



CONTRACT
BETWEEN
THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH
AND
[CARE MANAGEMENT ORGANIZATION]
FOR
PROVISION OF SERVICES TO GEORGIA FAMILIES

Note: DCH shall, in its own discretion, determine which exceptions to the Contract will be addressed. Furthermore, it is DCH's intent that the contracts with all vendors selected to provide these services contain consistent terms and conditions.

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THIS CONTRACT is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as “DCH” or the “Department”) and [**Care Management Organization**] (hereinafter referred to as the “Contractor”) and is made effective on the date signed by the DCH Commissioner after any approval required by the Centers for Medicare and Medicaid Services (CMS) (hereinafter referred to as the “Contract Effective Date”).

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 “Medicaid Program”), 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 [XXX] (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 (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 through 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:

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.

Action: 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 Care Management Organization (CMO) to act within the time frames provided in 42 CFR 438.408(b).

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.

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 federal law 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 request for review of an action, as “action” is defined in 42 C.F.R. §438.400.

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 (or Auto-Assignment): The assignment of a new Member to a PCP chosen by the Contractor, 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, 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 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 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.

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.

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 contact by the CMO, with a Potential Member, for the purposes of marketing a Member’s selection or Enrollment in a particular CMO.

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.

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 from January 1, 2011 through January 31, 2015 in which the Demonstration will be effective. This period may be extended upon CMS' approval of DCH's requested extension.

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 Benefits 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: A distinct set of Health Care services provided to a Member enrolled with a CMO on the dates that the services were delivered.

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 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 program serving medically fragile children operating in part under a Home-and-Community Based Waiver.

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 Action. 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.

Grievance System: The overall system that addresses the manner in which the CMO handles Grievances at the Contractor level.

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, 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 beginning 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.

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.

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 who must communicate in that 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 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 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.

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 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).

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.

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.

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: $\text{Pregnancy rate} = [\text{Number of pregnancies in age group} / \text{Female population in age group}] * 1000$. 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 Potential Members or P4HB participants.

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 360° 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 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.

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.

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).

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: Any third party who has a written Contract with the Contractor that have been assigned delegated functions and who have interactions with Members' Coordination of Care or the delivery of care.

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.

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 an Member applicant for or recipient of medical assistance.

Transition of Care: 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 or under DJJ supervision, transition from FFS Medicaid or commercial health plans to the Georgia Families 360° program; transition from a CMO to the Georgia Families 360° CMO, changes in Residential Placement, aging out of Foster Care or exiting DJJ supervision.

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.

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 360°

GFMOOC – 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

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

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 Benefits 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

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.

2.3 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 or its Agent will review the Medicaid Management Information System (MMIS) file daily and send written notification and information within two (2) Business Days to all Members who are determined eligible for GF. A Member shall have thirty (30) Calendar Days to select a CMO and a PCP. Each Family Head of Household shall have thirty (30) Calendar Days to select a CMO and PCP for each Member. DCH or its Agent will issue a daily notice of all Enrollments to the CMO.

2.3.3 If the Member does not choose a CMO within thirty (30) Calendar Days of being deemed eligible for GF, 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 If the Potential P4HB participant does not choose a CMO within thirty (30) Calendar Days of being deemed eligible for the Demonstration, 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 thirty (30) 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, whether chosen or Auto-Assigned, will be effective at 12:01 a.m. on the first (1st) Calendar Day after the Member's selection or Auto Assignment.
- 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, 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 in any Service Region, DCH will provide the CMOs in the Service Region 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. 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 threshold and/or use quality, cost, or other measures to conduct auto-assignments for reasons it deems necessary and proper.

2.4 DIENROLLMENT

- 2.4.1 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. Whether requested by the Member or P4HB participant or the Contractor the following are the timeframes for approved disenrollment:
- 2.4.2.1 If the Disenrollment request is received by DCH or its Agent on or before the managed care monthly process on the twenty-fourth (24th) Calendar Day of the month, the Disenrollment will be effective at midnight the first (1st) day of the month following the month in which the request was filed; and
- 2.4.2.2 If the Disenrollment request is received by DCH or its agent after the managed care monthly process on the twenty-fourth (24th) Calendar Day of the month, the Disenrollment will be effective at midnight the first (1st) day of the second (2nd) month following the month in which the request was filed.
- 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 the timeframes identified in 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 DCH will provide to the Contractor its methodology for identifying the prevalent non-English languages spoken. For the purposes of this Section, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State.

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.

2.8 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 Operations 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.

2.9 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.

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.
- 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 not discriminate against individuals on any basis, including but not limited to religion, gender, race, color, or national origin, 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, or national origin 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.

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:
 - 4.1.2.4.7.2.1 The PCP no longer meets the geographic access standards as defined in this Contract;

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

4.1.2.4.7.2.3 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 Within twenty-four (24) hours of the birth, the Contractor shall ensure the submission of a newborn notification form to DCH or its Agent. 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 4.1.2.3. Notice of the PCP Auto-Assignment shall be mailed to the mother within twenty-four (24) hours of assignment.

4.1.6 Assignment after Re-Enrollment

- 4.1.6.1 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.

4.1.7 Reporting Requirements

- 4.1.7.1 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.
- 4.1.7.2 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 every twelve (12) months thereafter.

- 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 4.1.1. 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.

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 Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH.

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.

4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5th) 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 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 Appeal with the Contractor;
 - 4.3.3.2.28.2 The requirements and timeframes for filing a Grievance or Appeal with the Contractor;
 - 4.3.3.2.28.3 The availability of assistance in filing a Grievance or Appeal with the Contractor;
 - 4.3.3.2.28.4 The toll-free numbers Members can use to file a Grievance or an Appeal 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 is pending, if the final decision is adverse to the Member.
- 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 and Appeal with the Contractor;
 - 4.3.3.3.20.2 The requirements and timeframes for filing a Grievance or Appeal with the Contractor;
 - 4.3.3.3.20.3 The availability of assistance in filing a Grievance or Appeal 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 thirty (30) Calendar Days before the effective date of 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;
- 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 447.60 and **Attachment J** of this Contract.

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. 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 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.
- 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, locations, office hours, telephone numbers of 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 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: Eighty percent (80%) of calls shall be 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. The remaining twenty percent (20%) of calls shall be answered by a person within one (1) minute of the call.
- 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;
 - 4.3.9.1.6 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, 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 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.

4.4.2 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 materials shall comply with the information requirements in 42 CFR 438.10 and detailed in Section 4.3.2 of this Contract.

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.

4.4.3.2 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. 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.

- 4.5.1.2 The Contractor shall at a minimum provide to P4HB participants Demonstration related Services and Benefits pursuant to the CMS Special Terms And Conditions (STCs) pertaining to the Planning for Health Babies 1115 Demonstration Waiver Program.
- 4.5.1.3 Dental Preventive Services that carry a limitation per year shall be limited to a 12-rolling month period.
- 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 Medical Necessity
 - 4.5.4.1 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:

- 4.5.4.1.1 Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;
 - 4.5.4.1.2 Compatible with the standards of acceptable medical practice in the community;
 - 4.5.4.1.3 Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
 - 4.5.4.1.4 Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and
 - 4.5.4.1.5 Not primarily custodial care unless custodial care is a Covered Service or benefit under the Members evidence of coverage.
- 4.5.4.2 There must be no other effective and more conservative or substantially less costly treatment, service and setting available.
- 4.5.4.3 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.
- 4.5.5 Experimental, Investigational or Cosmetic Procedures, Drugs, Services, or Devices
- 4.5.5.1 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.
- 4.5.6 Moral or Religious Objections
- 4.5.6.1 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:
 - 4.5.6.1.1 DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;

- 4.5.6.1.2 Members within sixty (60) Calendar Days before adopting the policy with respect to any service; and
- 4.5.6.1.3 Members before and during Enrollment.
- 4.5.6.2 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.
- 4.5.6.3 The Contractor acknowledges that such objection will be grounds for recalculation of rates paid to the Contractor by DCH.

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.

4.6.5 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 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.

4.6.7 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 Medicaid children eighteen (18) years old 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 collaborate with the Department of Public Health to ensure that all Providers use vaccines which have been made available, free of cost, under the VFC program for Members eighteen (18) years of age and younger. 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 438.6 (i) (1)-(2) 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.

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.

4.7 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 Contract 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 and maintain a network of Providers and facilities adequate to deliver Covered Services as described in the RFP and this Contract while ensuring adequate and appropriate provision of services to Members in rural areas, and which may include the use of telemedicine when appropriate to the condition and needs of the Member. 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.
- 4.8.1.2 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.
- 4.8.1.3 The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.
- 4.8.1.4 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.
- 4.8.1.5 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.
- 4.8.2.2 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.

4.8.3 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 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 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. Further, DCH does not currently recognize Store-and-Forward interactions of any kind. 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 make a reasonable effort to subcontract with all family planning clinics, including those funded by Title X of the Public Health Services Act.

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

4.8.12.1.3 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
Obstetric Providers	Two (2) within thirty (30) minutes or thirty (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	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
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
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
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
Mental 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.

4.8.22 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 The Contractor shall submit to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter all materials and information to be distributed and/or made available to Providers about Georgia Families.
- 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/EPSTD 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: Eighty percent (80%) of calls shall be 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. The remaining twenty percent (20%) of calls shall be answered within one (1) minute of the call.
 - 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 (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 Systems
 - 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 with the remittance advice of the processed Claim. 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 or appeals of multiple Claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment Claims included in the bundled complaint or appeal;
 - 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 Action to the Provider. The Notice of Adverse Action 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 Action 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..

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;
- 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 4.5.4;
- 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.

4.10.2 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.

4.10.5 Administrative Review Process/Law Hearing

- 4.10.5.1 The Contractor shall offer the opportunity for Administrative Review to any Provider against whom it proposes to take an adverse action 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.
- 4.10.5.2 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 action. The request must include all grounds for Administrative Review and must be accompanied by all supporting documentation.
- 4.10.5.3 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 Action

which informs the Provider of their right to a hearing before an Administrative Law Judge at the Office of State Administrative Hearings (OSAH).

4.10.5.4 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.

4.10.5.5 All Provider Administrative Appeals shall be transmitted to the Office of State Administrative Hearings.

4.10.6 Reporting Requirements

4.10.6.1 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.

4.10.7 Hospital Medicaid Financing Program Act (formerly known as the Provider Payment Agreement Act (PPA)).

4.10.7.1 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.

4.10.7.2 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 4.10.7.1. The report will include, but not be limited to monthly reports, by hospital, that provide the following data for each claim paid:

4.10.7.2.1 Claim Number;

4.10.7.2.2 Date of Service;

4.10.7.2.3 Date of Payment;

4.10.7.2.4 Base Paid Amount;

4.10.7.2.5 Add-on Paid Amount;

4.10.7.2.6 Interest Paid Amount; and

4.10.7.2.7 Total Paid Amount.

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 4.5.4.

- 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, or contractors based on:
 - 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, 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 Service 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 Service 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 three (3) Business Days 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.

4.11.2.8 The Contractor's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.

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 Transition of Members
 - 4.11.4.1 The Contractor shall coordinate the transfer of information when Members transition from one CMO to another, to the fee-for-service system, or to private insurance.
 - 4.11.4.2 Inpatient Acute Coverage Responsibility
 - 4.11.4.2.1 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 benefits, 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.
 - 4.11.4.2.2 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 benefits. 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.

- 4.11.4.2.3 Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned CMO.
- 4.11.4.2.4 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.
- 4.11.4.2.5 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.

4.11.4.3 Relinquishment of Members

- 4.11.4.3.1 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:
 - 4.11.4.3.1.1 Pregnancy (especially women who are high risk and in third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date)
 - 4.11.4.3.1.2 Major organ or tissue transplantation services which are in process, or have been authorized
 - 4.11.4.3.1.3 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing or other facilities

- 4.11.4.3.1.4 Significant medical conditions, (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments
- 4.11.4.3.1.5 Members who are in treatment such as:
 - 4.11.4.3.1.5.1 Chemotherapy, and/or radiation therapy; or
 - 4.11.4.3.1.5.2 Dialysis.
- 4.11.4.3.1.6 Members with ongoing needs such as:
 - 4.11.4.3.1.6.1 Durable medical equipment including ventilators and other respiratory assistance equipment;
 - 4.11.4.3.1.6.2 Home health services;
 - 4.11.4.3.1.6.3 Medically Necessary transportation on a scheduled basis; or
 - 4.11.4.3.1.6.4 Prescription medications.
- 4.11.4.3.1.7 Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible Members
- 4.11.4.3.1.8 Members who are currently hospitalized.

4.11.4.4 Long-Term Care Coverage Responsibility

- 4.11.4.4.1 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.
- 4.11.4.4.2 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.
- 4.11.4.4.3 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.
- 4.11.4.4.4 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.

4.11.5 Back Transfers

- 4.11.5.1 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.
- 4.11.5.2 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.
- 4.11.5.3 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.
- 4.11.5.4 The Contractor shall make available Provider education and clear policies regarding the “back transfer” Pre-Certification requirements along with the billing procedures.

4.11.6 Court-Ordered Evaluations and Services

- 4.11.6.1 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.

4.11.7 Second Opinions

- 4.11.7.1 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.
- 4.11.7.2 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.
- 4.11.7.3 The second opinion shall be provided at no cost to the Member.

4.11.8 Coordination and Continuity of Care Responsibilities

- 4.11.8.1 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.

- 4.11.8.2 The Contractor must develop and implement Care Coordination and Continuity of Care. Policies and procedures are designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and include, at a minimum, the following elements:
 - 4.11.8.2.1 The provision of an individual needs assessment and diagnostic assessment; 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;
 - 4.11.8.2.2 Includes a patient-centered approach to meet the needs of Members, addressing both developmental and chronic conditions;
 - 4.11.8.2.3 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. This treatment plan shall be approved in a timely manner by the Medical Director and in accordance with any applicable State quality assurance and Utilization Review standards;
 - 4.11.8.2.4 A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning or regular care management;
 - 4.11.8.2.5 A strategy to ensure the timely provision of services;
 - 4.11.8.2.6 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;
 - 4.11.8.2.7 Use of data analytics to identify patterns of care. DCH encourages the use of predictive modeling to identify high risk Members;
 - 4.11.8.2.8 Procedures and criteria for making Referrals to specialists and sub-specialists;
 - 4.11.8.2.9 Procedures and criteria for maintaining treatment plans and Referral Services when the Member changes PCPs;
 - 4.11.8.2.10 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;

- 4.11.8.2.11 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and
- 4.11.8.2.12 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.
- 4.11.8.3 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.
- 4.11.8.4 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.
- 4.11.8.5 Transition of Care
 - 4.11.8.5.1 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 Members, the Contractor shall cooperate with the receiving 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:
 - 4.11.8.5.1.1 Members who are currently hospitalized;
 - 4.11.8.5.1.2 Pregnant women who are high risk and in their third trimester, or are within thirty (30) Calendar Days of their anticipated delivery date;
 - 4.11.8.5.1.3 Major organ or tissue transplantation services which are in process, or have been authorized;
 - 4.11.8.5.1.4 Chronic illness, which has placed the Member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities;

- 4.11.8.5.1.5 Members who are in treatment such as Chemotherapy, radiation therapy, or Dialysis;
- 4.11.8.5.1.6 Members with ongoing needs such as Specialized Durable medical equipment, including ventilators and other respiratory assistance equipment;
- 4.11.8.5.1.7 Current Home health services;
- 4.11.8.5.1.8 Medically Necessary transportation on a scheduled basis;
- 4.11.8.5.1.9 Prescription medications requiring Prior Authorizations;
- 4.11.8.5.1.10 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
- 4.11.8.5.1.11 Members that are in ongoing outpatient treatment or that are receiving medication 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 Contractor 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.

4.11.8.6 Discharge Planning

- 4.11.8.6.1 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.
- 4.11.8.6.2 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.

4.11.8.6.3 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.

4.11.8.7 Care Coordination

4.11.8.7.1 The Contractor shall provide Care Coordination services which shall:

4.11.8.7.1.1 Be comprehensive: All services a Member receives are to be coordinated;

4.11.8.7.1.2 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions; and

4.11.8.7.1.3 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.

4.11.8.8 Coordination with Other Entities

4.11.8.8.1 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.

4.11.8.8.2 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.

4.11.8.8.3 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.

4.11.8.8.4 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:

4.11.8.8.4.1 NET vendors to ensure Members are able to access Medically Necessary services in a timely manner.

4.11.8.8.4.2 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.

4.11.8.8.4.3 DCH's CVO as set forth in Section 4.8.21.

4.11.8.8.4.4 DCH's Fiscal Agent Contractor.

4.11.8.8.4.5 The State Health Benefit Plan

4.11.8.8.4.6 Vendors identified by DCH to complete DCH required audits, reviews and special projects.

4.11.8.8.4.7 Other DCH vendors, including other Georgia Families CMOs to complete statewide initiatives.

4.11.8.8.4.8 Private insurance and Fee-for-Service providers

4.11.8.8.5 The Contractor shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with

4.11.8.9 Integration of Physical and Behavioral Health Services

4.11.8.9.1 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.

- 4.11.8.9.2 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.
- 4.11.8.9.3 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:
 - 4.11.8.9.3.1 Program Goals and Objectives
 - 4.11.8.9.3.2 Summary of activities and efforts to integrate and coordinate behavioral and physical health;
 - 4.11.8.9.3.3 Successes (e.g., exceeding performance targets) and opportunities for improvement;
 - 4.11.8.9.3.4 Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and
 - 4.11.8.9.3.5 Roadmap of activities planned for the next reporting

4.11.9 Disease Management

- 4.11.9.1 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.
- 4.11.9.2 Disease Management functions include, but are not limited to:
 - 4.11.9.2.1 Incorporating evidence-based guidelines or standards of care in program development.
 - 4.11.9.2.2 Utilizing clinical data to stratify Members for Enrollment based on levels of service intensity.
 - 4.11.9.2.3 Encouraging the Member's active participation and adherence to interventions.
 - 4.11.9.2.4 Educating the Member on their disease or condition to facilitate self-management.
 - 4.11.9.2.5 Consistently informing the Member on progress in the the confidentiality requirements in 45 CFR 160 and 45 CFR 164.

- 4.11.9.2.6 Promoting Coordination of Care by collaborating and communicating with Providers and other health care resources to improve Member outcomes.
- 4.11.9.3 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.
- 4.11.9.4 The Contractor must submit Quarterly status reports to DCH which include specified Disease Management Program data as listed in Section 5.71 in addition to the annual report.

4.11.10 Case Management

- 4.11.10.1 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.
- 4.11.10.2 Case Management functions include, but are not limited to:
 - 4.11.10.2.1 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;
 - 4.11.10.2.2 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;
 - 4.11.10.2.3 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;
 - 4.11.10.2.4 Coordination of Care, as previously described;
 - 4.11.10.2.5 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;

- 4.11.10.2.6 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;
 - 4.11.10.2.7 Follow up which includes assessing the achievement of established goals and identifying the overall impact of the plan of care;
 - 4.11.10.2.8 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
 - 4.11.10.2.9 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.
- 4.11.10.3 Case Management functions for the IPC component of the P4HB Demonstration include:
- 4.11.10.3.1 Early identification of P4HB IPC Participants who have or may have special needs;
 - 4.11.10.3.2 Assessment of a P4HB IPC Participant's risk factors;
 - 4.11.10.3.3 Development of a plan of care;
 - 4.11.10.3.4 Referrals and assistance to ensure timely access to Providers included and external to the Contractor's network;
 - 4.11.10.3.5 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;
 - 4.11.10.3.6 Resource Mothers Outreach;
 - 4.11.10.3.7 Monitoring;
 - 4.11.10.3.8 Continuity of care;
 - 4.11.10.3.9 Follow up; and
 - 4.11.10.3.10 Documentation
- 4.11.10.4 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.

4.11.10.5 The Contractor must monitor the effectiveness of the Resource Mothers Outreach and ensure such Outreach activities comply with the Resource Mothers Training Manual.

4.11.10.6 Levels of Case Management for the GF Program include:

4.11.10.6.1 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.

4.11.10.6.2 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.

4.11.10.6.3 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.

4.11.10.7 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.

4.11.10.8 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.

4.11.10.9 The Contractor will submit quarterly reports to DCH which include specified Case Management Program data as listed in Section 5.71 in addition to the annual report.

4.11.11 Reporting Requirements

4.11.11.1 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.

4.1.1.11.2 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.

4.1.1.11.3 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 two (2) 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 disproportionately 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 438.240. 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.
- 4.12.9.5 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.
- 4.12.9.6 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:

- 4.12.10.1.4.1 Report and analyze the patient safety programs and outcomes in place within the CMO's network of hospitals;
- 4.12.10.1.4.2 Report and analyze Medication recalls;
- 4.12.10.1.4.3 Report and analyze Medication errors;
- 4.12.10.1.4.4 Describe the results of site Inspections; and
- 4.12.10.1.4.5 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) 2017, 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. 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.

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 ("GFMOOC") and associated subcommittees as requested by DCH. The GFMOOC 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 GFMOOC 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 GFMOOC will be appointed by the DCH Commissioner or his designee. The GFMOOC 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 guard against Fraud 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.
- 4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below.
- 4.13.1.3 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 accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed.
 - 4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud , Waste and Abuse violations, including specific methodologies for such monitoring and auditing;

- 4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;
- 4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;
- 4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;
- 4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;
- 4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;
- 4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following:
 - 4.13.2.1.8.1 Prepayment review of claims;
 - 4.13.2.1.8.2 Claims edits;
 - 4.13.2.1.8.3 Post-processing review of Claims;
 - 4.13.2.1.8.4 Provider profiling;
 - 4.13.2.1.8.5 Quality Control; and
 - 4.13.2.1.8.6 Utilization Management.
- 4.13.2.1.9 Written standards for organizational conduct;
- 4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;
- 4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;
- 4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;
- 4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified; and

4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Georgia Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.

4.13.2.2 As part of the Program Integrity Program, the Contractor may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH 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:

4.13.2.2.1 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;

4.13.2.2.2 Provide Case Management and education reinforcement of appropriate medication use;

4.13.2.2.3 Annually assess the need for lock in for each Member;

4.13.2.2.4 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH; and

4.13.2.2.5 Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.

4.13.3 Coordination with DCH and Other Agencies

4.13.3.1 The Contractor shall cooperate 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.

4.13.3.2 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.

4.13.3.3 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.

4.13.4 Reporting Requirements

- 4.13.4.1 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 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.20.

4.14 INTERNAL GRIEVANCE/APPEALS SYSTEM

4.14.1 General Requirements

- 4.14.1.1 The Contractor's Grievance System shall include a process to receive, track, resolve and report on Grievances from its Members. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's 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.
- 4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.
- 4.14.1.3 The Contractor shall process each Grievance and Administrative Review 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.
- 4.14.1.4 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.
- 4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review 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.
- 4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision-making; 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:

- 4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;

4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and

4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.

4.14.2 Member Medical Review Process for PeachCare for Kids®

4.14.2.1 DCH also allows a state review on behalf of PeachCare for Kids® Members. If the Member, parent or other authorized representative of the Member believes that a denied service should be covered, the parent or such representative must send a written request for review to the CMO in which the affected child is enrolled.

4.14.2.2 If the decision of the Contractor review maintains the denial of service, a letter will be sent to the parent or representative detailing the reason for denial. If the parent or representative elects to dispute the decision, the parent or representative will have the option of having the decision reviewed by the Formal Grievance Committee. The request should be sent to:

Department of Community Health
PeachCare for Kids®
Administrative Review Request
2 Peachtree Street, NW, 37th floor
Atlanta, GA 30303-3159

4.14.2.3 The decision of the Formal Grievance Committee will be the final recourse available to the Member. In reference to the Formal Grievance level, the State assures:

4.14.2.3.1 Enrollees receive timely written notice of any documentation that includes the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which Enrollment may continue, pending review.

4.14.2.3.2 Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, or termination of health services, or failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Grievance level.

4.14.2.3.3 Decisions are written when reviewed by DCH and the Formal Grievance Committee.

4.14.2.3.4 Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.

4.14.2.3.5 Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, Members will be notified of the

timeframes for the appeals process once an appeal is filed with the Formal Grievance Committee.

- 4.14.2.3.6 Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.
- 4.14.2.3.7 Reviews that are not expedited due to an enrollee's medical condition will be completed within ninety (90) Calendar Days of the date of a request is made.
- 4.14.2.3.8 Reviews that are expedited due to an enrollee's medical condition shall be completed within seventy-two (72) clock hours of the receipt of the request.

4.14.3 Grievance Process

- 4.14.3.1 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 a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.
- 4.14.3.2 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.
- 4.14.3.3 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.
- 4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.

4.14.4 Proposed Action

- 4.14.3.1 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.
- 4.14.3.2 In the event of a Proposed Action, the Contractor shall notify the Member in writing. The Contractor shall also provide written notice of a Proposed Action to the Provider. This notice must meet the language and format requirements in accordance with Section 4.3.2 of this Contract and be sent in accordance with the timeframes described in Section 4.14.3.4.
- 4.14.3.3 The notice of Proposed Action must contain the following:

- 4.14.3.3.1 The Action the Contractor has taken or intends to take, including the service or procedure that is subject to the Action;
 - 4.14.3.3.2 Additional information, if any, that could alter the decision;
 - 4.14.3.3.3 The specific reason used as the basis of the Action;
 - 4.14.3.3.4 The reasons for the Action must have a factual basis and legal/policy basis;
 - 4.14.3.3.5 The Member's right to file an Administrative Review through the Contractor's internal Grievance System;
 - 4.14.3.3.6 The Provider's right to file a Provider Complaint as described in Section 4.9.7;
 - 4.14.3.3.7 The requirement that a Member exhaust the Contractor's internal Administrative Review Process;
 - 4.14.3.3.8 The procedures for exercising the rights outlined in this Section;
 - 4.14.3.3.9 The circumstances under which expedited review is available and how to request it; and
 - 4.14.3.3.10 The Member's right to have Benefits continue pending resolution of the Administrative Review with the Contractor, Member instructions on how to request that Benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.
- 4.14.3.4 The Contractor shall mail the notice of Proposed Action within the following timeframes:
- 4.14.3.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of one of the following exceptions:
 - 4.14.3.4.1.1 The Contractor has factual information confirming the death of a Member.
 - 4.14.3.4.1.2 The Contractor receives a clear written statement signed by the Member that
 - 4.14.3.4.1.2.1 he or she no longer wishes services; or
 - 4.14.3.4.1.2.2 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.

- 4.14.3.4.1.3 The Contractor establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.
- 4.14.3.4.1.4 The Member has been admitted to an institution where he is ineligible under the plan for further services.
- 4.14.3.4.1.5 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).
- 4.14.3.4.1.6 The Member's Provider prescribes an immediate change in the level of medical care.
- 4.14.3.4.1.7 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).
- 4.14.3.4.2 For Standard Service Authorization decisions that deny or limit services, within the timeframes required in Section 4.11.2.7.1.
- 4.14.3.4.3 If the Contractor extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.7, 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.
- 4.14.3.4.4 For authorization decisions not reached within the timeframes required in Section 4.11.2.7 for either standard or expedited Service Authorizations (which constitutes a denial and is thus an adverse action), notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.
- 4.14.3.5 Notice in Case of Probable Fraud
 - 4.14.3.5.1 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 Action should be taken because of probable Member

Fraud and the facts have been verified, if possible, through secondary sources.

4.14.4 Administrative Review Process

- 4.14.4.1 An Administrative Review is the request for review of a “Proposed Action”. The Member, the Member’s Authorized Representative, or the Provider acting on behalf of the Member with the Member’s written consent, may file an Administrative Review either orally or in writing. Unless the Member or Provider requests expedited review, the Member, the Member’s Authorized Representative, or the Provider acting on behalf of the Member with the Member’s or written consent, must follow an oral filing with a written, signed, request for Administrative Review. An Administrative Review must be filed within thirty (30) Calendar Days of the notice of Proposed Action.
- 4.14.4.2 Administrative Reviews shall be filed directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Administrative Review committee, but the delegation must be in writing.
- 4.14.4.3 The Contractor shall ensure that the individuals who make decisions on Administrative Reviews are individuals who were not involved in any previous level of review or decision-making and who are Health Care Professionals who have the appropriate clinical expertise in treating the Member’s Condition or disease if deciding any of the following:
 - 4.14.4.3.1 An Administrative Review of a denial that is based on lack of Medical Necessity.
 - 4.14.4.3.2 An Administrative Review that involves clinical issues.
- 4.14.4.4 The Administrative Review process shall provide the Member, the Member’s Authorized Representative, or the Provider acting on behalf of the Member with the Member’s written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing, and to examine the Member’s case file, including Medical Records, and any other documents and records considered during the Administrative Review process. The Contractor shall inform the Member of the limited time available to provide this in case of expedited review.
- 4.14.4.5 The Administrative Review process must include as parties to the Administrative Review the Member, the Member’s Authorized Representative, the Provider acting on behalf of the Member with the Member’s written consent, or the legal representative of a deceased Member’s estate.
- 4.14.4.6 The Contractor shall resolve each Administrative Review and provide written notice of the resolution, as expeditiously as the Member’s health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Contractor receives the Administrative Review. For expedited reviews and notice to affected parties, the Contractor has no longer than three (3) Working Days or as expeditiously as the

Member's physical or mental health condition requires, whichever is sooner. If the Contractor denies a Member's request for expedited review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) Calendar Days with a written notice. The Contractor shall also make reasonable efforts to provide oral notice for resolution of an expedited review of an Administrative Review.

- 4.14.4.7 The Contractor may extend the timeframe for standard or expedited resolution of the Administrative Review by up to fourteen (14) Calendar Days if the Member, Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, requests the extension or the Contractor demonstrates (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the Member's interest. If the Contractor extends the timeframe, it must, for any extension not requested by the Member, give the Member written notice of the reason for the delay.

4.14.5 Notice of Adverse Action

- 4.14.5.1 If the Contractor upholds the Proposed Action in response to an Administrative Review filed by the Member the Contractor shall issue a Notice of Adverse Action within the timeframes described in Sections 4.14.4.6 and 4.14.4.7.
- 4.14.5.2 The Notice of Adverse Action shall meet the language and format requirements as specified in 4.3.2 and include the following:
 - 4.14.5.2.1 The results and date of the Adverse Action including the service or procedure that is subject to the Action.
 - 4.14.5.2.2 Additional information, if any, that could alter the decision.
 - 4.14.5.2.3 The specific reason used as the basis of the Action.
 - 4.14.5.2.4 The right to request a State Administrative Law Hearing within thirty (30) Calendar Days from the date of the Notice of Adverse Action. The time for filing will begin when the filing is date stamped.
 - 4.14.5.2.5 The right to continue to receive Benefits pending a State Administrative Law Hearing.
 - 4.14.5.2.6 How to request the continuation of Benefits.
 - 4.14.5.2.7 Information explaining that the Member may be liable for the cost of any continued Benefits if the Contractor's Action is upheld in a State Administrative Law Hearing.
 - 4.14.5.2.8 Circumstances under which expedited resolution is available and how to request it.

4.14.6 Administrative Law Hearing

- 4.14.6.1 The State will maintain an independent Administrative Law Hearing process as defined in O.C.G.A. §49-4-153 and as required by federal law, 42 CFR 431.200. The 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.
- 4.14.6.2 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.
- 4.14.6.3 A Member, or Member's Authorized Representative may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by the Contractor. The parties to the Administrative Law Hearing shall include the Contractor as well as the Member, Member's Authorized Representative, or authorized representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member. DCH reserves the right to intervene on behalf of the interest of either party.
- 4.14.6.4 The hearing request and a copy of the adverse action letter must be received by the Contractor within thirty (30) Calendar Days or less from the date that the notice of Action was mailed.
- 4.14.6.5 A Member may request a Continuation of Benefits as described in Section 4.14.7 while an Administrative Law Hearing is pending.
- 4.14.6.6 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 while the Contractor Appeal and Administrative Law Hearing are Pending

- 4.14.7.1 As used in this Section, "timely" filing means filing on or before the later of the following:
 - 4.14.7.1.1 Within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Action.
 - 4.14.7.1.2 The intended effective date of the Contractor's Proposed Action.
- 4.14.7.2 The Contractor shall continue the Member's Benefits if the Member, or the Member's Authorized Representative files the Appeal timely; the Appeal 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.

- 4.14.7.3 If, at the Member's request, the Contractor continues or reinstates the Member's Benefits while the Appeal or Administrative Law Hearing is pending, the Benefits must be continued until one of the following occurs:
- 4.14.7.3.1 The Member withdraws the Appeal or request for the Administrative Law Hearing.
 - 4.14.7.3.2 Ten (10) Calendar Day pass after the Contractor mails the Notice of Adverse Action, unless the Member, within the ten (10) Calendar Day timeframe, has requested an Administrative Law Hearing with continuation of Benefits until an Administrative Law Hearing decision is reached.
 - 4.14.7.3.3 An Administrative Law Judge issues a hearing decision adverse to the Member.
 - 4.14.7.3.4 The time period or service limits of a previously authorized service has been met.
- 4.14.7.4 If the final resolution of Appeal is adverse to the Member, that is upholds the Contractor's Action, the Contractor may recover from the Member the cost of the services furnished to the Member while the Appeal is pending, to the extent that they were furnished solely because of the requirements of this Section.
- 4.14.7.5 If the Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires.
- 4.14.7.6 If the Contractor or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the Contractor shall pay for those services.

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.

- 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 to provide timely, complete and accurate information. Encounter data from the Contractor 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 the Division of Managed Care and Quality to make recommendations that can lead to the improvement of healthcare outcomes.
- 4.16.3.2 The Contractor 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.
- 4.16.3.3 The Contractor shall instruct 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 Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.

- 4.16.3.4 The Contractor shall submit to DCH's Fiscal Agent Contractor weekly cycles of data files. All identified errors shall be submitted to the Contractor from the Fiscal Agent Contractor each week. The Contractor shall address identified issues and resubmit the corrected file to the Fiscal Agent Contractor within seven (7) Business Days of receipt.
- 4.16.3.5 The Contractor is required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, NPI numbers, SSN numbers, Member Name, and DOB. These items must match the state's eligibility and provider file.
- 4.16.3.6 The Contractor's submitted Claims must include:
 - 4.16.3.6.1 Patient name;
 - 4.16.3.6.2 Date of birth;
 - 4.16.3.6.3 Place of service;
 - 4.16.3.6.3 Date of service;
 - 4.16.3.6.4 Type of service;
 - 4.16.3.6.5 Units of service;
 - 4.16.3.6.7 Diagnostic related groupings (DRGs);
 - 4.16.3.6.8 Treating Provider;
 - 4.16.3.6.9 NPI number of rendering Provider;
 - 4.16.3.6.10 NPI number of OPR Provider;
 - 4.16.3.6.11 Tax Identification Number;
 - 4.16.3.6.12 Facility code;
 - 4.16.3.6.13 A unique TCN;
 - 4.16.3.6.14 All additionally required CMS 1500 or UB 04 codes; and
 - 4.16.3.6.15 CMO Paid Amount.
- 4.16.3.7 For each submission of Claims per 4.16.3.5 and 4.16.3.6, Contractor must provide via DCH's required electronic format the following Cash Disbursements data elements:

- 4.16.3.7.1 Provider/Payee Number;
 - 4.16.3.7.2 Name;
 - 4.16.3.7.3 Address;
 - 4.16.3.7.4 City;
 - 4.16.3.7.5 State;
 - 4.16.3.7.6 Zip;
 - 4.16.3.7.8 Check date;
 - 4.16.3.7.9 Check number;
 - 4.16.3.7.10 Check amount; and
 - 4.16.3.7.11 Check code (i.e. EFT, paper check, etc.).
- 4.16.3.8 Contractor will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.
- 4.16.3.9 The Contractor shall submit ninety-nine percent (99%) of Encounter Data within thirty (30) Calendar Days of Claims payment – both for the original claim and any adjustment. DCH or its Agent will validate Encounter Data submission according to the Cash Disbursement journal of the Contractor and any of its applicable Subcontractors.
- 4.16.3.10 The Contractor shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the Fiscal Agent Contractor and DCH. The Encounter Error Rate is the occurrence of a single error in any Transaction Control Number (TCN) or encounter claim counts as an error for that encounter (this is regardless of how many other errors are detected in the TCN.)
- 4.16.3.11 The Contractor’s failure to comply with defined standard(s) will be subject to a Corrective Action Plan and the Contractor may be liable for liquidated damages.

4.16.5 Emergency Services

- 4.16.5.1 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.
- 4.16.5.2 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.

- 4.16.5.3 In processing claims for Emergency Services, the Contractor shall consider, at the time that a claim is submitted, at least the following criteria:
 - 4.16.5.3.1 The age of the patient;
 - 4.16.5.3.2 The time and day of the week the patient presented for services;
 - 4.16.5.3.3 The severity and nature of the presenting symptoms;
 - 4.16.5.3.4 The patient's initial and final diagnosis; and
 - 4.16.5.3.5 Any other criteria prescribed by DCH, including criteria specific to patient less than eighteen (18) years of age.
- 4.16.5.4 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.
- 4.16.5.5 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.

4.16.6 Reporting Requirements

- 4.16.6.1 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 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.

4.17.2 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.
- 4.17.2.8 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 seven (7) years in either live and/or archival Systems, as applicable. 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.

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 (12th) month of the contract year ending June 30th;

- 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.

4.18.3 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:

<u>Report</u>	<u>Frequency</u>
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
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	
Prior Authorization and Pre-Certification Report	Quarterly

Provider Network Adequacy and Capacity Report	Quarterly
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	4.3.7.9 4.9.5.8
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	4.4.4
MH/SA Policies and Procedures	4.6.11
EPSDT Policies and Procedures	4.7
Provider Selection and Retention Policies and Procedures	4.8.1.6
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 PPO, IPO, 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	4.8.1.8
PCP Selection Policies and Procedures	4.8.2.2
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
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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, which shall begin on July 1, and end at midnight on June 30 of the following year as follows:

Initial Term:	July 1, 2016 - 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

6.2 Pursuant to O.C.G.A. § 50-5-64(a)(2), all renewal options 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 Per Month basis for each Member enrolled in the Contractor's plan as detailed in **Attachment G** ("Capitation Payments") which is incorporated by this reference as if fully written herein. For the first partial month of a Member's enrollment in the Contractor's plan, DCH will prorate the Member'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's enrollment in the CMO. The number of enrolled Members will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's Fiscal Agent Contractor. The Capitation Payment will be multiplied by the number of enrolled Members. 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.

- 7.1.1.1 DCH will compensate the Contractor on a per member per month basis for each P4HB participant enrolled in the Contractor's plan (See **Attachment O**). The number of enrolled P4HB participants in each rate cell category will be determined by the records maintained in the 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 P4HB 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 by this Contract, such amount shall be withheld from the monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.
- 7.1.2 The relevant Deliverables concerning payment under this Contract shall be mailed to the Project Leader named in the Notice provision of this Contract.
- 7.1.3 The total of all payments made by DCH to Contractor under this Contract shall not exceed the per Member per month Capitation payments agreed to under **Attachment G**, which has been provided for through the use of State or federal grants or other funds. With the exception of payments provided to the Contractor in accordance with Section 7.2 on Performance Incentives, DCH will have no responsibility for payment beyond that amount. Also, the total of all payments to the Contractor will not exceed one hundred and five percent (105%) of the Capitation payment pursuant to 42 CFR 438.6 (hereinafter the "Maximum 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.

7.2 PERFORMANCE INCENTIVES

- 7.2.1 Beginning in Calendar Year (CY) 2017, 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. Therefore, the first incentive payments, if any, will be made in CY 2018.
- 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.
- 8.5.3 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.

8.6 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 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.
- 8.6.3 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.
- 8.6.4 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.
- 8.6.4.1 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.
- 8.6.4.2 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%933ChangesAheadforStandardonServiceOrganizations.aspx>.

- 8.6.4.3 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.
- 8.6.4.4 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.
- 8.6.4.5 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.
- 8.6.5 The Contractor shall submit to DCH and the US Department of Health and Human Services a "Disclosure of Ownership and Control Interest Statement"
 - 8.6.5.1 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.
 - 8.6.5.2 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.

8.6.5.3 Definition of A Party in Interest – As defined in Section 1318(b) of the Public Health Service Act, a party in interest is:

8.6.5.3.1 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;

8.6.5.3.2 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;

8.6.5.3.3 Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or

8.6.5.3.4 Any spouse, child, or parent of an individual as described in section 8.6.5.1.

8.6.5.4 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.

8.6.5.5 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.

- 8.6.5.6 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.
- 8.6.5.7 Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:
- 8.6.5.7.1 Any sale, exchange or lease of any property between the Contractor and a party in interest;
 - 8.6.5.7.2 Any lending of money or other extension of credit between the Contractor and a party in interest; and
 - 8.6.5.7.3 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.
- 8.6.5.8 The information which must be disclosed in the transactions listed in Section 8.6.5.7 between the Contractor and a party of interest includes:
- 8.6.5.8.1 The name of the party in interest for each transaction;
 - 8.6.5.8.2 A description of each transaction and the quantity or units involved;
 - 8.6.5.8.3 The accrued dollar value of each transaction during the fiscal year; and
 - 8.6.5.8.4 Justification of the reasonableness of each transaction.
- 8.6.5.9 All information regarding ownership and financial transactions which must be disclosed by the Contractor pursuant to Section 8.6.5 is due at any of the following times:
- 8.6.5.9.1 Upon the Contractor submitting the Contractor Proposal in accordance with the State's procurement process;
 - 8.6.5.9.2 Upon the Contractor executing this Contract with the State;
 - 8.6.5.9.3 Upon renewal or extension of this Contract;
 - 8.6.5.9.3 Within thirty (35) Calendar Days after any change in ownership; and
 - 8.6.5.9.4 At least once every quarter, if so requested by DCH.

8.6.6 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:

8.6.6.1 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.

8.6.6.2 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.

8.6.6.3 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.

8.6.6.4 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.

8.6.6.5 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.

8.6.7 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:

8.6.7.1 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 hereto 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. In addition, all inspections and evaluations shall be 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 reports, analyses, compilations of data or other Deliverables that are furnished to and retained by 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, except as provided herein. The foregoing provision does not apply to computer software or programming materials, user manuals, manuals or other documents created by Contractor that describe its internal policies, staffing, operating procedures, or Systems, or any

other records, papers, files, materials, or media of any kind that are identified and designated by Contractor as trade secret or proprietary information of Contractor, and as to which DCH does not give Contractor notice of objection to such designation within ten (10) Business Days of Contractor's submitting such materials and designation to DCH. 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 releases from such individuals, releasing DCH from any and all damages, claims or demands arising from such use.

13.2 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.

13.3 The Parties agree that access to or review of documents or materials by DCH or any other agency of State Government for informational or educational purposes shall not be regarded as having been "received" by DCH or such other agency within the meaning of O.C.G.A. Section 50-18-70 (a), except insofar as (1) copies of such documents or materials are retained and maintained by a State agency for future reference or use in the performance of State functions, or (2) the creation of such documents or materials, and approval of the specific content of such documents or materials, is expressly required by this Contract or any amendment thereto. The Parties further agree that Manuals, instructions, or other documents or materials created by Contractor for the use, information, and /or direction of its own employees, and that describe Contractor's internal procedures, policies, staffing, systems, operations, methodologies, or the like, shall not be regarded as records received or maintained by Contractor in the performance of a service or function for or on behalf of DCH, notwithstanding that such documents or materials may describe procedures, policies, systems, methodologies, operations, or the like that are applied or followed by Contractor in the course of fulfilling its obligations under this Contract.

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 proposed replacement 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 proposed 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 replacement and the DCH Project Leader shall have the same right of approval. Such process shall be repeated until a proposed replacement is approved by the DCH Project Leader. If, after sixty (60) Calendar Days from the notice of termination, a qualified 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 further agrees that it will not permit any of its employees or its Subcontractor's employees, including temporary or replacement employees, to perform the services under this Contract unless and until they pass any background test or check requested by the Department.

17.2 The Contractor also agrees to abide by 42 USCS § 1320a-7 and all other related provisions or laws. To that end, 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.

- 17.3 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.
- 17.4 Additionally, by signing or executing this Contract, the Contractor states and certifies that neither it nor any of its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any State or Federal department or agency.
- 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. 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 438.6 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.

18.2 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.

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 has complied with all disclosure and registration requirements for vendor lobbyists as set forth in O.C.G.A. § 21-5-1, et seq. and all other applicable law, including but not limited to registering with the State Ethics Commission. For the purposes of this Contract, vendor lobbyists are those who lobby State officials on behalf of businesses that seek a contract to sell goods or services to the State or oppose such contract.
- 21.3 As required by applicable Federal law, Contractor states and warrants that no federal money has been used for any lobbying of State officials, as required under applicable federal law.
- 21.4 Contractor agrees to sign and comply with **Attachment E, Vendor Lobbyist Disclosure and Registration Certification Form.**

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 shall preserve and make available all of its records pertaining to the performance under this Contract for a period of seven (7) 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 seven (7) 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 State Contractor or any of his duly Authorized Representatives, shall be retained by Contractor until such Appeals, litigation, Claims or exceptions have been disposed of.

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) and 42 CFR 434.38, 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/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 4.11.8;
 - 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 implementation date of July 1, 2016; 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;

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 an eighteen percent (18%) 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 Action 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 OTHER REMEDIES

25.7.1 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:

- 25.7.1.1 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;
- 25.7.1.2 Granting Members the right to terminate Enrollment without cause and notifying the affected Members of their right to disenroll;
- 25.7.1.3 Suspension of all new Enrollment, including default Enrollment, after the effective date of remedies;
- 25.7.1.4 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;
- 25.7.1.5 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;
- 25.7.1.6 Civil Monetary Fines in accordance with 42 CFR 438.704;
- 25.7.1.7 Additional remedies allowed under State statute or State regulation that address areas of non-compliance specified in 42 CFR 438.700;
- 25.7.1.8 Referral to appropriate state licensing agency for investigation; and
- 25.7.1.9 Referral to the Office of the Attorney General for investigation.

25.8 NOTICE OF REMEDIES

- 25.8.1 Prior to the imposition of either liquidated damages or other remedies, DCH will issue a written notice of remedies that will include the following:
 - 25.8.1.1 A citation to the law, regulation or Contract provision that has been violated;
 - 25.8.1.2 The remedies to be applied and the date the remedies will be imposed;
 - 25.8.1.3 The basis for DCH's determination that the remedies should be imposed;
 - 25.8.1.4 Request for a Corrective Action Plan, if applicable; and
 - 25.8.1.5 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 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
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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
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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 Contract Execution, 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; Equal Employment Opportunity (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375) and the Americans with Disability Act of 1993 (including but not limited to 28 C.F.R. § 35.100 *et seq.*). 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 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 completion of the project, voluntarily acquire any personal interest, direct or indirect, in this Contract or the proposed 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 the 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 term.
- 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 the actual Contractors 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:

Contract Administration:

Project Leader:

For [Care Management Organization]:

- 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, 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 INTERPRETATION

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 shall 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 **Attachment A**. Contractor agrees to sign and comply with **Attachment A**. The Contractor will secure from any Subcontractor hired to work in a drug-free workplace 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 8.6.5 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 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. For the purposes of this Section, a “relationship” is described as follows:

33.21.1.1 A director, officer or partner of the Contractor;

33.21.1.2 A person with beneficial ownership of five percent (5%) or more of the Contractor entity; and

33.21.1.3 A person with an employment, consulting or other arrangement with the Contractor’s obligations under its Contract with the State.

33.21.2 The Contractor shall submit a quarterly Program Integrity Exception List report that identifies Providers, owners, agents, employees, Subcontractors and contractors (as defined in Section 8.6.5.2) 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).

33.21.3 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).

33.22 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.

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

Clyde L. Reese III, Esq., Commissioner

Date

Chief – Division of Medical Assistance Plans

Date

[CARE MANAGEMENT ORGANIZATION]

BY: _____
Signature

Date

Print/Type Name

*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized by Corporate Resolution to Execute on Behalf of and Bind the Corporation to a Contract

EXHIBIT 1

REQUEST FOR PROPOSALS

Request for Proposal Number [XXX]

(to be placed here)

EXHIBIT 2
CONTRACTOR'S PROPOSAL
(to be placed here)

ATTACHMENT A

DRUG-FREE WORKPLACE CERTIFICATE

This certification is required by regulations implementing the Drug-Free Workplace Act of 1988 and O.C.G.A. § 50-24-1 *et seq.* The certification set out below is a material representation of fact upon which DCH relied when entering into **Contract #2016XXX** with **CONTRACTOR** (hereinafter referred to as the “Contractor”). False certification or violation of the certification shall be grounds for suspension of payments, termination of the contract, or government-wide suspension or debarment.

By signing this Drug-Free Workplace Certificate, Contractor certifies that it will provide a drug-free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession or use of a controlled substance or marijuana is prohibited in Contractor’s workplace and specifying the actions that will be taken against employees for violations of such policy;
2. Establishing a drug-free awareness program to inform employees about:
 - a. The dangers of drug abuse in the workplace;
 - b. Contractor’s policy of maintaining a drug-free workplace;
 - c. Any available drug counseling, rehabilitation, and employee assistance programs; and
 - d. The penalties that may be imposed upon employees for drug abuse violations;
3. Providing each employee with a copy of the statement provided for in paragraph (1) of this certification;
4. Notifying each employee in the statement provided for in paragraph (1) that, as a condition of employment, the employee shall:
 - a. Abide by the terms of the statement; and
 - b. Notify Contractor of any criminal drug statute conviction for a violation occurring in the workplace no later than five calendar days after such conviction;
5. Notifying DCH within ten calendar days after receiving notice under subparagraph 4(b) from an employee or otherwise receiving actual notice of such conviction;
6. Taking one of the following actions, within 30 days of receiving notice under subparagraph 4(b), with respect to any employee who is so convicted:
 - a. Taking appropriate personnel action against such an employee, up to and including termination; or
 - b. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency;

7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1, 2, 3, 4, 5, and 6.

[CONTRACTOR]

Signature

Date

ATTACHMENT B

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT, AND OTHER RESPONSIBILITY MATTERS



Federal Acquisition Regulation 52.209-5, Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters (March 1996)

- (A) The Contractor certifies, to the best of its knowledge and belief, that:
- (1) The Contractor and/or any of its Principals:
- A. Are are not presently debarred, suspended, proposed for debarment, or declared ineligible for award of contracts by any Federal agency; Have have not within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract or subcontract; violation of federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, evasion, or receiving stolen property; and Are are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity with commission of any of the offenses enumerated in subdivision (a)(1)(i)(B) of this provision.
- (2) The Contractor has has not within a three-year period preceding this offer, had one or more contracts terminated for default by any federal agency.
- (3) "Principals," for purposes of this certification, means officers, directors, owners, partners, and persons having primary management or supervisory responsibilities within a business entity (e.g., general manager, plant manager, head of a subsidiary, division, or business segment; and similar positions).

This certification concerns a matter within the jurisdiction of an Agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under 18 U.S.C. § 1001.

- (B) The Contractor shall provide immediate written notice to the Contracting Officer if, at any time prior to contract award, the Contractor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
- (C) A certification that if any of the items in paragraph (a) of this provision exist will not necessarily result in withholding of an award under this solicitation. However, the certification will be considered in connection with a determination of the Contractor's responsibility. Failure of the Contractor to furnish a certification or provide such additional information as requested by the Contracting Officer may render the Contractor nonresponsible.
- (D) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of a Contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
- (E) The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available to the Government, the Contracting Officer may terminate the contract resulting from this solicitation for default.

[CONTRACTOR]

Signature

Date

ATTACHMENT C

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
NON-PROFIT ORGANIZATION DISCLOSURE FORM**

Notice to all DCH Contractors: Pursuant to Georgia law, non-profit organizations that receive funds from a state organization must comply with audit requirements as specified in O.C.G.A. § 50-20-1 *et seq.* (hereinafter “the Act”) to ensure appropriate use of public funds. “Non-profit Organization” means any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized primarily for profit; and uses its net proceeds to maintain, improve or expand its operations. The term non-profit organization includes non-profit institutions of higher education and hospitals. For financial reporting purposes, guidelines issued by the American Institute of Certified Public Accountants should be followed in determining non-profit status.

The Department of Community Health (DCH) must report contracts with non-profit organizations to the Department of Audits and must ensure compliance with the other requirements of the Act. Prior to execution of any contract, the potential contractor must complete this form disclosing its corporate status to DCH. This form must be returned, along with proof of corporate status, to: Director, Contract Administration, Georgia Department of Community Health, 40th Floor, 2 Peachtree Street, N.W., Atlanta, Georgia 30303-3159.

Acceptable proof of corporate status includes, but is not limited to, the following documentation:

- Financial statements for the previous year;
- Employee list;
- Employee salaries;
- Employees’ reimbursable expenses; and
- Corrective action plans.

Entities that meet the definition of non-profit organization provided above and are subject to the requirements of the Act will be contacted by DCH for further information.

COMPANY NAME: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

CORPORATE STATUS: (check one) For Profit _____ Non-Profit _____

I, the undersigned duly authorized representative of _____ do hereby attest that the above information is true and correct to the best of my knowledge.

Signature

Date

ATTACHMENT D

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (hereinafter referred to as “Agreement”), effective this _____ day of _____, _____ (hereinafter the “Effective Date”) is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as “DCH”) and **[INSERT CONTRACTOR NAME]** (hereinafter referred to as “Contractor”) as **Attachment D** to **Contract No. XXXX** between DCH and Contractor dated _____ (hereinafter referred to as the “Contract”).

WHEREAS, DCH is a hybrid entity, as defined in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), and is required by HIPAA to enter into a Business Associate Agreement with certain entities that provide functions, activities, or services on behalf of or in support of health care components of DCH, which functions, activities or services involve the use of Protected Health Information as defined by HIPAA (“PHI”);

WHEREAS, Contractor, under the Contract provides functions, activities, or services involving the use of PHI;

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, DCH and Contractor (each individually a “Party” and collectively the “Parties”) hereby agree as follows:

1. Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms have in HIPAA and in 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 Agreement as the “Privacy Rule and Security Rule.” If the meaning of any defined term is changed by law or regulation, then this Agreement will be automatically modified to conform to such change. The term “NIST Baseline Controls” means the baseline controls set forth in National Institute of Standards and Technology (NIST) SP 800-53 established for “moderate impact” information.
2. Except as limited in this Agreement, Contractor may use or disclose PHI only to the extent necessary to meet its responsibilities as set forth in the Contract provided that such use or disclosure would not violate the Privacy Rule or the Security Rule, if done by DCH. Furthermore, except as otherwise limited in this Agreement, Contractor may:
 - A. Use PHI for internal quality control and auditing purposes.
 - B. Use or disclose PHI as Required by Law.
 - C. After providing written notification to DCH’s Office of Inspector General, use PHI to make a report to a health oversight agency authorized by law to investigate DCH (or

otherwise oversee the conduct or conditions of the DCH) about any DCH conduct that Contractor in good faith believes to be unlawful as permitted by 45 C.F.R. 164.502(j)(1). Notwithstanding the foregoing, Contractor shall not be required to provide prior written notice to DCH's Office of Inspector General if Contractor is provided written instruction otherwise by the health oversight agency authorized by law to investigate DCH.

- D.** Use and disclose PHI to consult with an attorney for purposes of determining Contractor's legal options with regard to reporting conduct by DCH that Contractor in good faith believes to be unlawful, as permitted by 45 C.F.R. 164.502(j)(1).
- 3.** Contractor represents and warrants that only individuals designated by title or name on Attachments D-1 and D-2 will request PHI from DCH or access DCH PHI in order to perform the services of the Contract, and these individuals will only request the minimum necessary amount of information necessary in order to perform the services.
- 4.** Contractor represents and warrants that the individuals listed by title on Attachment D-1 require access to PHI in order to perform services under the Contract. Contractor agrees to send updates to Attachment D-1 whenever necessary. Uses or disclosures of PHI by individuals not described on Attachment D-1 are impermissible.
- 5.** Contractor represents and warrants that the individuals listed by name on Attachment D-2 require access to a DCH information system in order to perform services under the Contract. Contractor agrees to notify the Project Leader and the Access Control Coordinator named on Attachment D-2 immediately, but at least within 24 hours, of any change in the need for DCH information system access by any individual listed on Attachment D-2. Any failure to report a change within the 24 hour time period will be considered a security incident and may be reported to Contractor's Privacy and Security Officer, Information Security Officer and the Georgia Technology Authority for proper handling and sanctions.
- 6.** Contractor agrees that it is a Business Associate to DCH as a result of the Contract, and represents and warrants to DCH that it complies with the Privacy Rule and Security Rule requirements that apply to Business Associates and will continue to comply with these requirements. Contractor further represents and warrants to DCH that it maintains and follows written policies and procedures to achieve and maintain compliance with the HIPAA Privacy and Security Rules that apply to Business Associates, including, but not limited to policies and procedures addressing HIPAA's requirements that Business Associates use, request and disclose only the minimum amount of PHI necessary to perform their services, and updates such policies and procedures as necessary in order to comply with the HIPAA Privacy and Security Rules that apply to Business Associates and will continue to maintain and update such policies and procedures. These policies and procedures, and evidence of their implementation, shall be provided to DCH upon request.
- 7.** The Parties agree that a copy of all communications related to compliance with this Agreement will be forwarded to the following Privacy and Security Contacts:

 - A.** At DCH: HIPAA Privacy and Security Specialist
Office of General Counsel
hipaa@dch.ga.gov

Sherman Harris
Agency Information Security Officer
sheharris@dch.ga.gov
404-656-9653

B. At Contractor: _____

8. Contractor further agrees that it will:

- A. Not request, create, receive, use or disclose PHI other than as permitted or required by this Agreement, the Contract, or as required by law.
- B. Establish, maintain and use appropriate administrative, physical and technical safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or the Contract. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.
- C. Implement and use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DCH. Such safeguards must include all NIST Baseline Controls, unless DCH has agreed in writing that the control is not appropriate or applicable.
- D. In addition to the safeguards described above, Contractor shall include access controls that restrict access to PHI to the individuals listed on D-1 and D-2, as amended from time to time, shall implement encryption of all electronic PHI during transmission and at rest.
- E. Upon DCH's reasonable request, but no more frequently than annually, obtain an independent assessment of Contractor's implementation of the NIST Baseline Controls and the additional safeguards required by this Agreement with respect to DCH PHI, provide the results of such assessments to DCH, and ensure that corrective actions identified during the independent assessment are implemented.
- F. Mitigate, to the extent practicable, any harmful effect that may be known to Contractor from a use or disclosure of PHI by Contractor in violation of the requirements of this Agreement, the Contract or applicable regulations. Contractor shall bear the costs of mitigation, which shall include the reasonable costs of credit monitoring or credit restoration when the use or disclosure results in exposure of information commonly used in identity theft.
- G. Maintain a business associate agreement with its agents or subcontractors to whom it provides PHI, in accordance with which such agents or subcontractors are contractually

obligated to comply with at least the same obligations that apply to Contractor under this Agreement, and ensure that its agents or subcontractors comply with the conditions, restrictions, prohibitions and other limitations regarding the request for, creation, receipt, use or disclosure of PHI, that are applicable to Contractor under this Agreement and the Contract.

- H.** Report to DCH any use or disclosure of PHI that is not provided for by this Agreement or the Contract of which it becomes aware.
- I.** Make an initial report to the DCH in writing in such form as DCH may require within three (3) business days after Contractor (or any subcontractor) becomes aware of the unauthorized use or disclosure. This report will require Contractor to identify the following:
 - i. The nature of the impermissible use or disclosure (the “incident”), which will include a brief description of what happened, including the date it occurred and the date Contractor discovered the incident;
 - ii. The Protected Health Information involved in the impermissible use or disclosure, such as whether the full name, social security number, date of birth, home address, account number or other information were involved);
 - iii. Who (by title, access permission level and employer) made the impermissible use or disclosure and who received the Protected Health Information as a result;
 - iv. What corrective or investigational action Contractor took or will take to prevent further impermissible uses or disclosures, to mitigate harmful effects, and to prevent against any further incidents;
 - v. What steps individuals who may have been harmed by the incident might take to protect themselves; and
 - vi. Whether Contractor believes that the impermissible use or disclosure constitutes a Breach of Unsecured Protected Health Information.

Upon request by the DCH HIPAA Privacy and Security Officer or the DCH Information Security Officer, Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and a proposed corrective action plan. Upon approval of a corrective action plan by the DCH, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH within five (5) business days of DCH’s request for proof of implementation.

- J.** Report to the DCH HIPAA Privacy and Security Officer and the DCH Agency Information Security Officer any successful unauthorized access, modification, or destruction of PHI or interference with system operations in Contractor’s information systems as soon as practicable but in no event later than three (3) business days of discovery. If such a security incident resulted in a use or disclosure of PHI not permitted

by this Agreement, Contractor shall also make a report of the impermissible use or disclosure as described above. Contractor agrees to make a complete report to the DCH in writing within two weeks of the initial report that includes a root cause analysis and, if appropriate, a proposed corrective action plan designed to protect PHI from similar security incidents in the future. Upon DCH's approval of Contractor's corrective action plan, Contractor agrees to implement the corrective action plan and provide proof of implementation to the DCH.

- K.** Upon DCH's reasonable request and not more frequently than once per quarter, report to the DCH Agency Information Security Officer any (A) attempted (but unsuccessful) unauthorized access, use, disclosure, modification, or destruction of PHI or (B) attempted (but unsuccessful) interference with system operations in Contractor's information systems. Contractor does not need to report trivial incidents that occur on a daily basis, such as scans, "pings," or other routine attempts that do not penetrate computer networks or servers or result in interference with system operations.
- L.** Cooperate with DCH and provide assistance necessary for DCH to determine whether a Breach of Unsecured Protected Health Information has occurred, and whether notification of the Breach is legally required or otherwise appropriate. Contractor 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.
- M.** If DCH determines that a Breach of Unsecured Protected Health Information has occurred as a result of Contractor's impermissible use or disclosure of PHI or failure to comply with obligations set forth in this Agreement or in the Privacy or Security Rules, provide all notifications to Individuals, HHS and/or the media, on behalf of DCH, after the notifications are approved by the DCH. Contractor shall provide these notifications in accordance with the security breach notification requirements set forth in 42 U.S.C. §17932 and 45 C.F.R. Parts 160 & 164 subparts A, D & E as of their respective Compliance Dates, and shall pay for the reasonable and actual costs associated with such notifications.

In the event that DCH determines a Breach has occurred, without unreasonable delay, and in any event no later than thirty (30) calendar days after Discovery, Contractor shall provide the DCH HIPAA Privacy and Security Officer a list of Individuals and a copy of the template notification letter to be sent to Individuals. Contractor shall begin the notification process only after obtaining DCH's approval of the notification letter.

- N.** Make any amendment(s) to PHI in a Designated Record Set that DCH directs or agrees to pursuant to 45 CFR 164.526 within five (5) business days after request of DCH. Contractor also agrees to provide DCH with written confirmation of the amendment in such format and within such time as DCH may require.

- O.** In order to meet the requirements under 45 CFR 164.524, regarding an individual's right of access, Contractor shall, within five (5) business days following DCH's request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH, provide DCH access to the PHI in an individual's Designated Record Set. However, if requested by DCH, Contractor shall provide access to the PHI in a Designated Record Set directly to the individual to whom such information relates.
- P.** Give the Secretary of the U.S. Department of Health and Human Services (the "Secretary") or the Secretary's designees access to Contractor's books and records and policies, practices or procedures relating to the use and disclosure of PHI for or on behalf of DCH within five (5) business days after the Secretary or the Secretary's designees request such access or otherwise as the Secretary or the Secretary's designees may require. Contractor also agrees to make such information available for review, inspection and copying by the Secretary or the Secretary's designees during normal business hours at the location or locations where such information is maintained or to otherwise provide such information to the Secretary or the Secretary's designees in such form, format or manner as the Secretary or the Secretary's designees may require.
- Q.** Document all disclosures of PHI and information related to such disclosures as would be required for DCH to respond to a request by an Individual or by the Secretary for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. By no later than five (5) business days of receipt of a written request from DCH, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the DCH HIPAA Privacy and Security Officer, Contractor shall provide an accounting of disclosures of PHI regarding an Individual to DCH. If requested by DCH, Contractor shall provide an accounting of disclosures directly to the individual. Contractor shall maintain a record of any accounting made directly to an individual at the individual's request and shall provide such record to the DCH upon request.
- R.** In addition to any indemnification provisions in the Contract, indemnify the DCH from any liability resulting from any violation of the HIPAA Privacy and Security Rules or Breach that arises from the conduct or omission of Contractor or its employee(s), agent(s) or subcontractor(s). Such liability will include, but not be limited to, all actual and direct costs and/or losses, civil penalties and reasonable attorneys' fees imposed on DCH.
- S.** For any requirements in this Agreement that include deadlines, pay performance guarantee payments of \$300.00 per calendar day, starting with the day after the deadline and continuing until Contractor complies with the requirement. Contractor shall ensure that its agreements with subcontractors enable Contractor to meet these deadlines.

9. DCH agrees that it will:

- A.** Notify Contractor of any new limitation in the applicable Notice of Privacy Practices in accordance with the provisions of the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such limitation will affect Contractor's use or disclosure of PHI.

- B. Notify Contractor of any change in, or revocation of, authorization by an Individual for DCH to use or disclose PHI to the extent that DCH determines in the exercise of its sole discretion that such change or revocation will affect Contractor's use or disclosure of PHI.
- C. Notify Contractor of any restriction regarding its use or disclosure of PHI that DCH has agreed to in accordance with the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such restriction will affect Contractor's use or disclosure of PHI.
- D. Prior to agreeing to any changes in or revocation of permission by an Individual, or any restriction, to use or disclose PHI, DCH agrees to contact Contractor to determine feasibility of compliance. DCH agrees to assume all costs incurred by Contractor in compliance with such special requests.

10. The Term of this Agreement shall be effective on the Effective Date and shall terminate when all of the PHI provided by DCH to Contractor, or created or received by Contractor on behalf of DCH, is destroyed or returned to DCH, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this section.

- A. **Termination for Cause.** Upon DCH's knowledge of a material breach of this Agreement by Contractor, DCH shall either:
 - i. Provide an opportunity for Contractor to cure the breach of Agreement within a reasonable period of time, which shall be within thirty (30) calendar days after receiving written notification of the breach by DCH;
 - ii. If Contractor fails to cure the breach of Agreement, terminate the Contract upon thirty (30) calendar days notice; or
 - iii. If neither termination nor cure is feasible, DCH shall report the breach of Agreement to the Secretary of the Department of Health and Human Services.

B. Effect of Termination.

- i. Upon termination of this Agreement, for any reason, DCH and Contractor shall determine whether return of PHI is feasible. If return of the PHI is not feasible, Contractor agrees to continue to extend the protections of this Agreement to the PHI for so long as the Contractor maintains the PHI and shall limit the use and disclosure of the PHI to those purposes that made return or destruction of the PHI infeasible. If at any time it becomes feasible to return or destroy any such PHI maintained pursuant to this paragraph, Contractor must notify DCH and obtain instructions from DCH for either the return or destruction of the PHI.
- ii. Contractor agrees that it will limit its further use or disclosure of PHI only to those purposes DCH may, in the exercise of its sole discretion, deem to be in the public interest or necessary for the protection of such PHI, and will take such

additional actions as DCH may require for the protection of patient privacy and the safeguarding, security and protection of such PHI.

iii. This Effect of Termination section survives the termination of the Agreement.

11. Interpretation. Any ambiguity in this Agreement shall be resolved to permit DCH and Contractor to comply with applicable laws, rules and regulations, the HIPAA Privacy Rule, the HIPAA Security Rule and any rules, regulations, requirements, rulings, interpretations, procedures or other actions related thereto that are promulgated, issued or taken by or on behalf of the Secretary; provided that applicable laws, rules and regulations and the laws of the State of Georgia shall supersede the Privacy Rule if, and to the extent that, they impose additional requirements, have requirements that are more stringent than or have been interpreted to provide greater protection of patient privacy or the security or safeguarding of PHI than those of the HIPAA Privacy Rule.

12. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations or liabilities whatsoever.

13. All other terms and conditions contained in the Contract and any amendment thereto, not amended by this Agreement, shall remain in full force and effect.

(Signatures on following page)

IN WITNESS WHEREOF, Contractor, through its authorized officer and agent, has caused this Agreement to be executed on its behalf as of the date indicated.

[CONTRACTOR]

BY: _____
SIGNATURE

DATE

TITLE*

* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

ATTACHMENT D-1

List of Individuals Permitted to Receive, Use and Disclose DCH PHI

The following Position Titles, as employees and/or representatives of Contractor, need access to DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

- _____
- _____
- _____
- _____
- _____

Transfers of PHI must comply with DCH Policy and Procedure 419: Appropriate Use of Information Technology Resources.

Approved methods of secure delivery of PHI between Contractor and DCH:

- A.** Secure FTP file transfer (preferred)
- B.** Encrypted email or email sent through “secure tunnel” approved by DCH Information Security Officer
- C.** Email of encrypted document (password must be sent by telephone only)
- D.** Encrypted portable media device and tracked delivery method

Contractor must update this list as needed and provide the updated form to DCH. Use of DCH Protected Health Information by individuals who are not described on this Attachment D-1, as amended from time to time, is impermissible and a violation of the Agreement. Contractor must update this Attachment D-1 as needed and provide the updated form to DCH.

DCH Project Leader Contact Information: [INSERT HERE]

ATTACHMENT D-2

Part 1:

Please initial beside the correct option. Please select only one option.

_____ Contractor DOES NOT need any user accounts to access DCH Information Systems.
Do not complete Part 2 of this form.

_____ Contractor DOES need user accounts to access DCH Information Systems. Please
complete Part 2 of this form.

Part 2:

Please complete the table below if you indicated that Contractor DOES need any user accounts to access DCH Information Systems. Please attach additional pages if needed.

List of Individuals Authorized to Access a DCH Information System Containing PHI

The following individuals, as employees and/or representatives of Contractor, need access to DCH Information Systems containing DCH Protected Health Information in order for Contractor to perform the services described in the Contract:

Full Name	Employer	DCH Information System	Type of Access (Read only? Write?)

The DCH Project Leader must submit a completed DCH Network Access Request Form for each individual listed above. Access will be granted and changed in accordance with DCH Policy and Procedure 435: Managing Authorization, Access and Control of Information Systems.

Contractor must notify the Project Leader identified in the Contract and the DCH Access Control Coordinator (dchois@dch.ga.gov and helpdesk@dch.ga.gov) immediately, but at least within 24 hours, after any individual on this list no longer needs the level of access described. Failure to provide this notification on time is a violation of the Agreement and will be reported as a security incident.

Contractor must update this Attachment D-2 as needed and provide the updated form to DCH.
DCH Project Leader Contact Information: [INSERT HERE]

ATTACHMENT E

VENDOR LOBBYIST DISCLOSURE AND REGISTRATION CERTIFICATION FORM



Pursuant to Executive Order Number 10.01.03.01 (the “Order”), which was signed by Governor Sonny Perdue on October 1, 2003, Contractors with the state are required to complete this form. The Order requires “Vendor Lobbyists,” defined as those who lobby state officials on behalf of businesses that seek a contract to sell goods or services to the state or those who oppose such a contract, to certify that they have registered with the State Ethics Commission and filed the disclosures required by Article 4 of Chapter 5 of Title 21 of the Official Code of Georgia Annotated. Consequently, every vendor desiring to enter into a contract with the state must complete this certification form. False, incomplete, or untimely registration, disclosure, or certification shall be grounds for termination of the award and contract and may cause recoupment or refund actions against Contractor.

In order to be in compliance with Executive Order Number 10.01.03.01, please complete this Certification Form by designating only one of the following:

- Contractor *does not have any* lobbyist employed, retained, or affiliated with the Contractor who is seeking or opposing contracts for it or its clients. Consequently, Contractor has not registered anyone with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.

- Contractor *does have* lobbyist(s) employed, retained, or affiliated with the Contractor who are seeking or opposing contracts for it or its clients. The lobbyists are:

Contractor states, represents, warrants, and certifies that it has registered the above named lobbyists with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.

[CONTRACTOR]

Signature

Date

ATTACHMENT F

RESERVED

ATTACHMENT G

CAPITATION PAYMENT

(to be placed here)

CONFIDENTIAL – NOT FOR CIRCULATION

ATTACHMENT H



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing**. Your request for a hearing, along with a copy of the adverse action letter, must be *received* within **thirty (30) days** of the date of the letter. Please mail your request for a hearing to [Managed Care Organization] at the following address:

[CMO Address Line 1]
[CMO Address Line 2]
[CMO Address Line 3]
[CMO Address Line 4]

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. Georgia Legal Services Program

1-800-498-9469

(Statewide legal services, EXCEPT

for the counties served by Atlanta Legal Aid)

2. Georgia Advocacy Office

1-800-537-2329

(Statewide advocacy for persons with disabilities or mental illness)

3. Atlanta Legal Aid

404-377-0701 (DeKalb/Gwinnett Counties)

770-528-2565 (Cobb County)

404-524-5811 (Fulton County)

404-669-0233 (So. Fulton/Clayton County)

678-376-4545 (Gwinnett County)

ATTACHMENT I

MAP OF SERVICE REGIONS/LIST OF COUNTIES BY SERVICE REGIONS

Atlanta	Central	East	North	SE	SW
Barrow	Baldwin	Burke	Banks	Appling	Atkinson
Bartow	Bibb	Columbia	Catoosa	Bacon	Baker
Butts	Bleckley	Emanuel	Chattooga	Brantley	Ben Hill
Carroll	Chattahoochee	Glascok	Clarke	Bryan	Berrien
Cherokee	Crawford	Greene	Dade	Bulloch	Brooks
Clayton	Crisp	Hancock	Dawson	Camden	Calhoun
Cobb	Dodge	Jefferson	Elbert	Candler	Clay
Coweta	Dooly	Jenkins	Fannin	Charlton	Clinch
DeKalb	Harris	Lincoln	Floyd	Chatham	Coffee
Douglas	Heard	McDuffie	Franklin	Effingham	Colquitt
Fayette	Houston	Putnam	Gilmer	Evans	Cook
Forsyth	Jones	Richmond	Gordon	Glynn	Decatur
Fulton	Lamar	Screven	Habersham	Jeff Davis	Dougherty
Gwinnett	Laurens	Taliaferro	Hall	Liberty	Early
Haralson	Macon	Warren	Hart	Long	Echols
Henry	Marion	Washington	Jackson	McIntosh	Grady
Jasper	Meriwether	Wilkes	Lumpkin	Montgomery	Irwin
Newton	Monroe		Madison	Pierce	Lanier
Paulding	Muscogee		Morgan	Tattnall	Lee
Pickens	Peach		Murray	Toombs	Lowndes
Rockdale	Pike		Oconee	Ware	Miller
Spalding	Pulaski		Oglethorpe	Wayne	Mitchell
Walton	Talbot		Polk		Quitman
	Taylor		Rabun		Randolph
	Telfair		Stephens		Seminole
	Treutlen		Towns		Schley
	Troup		Union		Stewart
	Twiggs		Walker		Sumter
	Upson		White		Terrell
	Wheeler		Whitfield		Thomas
	Wilcox				Tift
	Wilkinson				Turner
	Johnson				Webster
					Worth

ATTACHMENT J

APPLICABLE CO-PAYMENTS

Children under age twenty-one (21), pregnant women, nursing facility residents, members enrolled in breast and cervical cancer programs, and Hospice care Members are exempted from co-payments.

There are no co-payments for family planning services or for emergency services except as defined below.

Services cannot be denied to anyone based on the inability to pay these co-payments.

Service	Additional Exceptions	Co-Pay Amount
Ambulatory Surgical Centers		A \$3 co-payment to be deducted from the surgical procedure code billed. In the case of multiple surgical procedures, only one \$3 amount will be deducted per date of service.
FQHC/RHCs		A \$2 co-payment on all FQHC and RHC.
Outpatient		A \$3 member co-payment is required on all non-emergency outpatient hospital visits
Inpatient	Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility are exempted from the inpatient co-payment.	A co-payment of \$12.50 will be imposed on hospital inpatient services
Emergency Department		A \$3 co-payment will be imposed if the Condition is not an Emergency Medical Condition

ATTACHMENT K

INFORMATION MANAGEMENT AND SYSTEMS

(Requirements to be Defined by DCH and Provider at a Later Date)

ATTACHMENT L

DEMONSTRATION COVERED SERVICES

Family Planning Demonstration Services: Services provided to P4HB participants must be provided by a physician or an advanced practice nurse.

Services Include:

- Family planning initial or annual exams
- Follow up, brief and comprehensive visits
- Contraceptive services and supplies
- Patient education and counseling
- Counseling and referrals to:
 - Social services
 - Primary health care providers
- Family planning lab tests:
 - Pregnancy tests
 - Pap Smear and Pelvic exam
 - A colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are coverable as a family planning-related service under this Demonstration. Colposcopies which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital are not covered under this waiver as family planning-related services
- Screening, treatment and follow up for sexually transmitted infections (STIs), except HIV/AIDS and Hepatitis
 - Antibiotic treatment for STIs when the infections are identified during a routine family planning visit.
 - A follow up visit for the treatment/drugs may be covered
 - Subsequent follow-up visits to re-screen for STIs based on the Centers for Disease Control and Prevention guidelines
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/ drugs may be covered.
- Treatment of major complications related to the delivery of Demonstration related services such as:
 - Treatment of a perforated uterus due to an intrauterine device insertion;
 - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
 - Treatment of surgical or anesthesia-related complications during a sterilization procedure.
- Tubal Ligation (Sterilization)
 - Treatment and follow-up of an STI diagnosed at the time of sterilization.

- Family Planning pharmacy visits
- Folic acid and/or a multivitamin with folic acid.
- Select immunizations for aged 19 and 20. The Contractor shall provide all P4HB participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the Advisory Committee on Immunization Practices (ACIP) guidelines as needed
- P4HB participants age 18 receive vaccines at no cost under the Vaccines for Children (VFC) program
- Additionally women who have delivered a very low birth weight baby following implementation of the Demonstration will be eligible for Interpregnancy Care services including the Resource Mother Outreach benefit.
 - Interpregnancy Care (IPC) covered services:

In addition to the family planning and family planning related services listed above, P4HB participants enrolled in the IPC component of the waiver will receive:

- Primary Care services, up to 5 office/outpatient visits
 - Limited Dental Services
 - Management and treatment of chronic diseases
 - Substance abuse treatment including detoxification and intensive outpatient rehabilitation
 - Case Management/Resource Mother Outreach
 - Prescription drugs (non-family planning) for the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery
 - Non-emergency transportation
- Resource Mother Outreach only

Resource Mothers Outreach only services are available to women who are currently enrolled in and are receiving Title XIX services and benefits but who meet all other IPC Demonstration eligibility criteria.

ATTACHMENT M

DEMONSTRATION QUALITY STRATEGY

In order to assess and improve the quality of services delivered under this Demonstration, DCH will implement a rigorous quality strategy and evaluation process formally documented as the Demonstration Evaluation Design. This design or plan will be developed with assistance from Emory University, the independent contractor charged with evaluating the effectiveness of the Demonstration. The evaluation design must incorporate key goals, objectives and a set of performance measures that align well with the logical sequence through which the Demonstration can and will affect Provider's behavior such that the key outcomes - longer inter partum intervals, lower low birth weight rates and cost savings - can be achieved. The evaluation design must receive final approval from CMS. Reporting to CMS will occur on a quarterly and annual basis with a final report due to CMS at the end of the Demonstration period. Contractor reporting will be due on a quarterly and annual basis as identified below and in the CMS Special Terms and Conditions.

The Evaluation Design will include:

- Key Goals, Objectives and Performance Targets
- Program Hypotheses
- Performance Measures
- Analysis pertaining to the achievement of the Performance Targets
- Assessment of the rate at which the Demonstration was implemented
- Assessment of the Demonstration Providers' understanding of program eligibility, service coverage and payment rates across sites of care
- Assessment of the Providers' satisfaction with the Demonstration
- Assessment of the per Demonstration year changes in family planning visits regardless of payer source, per poor and near poor women in Georgia
- Determination of averted births among P4HB participants and tests of budget neutrality
- The relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for "targeted" versus control group women
- The relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among "targeted" and control groups
- The relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

Key Goals:

If participation in the Demonstration penetrates the eligible population to the extent hoped for and P4HB Participants are consistent users of family planning and IPC services and supplies, the DCH anticipates the following major outcomes can be achieved:

- Reduction of Georgia's low birth weight and very low birth weight rates over the course of the Demonstration period
- Reduction in the number of unintended pregnancies in Georgia

- Reduction in Georgia’s Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy related services.

Program Objectives

- Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the three year term of the Demonstration. Achievement of this objective will be measured by:
 - Total family planning visits pre and post the Demonstration;
 - Use of contraceptive services/supplies pre and post the Demonstration;
- Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant. Achievement of this objective will be measured by:
 - Use of inter-pregnancy care services (primary care and Resource Mothers Outreach) by women with a very low birth weight delivery;
- Decrease unintended and high-risk pregnancies among Medicaid eligible women and increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women. Achievement of this objective will be measured by:
 - Average inter-pregnancy intervals for women pre and post the Demonstration;
 - Average inter-pregnancy intervals for women with a very low birth weight delivery pre and post the Demonstration;
- Decrease in late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women. Achievement of this objective will be documented by:
 - The number of repeat teen births assessed annually
- Decrease the number of Medicaid-paid deliveries beginning in the second year of the Demonstration, thereby reducing annual pregnancy-related expenditures. Achievement of this objective will be measured by:
 - The number of Medicaid paid deliveries assessed annually
- Increase consistent use of contraceptive methods by incorporating Care Coordination and patient-directed counseling into family planning visits. Achievement of this objective will be measured by:
 - Utilization statistics for family planning methods
 - Number of Deliveries to P4HB participants
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women who are in need of services but who are not receiving them. Achievement of this objective will be measured by:
 - Enrollment statistics for the Demonstration.
- Increase the overall savings in Medicaid spending attributable to this Demonstration. Achievement of this objective will be measured by:
 - Documentation of achievement of financial savings targets

Program Hypotheses

- That the Demonstration will bring sufficient numbers of women into the program to increase the overall use of family planning services/supplies and will promote the more consistent use of effective contraceptive methods among program users.

That increased use of contraceptives will lead to reduced unintended pregnancies and in turn, unintended births among this population of women (as well as improved inter-pregnancy intervals). That teens are at high risk of unintended pregnancy a related hypothesis is that the rate of unintended births and repeat teen births will also fall post implementation of the waiver. That these changes will be sufficient to lower the number of overall Medicaid paid deliveries/births and hence, costs, such that the state and federal government will realize a net cost savings despite increased spending on family planning services.

Performance Reporting

In order for the program objectives to be achieved there must be sufficient outreach, uptake, and implementation of the Demonstration benefits. The performance measures identified below and in the CMS Special Terms and Conditions must be reported by the Contractor quarterly and annually or as identified in the CMS Special Terms and Conditions.

I. Assessment of the rate at which the Demonstration was implemented using Enrollment, Participation and Use of Services as Performance Measures:

- These reports are to be submitted to DCH within 30 Calendar Days from the close of the previous quarter (e.g., April 30 for the quarter ending March 31).
- Total number of Demonstration Enrollees per CMO stratified by Demonstration component – Family Planning only; IPC; Resource Mothers only
- Total number of Demonstration Enrollees per CMO stratified by age, race and ethnicity, county;
- Average months enrolled per CMO by Age, Race/Ethnicity and County;
- Proportion of LIM population per CMO enrolled in Resource Mothers Outreach
- Total number of P4HB participants per CMO stratified by age, race, ethnicity, county;
- Number of IPC P4HB participants per CMO stratified by age, race and ethnicity, county;
- Number of P4HB participants per CMO in the Resource Mothers only Outreach
- Overview of the Geographic variations in enrollment per CMO;
- Rate of use per CMO of:
 - All Family Planning Services by type;
 - All Contraceptives by type (inclusive of hormonal and non-hormonal contraceptives);
 - Counts of primary care visits for those in the IPC component of the Demonstration.
- Utilization statistics per CMO for all IPC services and IPC services by type

Sufficient “take up” of the Demonstration can only occur if both providers and women understand their new eligibility and coverage. An explanatory design component of the evaluation will help understand if there are barriers in the provider system that could prevent take up and/or visit rates.

II. Assessment of the Demonstration Providers’ s’ understanding of program eligibility, service coverage and payment rates across sites of care

- These semi-annual survey reports are due October 1st and April 1st.

Contractor shall submit a report semi-annually of Provider Surveys conducted by the Contractor with analysis reports highlighting responses to questions regarding knowledge and understanding of the Demonstration, level of participation and training/outreach.

- Contractor shall submit a report semi-annually of P4HB participant Surveys conducted by the Contractor with analysis reports highlighting responses to questions pertaining to satisfaction with eligibility and enrollment processes. The report shall address the following subjects:
 1. Satisfaction with CMO selection process
 2. Satisfaction with educational materials regarding the Demonstration
 3. Satisfaction with service options and services
 4. Satisfaction with contraceptive method
 5. Contraceptive failures/unintended births
 6. Satisfaction with provider selection
 7. Results and analysis of semi-annual member satisfaction surveys

The above data will be gathered through standardized semi-annual Provider and P4HB Participant Surveys administered by each CMO. Survey tools will be developed by the Demonstration's evaluator and made available to the Contractor for review and comment prior to being finalized. A summary of the Contractor's Provider and P4HB Participant survey data and qualitative interviews must be compiled by the Contractor and submitted to DCH by October 1st and April 1st of each Demonstration Year beginning with October 1st of Demonstration year 1.

III. Assessment of the per Demonstration year changes in family planning visits

- These annual reports are due June 30th. Total Demonstration expenses per CMO and stratified by Demonstration component – Family Planning Only, IPC, and Resource Mothers Outreach only
- The average per person expenditures for the IPC component per CMO
- The total expenditures per CMO for the first year infant life costs stratified by birth weight categories
- The average per person expenditures per CMO for the first year of life costs stratified by birth weight categories
- The total expenditures for VLBW deliveries per CMO
- The average per person expenditures for VLBW deliveries per CMO

IV. Determination of the number of averted births among P4HB Participants and tests of budget neutrality

- These annual reports are to be submitted within 45 calendar days of the end of the 4th quarter.
- Total Pregnancies per CMO stratified by age, race/ethnicity, county/region
- Total Pregnancies per Demonstration population paid per CMO stratified by age, race/ethnicity, county/region, FP only and IPC
- Contraceptive failures per CMO stratified by age, race/ethnicity, county/region

- Actual Live Births per CMO stratified by Age, Race/Ethnicity, county/region and weight categories

V. Determination of the relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for “targeted” versus control group women

- To be calculated by the Demonstration evaluator

VI. Assessment of the relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among “targeted” and control groups:

- These annual reports are to be submitted within 45 calendar days of the end of the 4th quarter.
- CMO documentation of events that occurred during the quarter or are anticipated to occur in the near future affecting the CMO’s health care delivery; benefits; enrollment; grievances; quality of care; access; other operational issues
- Total Births – Live Births and Fetal Deaths stratified by age, race/ethnicity, county/region per CMO
- Unintended Births-Percent of Births Reported as Unwanted or Mistimed per CMO

VII. Assessment of the relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

- These annual reports are due June 30th. Average number of months between pregnancies to the same woman (number of months between initial birth/fetal death event and subsequent birth/fetal death event – the gestational age of the subsequent event) per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in low birth weight or very low birth weight per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in a preterm delivery per CMO

Performance Measures

The Contractor’s failure to meet these goals shall result in a Category 2 Liquidated Damage as defined in Section 25.3 of the Contract.

- Reduction of Contractor membership’s LBW and VLBW rates over the course of the Demonstration period as measured by 10% cumulative reduction from CY 2010 baseline in the Contractor’s LBW and VLBW rates by January 31, 2015.
- 4% reduction in the Pregnancy Rate in the Contractor’s membership over the Demonstration period ending January 31, 2015.

Quarterly Report Data per CMO: Reports are to be submitted to DCH within 30 Calendar Days from the close of the previous quarter (e.g., April 30 for the quarter ending March 31).

- Demonstration expenditures including administrative costs;
- Total number of Demonstration enrollees;
- Total number of P4HB participants
- Total number of Demonstration enrollees stratified by age, race and ethnicity;
- Total number of P4HB participants stratified by age, race and ethnicity
- Total number of IPC enrollees stratified by age, race and ethnicity
- Total number of IPC P4HB participants stratified by age, race and ethnicity
- Total number of Family Planning only enrollees stratified by age, race and ethnicity
- Total number of Family Planning only P4HB participants stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only Enrollees stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only P4HB participants stratified by age, race and ethnicity
- Total number of P4HB participants utilizing services
- Utilization statistics for Family Planning only services by type
- IPC Problem and Strength Identification Quarterly Summary
- Total number of Care Plans for IPC Participants
- Utilization statistics for IPC Services by type;
- Contraceptive types utilized;
- Geographic variations in enrollment;
- Total number of P4HB participants (Participants include all individuals who obtain one or more covered family planning services through the Demonstration);
 - Events occurring during the quarter, or anticipated to occur in the near future that affect:
 - health care delivery
 - benefits
 - enrollment
 - grievances
 - quality of care
 - access
 - pertinent legislative activity
 - eligibility verification activities
 - other operational issues;
- Action plans for addressing any policy and administrative issues identified; and
- Evaluation activities and interim findings.

Annual Report Data per CMO – for Demonstration year 1, appropriate baseline calculations should also be reported using Calendar Year 2010 as the baseline year. Baseline calculations to include but not be limited to: total deliveries, pregnancy rate, total births, number of still births, LBW and VLBW rates, etc.

- Top five (5) Chronic Diseases/Conditions affecting P4HB participants in the IPC Demonstration component;
- The total number of deliveries to Contractor’s Medicaid Members;
- The pregnancy rate for Contractor’s Medicaid Members;

- The number of deliveries to the P4HB participants stratified by Demonstration component: FP Only; FP and IPC; Resource Mothers Only.
- The number of total births to the Contractor's Medicaid Members stratified by birth weight categories;
- The number of live births to P4HB participants in the FP only component of the Demonstration stratified by birth weight categories – Normal (2,500 grams or more), LBW (1,500 grams to 2,499 grams), VLBW (less than 1,500 grams);
- The number of live births to P4HB participants in the IPC component of the Demonstration stratified by birth weight category;
- The number of stillbirths to the IPC P4HB participants;
- IPC Problem and Strength Identification Yearly Summary
- The number of estimated averted births (using the baseline fertility rate) in the waiver application;
- The total and average per person Medicaid expenditures for the Demonstration;
- The total and average per person Medicaid expenditures for the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for the first year infant life costs stratified by birth weight categories;
- The number of VLBW deliveries to Contractor's P4HB participants;
- The number of VLBW deliveries that occur to P4HB participants in the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for VLBW deliveries;
- Results of P4HB participant and Provider satisfaction surveys.

ATTACHMENT N

RESOURCE MOTHER OUTREACH

Resource Mother:

The Resource Mother provides a broad range of paraprofessional services to P4HB participants in the Interpregnancy Care component of the Planning for Healthy Babies Program and their families. She performs certain aspects of case management including the provision of assistance in dealing with personal and social problems and may provide supportive counseling to P4HB participants and their families and/or serve as a liaison for social services.

The Contractor has the responsibility for training the Resource Mother and must utilize the standardized Resource Mothers Training Manual specified by DCH. DCH will also provide the Resource Mother Job description and technical support for the Resource Mother Outreach program.

The Contractor must ensure the Resource Mother Outreach is effective through monitoring of the Resource Mother's performance including an evaluation of the Resource Mother's P4HB participant contact activities and contact documentation.

The Resource Mother will carry out the following responsibilities:

- Complete P4HB participant intakes based on interviews with P4HB participants, their families, significant others and appropriate community agencies.
- Demonstrate skillful use of observation and assessment tools to evaluate the P4HB participant's needs and monitor the P4HB participant's progress towards treatment goals.
- Meet with P4HB participants via phone or in person to increase participants' adoption of healthy behaviors, including healthy eating choices and smoking cessation; increase participants' adoption of healthy behaviors such as healthy eating choices and smoking cessation.
- Support P4HB participants' compliance with primary care medical appointments including assistance with non-emergency transportation arrangements; serve as the liaison between P4HB participants and family members, significant others, nurses, physicians, and organizational components to facilitate communication, linkage and continuity of service.
- Consult with physicians, nurses, social workers, and case managers about problems identified and assist in the development of an appropriate action plan.
- Document compliance with appointments and enrollment and participation in planned services and benefits in the P4HB participant's case management record and/or required Demonstration forms.
- Prepare and disseminate pertinent reports for/to supervisors, colleagues and other appropriate individuals. Maintain program statistics for purposes of evaluation and research.

- Submit all data, forms and documentation per Demonstration guidelines.
- Provide short-term case management and referral services to P4HB participants with emergency situations.
- Support P4HB participants' compliance with medications to treat chronic health conditions including assisting the P4HB participant with obtaining needed medications and reinforcing the need for medication compliance.
- Assist the P4HB participant with the coordination of social services support for family and life issues; implement and organize the delivery of specific social services within the community and maintain an updated resource file.
- Assist Participants in locating and utilizing community resources including legal, medical, financial assistance, and other referral services; assist with linking mothers to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- Provide emotional support following substance abuse treatment;
- Provide mentoring for P4HB Participants;
- Assist mothers of VLBW babies to obtain regular preventive health visits and appropriate immunizations for their child;
- Link the VLBW infant's mother with community resources such as WIC;
- Provide the mother with the peer and emotional support needed to meet the health demands of her VLBW infant;
- Encourage the VLBW infant's mother to implement the parenting and child safety concepts taught during classes the mother will be encouraged to attend.

Technical Competencies of the Resource Mother

- Successfully complete Resource Mother training module and participate in ongoing in-service training as provided
- Knowledge of agency policies and procedures.
- Ability to coordinate and organize the delivery services.
- Ability to monitor client's progress toward meeting established goals.
- Knowledge of client's treatment goals.
- Ability to interview clients and/or families using established techniques.
- Ability to develop client profile.
- Knowledge of agency confidentiality policies.
- Knowledge of state and federal confidentiality laws and regulations.
- Knowledge of available community resources.
- Ability to make appropriate referrals.
- Knowledge of crisis intervention.

- Ability to develop P4HB participant service plan to assist P4HB participant in attaining social, educational and vocational goals.
- Ability to contact health care professionals to obtain additional background information.
- Knowledge of target population.
- Knowledge of agency specific software.
- Knowledge of available databases.
- Ability to prepare reports and case history records.
- Knowledge of eligibility requirements.
- Knowledge of what qualifies as an emergency situation.

Entry Qualifications

- High school diploma or GED and two years of experience in a social services related position or Bachelor's degree in a social services related field
- Valid driver's license
- Reliable vehicle with motor vehicle insurance coverage
- Good communication skills. Comfortable communicating with both professionals (physicians, nurses, social workers, etc.) and with lay persons

ATTACHMENT O

TABLE OF CONTRACTED RATES

Attachment O is a table displaying the contracted rates by rate cell for each contracted region. These rates will be the basis for calculating capitation payments in each contracted Region.

Rate Cell	P4HB Capitation Rates
Family Planning – All Regions Interpregnancy Care – All Regions	

For members receiving full Medicaid benefits either through a CMO or fee-for service, the following rate will be paid for Resource Mother services. For members enrolled in a CMO, this rate will be in addition to any capitation paid to provide medical services to the member.

Rate Cell	P4HB Capitation Rates
Resource Mother Services Only – All Regions	

ATTACHMENT P
STATEMENT OF ETHICS

Preamble

The Department of Community Health has embraced a mission to improve the health of all Georgians through health benefits, systems development, and education. In accomplishing this mission, DCH employees must work diligently and conscientiously to support the goals of improving health care delivery and health outcomes of the people we serve, empowering health care consumers to make the best decisions about their health and health care coverage, and ensuring the stability and continued availability of health care programs for the future. Ultimately, the mission and goals of the organization hinge on each employee's commitment to strong business and personal ethics. This Statement of Ethics requires that each employee:

- Promote fairness, equality, and impartiality in providing services to clients
- Safeguard and protect the privacy and confidentiality of clients' health information, in keeping with the public trust and mandates of law
- Treat clients and co-workers with respect, compassion, and dignity
- Demonstrate diligence, competence, and integrity in the performance of assigned duties
- Commit to the fulfillment of the organizational mission, goals, and objectives
- Be responsible for employee conduct and report ethics violations to the DCH Inspector General and to the DCH Ethics Officer
- Engage in carrying out DCH's mission in a professional manner
- Foster an environment that motivates DCH employees and vendors to comply with the Statement of Ethics
- Comply with the Code of Ethics set forth in O.C.G.A. Section 45-10-1 et seq.

Not only should DCH employees comply with this Statement of Ethics, but DCH expects that each vendor, contractor, and subcontractor will abide by the same requirements and guidelines delineated. Moreover, it is important that employees and members of any advisory committee or commission of DCH acknowledge the Statement of Ethics.

Ethical Guidelines

1. Code of Conduct

All employees of DCH are expected to maintain and exercise at all times the highest moral and ethical standards in carrying out their responsibilities and functions. Employees must conduct themselves in a manner that prevents all forms of impropriety, including placement of self-interest above public interest, partiality, prejudice, threats, favoritism and undue influence. There will be no reprisal or retaliation against any employee for questioning or reporting possible ethical issues.

2. Equal Employment

The Department is committed to maintaining a diverse workforce and embraces a personnel management program which affords equal opportunities for employment and advancement based on objective criteria. DCH will provide recruitment, hiring, training, promotion, and other conditions of employment without regard to race, color, age, sex, religion, disability, nationality, origin, pregnancy, or other protected bases. The Department expects employees to support its commitment to equal employment. The failure of any employee to comply with the equal employment requirements provided in DCH Policy #21 may result in disciplinary action, up to and including termination.

3. Harassment

DCH will foster a work environment free of harassment and will not tolerate harassment based on sex (with or without sexual conduct), race, color, religion, national origin, age, disability, protected activity (*i.e.*, opposition to prohibited discrimination or participation in a complaint process) or other protected bases from *anyone* in the workplace: supervisors, co-workers, or vendors. The Department strongly urges employees to report to the Human Resources Section any incident in which he or she is subject to harassment. Additionally, any employee who witnesses another employee being subjected to harassment should report the incident to the Human Resources Section. If DCH determines that an employee has engaged in harassment, the employee shall be subject to disciplinary action, up to and including termination, depending on the severity of the offense.

4. Appropriate Use of DCH Property

Employees should only use DCH property and facilities for DCH business and not for any type of personal gain. The use of DCH property and facilities, other than that prescribed by departmental policy, is not allowed. Furthermore, the use of DCH property and facilities for any purpose which is unlawful under the laws of the United States, or any state thereof, is strictly prohibited. Employees who divert state property or resources for personal gain will be required to reimburse the Department and will be subject to the appropriate disciplinary action, up to and including, termination.

5. Secure Workplace

DCH is committed to maintaining a safe, healthy work environment for its employees. Accordingly, it is DCH's expectation that employees refrain from being under the influence of alcohol or drugs in the workplace because such conduct poses a threat to the employee, as well as others present in the workplace. Additionally, DCH has a zero tolerance policy regarding violence in the workplace. Specifically, DCH will not condone the threat of or actual assault or attack upon, a client, vendor, or other employee. If an employee engages in violent behavior which results in an assault of another person, he or she will be immediately terminated.

6. Political Activities

Although the DCH recognizes that employees may have an interest in participating in political activities and desires to preserve employees' rights in participating in the political process, employees must be aware of certain allowances and prohibitions associated with particular political activities. DCH encourages employees to familiarize themselves with DCH Policy #416 to gain understanding about those instances when a political activity is disallowed and/or approval of such activity is warranted.

7. Confidentiality

DCH has a dual mandate in terms of confidentiality and privacy. Foremost, as a state agency, DCH must comply with the Georgia Open Records Act and Open Meetings Act. The general rule that is captured by those laws is that all business of the agency is open to the public view upon request. The exceptions to the general rule are found in various federal and state laws. In order to protect the individuals' health information that is vital to the delivery of and payment for health care services, DCH sets high standards of staff conduct related to confidentiality and privacy. Those standards are reinforced through continuous workforce training, vendor contract provisions, policies and procedures, and web-based resources.

8. Conflicts of Interest

Employees should always strive to avoid situations which constitute a conflict of interest or lend to the perception that a conflict of interest exists. Specifically, employees must avoid engaging in any business with the DCH which results in personal financial gain. Similarly, employees must encourage family members to avoid similar transactions since they are subject to the same restrictions as employees. DCH encourages its employees to seek guidance from the Office of General Counsel regarding questions on conflicts of interest.

9. Gifts

Employees are strictly prohibited from individually accepting gifts from any person with whom the employee interacts on official state business. Gifts include, but are not limited to, money, services, loans, travel, meals, charitable donations, refreshments, hospitality, promises, discounts or forbearance that are not generally available to members of the public. Any such item received must be returned to the sender with an explanation of DCH's Ethics Policy.

10. Relationships with Vendors and Lobbyists

DCH values vendors who possess high business ethics and a strong commitment to quality and value. Business success can only be achieved when those involved behave honestly and responsibly. Therefore, it is critical that employees ensure that vendors contracting with DCH are fully informed of DCH policies concerning their relationships with DCH employees and that these policies be uniformly applied to all vendors. Among other requirements, DCH expects that each vendor will honor the terms and conditions of its contracts and agreements. If DCH determines that a vendor has violated the terms and conditions of a contract or agreement, the vendor shall be held responsible for its actions.

Employees must ensure that fair and open competition exists in all procurement activities and contracting relationships in order to avoid the appearance of and prevent the opportunity for favoritism. DCH strives to inspire public confidence that contracts are awarded equitably and economically. DCH will apply the state procurement rules, guidelines, and policies. Open and competitive bidding and contracting will be the rule.

DCH recognizes that lobbyists, both regulatory and legislative, may from time to time seek to meet with DCH employees to advance a particular interest. DCH recognizes that employees may have personal opinions, even those that may be contrary to a position that DCH has adopted. DCH employees, however, must recognize that the public, including legislators and lobbyists, may have difficulty differentiating between the official DCH position and a personal opinion. Accordingly, employees should always work directly with the Director of Legislative Affairs in preparing any responses to requests or questions from elected officials and their staff or lobbyists.

11. Mandatory Reporting

If I have knowledge of any ethics violation, I am aware that I am responsible for reporting such violation to the DCH Inspector General and the DCH Ethics Officer. My good faith reports will be free from retaliation. If I am a supervisor, I am aware that I am responsible for reporting such violation and for forwarding any such report from a member of my staff to the DCH Inspector General and the DCH Ethics Officer. As a supervisor, I am additionally responsible for ensuring that the employees who report to me are aware of and comply with the ethical standards and policies that are applicable to their positions.

(Signatures on following page)

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understand the Georgia Department of Community Health's *Statement of Ethics*; and
- B. It agrees to comply with the provisions of the Georgia Department of Community Health's *Statement of Ethics*;

[CONTRACTOR]

Signature

Date

ATTACHMENT Q

DCH ETHICS IN PROCUREMENT POLICY

DCH Ethics In Procurement Policy	Policy No. 402
Effective Date: April 10, 2006 Revised and Restated: April 2, 2012	Page 1 of 12

I. THE COMMITMENT

The Department is committed to a procurement process that fosters fair and open competition, is conducted under the highest ethical standards, is fully compliant with all legal authority, and has the complete confidence and trust of the public it serves. To achieve these important public purposes, it is critical that current vendors and those making proposals to provide goods or services to the Department, as well as employees of the Department, members of the Board of Community Health, and independent contractors, consultants and temporary staffing agency employees currently on an assignment with DCH, have a clear understanding and an appreciation of, the DCH Ethics in Procurement Policy (the “Policy”).

II. SCOPE

This Policy is applicable to all Vendors and DCH Workers, as those terms are defined below.

III. ETHICAL PROCUREMENT STANDARDS

In order to maintain an ethical procurement process, DCH Workers and Vendors must act in accordance with the following standards:

A. Fulfilling Legitimate Business Needs

The procurement of goods and services will be limited to those necessary to accomplish the mission, goals, and objectives of the Department.

B. Identifying and Resolving Conflicts of Interest

Conflicts of interest shall be promptly identified and resolved early in the Procurement process. A “conflict of interest” exists when an individual possesses personal, financial or professional interests that compete, conflict or otherwise interfere with the individual’s actual or perceived ability to act in the best interests of the Department or carry out that individual’s duties in an impartial manner. A conflict of interest situation can arise when an individual takes actions or has interests that may make it difficult to perform his or her work objectively and effectively. Conflicts of interest also arise when an individual, or a family member of that individual, receives personal

benefits as a result of the individual's action, decision, or disclosure of Confidential Information in a Procurement.

C. Avoiding the Appearance of Impropriety

DCH Workers must take care to avoid any appearance of impropriety and must promptly disclose to their supervisors any material transaction or relationship that reasonably could be expected to give rise to a conflict of interest. Similarly, anyone engaged in a business relationship with the Department should avoid any appearances of impropriety.

D. Maintaining Impartiality

DCH Workers must maintain an impartial, arms' length relationship with anyone seeking to influence the outcome of a Procurement.

E. Declining Gifts

DCH Workers are prohibited at all times from soliciting, demanding, accepting, or agreeing to accept Gifts from Vendors, including Gifts from consultants, independent contractors or temporary staffing agency employees currently on assignment with DCH.

F. Avoiding Misrepresentations

DCH Workers and Vendors may not knowingly falsify, conceal or misrepresent material facts concerning a Procurement.

G. Obtaining Sufficient Authorization

DCH Workers may not obligate the Department without having received prior authorization from an approved official. Engaging in such activity is a misrepresentation of authority. DCH Workers who are consultants, independent contractors or temporary staffing agency employees shall not represent themselves as having the authority of a DCH employee.

H. Reporting Possible Conflicts of Interests

DCH Workers and Vendors involved in Procurements must promptly report possible conflicts of interests to DCH in accordance with Section V "General Requirements" of the Policy.

A DCH Worker's failure to act in accordance with these standards, or failure to follow the guidelines set forth herein shall be grounds for disciplinary action, up to and including, termination of the working relationship with DCH. Similarly, a Vendor's failure to comply with this Policy will result in appropriate action as determined by governing state and/or federal law, rules and regulations, and other applicable Department policies and procedures.

IV. DEFINITIONS

For purposes of this policy:

“Affiliate Vendor Team” shall include, but not be limited to, owners, employees, directors, officers, contractors, and consultants of a Vendor that directly or indirectly assist the Vendor in the preparation of response to a Procurement. For individual consultants, independent contractors and temporary staffing agency workers, the “Affiliate Vendor Team” includes the owners, employees, directors, officers, contractors and consultants of the company for whom the individual consultant, independent contractor or temporary staffing agency worker works.

“Confidential Information” shall mean all information not subject to disclosure pursuant to the Open Records Act, O.C.G.A. §50-18-70 et seq. For all Procurements governed by the State Purchasing Act, O.C.G.A. §50-5-50 et seq., “Confidential Information” shall also include records related to the competitive bidding and proposal process which, if disclosed prior to the issuance of the public notice of intent to award would undermine the public purpose of obtaining the best value for the Department. Such records include, but are not limited to, cost estimates, bids, proposals, evaluation criteria, evaluations of Vendors’ bids/proposals, negotiation documents, offers and counter-offers, and records revealing preparation for the Procurement.

“DCH” and “Department” shall mean the Georgia Department of Community Health.

“DCH Worker” shall mean any person who works for the Department as an employee or as an independent contractor, consultant or temporary staffing agency employee on assignment with the Department, as well as members of the Board of Community Health.

“DOAS” shall mean the Georgia Department of Administrative Services.

“Evaluation Team” shall mean a designated group of DCH Workers who review, assess, and score documents submitted to the Department in response to a Procurement Solicitation. An Evaluation Team for a Staffing Recruitment includes the individuals responsible for reviewing resumes submitted in response to the Staffing Recruitment Solicitation, interviewing prospective staffing agency workers, and approving the selection of the individuals.

“Family Member” shall mean a spouse, adult living in the household of the DCH worker, and relatives of the DCH Worker, his or her spouse, or an adult living in the household of the DCH Worker. Relatives include the following: parent/stepparent, grandparent, child, grandchild, brother (full, half, step), sister (full, half, step), uncle, aunt, nephew, niece, and first cousin.

“Financial Interest” shall mean an ownership interest in assets or stocks of the Vendor, current employment with the Vendor, or prospective employment with the Vendor. “Financial Interest” does not include an ownership interest in a Vendor that is part of a widely held investment fund (such as a mutual fund, regulated investment company, common trust fund maintained by a bank or similar financial institution, pension or deferred

compensation plan, or any other investment fund), if the individual has no ability to control the financial interests held by the fund AND (A) The fund is publicly traded or available; or (B) The assets of the fund are widely diversified, meaning it holds no more than 5% of the value of its portfolio in the securities of any one issuer, other than the U.S. Government, and no more than 20% in any particular economic or geographic sector.

“Gifts” shall mean anything of value, including but not limited to the following: goods, money, advances, personal services, entertainment, lodging, parking, real property or the use thereof, commissions, promises of future employment, stocks, bonds, notes or other investment interests in an entity, rights of action, intellectual property, gratuities, loans, extensions of credit, forgiveness of debts, memberships, subscriptions, travel or means of personal transportation, meals, tickets to events, charitable donations, refreshments, hospitality, and promises, discounts or forbearance that are not generally available to members of the public. A Gift need not be intended to influence or reward a DCH Worker.

“Issuing Officer” shall mean the Procurement Professional designated in the Procurement Solicitation to be the Vendor’s only point of contact with the Department following the public advertisement of the Procurement Solicitation until such time as the results of the Procurement Solicitation are publicly announced or the Procurement Solicitation is cancelled. The Issuing Officer is responsible for managing all communication during this time period, including, but not limited to, answering Vendors’ questions, contacting Vendors for clarification requests, negotiations, and contract discussions.

“Kickback” shall mean compensation of any kind directly or indirectly accepted by a DCH Worker from or on behalf of a Vendor seeking/competing for or doing business with the Department, for the purpose of influencing the award of a contract or the manner in which the Department conducts its business. Kickbacks include, but are not limited to, money, fees, gifts, employment opportunities for a DCH Worker or Family Member, commissions or credits. DCH Workers who are employed by a Vendor, such as consultants, independent contractors and temporary staffing agency workers, may receive payment from the Vendor associated with the work performed on a DCH assignment. However, any payment received by the consultant, independent contractor or staffing agency worker as a result of another DCH Worker’s services for the Department may be a prohibited kickback. For example, a consultant who owns a consulting company may receive compensation for his or her work on an assignment with DCH. However, if he or she employs an individual who then becomes a consultant for DCH, any mark-up or payment received as a result of the employee’s services for DCH shall be disclosed for evaluation by DCH and may be considered a kickback.

“Procurement” shall mean buying, purchasing, renting, leasing, or otherwise acquiring any supplies, services, or construction. The term also includes all activities that pertain to obtaining any supply, service, or construction, including description of requirements, selection and solicitation of sources, preparation and award of contract, as well as the disposition of any Protest. A Procurement is not limited to, but specifically includes, procurements which are either exempt or non-exempt either by statute or under DOAS rules, a procurement of professional services, a Staffing Recruitment and procurements under any other approved procurement vehicle.

“Procurement Manual” shall mean the most current version of the Georgia Procurement Manual released by DOAS.

“Procurement Professional” shall mean the Department’s Office of Procurement Services (OPS) staff member assigned to and responsible for managing the Procurement process, including, but not limited to, needs identification and fact-finding, market research, requests for information, development of requirements and specifications, determination of the Procurement strategy and management of the Procurement solicitation, evaluations and awards. The Procurement Professional is charged with adhering to the highest ethical standards and ensuring that Procurements are executed in a fair and impartial manner, consistent with applicable laws, rules and regulations, which may include the Georgia Procurement Manual (GPM), the Georgia State Purchasing Act and Department procurement policies.

“Procurement Solicitation” shall mean the Department’s solicitation of offers from Vendors for the needed supplies, services or construction. Procurement Solicitation shall include, but not be limited to, requests for quotes, requests for qualified contractors, requests for proposals, requests for approvals, requests for pre-qualifications, reverse auctions and any other approved solicitation method.

“Prohibited Contact” applies only to a Procurement subject to DOAS rules and refers to a Vendor’s contact with DCH Workers other than through the Issuing Officer after the public advertisement of a Procurement Solicitation and until such time as the results of the Procurement Solicitation are publicly announced or the Procurement Solicitation is cancelled. During that time period, “Prohibited Contact” shall mean contact with any DCH Worker, other than the Issuing Officer, whereby it could be reasonably inferred that such contact was intended to influence, or could reasonably be expected to influence, the outcome of a Procurement Solicitation. This prohibition includes, without limitation, personal meetings, meals, entertainment functions, telephonic communications, letters, faxes and e-mails, as well as any other activity that exposes the DCH Worker to direct contact with a Vendor. This prohibition does not include contacts with DCH Workers for the purpose of discussing existing on-going Department work which is unrelated to the subject of the Procurement Solicitation or existing consulting assignments. Inquiries regarding the status of a Procurement should always be directed to the Issuing Officer.

“Protest” shall mean a written objection by an interested party to Procurement Solicitation, or to a proposed award or award of a contract, with the intention of receiving a remedial result.

“Protestor” shall mean an actual bidder/offeror who is aggrieved in connection with a Procurement Solicitation or intended or actual contract award and who files a Protest.

“Requirements Team” shall mean a designated group of DCH Workers who develop a Procurement Solicitation. A Requirements Team for the selection of professional services, consultant or temporary staffing agency employee includes the individuals responsible for drafting the request for such professional, consultant or staffer and approving the posting of the request. A DCH Worker is not a member of a Requirements Team simply because he or she identifies potential Vendors or meets with potential Vendors or current Vendors to

discuss Departmental needs and review relevant information. A Requirements Team is formed once it is determined that a Procurement Solicitation or request for services is necessary to meet a Departmental need.

“Staffing Recruitment” shall mean a Procurement for the specific purpose of selecting temporary staffing agency employees in accordance with DOAS statewide contracts.

“Staffing Recruitment Professional” shall mean the Department’s Office of Human Resources staff member assigned to and responsible for managing the Staffing Recruitment process. The Staffing Recruitment Professional is charged with adhering to the highest ethical standards and ensuring that Staffing Recruitments are executed in a fair and impartial manner, consistent with applicable laws, rules and regulations.

“Staffing Recruitment Solicitation” shall mean a Procurement Solicitation for the specific purpose soliciting offers as part of a Staffing Recruitment.

“Vendor” shall mean any individual or entity seeking to do business or doing business with the Department, including, without limitation, contractors, professionals, consultants, suppliers, manufacturers seeking to act as the primary contracting party, officers and employees of the foregoing, any subcontractors, sub consultants and sub suppliers at all lower tiers, as well as any person or entity engaged by the Department to provide a good or service. A professional, consultant or temporary staffing agency and its employee who desires to be placed on an assignment with DCH is a Vendor. Once selected, the professional, consultant or temporary staffing agency employee remains a Vendor, but is also a DCH Worker.

V. General Requirements

A. Responsibilities of Procurement Professionals, Staffing Recruitment Professionals and DCH Workers who are on a Requirements Team or Evaluation Team

1. Procurement Professionals and Staffing Recruitment Professionals must ensure that DCH Workers participating in any Procurement activities have sufficient understanding of the Procurement and evaluation process and the applicable DCH and DOAS rules and regulations and policies associated with the processes.
2. Requirements Team members are tasked with developing standards of work, Procurement Solicitations and related documents in an objective and impartial manner. Typically, a Procurement Professional or Staffing Recruitment Professional facilitates the activities of a Requirements Team and a designated DCH Worker who is a Requirements Team member serves as the Head of the Requirements Team. Often, Requirements Team members are uniquely qualified to develop this material because of their experience with the industry. This experience may have been gained through employment or performance of services with Vendors. These Requirements Team members also maintain professional relationships that enable them to gather valuable information about current products and services. While participating on the Requirements Team, it is essential that Requirements Team members use their experiences and contacts

solely to benefit the Department. They must place aside any personal and/or professional biases or prejudices that may exist when developing standards of work, Procurement Solicitations and related documents. A DCH Worker serving on a Requirements Team must not allow the DCH Worker's or Family Member's personal or professional relationships (e.g., friendships, dating, prior or current employment) with employees, principals, directors, officers, etc. of a Vendor or individuals on the Affiliate Vendor Team to interfere with the ability to prepare these Procurement Solicitations fairly and objectively in the interests of the Department. Such relationships may give rise to the appearance of, and/or create an actual conflict of interest and must be promptly disclosed in writing to the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Requirements Team prior to the DCH Worker's participation on the Requirements Team using the Attestation Form attached as Exhibit A to this Policy (or Exhibit C to this Policy for a Staffing Recruitment), or a similar form provided by the Ethics Officer.

3. The designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer before making a determination as to whether a DCH Worker who has made any written disclosures on the Attestation Form or for whom there is a potential conflict of interest is permitted to participate on the Requirements Team. The Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists, and will notify the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Requirements Team. The Ethics Officer may recommend actions that are necessary to assure the objectivity and fairness of the Procurement Solicitation and to prevent the appearance of a conflict of interest. If an actual conflict or appearance of conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to exclude the individual from the Requirements Team or prepare a written description of the actions that will be taken to "cure" the conflict and assure the objectivity and fairness of the Procurement Solicitation. The designated Procurement Professional or Staffing Recruitment Professional shall maintain this written description of actions and ensure compliance with its terms. In some cases, disclosure of the conflict may be sufficient to "cure" the conflict.
4. Evaluation Team members are tasked with conducting objective, impartial evaluations, and, therefore, must place aside any personal and/or professional biases or prejudices that may exist. A DCH Worker serving on an Evaluation Team must not allow the DCH Worker's or DCH Worker's Family Member's personal or professional relationships (i.e. friendships, dating, prior or current employment) with employees, principals, directors, officers, etc. of a Vendor or individuals on the Affiliate Vendor Team to interfere with the rendering of fair and objective determinations. Such relationships may give rise to the appearance of, and/or create an actual conflict of interest and must be promptly disclosed in writing to the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Evaluation Team prior to the Worker's participation on the Evaluation Team using the Attestation Form attached as

Exhibit B to this Policy (or Exhibit C to this Policy for a Staffing Recruitment), or a similar form provided by the Ethics Officer.

5. The designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer before making a determination as to whether a DCH Worker who has made any written disclosures on the Attestation Form or for whom there is a potential conflict of interest is permitted to participate on the Evaluation Team. The Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists, and will notify the designated Procurement Professional or Staffing Recruitment Professional and the Head of the Evaluation Team. The Ethics Officer may recommend actions that are necessary to assure the objectivity and fairness of the Evaluation and to prevent the appearance of a conflict of interest. If an actual conflict or appearance of conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to exclude the individual from the Evaluation Team or prepare a written description of the actions that will be taken to “cure” the conflict and assure the objectivity and fairness of the Evaluation. The designated Procurement Professional or Staffing Recruitment Professional shall maintain this written description of actions and ensure compliance with its terms. In some cases, disclosure of the conflict may be sufficient to “cure” the conflict.
6. In the event that the Department determines that a conflict of interest does exist and a DCH Worker on a Requirements Team or Evaluation Team failed to make the appropriate disclosure, the Department will evaluate whether the conflict is of sufficient magnitude to disqualify the DCH Worker from further participation on the Requirements Team and/or the Evaluation Team. Furthermore, in the event that the Department determines that the conflict of interest did negatively impact the final Procurement Solicitation or the outcome of a Procurement, such DCH Worker may be subject to disciplinary action, up to and including termination of employment.
7. In the event the Department becomes aware that a DCH Worker maintains a relationship of any sort that may be a conflict of interest or may have the appearance of a conflict of interest with respect to a Procurement, the designated Procurement Professional or Staffing Recruitment Professional shall consult with the Ethics Officer, after which the Ethics Officer will make a determination as to whether an actual conflict or appearance of a conflict exists. Based on that determination and the impact of the conflict or the appearance of a conflict, the Ethics Officer may recommend actions that are necessary to cure the conflict or the appearance of a conflict. If an actual or appearance of a conflict exists, it is the responsibility of the designated Procurement Professional or Staffing Recruitment Professional to take appropriate action, up to and including the disallowance of the DCH Worker’s participation in any Procurement activities.
8. Prior to participating on a Requirements Team or an Evaluation Team, each DCH Worker (including the Head of the Requirements Team and Head of the Evaluation Team) and the designated Procurement Professional or Staffing Recruitment

Professional must execute the appropriate Attestation Form in Exhibit A or B to this Policy (or Exhibit C to this Policy for a Staffing Recruitment).

B. Responsibilities of DCH Workers who are not on a Requirements Team or Evaluation Team

All DCH Workers should be mindful of the importance of confidentiality during any Procurement. Even if a DCH Worker is not serving in the capacity of a member on the Evaluation Team or Requirements Team, all DCH Workers must refrain from engaging in conduct with a Vendor that could result in a conflict of interest or be considered a Prohibited Contact.

C. Responsibilities of DCH Workers who are also Vendors

A DCH Worker who is a consultant or temporary staffing agency employee on an assignment with DCH is also a Vendor. Consultants or temporary staffing agency employees shall provide professional, objective and impartial advice and services, and at all times hold the Department's interests paramount, without any consideration for future work for themselves or members of the Vendor Affiliate Team. In addition to the general obligations of a DCH Worker and Vendor, such individuals shall do the following in order for the Department to identify potential or perceived conflicts of interest that may impact procurements:

1. Disclose to the supervising DCH employee and Director of Human Resources every current and former employer
2. Disclose to the supervising DCH employee and Director of Human Resources the name of every current DCH Worker with whom the individual or the individual's Family Member has a current or pre-existing personal or professional relationship
3. Disclose to the supervising DCH employee and Director of Human Resources any project for another client that may give rise to an actual or perceived conflict of interest
4. Appropriately identify him or herself as an employee of the entity that actually pays his or her compensation and state that he or she is on a contract assignment with DCH
5. Ensure that he or she only performs work that is within the scope of the current assignment
6. Coordinate with the supervising DCH employee to ensure that his or her level of access to Confidential Information is limited to the scope of the current assignment

D. DOAS rules applicable

DOAS rules and regulations may apply to a Procurement, which DOAS rules and regulations may also be applicable to conflicts of interest and may be more restrictive than the provisions of this Policy. It is the responsibility of all DCH Workers to comply with DOAS rules and regulations, when applicable.

VI. VENDOR RESPONSIBILITIES

A. Gifts and Kick-Backs

Vendors may neither offer nor give any Gift or Kick-backs, directly or indirectly, to a DCH Worker. Similarly, no Vendor may offer or give any Gift or Kick-backs, directly or indirectly, to any member of a DCH Worker's Family. Such prohibited activity may result in the termination of the contract, in those cases where the Vendor has executed a contract with the Department. In the event that a potential Vendor who has submitted a response to a Procurement Solicitation engages in such activity, the Department shall act in accordance with DOAS protocol.

B. Family Relationships with DCH Workers

If a Vendor has a family or personal relationship with a DCH Worker, a Gift that is unconnected with the DCH Worker's duties at the DCH is not necessarily prohibited. In determining whether the giving of an item was motivated by personal rather than business concerns, the history of the relationship between the Vendor and DCH Worker shall be considered. However, regardless of the family or personal relationship between a Vendor and a DCH Worker, a Gift is strictly forbidden where it is being given under circumstances where it can reasonably be inferred that it was intended to influence the DCH Worker in the performance of his or her official duties.

C. Vendor Submittals

The Department expects all Vendors to be forthcoming, always submitting true and accurate information in response to a Procurement Solicitation or with regard to an existing business relationship. If the Department determines that the Vendor has intentionally omitted or failed to provide pertinent information and/or falsified or misrepresented material information submitted to the Department, the Department shall act in accordance with applicable state law and DOAS procurement policies and procedures.

Vendors must calculate the price(s) contained in any bid in accordance with the Georgia Procurement Manual.

D. Business Relations

A Vendor may not be allowed to conduct business with the Department for the following reasons:

1. Falsifying or misrepresenting any material information to the Department as set forth hereinabove;

2. Conferring or offering to confer upon a DCH Worker participating in a Procurement (which the entity has bid or intends to submit a bid) any Gift, gratuity, favor, or advantage, present or future; and
3. Any other reasons not explicitly set forth herein that are contained in the Georgia Procurement Manual or applicable Department policy.

E. *Prohibited Contact*

The Vendor is precluded from engaging in Prohibited Contact upon the release of a Procurement Solicitation or posting of a request for consulting or temporary staffing services, during the evaluation process, and any time prior to the Department's public announcement of the results of the Procurement Solicitation, filling of the temporary position, or the Department's cancellation of the Procurement Solicitation.

VII. USE OF CONFIDENTIAL INFORMATION

DCH Workers will not use Confidential Information for their own advantage or profit, nor will they disclose Confidential Information to any potential Vendor or to any unauthorized recipient. DCH Workers will comply with all confidentiality requirements set forth in DCH policies and applicable law.

VIII. ADDRESSING VIOLATIONS

A. *The Process*

All DCH Workers are responsible for bringing violations to the attention of the Issuing Officer under Procurement protocols, the Procurement Professional or the Staffing Recruitment Professional or to a supervisor/manager if the affected DCH Worker is not a part of the Procurement. The supervisor/manager and/or the designated Procurement Professional or Staffing Recruitment Professional shall promptly report such violation to the Ethics Officer. If for any reason it is not appropriate to report a violation to the DCH Worker's immediate supervisor or the designated Procurement Professional or Staffing Recruitment Professional, DCH Workers will report such violations or concerns to the Ethics Officer or the Office of Inspector General. Procurement Professionals, Staffing Recruitment Professionals and managers are required to report suspected ethics violations to the Ethics Officer and the Office of Inspector General, who have specific responsibility for investigating all reported violations.

Confirmed violations will result in appropriate disciplinary action, up to and including termination from employment. In some circumstances, criminal and civil penalties may be applicable.

The Ethics Officer or Inspector General will notify the DCH Worker making the report of the suspected violation of receipt of such report. All reports will be promptly

investigated and appropriate corrective action will be taken if warranted by the investigation.

B. Good Faith Filings

Anyone filing a complaint concerning a violation of this Policy must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation. Good faith reporting of suspected policy violations by others shall not jeopardize a DCH Worker's employment with the Department. However, any allegations that prove not to be substantiated and which prove to have been made maliciously or knowingly to be false will be viewed as a serious disciplinary offense.

C. Confidentiality

Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation. Additionally, all DCH Workers are expected to cooperate in the investigation of such violations. Failure to cooperate in an investigation may result in disciplinary action, up to and including termination from employment.

(Signatures on following page)

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understand the Georgia Department of Community Health's *Ethics in Procurement Policy*;
- B. It agrees to comply with those provisions of the Georgia Department of Community Health's *Ethics in Procurement Policy* applicable to Contractor; and
- C. It shall cooperate in good faith with the Georgia Department of Community Health so that the Georgia Department of Community Health and its workers will be in compliance with the *Ethics in Procurement Policy*.

[CONTRACTOR]

Signature

Date

ATTACHMENT R

CODE OF ETHICS AND CONFLICT OF INTEREST POLICY

Georgia Department of Community Health

Code of Ethics and Conflict of Interest Policy	Policy No. 401
Effective Date: November 1, 2006 Revision Date: January 26, 2011	Page 1 of 10

- References:**
1. O.C.G.A. §45-10-1 et seq.;
 2. O.C.G.A. § 21-5-1, et seq.;
 3. Governor’s Executive Order Establishing a Code of Ethics for Executive Branch Officers and Employees, January 10, 2011;
 4. DCH Ethics Statement
 5. DCH Ethics in Procurement Policy

I. Purpose

The purposes of this policy are to assist DCH Employees and Board members in maintaining the highest standards of ethics and to provide guidelines that DCH Employees and Board members should follow in order to avoid a conflict of interest or the appearance of conflict.

II. Definitions

For the purposes of this policy, the following terms shall have the following meanings:

- A. “Agency” shall mean any agency, authority, department, board, bureau, commission, corporation, committee, office, or instrumentality of the State of Georgia.
- B. “Board member” shall refer to all members of the Board of Community Health established under O.C.G.A. § 31-2-3.
- C. “Commissioner” shall mean the Commissioner of the Department of Community Health.
- D. “Department” shall refer to the Department of Community Health established under O.C.G.A. § 31-2-4.
- E. “Employee” shall mean any person who is employed by the Department.
- F. “Expenses” shall mean the provision of food, beverages, travel, lodging, and registration fees that are attendant to an Employee’s participation in a public meeting related to official or professional duties. Expenses are limited to those items that are

directly associated with the business or professional duties and are not attributable to personal, social or recreational activities.

- G. “Family Member” means a spouse, parent, grandparent, child, brother, sister, uncle, aunt, nephew, niece, first cousin, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepparent, stepchild, stepbrother, stepsister, half brother or half sister.
- H. “Gifts” shall mean, for the purposes of this Policy, money, advances, personal services, gratuities, loans, extensions of credit, forgiveness of debts, memberships, subscriptions, travel, meals, charitable donations, refreshments, hospitality, promises, discounts or forbearance that are not generally available to members of the public. A Gift need not be intended to influence or reward an Employee.
- I. “Honorarium” shall mean payment to a professional person for services for which no fee is required. Honorarium excludes such things as a certificate or other token of appreciation, which has nominal value and may be accepted as a ceremonial courtesy.
- J. “Indirectly” is intended to cover, but not be limited to, any scheme, device or plan which circumvents the literal language of this Policy but provides material financial benefits to a Board member or an Employee or such person’s Family Member. “Limited powers” shall mean those powers exercised by Public Officials, which affect and influence a specific agency. “Lobbyist” shall have the meaning set forth in O.C.G.A. Section 21-5-70(5).
- K. “Nepotism” shall mean demonstrating favor on the basis of Family Member relationship in employment decisions such as hiring, promotions, transfers, or terminations.
- L. “Part time” shall mean employed for less than thirty (30) hours per week for a continuous period of fewer than twenty-six (26) weeks.
- M. “Public Official” shall mean any person elected or appointed to a state office wherein the person has administrative and discretionary authority to receive and expend public funds and perform certain duties that impact the public.
- N. “State-wide powers” shall mean those powers exercised by Public Officials which affect and influence all of state government.
- O. “State” shall mean the State of Georgia.
- P. “Substantial interest” shall mean the direct or indirect ownership of more than 25 percent of the assets or stock of any business.
- Q. “Transacting business” shall mean to sell or lease any personal or real property, surplus personal or real property, or services on one’s behalf or on behalf of any third party as an agent, broker, dealer, or representative.

- R. “Vendor” shall mean the definition set forth in O.C.G.A. Section 45-1-6(a)(5), as well as any person seeking or opposing a certificate of need.
- S. “Value” shall mean actual retail price or cost attributable to a gift minus taxes and/or gratuities or a reasonable estimate based upon customary charges for like goods or services.

III. Code of Ethics

In fulfilling designated duties and responsibilities, Employees and Board members should be mindful of the following principles:

- A. Uphold the Constitution, laws, and legal regulations of the United States and the State.
- B. Give a full day’s labor for a full day’s pay and perform duties with earnest effort and best thought.
- C. Never discriminate unfairly by extending special favors or privileges, whether for remuneration or not, and never accept, for personal gain or for a Family Member, favors or benefits under circumstances which might be construed by reasonable persons as influencing the performance of governmental duties.
- D. Make no private promises of any kind binding upon the duties of office, since a government Employee has no private word, which can be binding on public duty.
- E. Refrain from engaging in business with the government, either direct or indirectly, which is inconsistent with the conscientious performance of governmental duties.
- F. Never use confidential information in the performance of governmental duties as a means of making a profit.
- G. Expose corruption.
- H. Seek to find and employ more efficient and economical ways of getting tasks accomplished.
- I. Uphold these principles, ever conscious that public office is a public trust.

IV. Transacting Business

A. DCH Board members and Employees

- 1. DCH Board members and Employees must refrain from transacting business with the Department for personal gain or on behalf of another party. However, it is allowable for DCH Board members and Employees to conduct business with other Agencies as long as the business transaction does not result in a benefit for the Department.

2. Part-time Employees, however, are allowed to transact business with the Department under the following circumstances:
 - a. the transaction resulted from a sealed competitive bid; or
 - b. the transaction does not exceed \$250.00 in benefit to the Employee, or transactions in a given calendar year do not, in the aggregate, exceed \$9,000.
3. A business in which DCH Board members or Employees maintain a substantial interest may not transact business with the Department.

B. Family Members

If a Family Member of a Public Official or Employee maintains a substantial interest in a business, that business may not engage in a business relationship with the Department. Because Family Members are subject to the same ethical constraints as Public Officials and/or Employees, Family Members may conduct business with other Agencies only as long as the business transaction does not result in a benefit for the Department. This prohibition stems from the presumption that the Public Official or Employee, by virtue of his or her Family Member's relationship, has benefited from the business transaction.

C. Exceptions

The following transactions are permitted:

1. A transaction by a full-time or part-time Public Official or part-time Employee that does not exceed \$250.00, or in the alternative, transactions, which in the aggregate in any given year, do not exceed \$9000 in value.
2. A transaction involving the sale of real property through eminent domain.
3. A transaction involving the purchase of health, life, disability, retirement or pension benefits as a part of compensation.
4. A transaction involving a Public Official or Employee and the sale of property or services, where State funds pay for the transaction, and the property or service remains with a third party who is restricted from selling the property or services to an Agency.
5. A transaction between a DCH Board member or Employee and a public contractor.
6. Any transaction involving an emergency purchase by the Department which must be made to protect the health, safety, or welfare of the citizens or property of Georgia; provided, however, that such emergency shall be attested to in writing by the DCH Division Chief under whose scope of responsibility the purchase is made.

7. A transaction wherein a Public Official or DCH Board member is the only source of supply within the State; provided, however, that the limitation to such exclusive, sole source shall be attested to in writing by the DCH Division Chief under whose scope of responsibility the transaction is made.
8. A transaction occurring before March 1, 1983.
9. A transaction involving the provision of Medicaid or Medicare related services and benefits to an Employee or his Family Member; provided, however, in the case of an Employee, he or she shall have no decision-making authority or influence over the determination of eligibility for or amount of such services or benefits.
10. Any transaction between a DCH board member or Employee and an entity within the University System wherein the transaction has been approved by the unit of the University System.
11. Any transaction occurring prior to a Public Official's qualification to run for office or acceptance of an appointment to a public office if the transaction predates the qualifying or acceptance date.
12. Any transaction, wherein the course of business, a DCH Board member or Employee collects sales tax, license fees, excise taxes, or commission as compensation for the performance of a service or good.

D. Disciplinary Actions and Other Remedial Actions

In the event that a DCH Board member or Employee participates in impermissible transactions and/or fails to comply with the reporting requirements in Paragraph V, the following consequences may result:

1. Removal from the Board by the Governor;
2. Termination from employment;
3. Civil fines not to exceed \$10,000; and
4. Restitution to the State for any financial benefit received as a result of the business transaction.

Similarly, if any business in which the DCH Board member's or Employee's Family Member has a substantial interest participates in an impermissible transaction, the business may be subject to the following consequences:

1. Civil fines not to exceed \$10,000; and

2. Restitution to the State for any financial benefit received a result of the business transaction.

V. Other Conflicts of Interest

A. Procurement

The Department is committed to a procurement process that fosters fair and open competition, is conducted under the highest ethical standards, and enjoys the complete confidence of the public. To achieve these important public purposes, it is critical that Employees and Board members have a clear understanding of, and an appreciation for, the ethics in procurement. See DCH Policy No. 402, "Ethics in Procurement" for further guidance.

B. Gifts

Employees are prohibited from accepting gifts from any person with whom the Employee interacts on official state business. To the extent that gifts of nominal value are offered, (i.e., gifts with value of less than \$25.00), they may be shared with other members of the DCH. Exceptions shall include perishable items, such as a basket of fruit, which may be accepted and promptly placed in a common area of state property for sharing among a group.

Employees are allowed, however, to accept a gift on behalf of any Agency or the Office of the Governor or when ceremonial courtesies require such an acceptance. Upon acceptance, the Employee should transfer the gift to DCH, the Office of the Governor, or in the alternative, to a charitable organization on behalf of DCH or the Office of the Governor.

If a Vendor has a personal relationship with the Employee, a Gift that is unconnected with the Employee's duties at the DCH is not necessarily prohibited. In determining whether the giving of an item was motivated by personal rather than business concerns, the history of the relationship between the Vendor and Employee shall be considered. However, regardless of the personal relationship between a Vendor and an Employee, a Gift is strictly forbidden where it is being given under circumstances where it can reasonably be inferred that it was intended to influence the Employee in the performance of his or her official duties.

C. Honoraria

Honoraria are payments to a professional person for services for which no fee is required. Honorarium excludes such things as a certificate or other token of appreciation, which has nominal value and may be accepted as a ceremonial courtesy. Employees are not allowed to accept honoraria.

D. Service on Boards

In general, Employees are restricted from serving as a corporate officer or director of for-profit or publicly held organizations. Notwithstanding the foregoing, each circumstance may be assessed on a case-by-case basis to determine if an actual conflict of interest exists, which would determine whether the Employee could provide such service.

Employees may provide pro bono services to non-profit organizations as long as such services do not negatively impact the Employee's ability to perform his or her duties effectively and with objectivity.

E. Dual Employment

See DCH Policy No. 411 for guidance regarding secondary employment.

F. Political Activities

See DCH Policy No. 416 for guidance regarding political activities.

G. Nepotism

The manner in which Family Members are employed in any organization may lend to an appearance of conflict of interest. The Governor's Executive Order Establishing a Code of Ethics for Executive Branch Officers and Employees prohibits an Employee from advocating for or causing the advancement, appointment, employment, promotion, or transfer of a Family Member to a position within the Department. Additionally, Georgia law restricts the Commissioner and Board members from engaging in that same activity wherein the salary of the Employee is \$10,000 annually or more.

In that the Department desires to assist supervisors in making equitable decisions regarding work assignments, promotions, performance evaluations, disciplinary actions, and all other actions which have a direct impact on an individual's employment, the Department reserves the right to impose the following restrictions:

1. Family Members of individuals currently employed by the Department may be hired only if they will not be working directly for or supervising a Family Member.
2. If Family Members are currently employed, they cannot be transferred into a direct reporting relationship.
3. If the Family Member relationship is established after employment and there is a direct reporting relationship, the manager shall make the determination as to which Employee shall be subject to transfer, if such transfer does not adversely affect the business needs of the Department.

This policy shall in no means violate state and federal laws regarding discrimination on the basis of marital status.

VI. Lobbyists

Employees must ensure that any vendor who submits bids and/or responses to request for proposals, submits an application for a certificate of need, or seeks confirmation of status, letter of non-reviewability, or opposition has certified on forms prescribed by the Department that any lobbyist employed or retained by the vendor has registered with the Government Transparency and Campaign Finance Commission and made the appropriate disclosures.

VII. Reporting Requirements

A. Annual Filing by All Board Members

Each Board member is required to file an annual affidavit relating to the impact of official actions on the member's private, financial and business interests. This affidavit must be filed with the Government Transparency and Campaign Finance Commission by January 31 of each year.

B. Annual Filing by Board Members and Employees Who Engaged in Certain Business Transactions

DCH Board members and Employees must report, on a form prescribed by the Government Transparency and Campaign Finance Commission, an itemized list of business transactions with the State of Georgia or any state agency. This disclosure statement, containing the previous year's business transactions, must be submitted to the Government Transparency and Campaign Finance Commission no later than January 31 of each year. A copy of this report should be submitted to the General Counsel.

Board members and Employees are not required to submit such disclosure statements if they have not transacted business or if such transactions include only those set forth in Paragraph IV(C)(1).

C. Annual Personal Financial Disclosure Filing by Commissioner

The Commissioner shall be required to file, on an annual basis, a financial disclosure statement, including all information contained in O.C.G.A. Section 21-5-50.

D. Report of Expenses and Fees

As a rule, all expenses for an Employee to participate in conferences, meetings and other activities on behalf of DCH shall be paid by DCH. Expenses include food, beverages, travel and lodging. In limited exceptions, a person or entity, on behalf of an

Employee, may offer to pay or waive registration fees when such fees are attendant to the Employee's participation in a public meeting related to official or professional duties; provided, however, that in no event may such fees be paid or waived by a contractor, vendor, potential bidder or lobbyist. Fees are limited to those items that are directly associated with the business or professional duties and are not attributable to personal, social or recreational activities.

A report of such fees must be filed with DCH's Ethics Officer no later than thirty (30) days after the fees have been paid or waived. The report should include:

1. Name and address of the person paying the registration fees; and
2. The description and value of each registration fee.

E. Report of Gifts

If an Employee receives a gift on behalf of DCH or the Office of the Governor, the Employee must file a report with DCH's Ethics Officer no later than thirty (30) days after the receipt of the gift. The report should include:

1. Name and address of the person giving the gift
2. The date the gift was given
3. The monetary value of the gift
4. An explanation of the disposition of the gift

VIII. Guidance

In the event that a DCH Board member or Employee has reason to believe that a conflict of interest might exist in a particular circumstance, the Board member or Employee should seek guidance from the DCH Inspector General.

In those situations where a DCH Board member has in fact identified a conflict involving a matter before the DCH Board, the Board member should immediately recuse himself or herself from any discussion or voting on the matter. The withdrawal of the Board member from consideration of the matter should be entered in the minutes of the meeting of the Board and made a part of the permanent records of the Department.

IX. Mandatory Reporting

Any and every employee who has knowledge of any ethics violation is responsible for reporting such violation to the DCH Inspector General and the DCH Ethics Officer. Good faith reports will be free from retaliation. Supervisors are responsible for reporting such violation and for forwarding any such report from any member of the supervisor's staff to the DCH Inspector General and the DCH Ethics Officer. Supervisors are additionally

responsible for ensuring that the employees under his or her supervision are aware of and comply with the DCH ethical standards and policies.

Reporting suspected policy violations by others shall not jeopardize an Employee's tenure with the Department. Anyone reporting a possible violation of this policy must be acting in good faith and have reasonable grounds for believing the information disclosed indicates a violation.

Any Department employee may report information, in good faith, concerning the possible violations of this policy in any Department programs or operations. No DCH employee will take action against, direct others to take action against, recommend personnel action against, approve personnel action against, or threaten another Department employee for questioning or reporting in good faith possible violations of this policy.

X. Acknowledgement of Policy

Each Board member and Employee shall sign an acknowledgement that he or she:

- A. Has received a copy of the policy;
- B. Has read and understands the policy or, at least, is aware of the policy and is accountable for compliance with it;
- C. Agrees to comply with the policy;
- D. Agrees to submit the Financial Disclosure Statement as required by this policy, if required; and
- F. Agrees to the disclosure of business transactions with the State.

(Signatures on the following page)

ACKNOWLEDGEMENT

Contractor hereby acknowledges that:

- A. It has received, read, and understand the Georgia Department of Community Health's *Code of Ethics and Conflict of Interest Policy*;
- B. It agrees to comply with those provisions of the Georgia Department of Community Health's *Code of Ethics and Conflict of Interest Policy* applicable to Contractor;
- C. It shall cooperate in good faith with the Georgia Department of Community Health so that the Georgia Department of Community Health and its workers will be in compliance with the *Code of Ethics and Conflict of Interest Policy*; and
- D. It is a contractor.

[CONTRACTOR]

Signature

Date

ATTACHMENT S

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	CONTRACTOR
Contract Title:	
Contract No.:	2016XXX

CONTRACTOR AFFIDAVIT

By executing this affidavit, the undersigned Contractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the Contractor identified above has registered with and is participating in a federal work authorization program*, in accordance with the applicability provisions and deadlines established in O.C.G.A. § 13-10-91.

The undersigned further agrees that, should it employ or contract with any subcontractor(s) in connection with the performance of services pursuant to this contract with the Georgia Department of Community Health (hereinafter "DCH"), Contractor will secure from such subcontractor(s) similar verification of compliance with O.C.G.A. § 13-10-91 on the attached Subcontractor Affidavit. Contractor further agrees to maintain records of such compliance and provide a copy of each such verification to DCH at the time the subcontractor(s) is retained to perform such service.

EEV / E-Verify™ Company Identification Number

E-Verify Authorization Date

BY: Signature of Authorized Officer or Agent
of Contractor

Signature Date

Printed Name of Authorized Officer or Agent

Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE

____ DAY OF _____, 20__

Notary Public

[NOTARY SEAL]

My Commission Expires:

*any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-603.

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	CONTRACTOR
Contract Title:	
Contract No.:	2016XXX

ADDITIONAL INSTRUCTIONS TO CONTRACTOR: Please list below all subcontractors and sub-subcontractors (if any) used to perform services under the DCH contract referenced above. In addition, you must attach a signed and notarized affidavit (third page of this form) from each of the subcontractors and sub-subcontractors listed below. The contractor is responsible for providing a signed and notarized affidavit to DCH within five (5) days of the addition of any new subcontractor or sub-subcontractor used to perform under the identified DCH contract.

Contractor's Name:	CONTRACTOR
Subcontractors:	

Sub-Subcontractors (if any)	
Name of Subcontractor:	Name of Sub-subcontractor:

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

Public Employer:	Georgia Department of Community Health
Contractor's Name:	CONTRACTOR
Contract Title:	
Contract No.:	2016XXX
Subcontractor's Name:	
Sub-Subcontractor's Name:	

**SUBCONTRACTOR AFFIDAVIT
 OR
 SUB-SUBCONTRACTOR AFFIDAVIT**

By executing this affidavit, the undersigned Subcontractor/Sub-subcontractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the Subcontractor/Sub-subcontractor which is engaged in the performance of services under a contract with the Contractor (or Subcontractor as applicable) on behalf of DCH has registered with and is participating in a federal work authorization program*, in accordance with the applicability provisions and deadlines established in O.C.G.A. § 13-10-91.

Please initial beside only one choice below:

1. I am an authorized representative of the Subcontractor identified above.
2. I am an authorized representative of the Sub-Subcontractor identified above.

 EEV / E-Verify™ Company Identification Number

 E-Verify Authorization Date

 BY: Signature of Authorized Officer or Agent
 of Subcontractor/Sub-Subcontractor (as applicable)

 Signature Date

 Printed Name of Authorized Officer or Agent

 Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN
 BEFORE ME ON THIS THE

____ DAY OF _____, 20__

[NOTARY SEAL]

 Notary Public

My Commission Expires:

**any of the electronic verification of work authorization programs operated by the United States Department of Homeland Security or any equivalent federal work authorization program operated by the United States Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-*

ATTACHMENT T

**MEMORANDUM OF UNDERSTANDING FOR
THE PEACHCARE PARTNERSHIP PROGRAM**

(To be placed here)

**Attachment U
Georgia Families**

Value Based Purchasing Measures

Figure Z: Value Based Purchasing Performance Measures and Targets - Georgia Families Core Measures

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
1	Preventive Care for Children: Well-child visits in the First 15 Months of Life – 6 or more visits – The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.		68.46		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
2	Preventive Care for Children: Childhood Immunization Status – Combo 10 – The percentage of children two years of age who had 4 DTaP; 3 IPV; 1 MMR; 3 HiB; 3 HepB; 1 VZV; 4 PCV; 1 HepA; 2 – 3 RV; and 2 Influenza vaccines by their second birthday.		40.28		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile
3	Developmental Screening: Developmental Screening in the first three years of life – The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.		42.82		70%		Absolute 10% improvement over CY 2017 rate		Absolute 10% improvement over CY 2018 rate
4	Preventive Care for Adolescents: Adolescents Well-Care Visits – The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.		52.55		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
5	Preventive Dental Services: Total Eligibles Receiving Preventive Dental Services – The percentage of individuals ages 1-20 who are enrolled for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental	52.65		60%		10% relative improvement above CY 2017 rate		10% relative improvement above CY 2018 rate	

**Attachment U
Georgia Families
Value Based Purchasing Measures**

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	service during the reporting period.								
6	Obesity Prevention: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile – Total – The percentage of members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, Counseling for nutrition, and Counseling for physical activity.		BMI %tile - 51.16; Nutrition Counseling – 61.11 Physical Activity; Counseling – 54.63		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile
7	Behavioral Health: Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase – The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Initiation Phase – 43.12; Continuation Phase – 59.22		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 90 th percentile	
8	Pregnancy-related Care: Prenatal and Postpartum Care – Postpartum Care – The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following: <i>Postpartum Care</i> - The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.		63.24		HEDIS 2016 National 75 th percentile		HEDIS 2017 National 90 th percentile		HEDIS 2018 National 90 th percentile
9	Birth Outcomes: Rate of Infants with Low Birth Weight – The percentage of live births that weighed less than 2,500 grams during the reporting period.	8.32		<= National Vital Statistics LBW rate published Dec of 2016		<= National Vital Statistics LBW rate published Dec of 2017		<= National Vital Statistics LBW rate published Dec or 2018	
10	Diabetes: Comprehensive Diabetes Care		HbA1c		HEDIS 2016		HEDIS 2017		HEDIS 2018

**Attachment U
Georgia Families
Value Based Purchasing Measures**

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	(18-75 years old) –The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing; HbA1c poor control (>9.0%); HbA1c control (<8.0%); HbA1c control (<7.0%) for a selected population; Eye exam (retinal) performed; Medical attention for nephropathy; and BP control (<140/90 Hg).		testing – 80.5; HbA1c >9 – 52.47; HbA1c <8 – 39.64; HbA1c <7 – 30.08; Eye exam – 57.81; Nephropathy – 74.51; BP control – 56.91		National 75 th percentile for HbA1c testing; 50 th percentile for all other rates		National 90 th percentile for HbA1c testing; 50 th percentile for > 9.0 and 75 th percentile for all other rates		National 90 th percentile for HbA1c testing; 25 th percentile for >9.0 and 75 th percentile for all other rates
11	Cardiovascular Conditions: Controlling High Blood Pressure (18-85) – The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.		48.36		HEDIS 2016 National 50 th percentile		HEDIS 2017 National 75 th percentile		HEDIS 2018 National 75 th percentile
12	Respiratory Conditions: Medication Management for People with Asthma – The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1) The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period; 2) The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	50% compliant - 5 – 11 yo – 49.08; 50% compliant- 12 – 18 yo – 46.26 75% compliant - 5 – 11 yo – 22.88; 75% compliant - 12 – 18 yo – 22.18		HEDIS 2016 National 75th percentile		HEDIS 2017 National 75th percentile		HEDIS 2018 National 90th percentile	
13	Experience with Care: CAHPS 5.0H Child Version – Shared Decision Making – This measure provides information on parents' experience with their child's Medicaid organization. A composite score is	Adult – 53.7% Child – 57.7%		Absolute 10% above baseline		Relative 10% above CY 2017 rate		Relative 10% above CY 2018 rate	

**Attachment U
Georgia Families
Value Based Purchasing Measures**

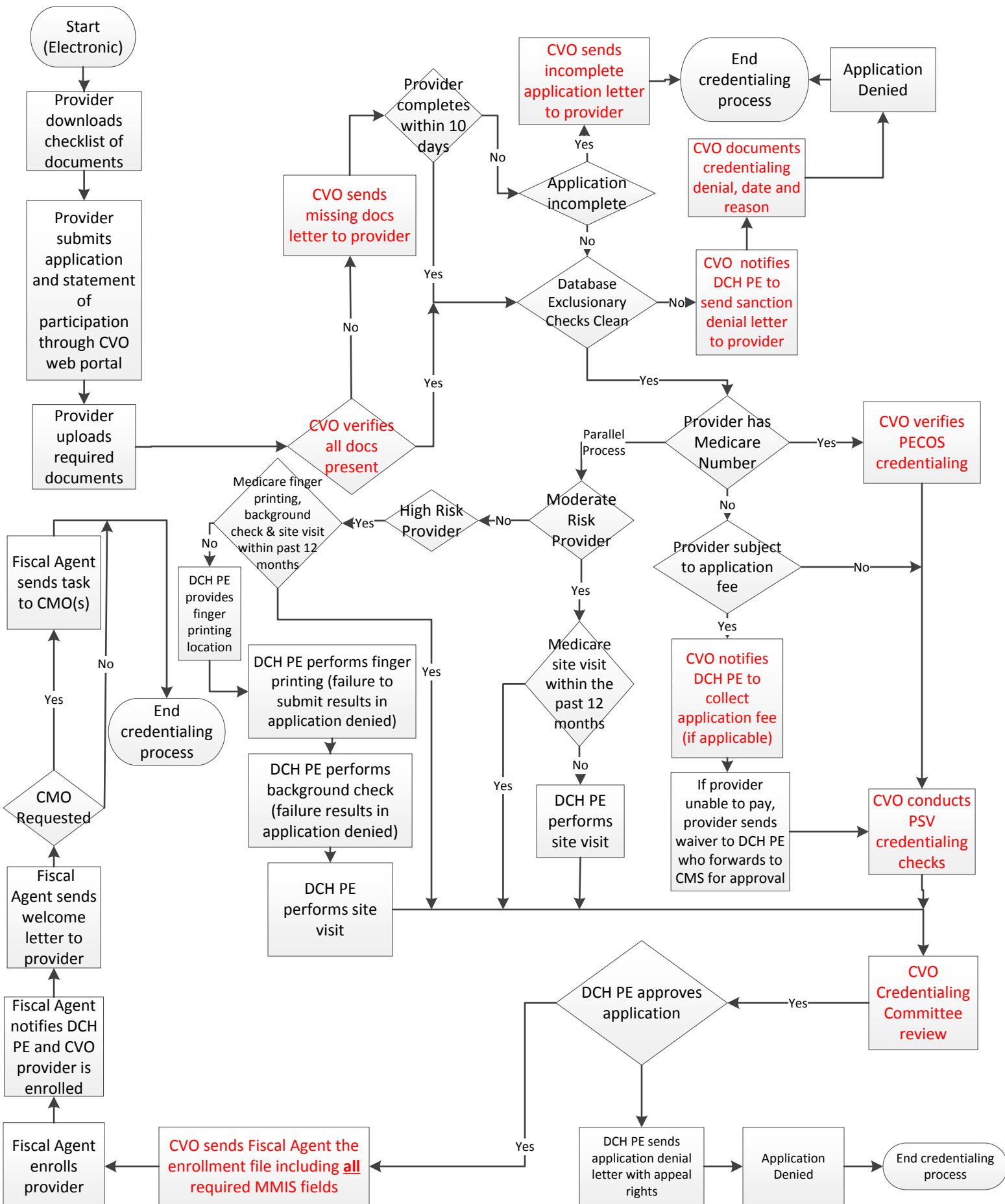
Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	calculated for the Shared Decision Making domain of member experience and responses of "Yes" and "A lot" are considered achievements for the Shared Decision Making composite.								
14.	Increase in the number of Patient Centered Medical Homes in the Contractor's Network – The percent increase of Providers enrolled in the Contractor's network that receive NCQA recognition.	Establish Baseline		Absolute 15% above baseline		Relative 15% above CY 2017 total		Relative 15% above CY 2018 total	

ATTACHMENT V

Georgia Department of Community Health

Traditional Managed Care Provider Credentialing Process

'Red' font indicates responsibilities of the CVO.



Note: This timeline represents a 30 Calendar Day window for the credentialing process for Traditional providers submitting clean applications and enrolling with a CMO. This timeline does not include steps needed for providers to contract with CMO(s).

**ATTACHMENT W
PROVIDER CREDENTIALING TIMELINES**

Georgia Department of Community Health

Provider Credentialing Timeline - Traditional Managed Care Providers

'Clean' Applications

Step No.	Credentialing Steps	Number of Calendar Days																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1	CVO verifies provider submitted all required docs, including statement of participation	1																													
2	CVO conducts database exclusionary checks (fraud and abuse verification)																														
3	CVO conducts PECOS Credentialing verification																														
4	CVO conducts PSV Credentialing verification																														
5	DCH PE conducts finger printing if needed (High-Risk Providers only)																														
6	DCH PE conducts background check if needed (High-Risk Providers only)																														
7	DCH PE conducts site visit, if needed (High and Moderate Risk Providers)																														
8	CVO Credentialing Committee Review																														
9	DCH PE approves application																														
10	CVO sends enrollment file to Fiscal Agent																														
11	Fiscal Agent enrolls providers and notifies DCH PE and CVO provider is enrolled																														
12	Fiscal Agent sends welcome letter to Provider and notifies CMO if requested by provider (Managed Care Only)																														

Note: This timeline represents a 30 Calendar Day window for the Credentialing process for Traditional providers submitting clean applications and enrolling with one or more CMO(s). This timeline does not include steps needed for Providers to contract with CMO(s).