (30) Calendar Days after DCH and the Department of Administrative Services, Risk Management Division, has received written notice thereof as evidenced by return receipt of registered letter or until such time as other valid and effective insurance coverage acceptable in every respect to DCH and providing protection equal to protection called for in the policy shown above shall have been received, accepted, and acknowledged by DCH. It is also agreed that said notice shall be valid only as to such project as shall have been designated by name in said notice.

28.0 IRREVOCABLE LETTER OF CREDIT

28.1 Within five (5) Business Days of the Contract Effective Date, or a later date as determined by DCH, Contractor shall obtain and maintain in force and effect an irrevocable letter of credit. For SFY 2017 and thereafter, on or before July 2 each following year, Contractor shall modify the amount of the irrevocable letter of credit in force and effect as of June 30 to equal 37.5% of the average of the incurred Capitation Payments calculated by the Department for the Contractor for the months of January, February and March. For each fiscal year, the irrevocable letter of credit shall be for the duration of that fiscal year.

28.2 If at any time during the year, the actual GF lives enrolled in Contractor's plan increases or decreases by more than twenty-five percent, DCH, at its sole

discretion, may increase or decrease the amount required for the irrevocable letter of credit.

28.3 With regard to the irrevocable letter of credit, DCH may recoup payments from the Contractor for liabilities or obligations arising from any act, event, omission or condition which occurred or existed subsequent to the Contract Effective Date of the Contract and which is identified in a survey, review, or audit conducted or assigned by DCH.

28.4 DCH may also, at its discretion, redeem Contractor's irrevocable letter of credit in the amount(s) of actual damages suffered by DCH if DCH determines that the Contractor is (1) unable to perform any of the terms and conditions of the Contract or if (2) the Contract is terminated by default or bankruptcy or material breach that is not cured within the time specified by DCH, or under both conditions described at one (1) and two (2).

29.0 COMPLIANCE WITH ALL LAWS

29.1 NON-DISCRIMINATION

The Contractor agrees to comply with applicable federal and State laws, rules and regulations, and the State's policy relative to nondiscrimination in employment practices because of political affiliation, religion, race, color, sex, physical handicap, age, or national origin including, but not limited to, Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972 as amended; the Age Discrimination Act of 1975, as amended; the Rehabilitation Act of 1973; Equal Employment Opportunity (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375) the Americans with Disability Act of 1990, as amended (including but not limited to 28 C.F.R. § 35.100 et seq.); and section 1557 of the Patient Protection and Affordable Care Act. Nondiscrimination in employment practices is applicable to employees for employment, promotions, dismissal and other elements affecting employment.

29.2 DELIVERY OF SERVICE AND OTHER FEDERAL LAWS

29.2.1 Contractor agrees that all work performed pursuant to this Contract shall comply fully with all applicable laws, statutes, case law, codes, rules, regulations, and procedures (whether administrative or otherwise) whether federal or State. Specifically, the Contractor agrees to comply with laws, regulations, and guidelines, including but not limited to §1902(a)(7) of the Social Security Act, DCH Policies and Procedures, HIPAA and the Health Insurance Title XIII of the American Recovery and Reinvestment Act of 2009 (the Health Information Technology for Economic and Clinical Health Act, or "HITECH"), and in the implementing regulations of HIPAA and HITECH. Implementing regulations are published as the Standards for Privacy and Security of Individually Identifiable Health Information in 45 C.F.R. Parts 160 and 164. Together, HIPAA, HITECH and their implementing regulations are referred to in this Contract as the "Privacy

Rule and Security Rule". The Contractor assumes responsibility for full compliance with all such applicable laws, regulations, and guidelines, and agrees to fully reimburse DCH for any loss of funds or resources or overpayment resulting from non-compliance by Contractor, its staff, agents or subcontractors, as revealed in audits conducted by or on behalf of DCH.

29.2.2 The provisions of the Fair Labor Standards Act of 1938 (29 U.S.C. § 201 et seq.) and the rules and regulations as promulgated by the United States Department of Labor in Title XXIX of the Code of Federal Regulations are applicable to this Contract. Contractor shall agree to conform with such federal laws as affect the delivery of services under this Contract including but not limited to the Titles VI, VII, XIX, XXI of the Social Security Act, the Federal Rehabilitation Act of 1973, the Davis Bacon Act (40 U.S.C. § 276a et seq.), the Copeland Anti-Kickback Act (40 U.S.C. § 276c), the Americans with Disabilities Act of 1990 (including but not limited to 28 C.F.R. § 35.100 et seq.), the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as Amended (33 U.S.C. 1251 et seq.); the Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); and Debarment and Suspension (45 CFR 74 Appendix A (8) and Executive Order 12549 and 12689). Contractor will agree to conform to such requirements or regulations as the United States Department of Health and Human Services may issue from time to time. Authority to implement federal requirements or regulations will be given to the Contractor by DCH in the form of a Contract amendment.

29.2.3 The Contractor shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

29.2.4 The Contractor shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

29.3 COST OF COMPLIANCE WITH APPLICABLE LAWS

The Contractor agrees that it will bear any and all costs (including but not limited to attorneys' fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not limited to federal and State statutes, case law, precedent, regulations, policies, and procedures which exist at the time of the execution of this Contract. The Contractor further agrees that it will bear any and all costs (including but not limited to attorneys' fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not limited to federal and state statutes, case law, precedent, regulations, policies, and procedures which become effective or are amended throughout

the life of the Contract. In the event of a disagreement on this matter, DCH's determination on this matter shall be conclusive and not subject to Appeal.

29.4 GENERAL COMPLIANCE

Additionally, the Contractor agrees to comply and abide by all laws, rules, regulations, statutes, policies, or procedures that may govern the Contract, the deliverables in the Contract, or either Party's responsibilities. To the extent that applicable laws, rules, regulations, statutes, policies, or procedures – either those in effect at the time of the execution of this Contract, or those which become effective or are amended during the life of the Contract – require the Contractor to take action or inaction, any costs, expenses, or fees associated with that action or inaction shall be borne and paid by the Contractor solely.

30.0 CONFLICT RESOLUTION

30.1 GOOD FAITH EFFORTS

Except for the right of either Party to apply to a court of competent jurisdiction for a temporary restraining order or other provisional remedy to preserve the status quo or prevent irreparable harm, the Parties agree to attempt in good faith to promptly resolve any dispute, controversy or claim arising out of or relating to this Contract, including but not limited to payment disputes, through negotiations between senior management of the Parties.

30.2 RESOLUTION

If the dispute cannot be resolved within thirty (30) Calendar Days of initiating such negotiations, the dispute shall be decided by the DCH Director of Contracts Administration, who shall reduce his or her decision to writing and mail or otherwise furnish a copy to the Contractor.

30.3 APPEAL

The written decision of the DCH Director of Contracts Administration shall be final and conclusive, unless the Contractor mails or otherwise furnishes a written appeal to the Commissioner of DCH within ten (10) Calendar Days from the date of receipt of such decision. The decision of the Commissioner or his duly authorized representative for the determination of such appeal shall be final and conclusive.

30.4 OTHER REMEDIES

If either Party is dissatisfied, after exhausting the administrative process described above, that Party may pursue its available legal and equitable remedies.

30.5 CONTINUATION OF WORK

Contractor and DCH agree that, the existence of a dispute notwithstanding, they will continue without delay to carry out all their respective responsibilities under this Contract.

31.0 CONFLICT OF INTEREST AND CONTRACTOR INDEPENDENCE

31.1 No official or employee of the State of Georgia or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the GF program shall, prior to the termination of this Contract, voluntarily acquire any personal interest, direct or indirect, in this Contract.

31.2 The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any material manner or degree with, or have a material adverse effect on the performance of its services hereunder. The Contractor further covenants that in the performance of this Contract no person having any such interest shall be employed.

31.3 All of the parties hereby certify that the provisions of O.C.G.A. §45-10-20 through §45-10-28, which prohibit and regulate certain transactions between State officials and employees and the State of Georgia, have not been violated and will not be violated in any respect throughout the duration of this Contract. Further, all parties will comply with the conflict of interest safeguards described in 42 CFR 438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Social Security Act applicable to contracting officers, employees, or independent contractors.

31.4 In addition, it shall be the responsibility of the Contractor to maintain independence and to establish necessary policies and procedures to assist the Contractor in determining if any Contractors or Subcontractors performing work under this Contract have any impairment to their independence. To that end, the Contractor shall submit a written plan to DCH within five (5) Business Days of Contract Award in which it outlines its Impartiality and Independence Policies and Procedures relating to how it monitors and enforces Contractor and Subcontractor impartiality and independence. The Contractor further agrees to take all necessary actions to eliminate threats to impartiality and independence, including but not limited to reassigning, removing, or terminating Contractors or Subcontractors.

32.0 NOTICE

32.1 All notices under this Contract shall be deemed duly given upon delivery, if delivered by hand, or three (3) Calendar Days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the addresses set forth below or to such other address as a party may designate by notice pursuant hereto.

For DCH:

Contracts Administration:
Director of Contracts Administration
Office of General Counsel
Georgia Department of Community Health
2 Peachtree, NW – 40th Floor
Atlanta, Georgia 30303

Project Leader:
Lynnette R. Rhodes, Executive Director
Medical Assistance Plans
Georgia Department of Community Health
Department of Community Health
2 Peachtree St. – 36th Floor
Atlanta, Georgia 30303
lrhodes@dch.ga.gov

For Amerigroup Georgia Managed Care Company, Inc.:

AMGP Georgia Managed Care Company, Inc.
Attn: Melvin Lindsey, President of the Georgia Medicaid Health Plan
4170 Ashford Dunwoody Road, Suite 100
Atlanta, Georgia 30319
melvin.lindsey@amerigroup.com

32.2 It shall be the responsibility of the Contractor to inform the Contract Administrator of any change in address in writing no later than five (5) Business Days after the change.

32.3 Within two (2) Business Days of receipt of notice, the Contractor shall inform DCH of any legal action, whether the action is formal, informal, administrative, mediation, arbitration, actual litigation, or proposed litigation, which is instituted against the Contractor by a Subcontractor, sub-subcontractor, vendor, supplier, or manufacturer.

32.4 The Contractor shall inform DCH immediately of any legal action, whether the action is formal, informal, administrative, mediation, arbitration, actual litigation, or proposed litigation, that it knows, knew, or should have known would be instituted or brought against the Contractor by a Subcontractor, sub-subcontractor, vendor, supplier, or manufacturer for work based on, arising from, or related to this Contract.

33.0 MISCELLANEOUS

33.1 ASSESSMENT OF FEES

The Contractor and DCH agree that DCH may elect to deduct any assessed fees from payments due or owing to the Contractor or direct the Contractor to make payment directly to DCH for any and all overpayments previously made to Contractor by DCH or any fees or penalties assessed against DCH as a result of Contractor's negligence, acts or omissions. The method of collection of assessed fees is solely and strictly at DCH's discretion.

33.2 ATTORNEY'S FEES

In the event that either party deems it necessary to take legal action to enforce any provision of this Contract, and in the event DCH prevails, the Contractor agrees to pay all expenses of such action including reasonable attorney's fees and costs at all stages of litigation as awarded by the court, a lawful tribunal, hearing officer or administrative law judge. If the Contractor prevails in any such action, the court or hearing officer, at its discretion, may award costs and reasonable attorney's fees to the Contractor. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

33.3 AUTHORITY

DCH has full power and authority to enter into this Contract, the person acting on behalf of and signing for the Contractor has full authority to enter into this Contract, and the person signing on behalf of the Contractor has been properly authorized and empowered to enter into this Contract on behalf of the Contractor and to bind the Contractor to the terms of this Contract. Each party further acknowledges that it has had the opportunity to consult with and/or retain legal counsel of its choice, read this Contract, understands this Contract, and agrees to be bound by it.

33.4 BINDING

This Contract and all of its terms, conditions, requirements, and amendments shall be binding on DCH, the Contractor, and their respective successors and permitted assigns.

33.5 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT AND OTHER MATTERS

The Contractor certifies that it is not presently debarred, suspended, proposed for debarment or declared ineligible for award of contracts by any federal or State agency or department.

33.6 CHOICE OF LAW OR VENUE

This Contract shall be governed in all respects by the laws of the State of Georgia. Any lawsuit or other action brought against DCH or the State based upon, or arising from this

Contract shall be brought in a court or other forum of competent jurisdiction in Fulton County in the State of Georgia.

33.7 CONTRACT DRAFTING

The Parties agree that each Party had an opportunity to have the legal counsel of its choice review, revise, edit, negotiate, and modify this Contract as needed or desired.

33.8 CONTRACT LANGUAGE INTEPRETATION

The Contractor and DCH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DCH's interpretation of the Contract language in dispute shall control and govern. DCH's interpretation of the Contract language in dispute shall not be subject to Appeal under any circumstance.

33.9 COOPERATION WITH AUDITS

33.9.1 The Contractor agrees to assist and cooperate with the Department in any and all matters and activities related to or arising out of any audit or review, whether federal, private, or internal in nature, at no cost to the Department.

33.9.2 The Parties also agree that the Contractor shall be solely responsible for any costs it incurs for any audit related inquiries or matters. Moreover, the Contractor may not charge or collect any fees or compensation from DCH for any matter, activity, or inquiry related to, arising out of, or based on an audit or review.

33.10 COOPERATION WITH OTHER CONTRACTORS

33.10.1 In the event that DCH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, the Contractor agrees to cooperate fully with such other contractors. The Contractor shall not commit any act that will interfere with the performance of work by any other contractor.

33.10.2 Additionally, if DCH eventually awards this Contract to another contractor, the Contractor agrees that it will not engage in any behavior or inaction that prevents or hinders the other Contractor's work related thereto. The Contractor agrees to submit a written turnover plan and/or transition plan to DCH within thirty (30) Calendar Days of receiving the Department's intent to terminate notice. The Parties agree that the Contractor has not successfully met this obligation until the Department accepts its turnover plan and/or transition plan.

33.10.3 The Contractor's failure to cooperate and comply with this provision, shall be sufficient grounds for DCH to halt all payments due or owing to the Contractor until it becomes compliant with this or any other contract provision. DCH's determination on the matter shall be conclusive and not subject to Appeal.

33.11 DRUG-FREE WORKPLACE

The Contractor must certify to DCH that a drug-free workplace will be provided for the Contractor's employees during the performance of this Contract as required by the "Drug-Free Workplace Act", O.C.G.A. § 50-24-1, et seq. and certify compliance with applicable federal law as set forth in **Attachment A**. Contractor agrees to sign and comply with **Attachment A**. The Contractor will secure from any Subcontractor hired to perform services under this Contract such similar certification. Any false certification by the Contractor or violation of such certification, or failure to carry out the requirements set forth in the State of Georgia or federal statutes, rules, regulations, policies, or guidelines relating to a drug-free workplace may result in the Contractor being suspended, terminated or debarred from the performance of this Contract.

33.12 ENFORCEABILITY

If, for any reason, a court of competent jurisdiction finds any provision of this Contract, or portion thereof, to be unenforceable, that provision shall be enforced to the maximum extent permissible so as to effect the intent of the Parties, and the remainder of this Contract shall continue in full force and effect.

33.13 ETHICS IN PUBLIC CONTRACTING

33.13.1 Contractor understands, states, and certifies that it made its proposal to the RFP without collusion or fraud and that it did not offer or receive any kickbacks or other inducements from any other Contractor, supplier, manufacturer, or Subcontractor in connection with its proposal to the RFP.

33.13.2 Contractor agrees to sign and comply with **Attachment P**, ***Statement of Ethics***, **Attachment Q**, ***DCH Ethics in Procurement Policy***, and **Attachment R**, ***Code of Ethics and Conflict of Interest Policy***.

33.14 FORCE MAJEURE

Neither party to this Contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party. Such acts shall include, but not be limited to, acts of God, strikes, riots, lockouts, and acts of war, epidemics, fire, earthquakes, or other disasters.

33.15 HOMELAND SECURITY CONSIDERATIONS

33.15.1 The Contractor shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the Contractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

33.15.2 If the Contractor performs services, or uses services, in violation of the foregoing paragraph, the Contractor shall be in material breach of this Contract and shall be liable to the Department for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Contractor shall be required to hold harmless and indemnify DCH pursuant to the indemnification provisions of this Contract.

33.15.3 The prohibitions in this Section shall also apply to any and all agents and Subcontractors used by the Contractor to perform any services under this Contract.

33.16 LEGAL CONSIDERATIONS

The Contractor agrees to be bound by the laws of the State of Georgia. The solicitation and this Contract shall be construed and interpreted in accordance with Georgia law, regardless of where services are performed, in the event a choice of law situation arises. The Contractor further acknowledges that nothing contained in this Contract, shall be construed as a waiver of the immunity from liability, which would otherwise be available to the State of Georgia under the principles of sovereign immunity. In particular, the Contractor agrees that the sole and exclusive means for the presentation of any claim against the State arising out of this Contract, shall be in accordance with all applicable Georgia statutes and the Contractor further covenants not to initiate legal proceedings in any State or Federal court in addition to, or in lieu of, any proceedings available under Georgia statutes.

33.17 LIMITATIONS OF LIABILITY/EXCEPTIONS

Nothing in this Contract shall limit the Contractor's indemnification liability or civil liability arising from, based on, or related to claims brought by DCH or any third party or any claims brought against DCH or the State by a third party or the Contractor.

33.18 OPEN RECORDS

33.18.1 In the event Contractor receives a public records request pursuant to any independent Freedom of Information legislation (including but not limited to the Freedom of Information Act ("FOIA"), 5 U.S.C. § 552 and/or the Georgia Open Records Act, O.C.G.A. § 50-18-71, et. seq.) while this Contract is in effect or after the termination of this Contract for any information relating to this Contract, Contractor shall provide a copy of the request to DCH's Open Records Officer at openrecordsrequest@dch.ga.gov and to the DCH HIPAA Privacy and Security Specialist specified in **Attachment D**, ***Business Associate Agreement***, on the same business day.

33.18.2 Upon notifying DCH of the request, Contractor agrees to comply with the response requirements, restrictions, and exceptions in the applicable statute(s) under which the request is made. Contractor will cooperate with DCH to ensure that DCH's interests are represented and that the confidentiality of the

information is not compromised by any actions or omissions of Contractor in relation to the public records request or responses thereto. If DCH objects and Contractor is still required by law to disclose the information, Contractor shall do so only to the minimum extent necessary to comply with the operation of the law, and shall provide DCH a copy of the information disclosed.

33.19 ORDER OF PRECEDENCE

33.19.1 This Contract shall include (1) The body of this Contract contained at pages x-y and **Attachments A-W**, (2) The Request for Proposal (**Exhibit 1**), and (3) The Contractor's Proposal (**Exhibit 2**).

33.19.2 In the event of any conflict in language between or among the provisions and documents incorporated into, referenced, or contained in the Contract, the order of precedence shall be as enumerated above, except that the terms of **Attachment D**, shall govern, for the express and agreed upon purpose of compliance with the more stringent protections of confidentiality, privacy, and security. Any other conflicts shall be clarified or decided by DCH.

33.20 OWNERSHIP AND FINANCIAL DISCLOSURE

33.20.1 The Contractor shall disclose each person or corporation with an ownership or control interest of five percent (5%) or more in the Contractor's entity for the prior twelve (12) month period as required in Section 8.6.6 of this Contract.

33.20.2 In the event Contractor is, or becomes during the course of this Contract, the wholly owned subsidiary of a publicly owned company, in lieu of the requirements set forth above, Contractor shall disclose financial statements of its immediate parent organization and identify each person, corporation, or entity with an ownership or control interest of five percent (5%) or more in the Contractor's entity for the prior twelve (12) consecutive calendar month period.

33.20.3 For the purposes of this Section, a person, corporation, or entity with an ownership or control interest shall mean a person, corporation, or entity that:

33.20.3.1 Owns directly or indirectly five percent (5%) or more of the Contractor's capital or stock or received five percent (5%) or more of its profits;

33.20.3.2 Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, and that interest is equal to or exceeds five percent (5%) of the total property and assets of the Contractor; and

33.20.3.3 Is an officer or director of the Contractor (if it is organized as a corporation), is a Member or manager in the Contractor's organization

(if it is organized as a limited liability company) or is a partner in the Contractor's organization (if it is organized as a partnership).

33.20.4 All ownership and financial disclosures shall be submitted to DCH when the Contractor's Proposal is submitted and updated or amended at least once every quarter, unless otherwise requested by DCH.

33.21 PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED AND SUSPENDED

33.21.1 The Contractor shall not knowingly have a relationship with an individual or entity, or an affiliate of an individual, who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

33.21.2 The Contractor may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.

For the purposes of this Section, a "relationship" is described as follows:

33.21.2.1 A director, officer or partner of the Contractor;

33.21.2.2 A subcontractor of the Contractor as governed by 42 CFR § 438.230.

33.21.2.3 A person with beneficial ownership of five percent (5%) or more of the Contractor's entity; and

33.21.2.4 A network provider or person with an employment, consulting or other arrangement with the Contractor, for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the State.

33.21.3 The Contractor and any Subcontractor shall submit a quarterly Program Integrity Exception List report that identifies Providers, owners, agents, employees, Subcontractors and contractors (as defined in Section 8.6.6.2) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities). (http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp) and/or the CMS MED (Medicare Exclusion Database).

33.21.4 All disclosures required under this Section shall be included in the Contractor's quarterly Fraud and Abuse Report (See Sections 4.13.4 and 5.7.1).

33.21.5 If DCH determines that Contractor fails to comply with the requirements of this

Section and 42 CFR 438.610, then DCH:

33.21.5.1 Shall notify the Secretary of the U.S. Department of Health and Human Services of the noncompliance;

33.21.5.2 May continue this Contract unless the Secretary of the U.S. Department of Health and Human Services directs otherwise; and

33.21.5.3 May not renew or otherwise extend the duration of the Contract unless the Secretary of the U.S. Department of Health and Human Services provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the Contract.

33.22 SECTION TITLES NOT CONTROLLING

The Section titles used in this Contract are for reference purposes only and shall not be deemed a part of this Contract.

33.23 SURVIVABILITY

The terms, provisions, representations and warranties contained in this Contract shall survive the delivery or provision of all services or Deliverables hereunder.

33.24 TIME IS OF THE ESSENCE

Time is of the essence in this Contract. Any reference to “Days” shall be deemed Calendar Days unless otherwise specifically stated.

33.25 WAIVER

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written consent of the parties. Forbearance or indulgence in any form or manner by either party, in any regard whatsoever, shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any remedy available under the Contract.

33.26 COMPLIANCE WITH O.C.G.A. § 50-5-85

Contractor certifies that it is not currently engaged in, and agrees for the duration of this Contract not to engage in, a boycott of Israel as defined in O.C.G.A. § 50-5-85. Contractor agrees to sign and comply with **Attachment Y,** ***Certification Regarding Compliance with O.C.G.A. § 50-5-85***.

33.27 SEXUAL HARASSMENT PREVENTION

33.27.1 In keeping with Executive Order 01.14.19.02, *Preventing Sexual Harassment in the Executive Branch of Government*, the State of Georgia, promotes respect and dignity and does not tolerate sexual harassment in the workplace. The State is committed to providing a workplace and environment free from sexual harassment for its employees and for all persons who interact with State government. All State of Georgia employees are expected and required to interact with all persons including other employees, contractors, and customers in a professional manner that contributes to a respectful work environment free from sexual harassment. Furthermore, the State of Georgia, including DCH, maintains an expectation that its contractors and their employees and subcontractors will interact with entities of the State of Georgia, their customers, and other contractors of the State in a professional manner that contributes to a respectful work environment free from sexual harassment.

Accordingly, pursuant to the State of Georgia's Statewide Sexual Harassment Prevention Policy (the "Policy"):

33.27.1.1 Within thirty (30) Calendar Days of the Effective Date of this Contract, Contractor shall ensure that all of its employees and subcontractors that are regularly on State premises or who will regularly interact[1] with State personnel under this Contract (hereinafter "such employees and subcontractors") have received, reviewed, and agreed, in writing, to comply with the Policy, as may be amended from time to time, which is located at http://doas.ga.gov/human-resources-administration/board-rules-policy-and-compliance/jointly-issued-statewide-policies/sexual-harassment-prevention-policy;

33.27.1.2 Contractor shall, within thirty (30) Calendar Days of the Effective Date of this Contract and on an annual basis thereafter, provide sexual harassment prevention training to such employees and subcontractors; or in the alternative, ensure that such employees and subcontractors complete the Georgia Department of Administrative Services' sexual harassment prevention training located at https://www.youtube.com/embed/NjVt0DDnc2s?rel=0. The initial

[1] For purposes of this Section 33.27.1.1, the term "interact" shall mean contact or dealings regarding business matters occurring in or otherwise affecting the workplace, including but not limited to, contact or dealings occurring both on and off work premises and during or outside of work hours and either by mail, in person, by telephone, or by electronic communication.

thirty (30) Calendar Day requirement for training, may be waived for any individual employees and subcontractors, who Contractor can demonstrate, through documentation to DCH, has completed sexual harassment prevention training offered by Contractor within one (1) year of the Effective Date of this Contract.

33.27.1.3 Upon request of the State, Contractor will provide documentation substantiating such employees and subcontractors': (i) written acknowledgment of the Policy, as outlined in Section 33.27.1.1; and (ii) annual attendance and completion of sexual harassment prevention training, in accordance with Section 33.27.1.2.

33.27.1.4 If Contractor, including its employees and subcontractors, violates the Policy, including but not limited to engaging in Sexual harassment and/or Retaliation, as such terms are defined in Section V of the Policy, Contractor may be subject to appropriate corrective action. Such action may include, but is not limited to, notification to the employer, removal from State premises, restricted access to State premises and/or personnel, termination of this Contract or any other contract between DCH and Contractor, and/or other corrective action(s) deemed necessary by the State.

34.0 AMENDMENT IN WRITING

34.1 No amendment, waiver, termination or discharge of this Contract, or any of the terms or provisions hereof, shall be binding upon either party unless confirmed in writing. Nothing may be modified or amended, except by writing executed by both parties.

34.2 If the Contractor desires an amendment or modification to any provision, condition, or obligation contained in this Contract, it must deliver a timely and written change order request to the Department that includes a detailed explanation of the proposed change, justification, and any and all potential cost implications, if any, for the proposed change.

34.3 Additionally, the Contractor understands and agrees that CMS and the Georgia Department of Administrative Services approval may be required before any such amendment or proposed amendment can become effective. DCH shall determine, in its sole discretion, when such approval is required.

34.4 Any agreement of the Parties to amend, modify, eliminate or otherwise change any part of this Contract shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be of full force and effect as set out herein.

35.0 CONTRACT ASSIGNMENT

35.1 Unless otherwise authorized by an act of the legislature, the rights of DCH under this Contract may be assigned to any other agency of the State of Georgia, with ten (10) Calendar Days' prior notice to Contractor.

35.2 Contractor shall not assign this Contract, in whole or in part, without the prior written consent of DCH, and any attempted assignment not in accordance herewith shall be null and void and of no force or effect. Any assignment or transfer of any interest under the Contract, by Contractor, shall be made explicitly subject to all rights, defenses, set-offs, or counterclaims, which would have been available to DCH against the Contractor in the absence of such assignment or transfer of interest. This provision includes reassignment of Contract due to change of ownership of Contractor.

36.0 PROHIBITION OF CERTAIN CONTRACT PROVISIONS

Contractor acknowledges that pursuant to Georgia Constitution Article 3, Section 6, Paragraph 6, the Department is prohibited from entering into any contract that grants any donation or gratuity or forgives any debt or obligation owing to the public.

37.0 SEVERABILITY

Any section, subsection, paragraph, term, condition, provision, or other part of this Contract that is judged, held, found or declared to be voidable, void, invalid, illegal or otherwise not fully enforceable shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be of full force and effect as set out herein. The Contract shall not be interpreted for or against any party on the basis that such party or its legal representatives caused part of or the entire Contract to be drafted.

38.0 COMPLIANCE WITH AUDITING AND REPORTING REQUIREMENTS FOR NONPROFIT ORGANIZATIONS (O.C.G.A. § 50-20-1 ET SEQ.)

The Contractor agrees to comply at all times with the provisions of the Federal Single Audit Act (hereinafter called the Act) as amended from time to time, all applicable implementing regulations, including but not limited to any disclosure requirements imposed upon non-profit organizations by the Georgia Department of Audits as a result of the Act, and to make complete restitution to DCH of any payments found to be improper under the provisions of the Act by the Georgia Department of Audits, the Georgia Attorney General's Office or any of their respective employees, agents, or assigns.

39.0 COUNTERPARTS/ELECTRONIC SIGNATURE

This Contract may be signed in any number of counterparts, each of which shall be an original, with the same effect as if the signatures thereto were upon the same instrument. Any signature below that is transmitted by facsimile or other electronic means shall be binding and effective as the original.

40.0 ENTIRE AGREEMENT

This Contract constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, representations or contracts. No written or oral agreements, representatives, statements, negotiations, understandings, or discussions that are not set out, referenced, or specifically incorporated in this Contract shall in any way be binding or of effect between the Parties.

(Signatures on following page)

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SIGNATURE PAGE

IN WITNESS WHEREOF, the parties state and affirm that, they are duly authorized to bind the respected entities designated below as of the day and year indicated.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

_____ _____
Caylee Noggle, Commissioner Date

_____ _____
Lynnette R. Rhodes, Esq. Date
Division of Medical Assistance Plans

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.

BY: _____ _____
Signature Date

_____
Print/Type Name

_____
*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Corporation to a Contract