

CONTRACT NUMBER: 16-11-1-01-001-0

CONTRACT BETWEEN

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

AND

BLUE CROSS AND BLUE SHIELD OF MONTANA

FOR

MONTANA HEALTH AND ECONOMIC LIVELIHOOD PARTNERSHIP
(HELP) PROGRAM

THIRD PARTY CLAIMS ADMINISTRATION SERVICES

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**CONTRACT FROM THE MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES**

CONTRACT NUMBER: 16-11-1-01-001-0

THIS CONTRACT, is entered into between the State of Montana Department of Public Health and Human Services, (the "Department"), 111 N. Sanders, P.O. Box 4210, Helena, Montana 59604, and Blue Cross and Blue Shield of Montana ("Contractor"), a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross Blue Shield Association, a Third Party Administrator whose nine (9) digit Federal ID Number is 36-1236610, and whose address is 560 North Park Avenue, P.O. Box 4309, Helena, Montana 59604.

THE PARTIES AGREE TO THE ENTIRE CONTRACT AS FOLLOWS:

SECTION 1 PURPOSE

The purpose of this Contract is to implement the provisions of Senate Bill 405, the Montana Health and Economic Livelihood (HELP) Program enacted by the 2015 Montana Legislature regarding third party administrator services ("TPA").

SECTION 2 TERM OF CONTRACT

The term of this Contract is from October 1, 2015 through December 31, 2017, unless terminated otherwise in accordance with the provisions of this Contract. Renewals of this Contract, by written agreement of both parties, may be made at one year intervals, or any interval that is advantageous to the Department. This Contract, including any renewals, may not exceed a total of seven years.

SECTION 3 SERVICES

- A. The Contractor must provide to the Department third party administrator services ("TPA Services"), to include technology services, as more fully described in the Department's Request for Proposals for Third Party Administrative Services ("RFP"), incorporated into this Contract as Addendum B and the Contractor's response to the RFP, incorporated into this Contract as Addendum C.
- B. Time is of the essence under this Contract. Uninterrupted and continuous delivery of the contracted goods and services is required.
- C. The Department has the option to add additional populations at any time during the term of the Contract. Should the Department exercise that option, the parties must agree upon consideration and time for the added population.

- D. The Contractor is responsible for identifying any insurance based third party liability (TPL) in relation to each participant and providing that information to the Department. The Contractor is also responsible for updating that TPL information.
- E. At the direction of the Department, the Contractor must send Explanation of Benefits (EOB) to participants through an electronic format and/or mail.
- F. The Contractor must comply, within the Department's designated timeframe, with the Federal reporting and compliance requirements. The Contractor must submit applicable reports, forms and certification to the Department in the format required by Federal law and regulations. The Contractor must submit interim reports, as requested by the Department, if needed for Federal audit purposes.
- G. The Contractor must provide T-MSIS, as defined by the Centers for Medicare and Medicaid Services (CMS) in the T-MSIS Data Dictionary V1.1, dated February 28, 2014, any modifications to the T-MSIS Data Dictionary V1.1, and as clarified in release correspondence by CMS.
- H. The Contractor must comply with requirements included in the following Addendums to this Contract:

ADDENDUM A: FEDERAL 1915B REQUIREMENTS
ADDENDUM B: REQUEST FOR PROPOSAL 16-2896P
ADDENDUM C: BCBSMT RESPONSE TO RFP 16-2896P
ADDENDUM D: SECTION 1115 WAIVER SPECIAL TERMS AND CONDITION
ADDENDUM E: SECTION 1915(b)(4) WAIVER SPECIAL TERMS AND
CONDITIONS

SECTION 4 DEPARTMENT RESPONSIBILITIES

- A. Eligibility Determination.

The Department is responsible for the determination of and administration of eligibility for the HELP Program.

- B. Participant Enrollment Information.

For every day of coverage throughout the term of this Contract, the Department must transmit "Participant Enrollment Information" to the Contractor in an 834 HIPAA compliant format. The Participant Enrollment Information must provide the Contractor with identifying information for participants. Specifications and the file layout for the Participant Enrollment Information are described in Appendix F: Information Technology (IT) Requirements, in RFP 16-2896P.

C. Notification to the Contractor

1. The Department must advise Contractor of any changes in HELP Program provisions, in writing, when possible at least three months prior to the date such changes will become effective.
2. The Department must notify Contractor of any subrogation recoveries.
3. The Department assumes the responsibility for the erroneous disbursement of benefits by Contractor in the event of error or neglect on the part of the Department in providing eligibility and coverage information to Contractor. This responsibility does not eliminate or reduce Contractor's duty to seek recovery or withhold over-payments from future disbursements to HELP Program providers. If Contractor caused the error and a recovery cannot be requested or be collected, then Contractor must be financially responsible for the claim payment.

D. Program Interpretation

Any Department decision as to any benefit, claim, appeal, or interpretation of any HELP Program related document, whether or not it involves an ambiguity or other dispute regarding medical or behavioral health benefits covered by the HELP Program, is final and binding on Contractor.

SECTION 5 CONSIDERATION AND PAYMENTS

A. Conditions For Payment For Implementation Of Information Technology Services

Payment for the implementation of the information technology services to be delivered in accordance with Sections 3.3 and 3.4 of the RFP is as follows:

1. 80% of the total contract price for IT implementation will be paid by the Department at such time as: 1) the Department determines that the necessary system features are fully installed and that the production of those features, inclusive of all interfaces, is acceptable, and 2) federal approval for the system features is received from CMS.
2. Upon determination that the necessary system features are fully installed and that the production of those features is acceptable, those features are subject to the technology warranties stated at subsections A. and C.3. of Section 6. The warranties are for the operation of the system and any developed interfaces in accordance with the Department specifications, requirements, and the designated time frames. Beginning from formal acceptance, the Contractor is responsible under the warranties for all fixes to the system features without further consideration from the Department.
3. The remaining 20% of the total contract price for IT implementation will be paid by the Department 2 years after the Department's formal acceptance of the installation

and of the production of the system features unless system issues have arisen that are unresolved.

B. TPA Services

1. The administrative fee is the payment made to the Contractor for claims administration services. The fee is set on a per member per month (“PMPM”) basis. The Department will provide a daily enrollment report to the Contractor that breaks out full member months and retroactive member months.
2. Full member months are those sent to the Contractor for enrollment between the 1st and the 15th calendar day of the current coverage month.
3. Retroactive member months are those sent to the Contractor for enrollment prior to the current coverage month.
4. PMPM fees will be reimbursed at \$5.50 PMPM for the month in which any participant is enrolled after the 15th of the month, and for any prior month for which the participant’s coverage is retroactively effective.

The Department will pay a fixed HELP Program all-inclusive PMPM fee of \$26.39 for January 1, 2016 – June 30, 2016. Starting July 1, 2016, monthly PMPM fees must be paid based on the number of HELP Program eligible participants.

Number of HELP Program Participants	PMPM Fee Indicate your all-inclusive (all services throughout this RFP and the resulting contract) HELP TPA Services per member per month fee.
January 1, 2016 – June 30, 2016	\$26.39
Up to 15,000 Participants	\$25.39
15,001 - 20,000 Participants	\$25.39
20,001 - 25,000 Participants	\$25.39
25,001 – 30,000 Participants	\$25.16
30,001 – 35,000 Participants	\$25.16
35,001 - 40,000 Participants	\$25.16
40,001 – 45,000 Participants	\$25.00
45,001 – 50,000 Participants	\$25.00
50,001 – 55,000 Participants	\$25.00
55,001 – 60,000 Participants	\$25.00
60,001 – 65,000 Participants	\$25.00
65,001 – 70,000 Participants	\$25.00
70,001 Participants and Above	\$25.00

For year two, the Department will pay the PMPM rates identified above, plus the annual CPI increase based on year one, not to exceed 3%.

Renewal PMPM Fee Rates Increase (if renewed)

Program Year	PMPM Percent Increase
Third Year (2018-2019) - not to exceed 3% above second year rates	Annual CPI increase based on prior year, not to exceed 3%
Fourth Year (2019-2020) - not to exceed 3% above third year rates	Annual CPI increase based on prior year, not to exceed 3%
Fifth Year (2020-2021) - not to exceed 3% above fourth year rates	Annual CPI increase based on prior year, not to exceed 3%
Sixth Year (2021-2022) - not to exceed 3% above fifth year rates	Annual CPI increase based on prior year, not to exceed 3%
Seventh Year (2022-2023) - not to exceed 3% above sixth year rates	Annual CPI increase based on prior year, not to exceed 3%

Separately Priced Retroactive Enrolled Participant Claims PMPM Fee

Indicate your TPA PMPM fee for claims processing services only for retroactively enrolled participants.	\$5.50
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Separately Priced Information Technology Development Cost

DPHHS may have the ability to reimburse the TPA for IT development costs for HELP TPA Services. Indicate your IT development cost for the October 1, 2015 – December 31, 2015 period.	\$3,750,000
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C. Billing Procedures and Requirements

1. TPA Services Reimbursement

- a. Full Member month's reimbursement will be based on the total number of Full Member Months times the PMPM Fee. Reimbursement will be based on the sum total of all Daily Enrollment Reports for the calendar month.
- b. Retroactive Member Months reimbursement will be based on the total number of Retroactive Member Months times the Retroactive Enrolled Participant Claims PMPM Fee.

- c. The Department must remit payment to the Contractor for a TPA Services Invoice on or before the last business day of each month in which the invoice is sent to the Department. Payment is made by electronic fund transfer but under extraordinary circumstances a paper check may be issued.

2. Claims Invoices

- a. The Contractor must submit a Weekly Claims Invoice to the Department for claims paid during the prior week. The Weekly Claims Invoice totals for claims paid must match the total(s) on the Weekly Claims Payment Report accompanying the weekly invoice. The report must include, at a minimum, the following information: participant name; participant CHIMES ID number; amount paid per date of service; and totals. Other fields requested by the Department must be added within 30 days.
- b. The Department will reimburse the Contractor at least once each week for the total number of claims processed and paid, upon receipt and successful acceptance of the weekly claims data.
- c. If the Department disputes specific claims or amounts, the Department must pay the amounts not in dispute and provide notice of the disputed claims and/or amounts to Contractor. The parties must work together to resolve disputed claims.

- D. Payment to the Contractor must be made to:
Health Care Service Corporation
300 E. Randolph
38th Floor (38.322C)
Chicago, IL 60601

E. Adjustments and Consideration

The Department may adjust the consideration to the Contractor under this Contract based on any reductions of funding, governing budget, erroneous or improper payments, audit findings, or failings in the Contractor's delivery of services.

F. Funding and Sources of Funding

The sources of the funding for the third party administrator and related services performed under this the state general fund and, from the federal Centers for Medicare and Medicaid. Prior to final federal approval the funding percentages are unknown.

G. Erroneous and Improper Payments

The Contractor may not retain any monies the Department pays in error or which the Contractor, its employees, or its agents improperly receive. Any monies the Contractor

receives in error are a debt the Contractor owes to the Department. The Contractor must immediately notify the Department if it determines a payment may be erroneous or improper, and must return that payment within 30 days to the Department. If the Contractor fails to return to the Department any erroneous or improper payment, the Department may recover such payment by any methods available under law or through this Contract, including deduction of the payment amount from any future payments to be made to the Contractor.

SECTION 6 WARRANTIES

A. Deliverables

Contractor represents and warrants that:

1. During the term of this Contract, Contractor's information technology system will perform, as required in this Contract and the RFP.
2. Contractor must promptly re-perform or otherwise cure information technology system operations that are not in compliance with the applicable requirements at no cost to Department.

B. Services

Contractor represents and warrants that:

1. That during the term of this Contract, it will perform all TPA Services in a professional manner and in accordance with the requirements of the Contract; and
2. That the Contractor must promptly re-perform or otherwise cure services that are not in compliance with the applicable requirements at no cost to Department.

C. Ability to Perform

Contractor represents and warrants that:

1. It has the financial stability and financial resources to carry out the services to be performed under this Contract for the duration of the term of this Contract;
2. It has the necessary types and numbers of personnel and the necessary operational resources and configurations to perform the services of this Contract effectively, efficiently, and competently;
3. It has established data systems that are capable of performing the necessary operations, maintaining necessary data, and are capable of interoperability with the Department systems for the purposes of performance of services under this Contract;

4. It is currently not subject to any form of federal or Department debarment from entering into public contracts or performing health care services for publically funded programs; and
5. Its methods of accounting are in material compliance with generally accepted accounting principles.

SECTION 7 ADDITIONAL REMEDIES

A. Withholding Payments

If the Contractor fails to perform services or to provide services in conformance with the requirements of this Contract, the RFP, and other referenced materials and authorities, the Department has the right, with notice, to withhold any and all payments directly related to the non-compliant services. The Department may withhold any payments due to the Contractor, without penalty or work stoppage by Contractor, until the Contractor cures performance to the satisfaction of the Department. The Contractor is not relieved of its performance obligations if any payment is withheld.

B. Reductions in Payments Due

Amounts owed to the Department by the Contractor under this Contract, including but not limited to liquidated or other damages, or claims for damages, may be deducted or set-off by Department from any money payable to Contractor pursuant to this Contract. The Department will provide a minimum of thirty (30) day notice to the Contractor of an intended deduction or offset.

C. Cover

If, in the Department's reasonable judgment, a default by the Contractor is not so substantial as to require termination of the entire Contract, reasonable efforts to induce the Contractor to cure the default are unavailing, the Contractor fails to cure such default within 30 calendar days of receipt of notice from the Department, and the default is capable of being cured by the Department or by another resource without unduly interfering with continued performance by the Contractor, the Department, without prejudice to any other remedy it may have, may terminate performance of the particular service that is in default and provide or procure the services reasonably necessary to cure the default. In the event of a termination for failure to perform under Section 33 Department will, without limiting its other available remedies, have the right to procure the terminated services that are the subject of the default on the open market and the Contractor will be liable for: (i) the cost difference between the contractual consideration for the terminated services and the reasonable replacement costs for those replacement services acquired from another vendor or expended by Department, provided that Department mitigates any such difference to the maximum extent reasonably possible; and (ii) if applicable, the following administrative costs directly related to the

replacement of this Contract: costs of competitive bidding, mailing, advertising and staff time costs. In addition, the Contractor must reasonably cooperate with the Department and its agents in providing for the necessary transition activities.

D. Right to Assurance

If the Department, in good faith, has reason to believe that the Contractor does not intend to, or is unable to perform or has refused to perform or continue performing all material obligations under this Contract, the Department may demand in writing that the Contractor give a written assurance of intent to perform. Failure by Contractor to provide written assurance within the number of days specified in the demand (in no event less than five business days) may, at the Department's option, be the basis for terminating this Contract under the terms and conditions or other rights and remedies available by law or provided by this Contract.

SECTION 8 LIQUIDATED DAMAGES

A. Generally

Any delay or failure by the Contractor to perform in accordance with the terms of this Contract will cause the Department damages that are difficult to quantify. The parties have agreed in accordance with applicable law that the amounts of liquidated damages set forth in the RFP and in this Contract are reasonable estimates of the Department's damages in relation to the harms that are specified.

B. Other Remedies

The assessment of liquidated damages by the Department will not constitute a waiver or release of any other remedy the Department may have under this Contract for Contractor's breach of this Contract, including without limitation, the Department's right to terminate this Contract.

C. Collection of Liquidated Damages

Amounts due to the Department as liquidated damages may be deducted by the Department from any money payable to Contractor under this Contract, or the Department may bill the Contractor as a separate item and the Contractor is obligated to promptly reimburse the Department for the sums owing.

D. Specific Liquidated Damages

The specific liquidated damages for the purposes of this Contract are the following:

1. Claims Entry

\$5,000 for each day that less than 100% of the total claims received on that day are not entered in the Contractor's data system within 24 hours of receipt. (See RFP Section 3.2.5 A2 for performance requirement.)

2. Adjudication

- a. \$5,000 for each day that the Contractor has processed less than 95% of those claims received on the 30th day prior to that particular date that are not in a pended status. (See RFP Section 3.2.5 for performance requirement.)
- b. \$5,000 for each day that the Contractor, has processed less than 99% of those claims received on the 75th day prior to that particular date that are not in a pended status. (See RFP Section 3.2.5 for performance requirement.)
- c. \$5,000 for each day that the Contractor, has processed less than 100% of those claims received on the 90th day prior to that particular date that are not in a pended status. (See RFP Section 3.2.5 for performance requirement.)

3. Data and Reporting Requirements

\$500 for each business day past the due date, as requested in writing by the Department, for a data compilation or program related report that the Contractor has failed to deliver. (See RFP Section 3.2.7 E for performance requirement.)

4. Key Personnel

- a. \$2,000 for each business day that the Contractor removes the Contractor's dedicated Contract Administrator from the HELP TPA Services Program to conduct other business. (See RFP Section 4.2 C for performance requirement.)
- b. \$1,000 for each business day that the Contractor removes other dedicated Key Personnel from the HELP TPA Services Program to conduct other business. (See RFP Section 4.2 C for performance requirement.)

5. Customer Services Center

- a. \$10,000 for each business day that the HELP TPA Services Program Customer Services Center is not in operation. (See RFP Section 3.2.7 C for performance requirement.)
- b. \$5,000 for each business day that the HELP TPA Services Program Customer Services Center is not fully operational. (See RFP Section 3.2.7 C for performance requirement.)

6. Provider Access

\$10,000 for each business day that the Contractor's HELP TPA Services is not meeting the necessary provider access requirements. (See RFP Section 3.2.1 for performance requirement.)

SECTION 9 CONFLICTS OF INTEREST AND ANTITRUST VIOLATIONS

- A. The Contractor must:
1. Comply with applicable State and Federal laws, rules and regulations regarding conflicts of interest in the performance of its duties under this Contract;
 2. Operate with complete independence and objectivity without actual, potential or apparent conflict of interest with respect to the activities conducted under this Contract;
 3. Establish safeguards to prohibit its board members, officers and employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain; and
 4. Have no interest nor acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.
- B. This Contract is subject to immediate termination if the Contractor engages in any violation of State or Federal law relating to:
1. Mail fraud, wire fraud, making false statements, price fixing and collusion to fix prices under the Sherman Act, 15 U.S.C. §§ 1-7 and engagement in kickback schemes in violation of the Anti-Kickback Act, 41 U.S.C. §§ 51-58; and
 2. Colluding with other Contractors in a noncompetitive manner to gain unfair advantage in providing services at a noncompetitive price in violation of 18-4-141, MCA.
- C. The Contractor may not enter into any contract or other arrangement for the use, purchase, sale lease or rental of real property, personal property or services funded with monies of this Contract if an employee, administrator, officer or director of the Contractor may receive a financial or other valuable benefit as a result. The Department may grant exceptions to this prohibition where it determines that the particular circumstances warrant the granting of an exception.

SECTION 10 REPORTING OF FALSE CLAIMS, FRAUD, AND OTHER CRIMINAL MATTERS

- A. The Contractor, its employees, agents and subcontractors must immediately report any credible evidence of misconduct involving Federal funds under this Contract, including any false claim under the Federal False Claims Act (31 U.S.C. §§ 3729-3733), to the

Office of Inspector General for the Federal Department of Health & Human Services, the Federal Department of Education or the Federal Department of Agriculture, as applicable.

- B. The Contractor must report to the Department or other Department authority any credible evidence that a violation of the Montana False Claims Act, at Title 17, chapter 8, part 4, MCA, has been committed.
- C. If this Contract relates to furnishing items or services funded with Medicaid monies at more than a single location, or under more than one contractual or other payment arrangement, and the receipt of Medicaid monies totaling \$5,000,000 or more annually, the Contractor and its subcontractors must establish and set forth policies to be submitted to their employees in writing by handbook or otherwise educating them regarding the Federal False Claims Act and other provisions specified in 42 U.S.C. § 1396a(a)(68).

SECTION 11 OWNERSHIP OF DATA AND DOCUMENTS/COPYRIGHT AND PATENT INFRINGEMENT/PROPRIETARY INFORMATION

A. Ownership of Data

All eligibility, claim and other HELP Program information provided to the Contractor, finished or unfinished documents, data, programs, or reports prepared by the Contractor under the Contract (collectively, "Work Product") is deemed the property of the Department. Upon expiration or termination of the Contract, all finished or unfinished Work Product must be turned over to the Department. The Work Product includes, but is not limited to, claims data, allowable fee data and all other details of claims payment.

B. Copyright/Patent Infringement

1. If a third party makes a claim against the Department that the deliverables and services furnished under this Contract infringe upon or violate any patent or copyright, the Department must promptly notify the Contractor. The Contractor must defend such claim in the Department's name or its own name, as appropriate, but at the Contractor's expense. The Contractor must indemnify the Department against all costs, damages, attorney fees, and all other costs and expenses of litigation that accrue as a result of such claim. If the Department reasonably concludes that its interests are not being properly protected, or if principles of governmental or public law are involved, it may enter any action.
2. If any deliverable furnished is likely to or does become the subject of a claim of infringement of patent or copyright, then the Contractor may, at its option, procure for the Department the right to continue using the alleged infringing deliverable, or modify the deliverable so that it becomes non-infringing. If none of the above options can be accomplished, or if the use of the deliverable by the Department is prevented by injunction, the Department must determine whether this Contract has been breached.

C. Proprietary Information

1. The information contained within this Contract and attachments, inclusive of Contractor's proposal and its attachments, if any, and information otherwise provided to the Department in relation to this contractual relationship is not confidential and is available for public inspection and copying unless determined in accordance with federal or state law to be confidential as personal consumer, recipient or employee information or as business/corporate proprietary information that is protected from release. To any extent required or allowed by law, the Department has the right to use for public purposes and to disclose to the public contractual information inclusive of reports, evaluations, statistics, and other management and performance information related to this Contract.
2. All public contractual information is available from the Department for inspection during regular business hours. The Contract liaison specified in this Contract should be contacted for purposes of inquiring as to the availability of and procedures for the release of public contractual information.
3. Claim of Proprietary Information.
 - a. The Department will only give consideration to a business/corporate claim of confidential trade secret or proprietary information if the Contractor has identified and segregated the information for which the claim is being asserted and has provided a detailed legal analysis supporting the claim of confidentiality. The Contractor must include with that claim the affidavit of legal counsel for the Contractor, on the form provided by the Department, titled "AFFIDAVIT FOR PROPRIETARY INFORMATION CONFIDENTIALITY", attesting to the legal counsel's legal relationship to the Contractor, acknowledging the primacy of federal and Montana law with respect to the claim, and indemnifying the Department with respect to defense and warranting the Contractor's responsibility for all legal costs and attorneys' fees, should the Department accept the claim as legitimate and as a result be subjected to administrative or legal contest.
 - b. The Department does not consider confidential the information that may be claimed by the Contractor to be confidential trade secret or proprietary information, if that information is legitimately available to the public without restriction through one or more other sources or has been legitimately released to the public otherwise by the proposer or other parties.
 - c. The Department will provide the Contractor timely notice of any administrative or legal request or contest from a third party seeking release of contractual and related information for which the Contractor has properly made a claim that the information is confidential as trade secret or proprietary

information. If the Department determines that such information is subject to the public right to know and must be released as requested, the Department will provide the Contractor with notice of the intended release ten working days prior to the date of the proposed release. The notice period is intended to allow the Contractor to make arrangements, if desired, to intervene through an appropriate legal forum to contest the release.

SECTION 12 CREATION AND RETENTION OF RECORDS

- A. The Contractor must maintain all records, (written, electronic or otherwise) documenting compliance with the requirements of the Contract and its attachments, and with Department and Federal law, relating to performance, monetary expenditures and finances during the term of this Contract and for ten (10) years after its completion date.

- B. If any litigation, reviews, claims or audits concerning the records are begun before the expiration of the ten (10) year period, the Contractor must continue to retain them until such litigation, reviews, claims, or audits are resolved. The Contractor must provide authorized Department and Federal entities, including Montana DPHHS, the U.S. Departments of Health and Human Services, Agriculture, Energy and Education, their auditors, investigators and agents, with timely and unrestricted access at all reasonable times and places to all of the Contractor's records, materials and information including any and all audit reports with supporting materials and work documents related to the delivery of goods and services provided under this Contract for purposes of audit and other administrative activities and investigations. Access must be provided in a format acceptable to those authorized entities, who may record and copy any information and materials necessary for any administrative activity, investigation and audit or other administrative activity or investigation.

SECTION 13 ACCOUNTING, COST PRINCIPLES, AND AUDIT

- A. Audits and Other Investigations

The Department and any other legally authorized Federal and State entities and their agents may conduct administrative activities and investigations, including audits, to assure the appropriate administration and performance of this Contract; and the proper expenditure of monies, delivery of goods, and provision of services pursuant to this Contract. The Contractor must provide the Department and any other authorized governmental entity and their agents access at all reasonable times and places to and the right to record or copy any and all of the Contractor's records, materials and information necessary for the conduct of any administrative activity, investigation or audit. Administrative activities and investigations may be undertaken and access must be afforded under this section from the time the parties enter the Contract until the expiration of ten (10) years from the completion date of this Contract.

The Department must ensure that the Contractor contracts annually for the conduct of, an independent audit to report on the accuracy, truthfulness, and completeness of financial and program data submitted to the Department by, or on behalf of the Contractor.

B. Corrective Action

If directed by the Department, the Contractor must take corrective action to resolve audit findings. The Contractor must prepare a corrective action plan detailing actions the Contractor proposes to undertake to resolve those audit findings. The Department may direct the Contractor to modify the corrective action plan.

C. Reimbursement for Sums Owing

The Contractor must reimburse or compensate the Department in any other manner as the Department may direct for any sums of monies determined by an audit or other administrative activity or investigation to be owing to the Department.

D. Federal Financial Requirements

1. The Contractor must maintain appropriate financial, accounting and programmatic records necessary to substantiate conformance with Federal requirements governing fund expenditures, even if this Contract is not cost / budget based.
2. The Contractor must comply with the federal audit requirements set forth in 2 CFR 200.201 through 200.521, as may be applicable.

SECTION 14 ASSIGNMENT, TRANSFER, AND SUBCONTRACTING

- A. The Contractor may not assign, transfer, delegate or subcontract this Contract in whole or in part, or any right or duty arising under this Contract, unless the Contractor submits a written request to the Department's liaison and the Department gives its express written approval to the assignment, transfer delegation or subcontract. The Contractor must provide 30 day prior notice to the Department of any intended entry into a subcontract, transfer, or assignment for the performance of any services under this Contract.
- B. The Contractor must immediately notify the Department of any litigation concerning any assignment, transfer, delegation or subcontract.
- C. In accordance with the sections of this Contract regarding indemnification, the Contractor must indemnify and hold the Department harmless with respect to any suit or action arising out of or brought by any party to an assignment, transfer, delegation or subcontract.
- D. Any assignment, transfer, delegation, or subcontracting of the Contractor's rights or duties under this Contract does not relieve the Contractor from its responsibility and

liability for performance of all Contractor obligations under this Contract. The Contractor will be as fully responsible for the acts or omissions of any Subcontractor as it is for its own acts or omissions.

SECTION 15 CONTRACT PERFORMANCE SECURITY

- A. An Irrevocable Letter of Credit (Attachment 2) in the amount of 25% of the total Contract price shall secure the performance of Contractor, and shall secure in part or in whole any damages, cost or expenses resulting from Contractor's breach hereunder or liability caused by Contractor. In the event of a breach, the Irrevocable Letter of Credit shall become payable to the Department for any outstanding damage assessments made by the Department against Contractor. An amount up to the full amount of the Irrevocable Letter of Credit may also be applied to Contractor's liability for any administrative costs and/or excess costs incurred by the Department in obtaining similar Software, Deliverables, other products and Services to replace those terminated as a result of Contractor's breach. The Department may seek other remedies in addition to the Letter of Credit.

- B. The original Letter of Credit must be provided to the following address within 10 business days from the Effective Date: State Procurement Bureau, P.O. Box 200135, Helena, MT 59620-0135.

SECTION 16 INDEMNIFICATION

- A. The following apply for the purpose of this section:
 - 1. "Contractor" includes the Contractor and any officer, employee, volunteer, agent, subcontractor, representative or assignee of the Contractor and any other person, partnership, corporation, or other legal entity performing work or services, or providing materials under this Contract for or on behalf of the Contractor.
 - 2. "State of Montana" includes the State of Montana and the Department, and any of their officials, employees, volunteers or agents acting within the scope of their duties and responsibilities.
 - 3. "Allegation of liability" includes both actual and alleged claims, demands, and legal causes of action.

- B. The Contractor must at its sole cost and expense indemnify, defend, and hold harmless the State of Montana against any allegations of liability of any kind, relating to personal injury, death, damage to property, or any other legal obligation, and any resulting judgments, losses, damages, liability, penalties, costs, fees, cost of legal defense and attorney's fees in favor of third parties, including the officers, employees and agents of the Contractor. The obligation of the Contractor to indemnify, defend and hold harmless the State of Montana under this section does not extend to losses, liabilities, damages,

costs, or fees arising solely out of or resulting solely from the actions, failures, or omissions of the State of Montana.

C. Additional Indemnification.

Claims under this provision also include those arising out of or in any way connected with Contractor's breach of this Contract, including any Claims asserting that any of Contractor's employees are actually employees or common law employees of the State or any of its agencies, including but not limited to, excise taxes or penalties imposed on the State under Internal Revenue Code ("Code") §§ 4980H, 6055 or 6056.

D. The Department must give the Contractor notice of any allegation of liability and at the Contractor's expense the Department must cooperate in the defense of the matter.

E. If the Department determines the Contractor has failed to fulfill its obligations as the indemnitor under this Section, the Department may proceed to undertake its own defense. If the Department undertakes its own defense, the Contractor must reimburse the Department for any and all costs to the Department resulting from settlements, judgments, losses, liabilities, and penalties and for all the costs of defense incurred by the Department including but not limited to attorney fees, investigation, discovery, experts, and court costs.

SECTION 17 LIMITATIONS OF STATE LIABILITY

A. Any liabilities of the State of Montana and its officials, employees and agents are governed and limited by the provisions of Title 2, chapter 9, MCA, for all acts, omissions, negligence, or alleged acts or omissions, negligent conduct, and alleged negligent conduct related to this Contract.

B. The Department shall not be liable, regardless of the form of action, whether in contract, tort, negligence, strict liability or by statute or otherwise, for any claim related to or arising under this Contract for consequential, incidental, indirect, special, or exemplary damages, including without limitation lost profits and lost business opportunities.

SECTION 18 INSURANCE COVERAGE

A. GENERAL REQUIREMENTS

1. The following definitions apply for the purposes of this section.

- a. "Contractor's agents" means subcontractors, representatives, assignees, volunteers and any other person, partnership, corporation, or other legal entity performing work or services, or providing materials under this Contract on behalf of Contractor.

- b. "Claim" means both actual and alleged claims, demands, and legal causes of action.
2. The Contractor must acquire and maintain adequate liability insurance coverage in the forms and amounts stated in this Section to assure the State of Montana that there is insurance coverage for any potential losses, damages, and other expenses that may arise in the Contractor's performance of this Contract.
3. The Contractor must provide the Department with a copy of the certificate of insurance prior to performance showing compliance with the requisite coverage and at the request of the Department must provide copies of any insurance policies pertinent to the requisite coverage, any endorsements to those policies, and any subsequent modifications of those policies.
4. The Contractor must maintain the insurance required in this Section throughout the time period of this Contract. During the term of this Contract, the required insurance may not be changed in any way which renders it not in conformance with the requirements of this Section, including but not limited to cancellation of the insurance, allowing the insurance to expire, reduction or restriction of the terms and coverage, until the Contractor has given the Department's liaison 30 days' written notice prior to the change and the Contractor has obtained written commitment for replacement coverage that is in conformance with the requirements of this Section and proof that the replacement coverage is given with the notice to the Department. The Contractor must notify the Department immediately of any material change in insurance coverage and must provide to the Department copies of any new certificate or of any revisions to the existing certificate issued.
5. The Contractor is responsible for paying all premiums and deductibles for each insurance policy required by this Contract.
 - a. Any deductible or self-insured retention must be declared to the Department. At the request of the Department, the Contractor must
 - 1) Reduce or eliminate such deductibles or self-insured retentions in relation to the Department, its officials, employees, and volunteers; or
 - 2) Procure a bond guaranteeing payment of losses and related investigations, claims administration, and defense expenses.
6. Each insurance policy required in this Section must be purchased from an insurance carrier authorized to do business in the State of Montana with an A.M. Best's rating of no less than A-, or through a qualified self-insurer plan implemented in accordance with Montana law and subject to the approval of the Department.
7. Except for professional liability insurance, the Contractor's insurance must include coverage for its subcontractors, or the Contractor must furnish to the

Department copies of separate certificates of insurance and endorsements for each subcontractor. Except for professional liability insurance, Contractor's insurance coverage must also specify that the Department, including its officials, employees, agents and volunteers, is covered as additionally insured for liability arising out of activities performed by or on behalf of the Contractor, including the insured's general supervision of the Contractor's officers, employees and agents and of the Contractor's performance, the services and products, and the completed operations; and arising in relation to the premises owned, leased, occupied, or used by the Contractor.

8. The Contractor's Commercial General Liability insurance coverage under any insurance policy necessary for performance of this Contract is the primary insurance in respect to the State of Montana, including its officials, agents, employees, and volunteers and must apply separately to each project or location. Any insurance or self-insurance maintained by the State of Montana, its officials, employees, agents, and volunteers is in excess of the Contractor's insurance and does not contribute with it.
9. If the total of losses for submitted claims exceeds the aggregate amount of insurance coverage a Contractor has, the Contractor must procure additional coverage based upon those increased claims for the remaining term of this Contract.

B. General Liability Insurance

1. The Contractor must have primary general liability insurance coverage that covers tort and other claims of liability arising from personal harm or losses, bodily injuries, death, or damages to or losses on real and personal property or for other liabilities that may be claimed in relation to the Contractor's performance. The insurance must cover claims that may be caused by any act, omission, or negligence of the Contractor or the Contractor's officers, employees, or agents.
2. General liability insurance coverage must have combined single limits for bodily injury, personal harm or loss, and property damage or loss of \$1,000,000 per occurrence and \$2,000,000 per aggregate year, or as established by statutory tort limits of \$750,000 per claim and \$1,500,000 per occurrence as provided by a self-insurance pool insuring counties, cities or towns pursuant to 2-9-108, MCA.

C. Professional or Errors and Omissions Liability Insurance

1. The Contractor must have professional insurance to cover such claims as may be caused by an error, omission, or other negligent act of the Contractor as a professional and any other employed or subcontracted professional staff involved in providing the contracted services.

2. At minimum, the coverage must have combined single limits for each wrongful act of \$1,000,000 per occurrence and \$2,000,000 aggregate per year.
3. If occurrence coverage is not available or is cost prohibitive, the Contractor may provide "claims made" coverage if:
 - a. the commencement date of this Contract does not fall outside the effective date of insurance coverage; and
 - b. the claims made policy has a three-year tail for claims that are filed after the cancellation or expiration date of the policy.

SECTION 19 COMPLIANCE WITH BUSINESS, TAX, LABOR, AND OTHER LEGAL AUTHORITIES

- A. The Contractor assures the Department that the Contractor is legally authorized under Department and Federal business and tax legal authorities to conduct business in accordance with this Contract.
- B. The Contractor and its employees, agents and subcontractors are not employees of the Department and the Contractor may not in any manner represent or maintain the appearance that they are employees.
- C. The Contractor must maintain coverage for the Contractor and the Contractor's employees through workers' compensation, occupational disease, and any similar or related statutorily required insurance program at all times during the term of this Contract. The Contractor must provide the Department with proof of necessary insurance coverage as it may be issued to the Contractor and must immediately inform the Department of any change in the status of the Contractor's coverage.
- D. If the Contractor has received an Independent Contractor certification from the Montana Department of Labor and Industry as to the Contractor for workers' compensation and other purposes, the Contractor must provide the Department with a copy of the current certification and must immediately inform the Department of any change in the status of the Contractor's certification. This requirement is not applicable if the Contractor's occupation under Montana law is a recognized professional occupation that when practiced as an independent business may be conducted without the Independent Contractor certification.
- E. The Contractor and its employees, agents and subcontractors must report to the Department or other appropriate Department authority any credible evidence that an act in violation of the Montana False Claims Act, at Title 17, chapter 8, part 4, MCA, has been committed.
- F. The Contractor, as a Contractor for the Department, must comply on an on-going basis with the Montana prevailing wage requirements in Title 18, chapter 2, part 4, MCA

unless the services contracted for are “human services” or one of the other exclusions from the prevailing wage requirement.

- G. The Contractor may not use a person as an independent contractor in the performance of its duties and responsibilities under this Contract unless that person is currently certified in accordance with Montana legal authorities as an Independent Contractor and remains so, or is otherwise exempt under Montana legal authorities from the requirement to possess an Independent Contractor Certification.
- H. The Contractor is solely responsible on an on-going basis for and must meet all labor, health, safety, and other legal requirements, including payment of all applicable taxes, premiums, deductions, withholdings, overtime and other amounts, which may be legally required with respect to the Contractor, the Contractor’s employees, and any persons providing services on behalf of the Contractor under this Contract.
- I. The Contractor must comply on an on-going basis with all applicable Federal and State legal authorities, executive orders, Federal administrative directives, Federally approved waivers for program administration, regulations and written policies, including those pertaining to licensing.
- J. The Contractor must only employ, contract or otherwise engage personnel who are authorized to work in the United State in accordance with applicable Federal and State laws.
- K. The section of this Contract regarding indemnification applies with respect to any and all claims, obligations, liabilities, costs, attorney fees, losses or suits involving the Department that accrue or result from the Contractor’s failure to comply with this section, or from any finding by any legal authority that any person providing services on behalf of the Contractor under this Contract is an employee of the Department.

SECTION 20 COMPLIANCE WITH THE AFFORDABLE CARE ACT

- A. Contractor is Employer.

Contractor is the employer and, therefore, responsible for providing healthcare benefits for its employees under the Patient Protection and Affordable Care Act. Contractor represents and warrants that all individuals who perform services for an agency of the State are and at all times shall remain Contractor's common law employees. Contractor further acknowledges and agrees that, throughout the term of this contract, Contractor retains the right to direct and control its employees.

- B. State Benefit Plans.

Contractor agrees and acknowledges that it, its agents or employees are not entitled to participate in any of the benefit plans or programs that the State now or hereafter maintain for its employees. If any state or federal court, or any local, state or federal

government agency, division or other related government entity, shall determine that Contractor, its agents, or employees, are considered an employee or common law employee of the State, or if for any reasons Contractor, its agents or employees, were to meet the eligibility criteria with respect to any benefit plan or program now or hereafter available to State employees or otherwise become eligible to participate in any State-sponsored benefit plans or programs, Contractor, its agents, or employees, waive any right to participate in, either retrospectively or prospectively, or receive any benefits under any State-sponsored benefit plans or programs. This waiver of any right to participate in State-sponsored employee benefit programs represents a material component of the terms and compensation agreed to by these parties and is not in any way conditioned on any representation or assumption concerning status of Contractor, its agents, or employees, with respect to the State, as employee, common law employee, independent contractor or temporary employee. This provision is not intended to preclude a family member of a State employee who is an employee or an agent of the Contractor from participation in the State Benefit Plan as provided by state law.

C. Contractor Provided Health Care Coverage.

Contractor represents and warrants that it will offer to all its agents or employees, who perform services for the State under this contract for more than 29 hours per week and their dependents under age 26, health care coverage under its health care plans and that such coverage provides minimum essential coverage, provides minimum value, and is affordable for purposes of the employer responsibility provisions under Section 4980H of the Code, and would otherwise satisfy the requirements of Code § 4980H if provided by the State.

D. Reporting Requirements.

Contractor further represents and warrants that it will satisfy all reporting requirements under Internal Revenue Code §§ 6055 and 6056 with respect to its officers, employees, and agents who perform services for the State under the terms of this Contract.

E. Auditing.

The State may audit Contractor's operations to ensure that the representations and warranties set forth above have been complied with.

SECTION 21 CIVIL RIGHTS

A. Discrimination Prohibited Under Federal and State Authorities

The Contractor may not discriminate in any manner against any person on the basis of an individual's race, color, national origin, age, physical or mental disability, marital status, religion, creed, sex, sexual orientation, political belief, genetic information, veteran status, culture, social origin or condition, or ancestry in the performance of this Contract or in the delivery of State services or funding on behalf of the State. Likewise, the

Contractor may not tolerate discrimination or harassment because of a person's marriage to or association with individuals in one of the previously mentioned protected classes. The Contractor may not receive funds from the State if the Contractor engages in discrimination on the basis an individual's race, color, national origin, age, physical or mental disability, marital status, religion, creed, sex, sexual orientation, political belief, genetic information, veteran status, culture, social origin or condition, or ancestry.

B. Compliance with Federal and State Authorities

The Contractor must comply, as applicable, with the provisions of:

1. The Montana Human Rights Act (49-2-101, *et seq.*, MCA);
2. The Montana Governmental Code of Fair Practices (49-3-101, *et seq.*, MCA);
3. The Federal Civil Rights Act of 1964 (42 U.S.C. 2000d, *et seq.*), prohibiting discrimination based on race, color, or national origin;
4. The Federal Age Discrimination In Employment Act of 1975 (42 U.S.C. 6101, *et seq.*), prohibiting discrimination based on age;
5. The Education Amendments of 1972 (20 U.S.C. 1681), prohibiting discrimination based upon gender;
6. Section 504 of the Federal Rehabilitation Act of 1973 (29 U.S.C. 794), prohibiting discrimination based upon disability;
7. The Federal Americans with Disabilities Act of 1990 (42 U.S.C. 12101, *et seq.*), prohibiting discrimination based upon disability;
8. The Vietnam-Era Veterans Readjustment Assistance Act (38 U.S.C. 4212);
9. The Federal Executive Orders 11246, 11478, and 11375 and 41 CFR Part 60, requiring equal employment opportunities in employment practices;
10. The Federal executive Order 13166 requiring facilitation of access for persons with limited English proficiency to Federally funded services; and
11. State of Montana Office of the Governor Executive Order No. 41-2008.

C. Civil Rights Violations

The Department may undertake any and all actions, including contract termination, necessary to remedy any prohibited discriminatory action by the Contractor or to remedy any failure by the Contractor to carry out an affirmative action as required in Federal or State legal authorities.

SECTION 22

FEDERAL REQUIREMENTS

A. Generally

Prior to signing this Contract, the Contractor must sign and submit to the Department OMB Form 424B (Rev. 7-97) (known as “Assurances – Non-Construction Program”) and the Department’s “Certification of Compliance with Certain Requirements for Department of Public Health & Human Services (May 2011)”. The Contractor must comply with and ensure its subcontractors’ compliance with the applicable Federal requirements and assurances in those forms, including any related reporting requirements. The Contractor is responsible for determining which requirements and assurances are applicable to the Contractor.

Obtain OMB 424B at www.whitehouse.gov/omb, the Office of Management and Budget website. Search for “grants management” to access the form for printing. The department form referenced above may be obtained from the procurement official.

B. Political and Lobbying Activities

1. Except as expressly permitted by State and Federal legal authorities, the Contractor, its employees and agents may not use any monies received under the terms of this Contract to make payments for salaries, expenses or otherwise related to:
 - a. Any political activities;
 - b. Publicity or propaganda, or the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the U.S. Congress or a State legislature, except for presentations to the U.S. Congress or a State legislative body or one or more of its members as an aspect of normal and recognized executive-legislative relationships;
 - c. The awarding of any Federal contract, grant or loan, the making of any cooperative agreement or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement; and
 - d. Influencing or attempting to influence:
 - 1) A member, officer or employee of the U.S. Congress or of any branch of any state or local legislative body, an employee of a member or officer of the U.S. Congress or of any branch of any state or local legislative body;
 - 2) Any legislation or appropriations pending before the U.S. Congress or a state or local legislative body; or

- 3) Any officer or employee of any Federal or state agency.
2. If the Contractor, or its employees or agents pay any funds other than the monies received under this Contract to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress or an employee of a member of the U.S. Congress in connection with this Contract, the Contractor must complete and submit to the Department the Federally required form, "STANDARD FORM LLL". The Contractor must cooperate with any investigation undertaken regarding the expenditure of funds for political or lobbying activities.

Obtain the Federal standard form referenced above through the Office of Management and Budget website at www.whitehouse.gov/omb. Search for "grants management" to access standard form "SF LLL" for printing.

3. Federally appropriated monies received through the programs of the Federal Departments of Health and Human Services, Education, and Labor, as provided in Section 503 of H.R. 3547,"Consolidated Appropriations Act, 2014", and as may be provided by congressional continuing resolutions or further budgetary enactments, may not be used:
 - a. To fund publicity or propaganda, or for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the U.S. Congress or a state legislature, except for presentations to the U.S. Congress or a state legislative body or one or more of its members as an aspect of normal and recognized executive-legislative relationships.
 - b. To pay the salary or expenses of any grant or contract recipient, or agent acting for the recipient, related to any activity designed to influence legislation or appropriations pending before the U.S. Congress or a State or local legislative body.
4. The Contractor must cooperate with any investigation undertaken regarding the expenditure of funds for political or lobbying activities.

C. Disclosure of Ownership and Control Information (Federal Medicaid monies)

1. The following definitions apply for the purposes of this subsection.
 - a. An ownership or control interest means the possession of equity in the capital, the stock or the profits of the Contractor, and includes:
 - 1) An ownership or an indirect ownership interest or combination of both totaling five percent or more in the Contractor;
 - 2) An ownership of five percent or more in any mortgage, deed of trust, note or other obligation secured by the Contractor if that

interest equals at least five percent of the value of the property or assets of the Contractor;

- 3) An officer or director of the Contractor's corporation; and
- 4) A partner if the Contractor is a partnership.

Determinations of ownership and control interest percentages including indirect ownership are made in accordance with 42 CFR 455.102.

- b. A managing employee is a general manager, business manager, administrator, director or other person who exercises operations or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor.
 - c. An agent is any person who has been delegated the authority to obligate or act in behalf of the Contractor.
2. Prior to entry into this Contract and annually thereafter, the Contractor must disclose to the Department:
- a. The name of each corporation or person with an ownership or control interest in the Contractor or in any subcontractor of the Contractor;
 - b. The name of the Contractor's managing employee;
 - c. The name of any person who has ownership or control interest in the Contractor or who is the Contractor's managing employee or agent who has been convicted of a Federal crime related to Federal health care programs;
 - d. Whether any person named as having an ownership or control interest who also is related as a spouse, parent, child or sibling or another named person; or has an ownership or control interest in another disclosing entity, and if so, the identity of that other disclosing entity.
3. Within 35 days of the Department requesting it, the Contractor must disclose:
- a. Ownership of any subcontractor with whom the Contractor has had more than \$25,000 in business transactions in the 12 month period ending on the date the Department made its request; and
 - b. Any 'significant business transactions' occurring between the Contractor and a wholly owned supplier or between the Contractor and any subcontractor during the five year period ending on the date of the request

4. The ownership and control disclosure in this subsection must include the tax identification number, primary business address including post office box, if applicable, every business location, if applicable, of any corporation and the social security number, name, date of birth, and address of any person including a managing employee.
5. The Department may deny or terminate enrollment as a Medicaid provider to any entity that fails to comply with the reporting requirements in this subsection.

D. Prohibition on Contracting with Federally Debarred Entities or Persons

1. General Prohibition On Contracting With Federally Debarred Entities Or Persons
 - a. The Department, in accordance with The Federal Acquisition Streamlining Act of 1994, P.L. 103-355, and Executive Orders #12549 and #12689, is prohibited from contracting with any entity that is debarred, suspended, or otherwise excluded from participating in procurement activities funded with Federal monies. This prohibition also extends to contracting with an entity that has a director, officer, partner, person with beneficial ownership of more than 5 percent of the entity's equity, employee, consultant, or person otherwise providing items and services that are significant and material to the entity's obligations under this Contract with the Department if that person has been debarred, suspended or otherwise excluded from participating in procurement activities funded with Federal monies. The general Federal listing of debarred persons and entities for contracting purposes is maintained by the Federal General Services Administration (GSA) at System For Award Management, SAM.gov.
 - b. If the Department finds that the Contractor is not in compliance with these Contract related Federal debarment requirements, the Department:
 - 1) Must notify the Federal government;
 - 2) May continue this Contract for its current term unless the Secretary of the Federal Department of Health and Human Services or other authorizing Federal authority directs otherwise; and
 - 3) May only renew or otherwise extend the duration of the existing contract with the Contractor if the Federal government provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending this Contract.
2. Prohibition On Contracting With Entities Or Persons Debarred By The Federal Department Of Health & Human Services

At the time of engagement and monthly thereafter, the Contractor must check the "List of Excluded Individuals/Entities" maintained by the Office of Inspector General for the Federal Department of Health & Human Services at

<http://exclusions.oig.hhs.gov/> to determine whether any person or entity engaged with or employed by the Contractor appears on the list and must immediately report to the Department any person or entity who appears on the list and must take appropriate action to terminate the Contractor's relationship with the debarred person.

3. The Department must terminate this Contract immediately if the Contractor:
 - a. As an entity is debarred, suspended, or otherwise excluded by the Federal Office of Inspector General (OIG) or by the Department under Federal or state legal authority from participating in Federally funded procurement activities or from receiving reimbursement through a health care program unless the OIG provides a lawful waiver of the debarment exclusion; or
 - b. Employs or engages a person who is debarred or subject to debarment from receiving reimbursement through Federal and state health care programs, including a director, officer, partner, person with beneficial ownership of more than five percent of the Contractor's equity, employee, consultant, or person otherwise providing items and services that are significant and material to the Contractor's obligations under this Contract with the Department.

E. Reporting for Compliance with the Federal Transparency Act

The Federal Accountability and Transparency Act requires that sub-recipients of Federal monies received from the Department either through a Federal grant or contract, including contracts with Federal Medicaid monies as consideration, must report to the Department the information specified in this subsection. This requirement applies only to contracts having consideration greater than \$25,000.

1. The following definitions apply for the purpose of with this Section:
 - a. "Entity" includes a corporation, an association, a partnership, a limited liability company, a limited liability partnership, a sole proprietorship, a nonprofit corporation, any other legal business entity, a tribe or tribal entity, an institution of higher education and a state or local government. It does not include a natural person and performance is not related to any business or nonprofit organization that the person may own, control or operate.
 - b. "Federal award" includes monies received by the Department through Federal grants and contracts, and includes the expenditure of Federal monies under cooperative agreements, including all forms of Medicaid payments. It does not include payments and reimbursements made to vendors of supplies, equipment, maintenance and other routine services.

- c. "Total compensation" includes the cash and noncash dollar value earned by the official/executive during the Contractor's past fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):
 - 1) Salary and bonus;
 - 2) Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments;
 - 3) Earnings for services under non-equity incentive plans. Does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees;
 - 4) Change in pension value. This is the change in present value of defined benefit and actuarial pension plans;
 - 5) Above-market earnings on deferred compensation which is not tax-qualified; and
 - 6) Other compensation. For example, severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property if the value for the executive exceeds \$10,000.
2. The Contractor must submit to the Department the following information related to the monies paid pursuant to this Contract in the time and manner the Department directs in fulfillment of the reporting requirements of the Federal Funding Accountability And Transparency Act (FFATA or Transparency Act), P.L. 109-282, as amended by Section 6202(a), P.L. 110-252-1:
 - a. Name of the entity receiving the award;
 - b. The pertinent NAICS code for the Contractor's business activity;
 - c. The Data Universal Numbering System (DUNS) identifier assigned to the Contractor or other unique identifier of the entity receiving the award;
 - d. The DUNS identifier or other unique identifier assigned to the parent entity of the recipient, should the recipient be owned by another entity;
 - e. Award title;
 - f. Descriptive purpose of the funding action;
 - g. The amount of the award;
 - h. The transaction type;
 - i. The funding agency;
 - j. The Catalog of Federal Domestic Assistance number for grant derived program funding;

- k. The program source;
 - l. The location of the entity receiving the award, including four data elements for the city, state, congressional district, and country; and
 - m. The location of the primary place of performance under the award, including four data elements for city, state, congressional district, and country.
3. The Contractor must mail to the Department each year during the term of the Contract an "Officers/Executive Compensation Report" (the Compensation Report) if the Contractor has:
- Reported gross income in the previous tax year totaling \$300,000 or more;
 - Consideration for this Contract totaling \$25,000 or more at the signing of or any time during the term of the Contract;
 - Annual gross revenues totaling more than \$25,000,000; and
 - Federal awards which constitute 80% of the Contractor's annual gross revenues.
- a. The Compensation Report must present (1) the individual names and total compensation of the five most highly compensated officers/executives of the Contractor for the most recent full calendar year and (2) the Contractor's Data Universal Numbering System (DUNS) number issued through Dun and Bradstreet. The most highly compensated officers/executives reporting is limited to persons who are engaged in governance and management and is not including highly compensated professionals such as physicians who do not participate substantively in governance or management.
 - b. The Contractor must submit the Compensation Report to the Department by the end of the month following the month in which the total of the monies obligated through this Contract is at \$25,000 or more, whether occurring at the time of signing or at some later date due to a contractual amendment. The Contractor must continue to submit the Compensation Report annually during the term of the Contract on the anniversary of the initial date of submittal, even if the total consideration for the Contract is later amended to be less than \$25,000.
 - c. The Contractor must submit the Compensation Report to the Department by first-class mail addressed as follows:
 - DPHHS
 - Attn: BFSD-FFATA Reporting
 - PO Box 4210
 - Helena, MT 59604-4210
 - d. In lieu of the Report, the Contractor may submit to the Department the most currently available public report of compensation information as reported to:

- 1) The Security and Exchange Commission (SEC) under sections 13(a) or 15(d) of the Securities Exchange Act of 1934 through the Contractor's annual proxy statement; or
 - 2) The Internal Revenue Service under section 6104 of the Internal Revenue Code of 1986 through Section VII of the Contractor's Form 990.
- e. The Contractor does not need to report the compensation information of its top 5 officers/executives if the Federal government designates that information as classified and not subject to public release.

F. Text Messaging While Driving

The Contractor, its officers, employees, agents and subcontractors are prohibited from engaging in any other form of electronic data retrieval or electronic data communication while driving in vehicles for purposes of the work contracted for through this Contract, including text messaging, reading from or entering data into any handheld or other electronic device, SMS texting, e-mailing, instant messaging, and obtaining navigational information. Driving includes operating a motor vehicle on an active roadway with motor running, including while temporarily stationary due to traffic, a traffic light, stop sign or otherwise. It does not include operating a motor vehicle with or without the motor running when one has pulled over to the side of, or off, an active roadway and has halted in a location where one can safely remain stationary. The Contractor and its subcontractors are responsible for ensuring that owners, officers, employees, agents and subcontractors are aware of and adhere to the requirements of this provision.

SECTION 23 CONFIDENTIALITY OF PERSONAL INFORMATION AND COMPLIANCE WITH THE FEDERAL HIPAA AND HITECH PRIVACY AND SECURITY REQUIREMENTS

A. The following definitions apply for the purpose of this section.

1. "Personal information" means information appearing in any form, whether written, electronic or otherwise, concerning a person who is:
 - a. A consumer or recipient of services delivered by a Departmental program;
 - b. Otherwise the subject of a Departmental activity; or
 - c. A Departmental employee.
2. "Confidential personal information" means personal information which Federal or state legal authorities or regulations protect from general public access and release. "Confidential personal information" includes but is not limited to the name, social security number, driver's license number, street and postal addresses, phone number, email address, medical data, protected health information as

defined for purposes of the Federal Health Insurance Portability and Accountability Act (HIPAA) and Health Information for Economic and Clinical Health Act (HITECH), programmatic individual eligibility information, programmatic individual case information, programmatic payment and benefit information and information obtained from the IRS or other third parties that is protected as confidential.

B. Confidential Personal Information Held by the Contractor

During the term of this Contract, the Contractor, its employees, subcontractors and agents must treat and protect as confidential all material and information the Department provides to the Contractor or which the Contractor acquires on behalf of the Department in the performance of its contractual duties and responsibilities which contain personal information or confidential personal information and must use or disseminate such materials and information only in accordance with the terms of this Contract and any governing legal and policy authorities.

C. Security of Confidential Personal Information.

In its use and possession of confidential personal information, the Contractor must conform to security standards and procedures meeting or exceeding current best business practices as defined by the National Institute of Standards and Technology cyber-security standards. State of Montana has adopted FIPS 199 security risk level of MODERATE and that DPHHS has adopted the moderate baseline set of controls out of NIST SP 800-53 rev 4. Upon the Department's request, the Contractor must allow the Department to review and approve any specific security standards and procedures of the Contractor.

The Department requires all FTI, PHI, and PII data to be encrypted whether in motion or at rest. The encryption must be FIPS 140-2 compliant.

D. Notice by Contractor of Unauthorized Disclosures or Uses of Confidential Personal Information.

Immediately upon discovering any unauthorized disclosure or use of confidential personal information by the Contractor, its employees, subcontractors, agents, the Contractor must confidentially report the disclosure or use to the Department in detail, and must undertake immediate measures to retrieve all such confidential personal information and to prevent further unauthorized disclosure or use of confidential personal information.

E. Notice by Contractor of Investigations, Complaints, Litigation Concerning the Use and Protection of Confidential Personal Information.

1. The Contractor must provide the Department with written notice within five work days of the Contractor receiving notice of any of the following:

- a. Any complaint lodged with, investigation initiated by, or any determination made by any Federal entity [including the Federal Department of Health and Human Services' Office of Civil Rights (OCR) and the Federal Department of Justice] related to any purported non-compliance by the Contractor with the Federal HIPAA and HITECH Acts and their implementing regulations; or
 - b. Any administrative action or litigation initiated against the Contractor based on any legal authority related to the protection of confidential information.
2. With its notice, the Contractor must provide the Department with copies of any relevant pleadings, papers, administrative or legal complaints and determinations.
- F. Contractor Compliance with the Federal HIPAA and HITECH Acts and the Implementing Regulations Governing the Use and Possession of Personal Healthcare Information.
1. If the Contractor uses or possesses individually identifiable personal healthcare information for purposes related to the performance of any services provided under this Contract, the Contractor must comply with the privacy and security requirements of the Federal HIPAA of 1996 and HITECH Acts enacted as part of the American Recovery and Reinvestment Act of 2009, and the regulations implementing those requirements as they apply to the Contractor.
 2. If the Contractor is a Business Associate as defined at 45 CFTR 160.103, it must comply with the privacy and security requirements for functioning as a Business Associate of the Department or as a "Covered Entity" under Federal HIPAA and HITECH. In addition to executing this Contract, the Contractor must execute the Business Associate Agreement attached to this Contract as Attachment G.
 3. The Contractor must sign the Department's Certification Form attached to this Contract as Attachment 3, certifying that the Contractor is in full compliance with applicable HIPAA and HITECH requirements as a Covered Entity or a Business Associate, as those terms are defined at 45 CFR 160.103.

SECTION 24 PUBLIC INFORMATION AND DISCLAIMERS

- A. The Contractor may not access or use personal, confidential, or privileged information obtained through the Department, its agents and Contractors, unless the Contractor does so:
1. in conformity with governing legal authorities and policies;
 2. with the permission of the persons or entities from whom the information is to be obtained; and

3. with the review and approval by the Department prior to use, publication or release.

Privileged information includes information and data the Department, its agents and Contractors produce, compile or receive for state and local contractual efforts, including those local and state programs with which the Department contracts to engage in activities related to the purposes of this Contract.

- B. The Contractor may not use monies under this Contract to pay for media, publicity or advertising that in any way associates the services or performance of the Contractor or the Department under this Contract with any specific political agenda, political party, a candidate for public office, or any matter to be voted upon by the public. Media includes but is not limited to commercial and noncommercial print, verbal and electronic media.
- C. The Contractor must inform any people to whom it provides consultation or training services under this Contract that any opinions expressed do not necessarily represent the position of the Department. All public notices, information pamphlets, press releases, research reports, posters, public service announcements, web sites and similar modes of presenting public information pertaining to the services and activities funded with this Contract prepared and released by the Contractor must include the statement:

“This project is funded in whole or in part under a contract with the Montana Department of Public Health and Human Services. The statements herein do not necessarily reflect the opinion of the Department.”

- D. The Contractor must state the percentage and the monetary amount of the total program or project costs of this Contract funded with (a) Federal monies and (b) non-Federal monies in all statements, press releases, and other documents or media pieces made available to the public describing the services provided through this Contract.
- E. Before the Contractor uses, publishes, releases or distributes them to the public or to local and state programs, the Department must review and approve all products, materials, documents, publications, press releases and media pieces (in any form, including electronic) the Contractor or its agents produce with contract monies to describe and promote services provided through this Contract.

SECTION 25 PARTICIPANT GRIEVANCES AND APPEALS

- A. The Contractor must inform providers and participants of services provided through this Contract of any right there may be to present grievances to the Contractor and the Department or to receive a fair hearing.
- B. If an appeal for a fair hearing is filed, the Contractor must appear to present evidence in any hearing that may be held.

- C. The Contractor, as directed by the Department, must provide services in accordance with the decision in a fair hearing concerning services provided by the Contractor to a participant of services.
- D. The Contractor must provide services in accordance with the administrative review and fair hearing process as described in RFP16-2896P, and the Contractor's response to RFP16-2896P.

SECTION 26 CONTRACTUAL DISPUTE RESOLUTION PROCESS

Prior to pursuing termination of this Contract, the parties agree to attempt in good faith to promptly resolve any dispute, controversy or claim arising out of or relating to this Contract, through negotiations between senior management of the parties and their designees. If either party determines that the dispute cannot be resolved after initiating such negotiations, either party may terminate such negotiations.

SECTION 27 CONTRACTOR COOPERATION AND DEPARTMENTAL GUIDANCE

- A. Cooperation with the Department and Other Governmental Entities

The Contractor must ensure that Contractor's personnel cooperate with the Department or other State or Federal administrative agency personnel at no cost to the Department for purposes relating to the delivery and administration of the contracted for services including but not limited to the following purposes:

1. investigation and prosecution of fraud, abuse, and waste;
2. audit, inspection, or other investigative purposes; and
3. testimony in judicial or quasi-judicial proceedings or other delivery of information to other agencies investigators or legal staff.

- B. Departmental Guidance

The Contractor may request guidance from the Department in administrative and programmatic matters that are necessary to the Contractor's performance. The Department may provide such guidance as it deems appropriate. Guidance may include copies of regulations, statutes, standards and policies that are to be complied with under this Contract. The Department may supply interpretations of such materials and this Contract to assist the Contractor with compliance. A request for guidance does not relieve the Contractor of any obligation to meet the requirements of this Contract. The Department must not provide legal services to the Contractor in any matters relating to the Contractor's performance under this Contract.

SECTION 28 ACCESS TO PREMISES

The Contractor must provide the State of Montana and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the Contractor's premises or other places where contractual performance occurs to inspect, monitor or otherwise evaluate contractual performance. The Contractor must provide reasonable facilities and assistance for the safety and convenience of the persons performing these duties. All inspection, monitoring and evaluation must be performed in such a manner as not to unduly interfere with contractual performance.

SECTION 29 REGISTRATION OF OUT OF STATE ENTITIES

- A. If the Contractor is incorporated in a state other than Montana or in a foreign country and is conducting business in Montana, it may be required by 35-1-1026 and 35-8-1001, MCA to register with the Montana Secretary Of State Office. Further information concerning these requirements may be obtained through the Montana Secretary of Department's Office at <http://sos.mt.gov/> or by calling 406-444-3665.
- B. A business entity required to register in the State of Montana must show proof of a current certificate of authority to conduct business prior to entry into or continued performance under this Contract.

SECTION 30 LIAISON AND SERVICE OF NOTICES

- A. Duane Preshinger, 406-444-4458(phone), 406-444-1861(fax), dpreshinger@mt.gov, is the liaison for the Department. Mark Owen, 312-653-1166(phone), 312-653-1499(fax), Mark_Owen@bcbsil.com, 300 E. Randolph, Chicago, IL 60601, is the liaison for the Contractor. These persons serve as the primary contacts between the parties regarding the performance of this Contract.
- B. Written notices, reports and other information required to be exchanged between the parties must be directed to the liaison at the parties' addresses set out in this Contract.

SECTION 31 PERFORMANCE ASSESSMENTS AND CORRECTIVE ACTIONS

- A. The Department may assess the Contractor's performance under this Contract to any extent and at any time.
- B. If the Department determines the Contractor or any employee, agent, or subcontractor of the Contractor, is failing to perform the duties and requirements under this Contract, the Department may provide written notice of such failure to the Contractor. Within ten (10) business days after receipt of the written notice, the Contractor must investigate the matters set forth in the notice and submit a written response to the Department setting forth in detail any actions the Contractor agrees to undertake to remedy the failure. The time for responding may be extended by agreement of the parties. If in the opinion of the

Department the actions the Contractor sets forth in its response are not sufficient to remedy the failure, the Department may propose written amendment of the Contract setting forth corrective actions the Department deems necessary to remedy the failure. If the parties cannot agree to such amendment, or if corrective actions agreed to pursuant to amendment are not performed or completed, the Department may exercise any right it has under this Contract, including but not limited to termination of the Contract. Corrective actions may include but are not limited to:

1. performance requirements;
2. repayment requirements;
3. accountability or review measures; and
4. training or supervision requirements.

- C. The Department may exercise any right it has under this Contract, including but not limited to termination, without first undertaking corrective action pursuant to subsection B of this Section, or after having begun or undertaken corrective action under subsection B.

SECTION 32 FORCE MAJEURE

If the Contractor or Department is delayed, hindered, or prevented from performing any act required under this Contract by reason of delay beyond the control of the asserting party including, but not limited to, theft, fire, or public enemy, severe and unusual weather conditions, injunction, riot, strikes, lockouts, insurrection, war, or court order, then performance of the act must be excused for the period of the delay. "Beyond the control" means an unanticipated grave natural disaster or other phenomenon or event of an exceptional, inevitable, and irresistible character, the effects of which could not have been prevented or avoided by the exercise of due care or foresight. In that event, the period for the performance of the act must be extended for a period equivalent to the period of the delay. Matters of the Contractor's finances must not be considered a *force majeure*.

SECTION 33 CONTRACT TERMINATION

- A. The Department may terminate this Contract for convenience. The Department must give notice of termination to the Contractor at least sixty (60) days prior to the effective date of termination. In the event of such termination for convenience, the Contractor will be paid for all Services rendered satisfactorily to the termination date and for any direct costs (not including anticipated profits) incurred by the Contractor as a result of the termination. Such payment constitutes the Contractor's sole right and remedy. The Department has the right to terminate for convenience even when a condition of force majeure exists.

- B. This Contract is subject to immediate termination if the Contractor engages in any violation of state or federal law listed in this Contract or any Attachment to this Contract.
- C. The Department may terminate this Contract in whole or in any aspect of performance under the Contract if:
 - 1. Federal or State funding for this Contract becomes unavailable or reduced for any reason;
 - 2. The Contractor fails to perform in accordance with the terms of the Contract; or
 - 3. The Contractor fails to perform in accordance with any applicable governing legal authority, including but not limited to:
 - a. The American Recovery and Reinvestment Act of 2009;
 - b. The Government Funding Transparency Act of 2008;
 - c. The Federal Funding Accountability And Transparency Act of 2006;
 - d. The Federal and State acts prohibiting false claims;
 - e. The Federal and State legal authorities requiring and implementing debarment;
 - f. The Federal and State antitrust and other anticompetitive legal authorities including the Sherman Act;
 - g. The Federal and State civil rights legal authorities; and
 - h. State licensing legal authorities.
 - i. The Contractor materially breaches this Contract. In that event, the Department must give Contractor written notice of such breach and timeframe for the Contractor to take corrective action. Contractor must correct the breach within 30 calendar days of receipt of such notice unless the cure period is otherwise specified in the written notice of breach. If the breach is not corrected timely, this Contract may be terminated immediately, in whole or in part, by notice from the Department to the Contractor. The option to terminate is at the sole discretion of the Department. Events of material breach by the Contractor include but are not limited to:
 - a. if deliverables and services furnished by the Contractor fail to conform to any requirement of this Contract after the 30 calendar day opportunity for correction as defined above has been provided;

- b. failure by the Contractor to submit any report required by this Contract; or
 - c. failure by the Contractor to perform any of the other covenants and conditions of this Contract, including beginning work under this Contract without prior Montana Department of Administration approval.
- 4. Except as may be otherwise required or necessitated by Federal or State legal authorities including the Recovery and Reinvestment Act, the Department must give written notice of termination to the contract liaison for the Contractor at least sixty (60) days prior to the effective date of termination of the Contract unless the parties agree in writing to a different notice period.
- D. The Contractor must within 60 days following notice of contract termination, provide the Department with data on premiums paid, co-payments paid, coordination of benefits, lifetime maximums, eligibility information, other termination data as defined by the Department and a plan for the claims run out process which would be reasonably required by another organization to provide ongoing claims administration by an electronic file as specified by the Department.
- E. Notice of termination given to the Department by the Contractor may only be revoked with the consent of the Department.
- F. Upon expiration, termination or cancellation of this Contract, the Contractor must:
 - 1. assist the Department, its agents, representatives and designees in closing out the Contract, and in providing for the orderly transfer of contract responsibilities and the continued delivery of contract services by the Department or its designee, and must allow the Department access of the Contractor's facilities, records and materials to fulfill these requirements, and
 - 2. process and pay claims incurred but not received prior to the expiration or termination of this Contract for a period of twelve (12) months after the date of expiration or termination, subject to the following conditions:
 - a. The Department must reimburse Contractor for claims paid in accordance with the process set forth in Section 5.C.2 of this Contract, and
 - b. The Department must pay Contractor One Hundred percent (100%) of the current administrative fees for a period of two months following the expiration or termination of this Contract. The current administrative fees are based on the average population in the three months preceding the expiration or termination date.

3. within a reasonable time after the expiration or termination of this Contract, provide the Department with an estimate of the HELP Programs' liability for claims incurred but not reported.

SECTION 34 CHOICE OF LAW, REMEDIES AND VENUE

- A. This Contract is governed by the laws of the State of Montana. In accordance with Montana Code Annotated § 18-1-401, the district courts of the State of Montana have exclusive original jurisdiction to entertain claims or disputes arising out of contracts entered into by the Department.
- B. For purposes of litigation concerning this Contract, venue must be in the First Judicial District in and for the County of Lewis and Clark, State of Montana.
- C. If there is litigation concerning this Contract, the Contractor must pay its own costs and attorney fees.
- D. If there is a contractual dispute, the Contractor agrees to continue performance under this Contract unless the Department in writing explicitly waives performance.
- E. Any remedies provided by this Contract are not exclusive and are in addition to any other remedies provided by law.

SECTION 35 SCOPE, AMENDMENT, AND INTERPRETATION OF CONTRACT

- A. This Contract consists of numbered pages 1 through 45, and the following Addendums and Attachments:

ADDENDUM A: REQUEST FOR PROPOSAL 16-2896P

ADDENDUM B: BCBSMT RESPONSE TO RFP 16-2896P

ADDENDUM C: SECTION 1115 WAIVER SPECIAL TERMS AND CONDITION

ADDENDUM D: SECTION 1915(b)(4) WAIVER SPECIAL TERMS AND CONDITIONS

ATTACHMENT 1: BUSINESS ASSOCIATE AGREEMENT

ATTACHMENT 2: IRREVOCABLE LETTER OF CREDIT

ATTACHMENT 3: ANNUAL CERTIFICATION FOR DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES OF THE CONTRACTOR'S COMPLIANCE WITH CERTAIN STATE AND FEDERAL REQUIREMENTS

ATTACHMENT 4: SECTION 1915(B) AND SECTION 1115 RESPONSIBILITY MATRIX

The HELP Program, as authorized by SB 405 enacted during the 2015 Montana Legislative Session, is conditioned upon and subject to the Special Terms and Conditions contained in the Medicaid Program waivers issued by the Centers for Medicare and

Medicaid Services under sections 1115 and 1915b of the Social Security Act. The State of Montana, by and through its Department of Public Health and Human Services, and Blue Cross Blue Shield of Montana, its selected third party administrator, have agreed within the attached matrices as to the division of labor with respect to compliance with CMS' Special Terms and Conditions. Any task marked as an HSCS responsibility and any task indicated as a joint responsibility mean that BCBSMT/HCSC retains operational responsibility for that task. However, DPHHS retains oversight responsibility and ultimately overall compliance responsibility for each task noted in the matrices

- B. The Contractor, after termination or expiration of this Contract, remains subject to and obligated to comply with all legal and continuing contractual obligations arising in relation to its duties and responsibilities that may arise under this Contract.
- C. No statements, promises, or inducements made by either party or their agents are valid or binding if not contained in this Contract and the materials expressly referenced in this Contract as governing the contractual relationship.
- D. The headings to the section of this Contract are convenience of reference and do not modify the terms and language of the sections to which they are headings.
- E. No contractual provisions from a prior contract of the parties are valid or binding in this contractual relationship.
- F. Except as may be otherwise provided by its terms, this Contract may not be enlarged, modified or altered except by written amendment signed by the parties to this Contract.
- G. If there is a dispute as to the duties and responsibilities of the parties under this Contract, the Contract along with any attachments prepared by the Department, including request for proposal, if any, govern over the Contractor's proposal, if any.
- H. If a court of law determines any provision of this Contract is per se or as applied legally invalid, all other provisions of this Contract remain in effect and are valid and binding on the parties.
- I. Any provision of this Contract that is determined to conflict with any Federal or State law or regulation, whether per se or as applied, is inoperative to the extent it conflicts with that authority and is to be considered modified to the extent necessary to conform with that authority.
- J. Waiver of any default, breach or failure to perform under this Contract may not be construed to be a waiver of any subsequent default, breach or failure of performance. In addition, waiver of a default, breach or failure to perform may not be construed to be a modification of the terms of this Contract unless reduced to writing as an amendment to this Contract.

The parties through their authorized agents have executed this Contract on the dates set out below.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

By:  Date 12/16/15

Name: Richard H. Opper

Title: Director, Montana DPHHS

CONTRACTOR

BY:  Date: 12/16/15

Name: Michael E. Frank

Title: President

Approved as to Form:



Procurement Officer
State Procurement Bureau

14 Dec 2015
(Date)

ATTACHMENT 1
BUSINESS ASSOCIATES AGREEMENT

ATTACHMENT 1 - BUSINESS ASSOCIATE AGREEMENT

PARTIES

This Business Associate Agreement (Agreement) is entered into between the Department of Public Health and Human Services, (the Department), State of Montana (State), 111 N. Sanders, P.O. Box 4210, Helena, Montana 59604, (406) 444-2995, e-mail _____ and Blue Cross and Blue Shield of Montana (Business Associate) whose nine (9) digit Federal ID Number is _____, and whose address, phone number, and e-mail address are 560 North Park Avenue, P.O. Box 4309, Helena, MT 59604, 406-437-5000, and michael-frank@bcbsmt.com.

THE PARTIES AGREE THAT THE BUSINESS ASSOCIATE OBLIGATIONS ARE AS FOLLOWS:

A. Business Associate Status

1. The Department is subject to and must comply with provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as codified at 42 U.S.C. § 1320d-d8, and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), enacted as part of the American Recovery and Reinvestment Act of 2009, as codified at 42 U.S.C. §§ 300jj et seq. and §§ 17901, et seq. and the implementing regulations for the two acts at 45 CFR Parts 160, 162 and 164.

2. The Department has determined that the Department in its entirety is a covered entity as defined in the implementing regulations. Under the HIPAA and HITECH and the implementing regulations, the Business Associate, as an entity that performs or assists in the performance of an administrative or data function for the Department involving the use or disclosure of protected health information (PHI) for the Department, is acting as a business associate of a covered entity.

B. Definitions that Apply to This Agreement

Terms used in this Agreement have the same meaning as those terms in the HIPAA and HITECH Acts and the implementing regulations.

C. Status as a Business Associate

The Business Associate agrees that it is a Business Associate of the Department, as defined at 45 CFR § 160.103, and further agrees that it is obligated to comply with the terms of this Agreement and with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

D. Obligations of Business Associate

The Business Associate, as a business associate of the Department, must:

1. use or disclose PHI, including E-PHI, only as is permitted or required by this Agreement, in compliance with the Department's minimum necessary standard policies and procedures, or by applicable law inclusive of 45 CFR Parts 160, 162 and 164;
2. use appropriate safeguards to prevent use or disclosure of PHI and E-PHI other than as provided for by this Agreement or by law;
3. implement appropriate administrative, physical and technical security safeguards as set forth in § 164.306, § 164.308, and § 164.312, that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and prevent use or disclosure of the PHI other than as provided for by this Agreement;
4. mitigate to the extent practicable and as may be directed by the Department any harmful effect that is known to the Business Associate of a use or disclosure of PHI by the Business Associate that is in violation of the requirements of this Agreement;
5. report in a timely manner as required by law and this Agreement to the Department any use or disclosure of the PHI not provided for by this Agreement inclusive of uses and disclosures of information that are not in compliance with the minimum necessary standard;
6. report to the Department any security incident of which it becomes aware, and at the request of the Department must identify: i) the date of the security incident, ii) the scope of the security incident, iii) the Business Associate's response to the security incident, and iv) the identification of the party responsible for causing the security incident, if known;
7. enter, as required by 45 CFR § 164.504, into Business Associate Agreements containing the terms and conditions as required by the HIPAA and HITECH Acts and the implementing regulations and as are stated in this Agreement, with any subcontractors performing services in relation to the services being provided by the Business Associate for the Department that involve PHI; and
8. make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of the Department, available to the Department, or to the Secretary of the Federal Department of Health and Human Services in accordance with § 164.408, in a time and manner prescribed by the Department or designated by the Secretary, for purposes of the Secretary determining the Department's and the Business Associate's compliance with the Privacy Regulation, the Security Regulation and the HITECH Act;

9. document disclosures of PHI and collect information related to those disclosures necessary for the Department to respond to a request by a person for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528 and Section 13405(c) of the HITECH Act;

10. provide to the Department or a person, in time and manner prescribed by the Department, documentation necessary for the Department to respond to a request by a person for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Notwithstanding 45 CFR § 164.528(a)(1)(i), the Business Associate must document disclosures of PHI made through an electronic health record to carry out treatment, payment or health care operations as provided by 45 CFR § 164.506 in the three years prior to the date on which the accounting is requested, and to collect information related to such disclosures as required by the Secretary in regulation pursuant to Section 13405(c)(2) of the HITECH Act;

11. implement a response program, in compliance with Section 13402 of the HITECH Act and implementing regulations, and Subpart D of 45 CFR Part 164 that specified the actions to be taken when the Business Associate detects or becomes aware of unauthorized access to information systems. The response program must include the following features:

a. The Business Associate must notify the Department, by facsimile or telephone, of any breach or suspected breach of its security related to areas, locations, or computer system which contain unsecured PHI, including, without limitation, any instance of theft, unauthorized access by fraud, deception, or other malfeasance or inadvertent access (an "incident") in accordance to 45 CFR § 164.410, as promptly as possible, upon having reason to suspect that an incident may have occurred or determining the scope of any such incident, but in no event later than two (2) business days upon having reason to suspect that an incident may have occurred;

b. In the event of any incident, the Business Associate must provide to the Department, in writing, those details concerning the incident as the Department may request, and must cooperate with the Department, its regulators and law enforcement to assist in regaining possession of the unsecured PHI and in preventing its further unauthorized use, and take any necessary remedial actions as may be required by the Department to prevent other or further incidents;

c. If the Department determines that it may need to notify any person(s) as a result of such incident that is attributable to the Business Associate's breach of its obligations under this Agreement, the Business Associate must bear all reasonable direct and indirect costs associated with the determination, including, without limitation, the costs associated with providing notification to the affected person, providing fraud monitoring or other services to affected persons and any forensic analysis required to determine the scope of the incident;

d. The Business Associate, working in cooperation with the Department, must update the notice provided to the Department under this Agreement of the incident to include, to the extent possible and as soon as possible, the identification of each person whose unsecured PHI has been, or is reasonably believed by the Business Associate or the Department to have been accessed, acquired, used or disclosed during the incident and must provide any of the following information the Department is required to include in its notice to the person pursuant to 45 CFR § 164.404(c):

- (1) A brief description of what happened, including the date of the incident and the date of the discovery of the incident, if known;
- (2) A description of the types of unsecured PHI that were involved in the incident (e.g., Social Security Number, full name, date of birth, address, diagnosis);
- (3) Any steps the person should take to protect themselves from potential harm resulting from the incident;
- (4) A brief description of what is being done to investigate the incident, mitigate the harm, and protect against future incidents;
- (5) Contact procedures for persons to ask questions or learn additional information which shall include a toll-free number, an e-mail address, website, or postal address;
- (6) This additional information must be submitted to the Department immediately at the time the information becomes available to the Business Associate;

12. limit its use and disclosure of PHI created or received by the Business Associate from or on behalf of the Department to uses or disclosures as are permitted to the Business Associate under the applicable requirements of 45 CFR § 164.504(e) and the HITECH Act and the terms of this Agreement. The Business Associate must also comply with the additional requirements of Subtitle D of the HITECH Act that relate to privacy and that apply to covered entities and to the Business Associate as a business associate; and

13. comply with a person's request under 45 CFR § 164.522(a)(1)(i)(A) that the Business Associate restrict the disclosure of the person's PHI.

E. Permitted Uses, Disclosures and Limitations

1. Except as otherwise limited in this Agreement, the Business Associate may use or disclose PHI on behalf of, or to provide services to, the Department for the following purposes, if such use or disclosure of PHI would not violate the requirements of the

HIPAA and HITECH Acts and the implementing regulations if done by the Department or otherwise violate the minimum necessary policies and procedures of the Department:

2. The Business Associate may use PHI to report violations of federal and state laws to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1) and (2).

3. The Business Associate, as required by 45 CFR § 164.504(e)(1)(iii), must terminate any business associate agreement with a subcontractor that violates the requirements of this Agreement or the application law.

4. The Business Associate shall not directly or indirectly receive remuneration in exchange for PHI that is created or received by the Business Associate from or on behalf of the Department.

F. Use and Disclosure for Business Associate's Purposes

1. The Business Associate must use and disclose PHI that is created or received by the Business Associate from or on behalf of the Department in compliance with each applicable requirement of 45 CFR § 164.504(e) and the HITECH Act.

2. The Business Associate may use and disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate provided that:

- a. the disclosures are required by law;
- b. the disclosures are expressly authorized in this Agreement by the Department;
- c. the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only for the purpose for which it was disclosed to the person; and
- d. the Business Associate requires the person to whom the information is disclosed to report immediately any incident of which it is aware in which the confidentiality of the information has been breached.

3. The Business Associate may only use PHI for Data Aggregation purposes if the Department in this Agreement expressly authorizes those purposes and the Data Aggregation is permitted in accordance with 42 CFR § 164.504(e)(2)(i)(B).

4. To the extent otherwise permitted by this Agreement, a communication that is described in the definition of Marketing in 45 CFR § 164.501 for which the Department

receives or has received Direct or Indirect Payment (excluding payment for Treatment) in exchange for making such communication, shall not be considered a Health Care Operation unless:

- a. such communication describes only a drug or biologic that is currently prescribed for the recipient of the communication and any payment received in exchange for making such a communication is reasonable in amount; or
- b. the communication is made by the Business Associate on behalf of the Department and the communication is otherwise consistent with this Agreement. No communication may be made by the Business Associate without prior written authorization by the Department.

G. Obligations of the Department

1. The Department must notify the Business Associate of any limitation(s) in the Department's notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of PHI. A copy of the Department's Notice of Privacy Practice is attached to this Agreement and incorporated herein.

2. The Department must notify the Business Associate of any changes in, or revocation of, permission by a person to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

3. The Department must notify the Business Associate of any restriction to the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

4. The Department, except as may be expressly agreed to by the parties and stated in this Agreement, may not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the requirements of the HIPAA and HITECH Acts and the implementing regulations if done by the Department.

H. Term and Termination

1. **Term.** The term of this Agreement shall be effective as of the effective date that the Business Associate begins delivery of its services and shall terminate when all of the PHI provided by the Department to the Business Associate, or created or received by the Business Associate on behalf of the Department, is destroyed or returned to the Department, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this subsection.

2. **Termination for Cause.** Upon the Department's knowledge of a breach, as defined in § 164.402, by the Business Associate, the Department, as its sole discretion, must:

- a. provide an opportunity for the Business Associate to:
- b. cure the breach; or
- c. end the violation and terminate this Agreement if the Business Associate does not cure the breach; or
- d. end the violation within the time specified by the Department; or
- e. immediately terminate this Agreement if the Business Associate has breached a material term of this Agreement and cure is not possible; or
- f. if neither termination nor cure are feasible, the Department must report the violation to the Secretary.

3. Upon the Business Associate's knowledge of a material breach by the Department, the Business Associate must either:

- a. notify the Department of such breach in reasonable detail, and provide an opportunity for the Department to cure the breach or violation; or
- b. if cure is not possible, the Business Associate may immediately terminate this Agreement; or
- c. if neither termination nor cure is feasible, the Business Associate shall report the violation to the Secretary.

4. The Department may unilaterally terminate this Agreement with the Business Associate upon thirty (30) days written notice in the event:

- a. the Business Associate does not promptly enter into negotiations to amend this Agreement when requested by the Department pursuant to the terms of this Agreement; or
- b. the Business Associate does not enter into an amendment to this Agreement providing assurance regarding the safeguarding of PHI that the Department, in its sole discretion, deems sufficient to satisfy the standards and requirements of the HIPAA and HITECH Acts and the implementing regulations.

I. Effect of Termination.

1. Except as provided in this subsection, upon termination of this Agreement, for any reason, the Business Associate shall at the Department's sole discretion return or destroy all PHI received from the Department, or created or received by Business Associate on behalf of the Department. This Agreement shall apply to PHI that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the PHI.

2. In the event that the Business Associate determines that returning or destroying the PHI is infeasible, the Business Associate must provide to the Department notification of the conditions that make return or destruction infeasible. Upon written agreement by the Department that return or destruction of PHI is infeasible, the Business Associate must extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as the Business Associate maintains such PHI.

J. Miscellaneous.

1. Regulatory References. A reference in this Agreement to a section in the Privacy Regulation or Security Regulation means the section as in effect or as amended.
2. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Department to comply with the requirements of the HIPAA and HITECH Acts and the implementing regulations.
3. Survival. The respective rights and obligations of the Business Associate under this Agreement shall survive the termination of this Agreement.
4. Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Department to comply with the requirements of the HIPAA and HITECH Acts and the implementing regulations.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

By: 

Date: 12/15/10

Department of Public Health and Human Services

Po Box 4210

Helena MT 59604
Address

406-444-6533
Phone Number

BUSINESS ASSOCIATE

By: Michael E. Frank

Date: 12/16/15

Michael E. Frank President
Typed/Printed Name Title

560 North Park Avenue, P.O. Box 4309, Helena, Montana 59604
Address

406-437-5000
Phone Number

36-1236610
Federal I.D. Number

ATTACHMENT 2

IRREVOCABLE LETTER OF CREDIT

JPMorgan Chase Bank, N.A.
Global Trade Services
131 South Dearborn, 5th Floor
Mail Code: IL1-0236
Chicago, IL 60603-5506

OCT 7, 2015
OUR L/C NO.: CTCS-703260

TO:
STATE OF MONTANA
125 NORTH ROBERTS
ROOM 165 MITCHELL BUILDING,
P.O. BOX 200135
HELENA, MT 59620-0135

APPLICANT:
BLUE CROSS BLUE SHIELD OF MONTANA
A DIVISION OF HEALTH CARE SERVICE
CORPORATION
P.O. BOX 4309
HELENA, MT 59604

WE HAVE ESTABLISHED OUR IRREVOCABLE STANDBY LETTER OF CREDIT IN YOUR FAVOR
AS DETAILED HEREIN SUBJECT TO ISP98

DOCUMENTARY CREDIT NUMBER: CTCS-703260

FURTHER IDENTIFICATION: ISSUE

DATE OF ISSUE: OCTOBER 7, 2015

BENEFICIARY: STATE OF MONTANA
125 NORTH ROBERTS
ROOM 165 MITCHELL BUILDING,
P.O. BOX 200135
HELENA, MT 59620-0135

APPLICANT: BLUE CROSS BLUE SHIELD OF MONTANA
A DIVISION OF HEALTH CARE SERVICE
CORPORATION
P.O. BOX 4309
HELENA, MT 59604

DATE AND PLACE OF EXPIRY: DECEMBER 31, 2017
AT OUR COUNTER

DOCUMENTARY CREDIT AMOUNT: USD3,201,120.00

AVAILABLE WITH: JPMORGAN CHASE BANK, N.A.
CHICAGO, IL
BY PAYMENT

JPMorgan Chase Bank, N.A.
Global Trade Services
131 South Dearborn, 5th Floor
Mail Code: IL1-0236
Chicago, IL 60603-5506

OCT 7, 2015
OUR L/C NO.: CTCS-703260

IT IS A CONDITION OF THIS LETTER OF CREDIT THAT IT SHALL BE AUTOMATICALLY EXTENDED WITHOUT AMENDMENT FOR ADDITIONAL 12 MONTH PERIODS FROM THE PRESENT OR EACH FUTURE EXPIRATION DATE, UNLESS AT LEAST 30 DAYS PRIOR TO THE CURRENT EXPIRY DATE WE SEND NOTICE IN WRITING TO YOU VIA SWIFT, OR HAND DELIVERY AT THE ABOVE ADDRESS, THAT WE ELECT NOT TO AUTOMATICALLY EXTEND THIS LETTER OF CREDIT FOR ANY ADDITIONAL PERIOD. HOWEVER IN NO EVENT SHALL THIS LETTER OF CREDIT BE AUTOMATICALLY EXTENDED BEYOND THE FINAL EXPIRY DATE OF DECEMBER 31, 2018. UPON SUCH NOTICE TO YOU, YOU MAY DRAW ON US AT SIGHT FOR AN AMOUNT NOT TO EXCEED THE BALANCE REMAINING IN THIS LETTER OF CREDIT WITHIN THE THEN-APPLICABLE EXPIRY DATE, BY YOUR SWIFT OR PRESENTATION OF YOUR DRAFT AND DATED STATEMENT PURPORTEDLY SIGNED BY ONE OF YOUR OFFICIALS READING AS FOLLOWS:

QUOTE

THE AMOUNT OF THIS DRAWING USD UNDER JPMORGAN CHASE BANK, N.A. LETTER OF CREDIT NUMBER CTCS-703260 REPRESENTS FUNDS DUE US AS WE HAVE RECEIVED NOTICE FROM JPMORGAN CHASE BANK, N.A. OF THEIR DECISION NOT TO AUTOMATICALLY EXTEND LETTER OF CREDIT NUMBER CTCS-703260 AND THE UNDERLYING OBLIGATION REMAINS OUTSTANDING.

UNQUOTE

IN THE EVENT THIS LETTER OF CREDIT IS SUBSEQUENTLY AMENDED BY US TO EITHER:

- I) RESCIND A NOTICE OF NON-EXTENSION AND TO EXTEND THE EXPIRY DATE HEREOF TO A FUTURE DATE, OR
 - II) EXTEND THE EXPIRY DATE TO A DATE THAT IS AFTER THE STATED FINAL EXPIRY DATE HEREOF,
- SUCH EXTENSION SHALL BE FOR THAT SINGLE PERIOD ONLY AND THIS LETTER OF CREDIT WILL NOT BE SUBJECT TO ANY FUTURE AUTOMATIC EXTENSIONS UNLESS OTHERWISE STATED.

ADDITIONAL DETAILS:

FUNDS UNDER THIS CREDIT ARE AVAILABLE AGAINST PRESENTATION OF THE BENEFICIARY'S SIGNED AND DATED STATEMENT REFERENCING OUR LETTER OF CREDIT NO. CTCS-703260, STATING THE AMOUNT OF THE DEMAND AND READING AS FOLLOWS:

"WE ARE HEREBY DRAWING UNDER JPMORGAN CHASE BANK, N.A.'S STANDBY LETTER OF CREDIT NUMBER CTCS-703260 IN THE AMOUNT OF USD.....

JPMorgan Chase Bank, N.A.
Global Trade Services
131 South Dearborn, 5th Floor
Mail Code: IL1-0236
Chicago, IL 60603-5506

OCT 7, 2015
OUR L/C NO.: CTCS-703260

AS BLUE CROSS BLUE SHIELD OF MONTANA HAS NOT PERFORMED THEIR CONTRACTUAL OBLIGATIONS UNDER CONTRACT NUMBER RFP16-2896P."

THIS LETTER OF CREDIT MAY BE CANCELLED PRIOR TO EXPIRATION PROVIDED THE ORIGINAL LETTER OF CREDIT (AND AMENDMENTS, IF ANY) ARE RETURNED TO JPMORGAN CHASE BANK, N.A., CHICAGO, IL WITH A STATEMENT SIGNED BY THE BENEFICIARY STATING THAT THE ATTACHED LETTER OF CREDIT IS NO LONGER REQUIRED AND IS BEING RETURNED TO THE ISSUING BANK FOR CANCELLATION.

WE ENGAGE WITH YOU THAT PRESENTATIONS MADE UNDER AND IN CONFORMITY WITH THE TERMS AND CONDITIONS OF THIS CREDIT WILL BE DULY HONORED ON PRESENTATION IF PRESENTED ON OR BEFORE THE EXPIRATION AT OUR COUNTERS AT 131 SOUTH DEARBORN, 5TH FLOOR, MAIL CODE IL1-0236, CHICAGO, IL 60603-5506, ATTN: STANDBY LETTER OF CREDIT UNIT. ALL PAYMENTS DUE HEREUNDER SHALL BE MADE BY WIRE TRANSFER TO THE BENEFICIARY PER THEIR INSTRUCTIONS. THE ORIGINAL LETTER OF CREDIT MUST ACCOMPANY THE DOCUMENTS REQUIRED UNDER THIS CREDIT FOR ENDORSEMENT. ALL DOCUMENTS PRESENTED MUST BE IN ENGLISH

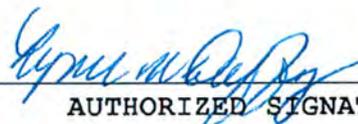
THIS LETTER OF CREDIT IS GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH THE LAWS OF THE STATE OF NEW YORK, AND, EXCEPT AS OTHERWISE EXPRESSLY STATED HEREIN, TO THE INTERNATIONAL STANDBY PRACTICES, ICC PUBLICATION NO. 590 (THE "ISP98"), AND IN THE EVENT OF ANY CONFLICT, THE LAWS OF THE STATE OF NEW YORK WILL CONTROL, WITHOUT REGARD TO PRINCIPLES OF CONFLICT OF LAWS.

PLEASE ADDRESS ALL CORRESPONDENCE REGARDING THIS LETTER OF CREDIT TO THE ATTENTION OF THE STANDBY LETTER OF CREDIT UNIT, 131 SOUTH DEARBORN, 5TH FLOOR, MAIL CODE IL1-0236, CHICAGO, IL 60603-5506 INCLUDING THE LETTER OF CREDIT NUMBER MENTIONED ABOVE. FOR TELEPHONE ASSISTANCE, PLEASE CONTACT

JPMorgan Chase Bank, N.A.
Global Trade Services
131 South Dearborn, 5th Floor
Mail Code: IL1-0236
Chicago, IL 60603-5506

OCT 7, 2015
OUR L/C NO.: CTCS-703260

THE STANDBY CLIENT SERVICE UNIT AT 1-800-634-1969, OR 1-813-432-1210, AND
HAVE THIS LETTER OF CREDIT NUMBER AVAILABLE.



AUTHORIZED SIGNATURE

ATTACHMENT 3

**ANNUAL CERTIFICATION FOR DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
OF THE CONTRACTOR'S COMPLIANCE WITH CERTAIN STATE AND FEDERAL
REQUIREMENTS
(JUNE 2011)**

ANNUAL CERTIFICATION FOR DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES OF THE CONTRACTOR'S COMPLIANCE WITH CERTAIN STATE AND FEDERAL REQUIREMENTS (JUNE 2011)

This annual certification form is standardized for general use by the Department Of Public Health And Human Services (Department) in contracting relationships. Not all of these assurances may be pertinent to the Contractor's circumstances. The Contractor in signing this form is certifying compliance only with those requirements that are legally or contractually applicable to the circumstances of the contractual relationship of the Contractor with the Department.

These assurances are in addition to those stated in the federal OMB 424B (Rev. 7-97) form, known as "ASSURANCES - NON-CONSTRUCTION PROGRAMS", issued by the federal Office of Management of the Budget (OMB). Standard Form 424B is an assurances form that must be signed by the Contractor if the Contractor is to be in receipt of federal monies.

There may be program specific assurances, not appearing either in this form or in the OMB Standard Form 424B, for which the Contractor may have to provide additional certification.

This form and OMB Standard Form 424B are to be provided with original signatures to the Department's contract liaison. The completed forms are maintained by the Department in the pertinent procurement and contract files.

Further explanation of several of the requirements certified through this form may be found in the text of related contract provisions and in the Department's policies pertaining to procurement and contractual terms. In addition, detailed explanations of federal requirements may be obtained through the Internet at sites for the federal departments and programs and for the Office for Management of the Budget (OMB) and the General Services Administration (GSA).

ASSURANCES

The Contractor, Blue Cross and Blue Shield of MT for the purpose of contracting with the Montana Department of Public Health & Human Services, by its signature on this document certifies to the Department its compliance, as may be applicable to it, with the following requirements.

The Contractor assures the Department:

GENERAL COMPLIANCE REQUIREMENTS

- A. That the Contractor does not engage in conflicts of interest in violation of any state or federal legal authorities, any price fixing or any other anticompetitive activities that violate the federal antitrust Sherman Act, 15 U.S.C. §§1 – 7, Anti-Kickback Act, 41 U.S.C. §§ 51-58, and other federal legal authorities. And that the Contractor does not act in violation of 18-4-141, MCA or other legal authorities by colluding with other contractors for the purpose of gaining unfair advantages for it or other contractors or for the purpose of providing the services at a

noncompetitive price or otherwise in a noncompetitive manner. (reference Contract Section titled "Antitrust Violations")

- B. That the Contractor does not act in violation of the federal False Claims Act at 31 U.S.C. §§ 3729–3733 (the "Lincoln Law") or of the Montana False Claims Act, at Title 17, chapter 8, part 4, MCA. And that the Contractor and its employees, agents and subcontractors act to comply with requirements of the federal False Claims Act by reporting any credible evidence that a principal, employee, agent, contractor, subgrantee, subcontractor, or other person has submitted a false claim to the federal government. (reference Contract Section titled "Reporting Of False Claims, Fraud, And Other Criminal Matters")
- C. That the Contractor is solely responsible for and must meet all labor, tax, and other legal authorities requirements pertaining to its employment and contracting activities, inclusive of insurance premiums, tax deductions, unemployment and other tax withholding, overtime wages and other employment obligations that may be legally required with respect to it. (reference Contract Section titled "Compliance With Business, Tax, Labor, And Other Legal authorities")
- D. That the Contractor maintains necessary and appropriate workers compensation insurance coverage. (reference Contract Section titled "Compliance With Business, Tax, Labor, And Other Legal authorities")
- E. That the Contractor is an independent contractor and possesses, unless by law not subject to or exempted from the requirement, a current independent contractor certification issued by the Montana Department Of Labor And Industry in accordance with 39-71-417 through 39-71-419, MCA. (reference Contract Section titled "Compliance With Business, Tax, Labor, And Other Legal authorities")
- F. That the Contractor's subcontractors and agents are in conformance with the requirements of Sections B, C, and D of this Certification.
- G. That the Contractor, any employee of the Contractor, or any subcontractor in the performance of the duties and responsibilities of the proposed contract: 1) are not currently suspended, debarred, or otherwise prohibited in accordance with 2 CFR Part 180, OMB Guidelines To Agencies On Governmentwide Debarment and Suspension (nonprocurement) from entering into a federally funded contract or participating in the performance of a federally funded contract; and 2) are not currently removed or suspended in accordance with 18-4-241, MCA from entering into contracts with the State Of Montana. (reference Contract Section titled "Federal Requirements")
- H. That the Contractor is in compliance with those provisions of the privacy, security, electronic transmission, coding and other requirements of the federal Health Insurance Portability And Accountability Act of 1996 (HIPAA) and the federal Health Information Technology For Economic And Clinical Health (HITECH), a part of the American Recovery And Reinvestment Act Of 2009, and the implementing federal regulations for both acts that are applicable to contractual performance if the Contractor is either a Covered Entity or a Business Associate as defined for purposes of those acts. (reference Contract Sections titled "Confidentiality Of

Personal Information And Compliance With The Federal HIPAA And HITECH Privacy And Security Requirements" and "Business Associate Obligations")

- I. That, as required by legal authorities or contract, the Contractor maintains smoke and tobacco free public and work sites. And if the contract performance is related to the delivery of a human service, the Contractor does not perform any work involved in the production, processing, distribution, promotion, sale, or use of tobacco products or the promotion of tobacco companies; or 3) accept revenues from the tobacco industry or subsidiaries of the tobacco industry if the acceptance results in the appearance that tobacco use is desirable or acceptable or in the appearance that the contractor endorses a tobacco product or the gifting tobacco related entity. (reference Contract Section titled "Tobacco-free Workplace And Other Restrictions")

COMPLIANCE REQUIREMENTS FOR FEDERALLY FUNDED CONTRACTS

- J. That the Contractor, in conformance with the Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*), prohibits smoking at any site of federally funded activities that serve youth under the age of 18. This federal prohibition is not applicable to a site where the only federal funding for services is through Medicaid monies or the federally funded activity at the site is inpatient drug or alcohol treatment.
- K. That the Contractor does not expend federal monies in violation of federal legal authorities prohibiting expenditure of federal funds on lobbying the United States Congress or state legislative bodies or for any effort to persuade the public to support or oppose legislation. (reference Contract Section titled "Federal Requirements")
- L. That the Contractor maintains in compliance with the Drug-Free Workplace Act of 1988, 41 U.S.C. 701, *et seq.*, drug free environments at its work sites, providing required notices, undertaking affirmative reporting, and other requirements, as required by federal legal authorities.
- M. That the Contractor is not delinquent in the repayment of any debt owed to a federal entity.
- N. That the Contractor, if expending federal monies for research purposes, complies with federal legal authorities relating to use of human subjects, animal welfare, biosafety, misconduct in science and metric conversion.
- O. That the Contractor, if receiving aggregate payments of medicaid monies totaling \$5,000,000 or more annually, has established in compliance with 1902(a)(68) of the Social Security Act, 42 U.S.C. 1396a(a)(68), written policies with educational information about the federal False Claims Act at 31 U.S.C. §§ 3729–3733 (the "Lincoln Law") and presents that information to all employees. (reference Contract Section titled "Reporting Of False Claims, Fraud, And Other Criminal Matters")
- P. That the Contractor is in compliance with the executive compensation reporting requirement of the Federal Funding Accountability And Transparency Act (FFATA or Transparency Act), P.L. 109-282, as amended by Section 6202(a), P.L. 110-252-1, either in that the Contractor does

not meet the criteria necessitating the submittal of a report by an entity or in that, if the Contractor meets the criteria mandating reporting, the Contractor produces the information in a publicly available report to the Securities And Exchange Commission (SEC) or to the Internal Revenue Service and provides the report in a timely manner to the Department or produces a separate report with the information and submits that report to the in a timely manner to the Department. (reference Contract Section titled "Federal Requirements")

- Q. That the Contractor, if a contractor for the delivery of medicaid funded services, is in compliance with the requirements of 42 C.F.R. §§ 455.104, 455.105, and 455.106 concerning disclosures of ownership and control, business transactions, and persons with criminal convictions. (reference Contract Section titled "Federal Requirements").
- R. That the Contractor, if providing federally funded health care services, is not as an entity currently federally debarred from receiving reimbursement for the provision of federally funded health care services and furthermore does not currently have any employees or agents who are federally debarred from the receiving reimbursement for the provision of federally funded health care services. (reference Contract Section titled "Federal Requirements")

COMPLIANCE REQUIREMENTS FOR FEDERALLY FUNDED CONTRACTS INVOLVING THE PURCHASE OR DEVELOPMENT OF PROPERTY

- S. That the Contractor manages any real, personal, or intangible property purchased or developed with federal monies in accordance with federal legal authorities.
- T. That the Contractor, if expending federal monies for construction purposes or otherwise for property development, complies with federal legal authorities relating to flood insurance, historic properties, relocation assistance for displaced persons, elimination of architectural barriers, metric conversion and environmental impacts.
- U. That the Contractor, if the contract exceeds \$100,000, complies with mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the federal Energy Policy and Conservation Act, Pub. L. 94-163, 42 U.S.C. §6321 et. seq.
- V. That the Contractor, if the contract exceeds \$100,000, complies with all applicable standards, orders and requirements issued under section 306 of the Clean Air Act, 42 U.S.C. 7607, section 508 of the Clean Water Act, 33 U.S.C. 1368, Executive Order 11738, and U.S. Environmental Protection Agency regulations, 40 C.F.R. Part15 and that if the Contractor enters into a subcontract that exceeds \$100,000 these requirements are in that contract.

INSERT NAME OF CONTRACTOR

Signature Of Authorized Certifying Official

By: Michael E. Frank Date 12/16/15
Michael E. Frank as President
Typed/Printed Name Title

560 N. Park Ave., P.O. Box 4309

Helena, MT 59604
Address

michael-frank@bcbsmt.com
email

406-437-5000
Phone Number

36-1236610
Federal I.D. Number

ATTACHMENT 4

SECTION 1915(B) AND 1115 RESPONSIBILITY MATRIX

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
3.4. Network Adequacy. The State must develop and enforce network adequacy standards for the TPA consistent with this STC.				X	X		
3.4.1. At a minimum, the State must develop network adequacy standards for the following provider types, if covered under the TPA contract:				X	X		
3.4.1.1. Primary care.				X	X		
3.4.1.2. OB/GYN.				X	X		
3.4.1.3. Behavioral health.				X	X		
3.4.1.4. Specialists				X	X		
3.4.1.5. Hospital.				X	X		
3.4.2 Network standards established under this section must include all geographic areas covered by the TPA. In developing network adequacy standards under this section the State must consider, at a minimum, the following elements:				X	X		
3.4.2.1. The anticipated Medicaid enrollment.				X	X		
3.4.2.2. The expected utilization of services.				X	X		
3.4.2.3. Comparability to traditional Medicaid program.				X	X		
3.4.2.4. Geography and other factors relevant to Montana when establishing such standards.				X	X		
3.4.3. The TPA's network must include:		X			X		DPHHS will retain oversight
3.4.3.1. No less than 90% of the hospitals in the state;		X			X		
3.4.3.2. No less than 80% of the non-hospital licensed health care providers in the state;		X			X		
3.4.3.3. No less than 80% of the OB/GYNs serving the Non-TPA-Medicaid- FFS-Enrollees;		X			X		
3.4.3.4. No less than 80% of the behavioral health providers serving the Non- TPA- Medicaid-FPS-Enrollees;		X			X		
3.4.4. If the State grants an exception to the network standards required under this section, it must monitor enrollee access to that provider type on an ongoing basis and include the findings to CMS in the managed care program assessment report STC 3.6.				X	X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
3.4.5. The State must publish the network adequacy standards developed under this section on its website. Upon request, network adequacy standards must also be made available at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services.				X	X		HCSC provides at no cost to members standards and the State will publish.
3.5. Readiness Reviews. The State must assess the readiness of the TPA prior to the State implementing the TPA program.				X	X	X	DPHSS to define the readiness plan and timeline (Desktop and Onsite).
3.5.1. The State must conduct a readiness review of the TPA as follows:				X	X	X	
3.5.1.1 Prior to the effective date of beneficiary enrollment.				X	X	X	
3.5.1.2. Completed in sufficient time to ensure adequate time to address barriers to a smooth implementation of contractual requirements.				X	X	X	
3.5.1.3. Readiness reviews must include both a desk review of documents and on-site reviews of the TPA. On-site reviews must include interviews with the TPA staff and leadership that manage key operational areas.				X	X	X	
3.5.2. The State's readiness review of the TPA must assess the ability and capacity of the TPA to perform satisfactorily for the following areas:		X			X	X	
3.5.2.1. Operations/Administration, including:		X			X	X	
3.5.2.1.1 Administrative staffing and resources.		X			X	X	
3.5.2.1.2. Delegation and oversight of the TPA responsibilities.		X			X	X	
3.5.2.1.3. Enrollee and provider communications.		X			X	X	
3.5.2.1.4. Customer service and notification of grievance and appeals rights		X			X	X	
3.5.2.1.5. Member services and outreach.		X			X	X	
3.5.2.1.6. Provider Network Management.		X			X	X	
3.5.2.1.7. Program Integrity/Compliance.		X			X	X	
3.5.2.2. Service delivery, including:		X			X	X	
3.5.2.2.1. Care coordination;		X			X	X	
3.5.2.2.2 Service planning;		X			X	X	
3.5.2.2.3. Quality improvement, and		X			X	X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
3.5.2.2.4. Utilization review.		X			X	X	
3.5.2.3. Financial management, including:		X			X	X	
3.5.2.3.1. Reporting and monitoring.		X			X	X	
3.5.2.4. Systems management, including:		X			X	X	
3.5.2.4.1. Claims management; and		X			X	X	
3.5.2.4.2. Post-adjudicated claims data and enrollment information management.		X			X	X	
3.6 TPA Monitoring System. The State must have in effect a monitoring system for the TPA.					X	X	State retains oversight responsibility, individual parts belong to HCSC
3.6.1. The State's system must address all aspects of the TPA, including at least the following areas:		X			X	X	
3.6.1.1 Administration and management.		X			X	X	
3.6.1.2. Customer service systems, notification of appeals rights, and appeal requirements under STC 9.5.		X			X	X	
3.6.1.3. Claims management.		X			X	X	
3.6.1.4. Enrollee materials and customer services.		X			X	X	Oversight and DPHHS info
3.6.1.5. Information systems, including post-adjudicated claims data reporting.		X			X	X	
3.6.1.6. Medical management, including utilization management.		X			X	X	
3.6.1.7. Program integrity, including a system to verify and document that any responsibilities delegated to the TPA related to STC 3.8 are conducted in compliance with the State's written instructions.		X			X	X	
3.6.1.8. Provider network management.		X			X	X	
3.6.1.9. Availability and accessibility of services.		X			X	X	
3.6.1.10. Quality improvement efforts.		X			X	X	
3.6.1.11. All other provisions of the contract, as appropriate.		X			X	X	
3.6.2. The State must use data collected from its monitoring activities to improve the performance of the TPA. The State must collect the following monitoring information at a minimum:			X		X	X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
3.6.2.1. Member grievance and appeal logs.		X			X	X	
3.6.2.2. Provider complaint and appeal logs.		X			X	X	
3.6.2.3. Results from any enrollee satisfaction survey conducted by the State or TPA.		X			X	X	
3.6.2.4. Performance on any required quality measures.		X			X	X	
3.6.2.5. An annual performance report card for the TPA.		X			X	X	
3.6.2.6. Audited financial and post-adjudicated claims data submitted by the TPA.		X			X	X	
3.6.2.7. Customer service performance data submitted by the TPA.		X			X	X	
3.7. Monitoring Report to CMS. The State must submit to CMS no later than 150 days after each contract year, a report on the demonstration and TPA operations that support the demonstration.			X				DPHSS to identify requirements - BCBS needs a clear format direction (e.g data elements, timeframe) etc. to make sure we provide timely and correct info.
3.7.1. The annual report authorized under this demonstration will be deemed to satisfy the requirement of this STC provided that the report provides information on, and an assessment of, the TPA's operations to support the demonstration and include, at a minimum, the following:			X				
3.7. 1.1. Performance of the TPA financial and accounting system, including the ability to reconcile the accounting system to all post-adjudicated claims.		X					
3.7.1.2. Post adjudicated claims data reporting by the TPA.		X					
3.7. 1.3. Enrollment of the TPA.		X					
3.7.1.4. Modifications to, and implementation of, TPA benefits covered under the contract with the State.		X					

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
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3.7.1.5. Customer service, grievance and appeals rights.		X					
3.7.1.6. Availability and accessibility of covered services within the TPA contracts.		X					
3.7.1.7. Evaluation of the TPA performance on quality measures, including as applicable, consumer report card, surveys, or other reasonable measures of performance.				X			Self-evaluation by HCSC is requested. This action item will start with HCSC self Audit, we need to discuss specifics like Consumer report card in more detail.
3.7.1.8. Results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with the TPA to improve performance.		X					
3.7.2 The program report required in this section must be:			X				
3.7.2.1. Posted on the State's website.			X				
3.8 Screening and Enrolling Providers. The State must ensure that all TPA network providers are screened and enrolled, and periodically revalidated, in accordance with the requirements of 42 CFR 455, subparts Band E. This STC does not require the TPA's network provider to render services to Medicaid beneficiaries other than TPA- Medicaid-FFS enrollees.		X			X		
3.8.1. The State must review the ownership and control disclosures submitted by the TPA and any subcontractors in accordance with 42 CFR 455 subpart B.			X		X		
3.8.2. Consistent with the requirements at 42 CFR 455.436, the State must confirm the identity and determine the exclusion status of the TPA, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the TPA through routine checks of Federal databases. The Federal databases include the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe.		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
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3.8.2.1. These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the State determines a match, it must promptly notify the TPA and CMS.		X			X		
3.8.3. If the State elects to delegate any of its responsibilities under STC 3.8 to the TPA, such delegation in shall be in writing and shall clearly detail the responsibilities of the TPA. The delegation shall require the TPA to routinely demonstrate that it is performing the delegated duties consistent with the requirements of 42 CFR 455 and related guidance.		X			X		
3.9. TPA Audit Requirements. The State must ensure that the TPA periodically, but no less frequently than once every 3 years, contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the post-adjudicated claims, financial and program data submitted by, or on behalf of the TPA. The audit must be specific to the TPA's Medicaid service line.		X		X	X		BCMSMT will have an annual independent external audit.
3.10. Whistleblower Requirements. The State must receive and investigate information from whistleblowers relating to the integrity of the TPA, subcontractors, or network providers receiving Federal funds through the TPA.			X				
3.11. State Assurance of TPA Capacity to CMS. After the State reviews the documentation submitted by the TPA, the State must submit an assurance of compliance to CMS that the TPA meets the State's requirements for availability of services, as set forth in STC 8.2. The submission to CMS must include documentation of an analysis that supports the assurance of the adequacy of the network for the TPA related to its provider network.				X	X		Submission focus = DPHHS documentation = BCMSMT to DPHHS
3.11.1. The State must make available to CMS, upon request, all documentation collected by the State from the TPA to demonstrate compliance with this section.				X	X		
3.12. In Lieu Of Services. The State shall prohibit the TPA from providing "in lieu of services" as a substitute for State Plan Services.		X					

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
3.13. Upper Payment Limit. The State will ensure that any applicable services provided through the TPA are subject to UPL requirements under 42 CFR 447.272 and 42 CFR 447.321. In addition, any applicable services provided through the TPA shall be subject to the upper limit requirements at 42 CFR 447.362.			X				
4. General TPA Contract Requirements							DPHHS retains responsibility to make sure elements are IN the contract, HCSC will have responsibility to comply
4.1. Applicability of Federal and State Laws. The contract between the State and the TPA must comply with all applicable Federal and State laws and regulations including, but not limited to:	Y			X			DPHHS to reconcile to criteria in the contract
4.1.1. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80;				X			
4.1.2. Title IX of the Education Amendments of 1972 (regarding education programs and activities);				X			
4.1.3. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;				X			
4.1.4. The Rehabilitation Act of 1973;				X			
4.1.5. The Americans with Disabilities Act of 1990 as amended; and				X			
4.1.6. Section 1557 of the Patient Protection and Affordable Care Act.				X			
4.2 Privacy Requirements. The State must ensure, through its contract with the TPA, that (consistent 42 C. F.R. 431, subpart F), for medical records and any other health and enrollment information that identifies a particular enrollee, the TPA uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.	Y			X			DPHHS retains responsibility to make sure elements are IN the contract, HCSC will have responsibility to comply

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
4.3. Inspection and Audit. All contracts associated with this waiver, including with the TPA, must provide that the State, CMS, and the Office of the Inspector General may, at any time, inspect and audit any records or documents of the TPA or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted.	Y			X			DPHHS retains responsibility to make sure elements are IN the contract, HCSC will have responsibility to comply
5. Subcontractual Relationships and Delegation Requirements							
5.1. General Requirements for Subcontractual Relationships. The requirements of this section apply to the contract or written arrangement that the TPA has with any individual or entity that relates directly or indirectly to the performance of the TPA's obligations under its contract with the State. The State must ensure, through its contracts with the TPA, that:		X					
5.1.1. Notwithstanding any relationship(s) that the TPA may have with any other individual or entity, the TPA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and		X					
5.1.2. All contracts or written arrangements between the TPA and any individual or entity that relates directly or indirectly to the performance of the TPA's activities or obligations under its contract with the State must meet the requirements of this section of the STCs.		X					
5.2. Specific Requirements for Subcontractual Relationships. Each contract or written arrangement described in paragraph (b) of this section must specify that:		X					
5.2.1. If any of the TPA's activities or obligations under its contract with the State are delegated to another individual or entity :		X					
5.2.1.1. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.		X					
5.2.1.2. The individual or entity agrees to perform the delegated activities and reporting responsibilities specified in compliance with the TPA's contract obligations.		X					

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
5.2.1.3. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the TPA determines that the individual or entity has not performed satisfactorily.		X					
5.2.1.4. The individual or entity agrees to comply with all applicable Medicaid , laws, regulations, subregulatory guidance, and contract provisions.		X					
5.2.2. The subcontracting individual or entity agrees that:		X					
5.2.2.1. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, computer or other electronic systems of the individual or entity, or of the individual's or entity's contractor or subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the contract with the State, if the reasonable possibility of fraud is determined to exist by any of these entities.		X					-
5.2.2.2. The individual or entity will make available, for purposes of an audit, evaluation, or inspection described this section, its premises, physical facilities, equipment, and records relating to its Medicaid enrollees.		X					-
5.2.2.3. The right to audit under this section will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.		X					-
5.2.2.4. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the individual or entity at any time.		X					-
6. Provider-Related TPA Contract Requirements							
6.1. Excluded Providers. The TPA may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
6.2. Provider Selection. The State must ensure, through its contracts with the TPA, that the state reviews and approves the TPA's written credentialing and recredentialing policies and procedures for selection and retention of providers. The state must determine that the policies and procedures:	Y	X					
6.2.1. Assure access to quality, efficient and economic provisions of covered services; and		X			X		
6.2.2. Do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.		X			X		
6.3. Provider Preventable Conditions. The contract between the State and the TPA must comply with the requirements mandating provider identification of provider preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR 447.26. The TPA must report to the State all identified provider-preventable conditions in a form and frequency as specified by the State no less frequently than quarterly.	Y	X			X		Add by # letter Check RFP for current language
6.4. Physician Incentive Plan Requirements. The State must require the TPA, to the extent applicable, to comply with the physician incentive plan requirements set forth in 42 CFR 422.208 and 422.210. In applying the provisions of 42 C.F.R. 422.208 and 422.210, references to "MA organization," "CMS," and "Medicare beneficiaries" must be read as references to "TPA," "State," and "Medicaid beneficiaries," respectively.	Y	X				X	
6.5. No Provider Discrimination. The State through its contract with the TPA shall ensure that the TPA does not discriminate in the 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 on the basis of that license or certification. If the TPA declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. Nothing in this paragraph shall be construed to:	Y	X			X		
6.5.1. Require the TPA to contract with providers beyond the number that the State has determined to be necessary to meet the needs of its enrollees,		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
6.5.2. Preclude the TPA from establishing measures that the State authorizes it to implement to maintain quality of services and control costs, that are consistent with enrollee access to quality health care services.		X			X		
7. Enrollee Rights and Beneficiary Protections Requirements							
7.1. Enrollee Rights: General Principle. An enrollee of the TPA has the right to be furnished health care services in accordance with STCs 8.2, 8.7, 8.9, and 9.1.		X				X	
7.2. Enrollee Freedom to Exercise their Rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the TPA and its network providers or the State agency treat the enrollee.		X				X	
7.2.1. The contract between the State and the TPA must allow each enrollee to choose his or her health professional to the extent possible and appropriate.		X				X	
7.3. Requirement for Written Policies and Procedures. The State must ensure that that the TPA has written policies regarding the enrollee rights specified in this section, and that the TPA complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights.		X				X	
7.4. Guaranteed Enrollee Rights. The State must ensure that each TPA enrollee is guaranteed the following rights:		X					
7.4.1. Receive information in accordance with these STCs.		X					
7.4.2. Be treated with respect and with due consideration for his or her dignity and privacy.		X					
7.4.3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.		X					
7.4.4. Participate in decisions regarding his or her health care, including the right to refuse treatment.		X					

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
7.4.5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.		X					
7.4.6. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.		X					
7.5. Prohibition on Restricting Health Care Professionals. The TPA may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:		X			X		
7.5.1. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.		X			X		
7.5.2. Any information the enrollee needs to decide among all relevant treatment options.		X			X		
7.5.3. The risks, benefits, and consequences of treatment or nontreatment.		X			X		
7.5.4. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.		X			X		
7.6. Sanctions for Violating Enrollee Rights. The State shall ensure through its contract with the TPA, that the TPA shall be subject to sanctions if it violates the prohibition in STC 7.5.	Y	X					
8. Access to Services and Coordination of Care Requirements							
8.1. Access to Services: General Requirements. The State must ensure that all services covered under the HELP Program TPA Alternative Benefit Plan that are offered through the TPA are available and accessible to enrollees of the TPA in a timely manner. The State must also ensure that TPA provider network for services covered under the contract meet the standards developed by the State in accordance with STC 3.4				X			

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
8.2. The State must ensure , through its contract with the TPA, that the TPA, consistent with the scope of its contracted services, meets the following requirements:	Y			X	X		
8.2.1. The TPA shall maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.		X			X		
8.2.2. The TPA shall provide female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.		X			X		
8.2.3. If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the TPA must adequately and timely cover these services out of network for the enrollee, for as long as the TPA's provider network is unable to provide them.		X			X		
8.2.3.1. The State may require that the out-of-network provider is enrolled in Montana Medicaid or for a provider that is not enrolled in Montana Medicaid, that the TPA negotiate a rate that is no greater than the rate the provider would receive if enrolled in Montana Medicaid. These requirements cannot be used as basis for the TPA or State not providing an enrollee services included in the HELP Program TPA Alternative Benefit Plan.		X			X		
8.2.4. The TPA shall require out-of-network providers to coordinate with the TPA for payment and ensure the cost to the enrollee is no greater than it would be if the services were furnished within the network.		X			X		
8.3. Enrollee Access to Choice of Providers. Montana Medicaid beneficiaries receiving services through the TPA will have a choice of primary care providers and specialty providers. To the extent beneficiary access to such providers is limited in the future, the State through its contract with the TPA must permit the beneficiary:		X			X		
8.3.1. To choose from at least two primary care providers.		X			X		
8.3.2. To obtain services from any other provider under any of the following circumstances:		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
8.3.2.1. The service or type of provider (in terms of training, experience, and specialization) is not available within the TPA network.		X			X		
8.3.2.2. The provider is not part of the TPA network, but is the main source of a service to the beneficiary, provided that:		X			X		
8.3.2.3. The provider is given the opportunity to become a participating provider under the same requirements for participation in the TPA network as other network providers of that type.		X			X		
8.3.2.4. If the provider chooses not to join the network, or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 calendar days (after being given an opportunity to select a provider who participates).		X			X		
8.3.2.5. The only provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.		X			X		
8.3.2.6. The beneficiary's primary care provider or other provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.		X			X		
8.3.2.7. The State determines that other circumstances warrant out-of-network treatment, including:		X			X		
8.3.2.7.1. If a beneficiary has exceptional health care needs including medical, behavioral health or developmental conditions;		X			X		
8.3.2.7.2. If a beneficiary lives in a region where the TPA is unable to contract with sufficient providers;		X			X		
8.3.2.7.3. Required continuity of care for a beneficiary is not available or is not cost effective to be effectively delivered through the TPA; or		X			X		
8.3.2.7.4. The beneficiary is otherwise exempt under Federal law.		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments	
		HSCC	DPHHS	Joint	POD 1	POD 2
8.4. Enrollee Changing Primary Care Providers. Montana Medicaid beneficiaries receiving services through the TPA will not have any limitations with respect to changing primary care providers. To the extent an enrollee of the TPA has limited access to primary care providers in the future, any limitation the State or the TPA imposes on his or her freedom to change between primary care providers must still allow the beneficiary to change primary care providers for the following:		X			X	
8.4.1. For cause, at any time;		X			X	
8.4.2. Without cause, at the following times:		X			X	
8.4.2.1. During the 90 days following the date of the beneficiary's initial enrollment into the TPA, or the date the State sends the beneficiary notice of the enrollment, whichever is later.		X			X	
8.4.2.2. At least once every 12 months thereafter.		X			X	
8.4.2.3. Upon automatic reenrollment, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.		X			X	
8.5. Requirements for TPA Oversight of Network Providers. The State must ensure that the contract with the TPA requires the TPA to do the following:	Y	X			X	
8.5.1. Meet, and require its network providers to meet, the State's standards for timely access to care and services, taking into account the urgency of the need for services.		X			X	
8.5.2. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid beneficiaries that are not TPA-Medicaid-FFS enrollees.		X			X	
8.5.3. Establish mechanisms to ensure compliance by network providers.		X			X	
8.5.4. Monitor network providers regularly to determine compliance.		X			X	
8.5.5. Take corrective action if there is a failure to comply by a network provider.		X			X	
8.6. TPA Participation in Culturally Competent Care Efforts. The State must ensure that the contract with the TPA requires the TPA to participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.	Y	X				X

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
8.7. Requirements for Accessibility. The State must ensure that the contract with the TPA requires that the TPA must ensure that its network providers provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	Y	X			X		
8.8. TPA Assurances of Capacity to the State. The State must ensure, through its contract with the TPA, that the TPA gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under STC 8.8.	Y	X			X		
8.8.1. The State must ensure, through its contract with the TPA, that the TPA must submit documentation to the State, in a format specified by the State to demonstrate that it complies with the following requirements:		X			X		
8.8.1.1. Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area.		X			X		
8.8.1.2. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.		X			X		
8.8.2. The State must ensure, through its contract with the TPA, that the TPA must submit the documentation described in paragraph (g) of this section as specified by the State, but no less frequently than the following:		X			X		
8.8.2.1. At the time it enters into a contract with the State.		X			X		
8.8.2.2. On an annual basis.		X			X		
8.8.2.3. At any time there has been a significant change (as defined by the State) in the TPA's operations that would affect the adequacy of capacity and services, including, but not limited to changes in the TPA's services, benefits, geographic service area, composition of or payments to its provider network.		X			X		
8.9. Care Coordination Requirements. The State must ensure, through its contract with the TPA, that the TPA must implement procedures to deliver care to and coordinate services for all TPA enrollees. These procedures must meet State requirements and must do the following:	Y	X				X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments	
		HCSC	DPHHS	Joint	POD 1	POD 2
8.9.1. Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee.		X				X
8.9.2. Coordinate the services the TPA furnishes to the enrollee:		X				X
8.9.2.1. Between settings of care including appropriate discharge planning for short term and long-term hospital and institutional stays;		X				X
8.9.2.2. With the services the enrollee receives from any other delivery system; and		X				X
8.9.2.3. With the services the enrollee receives in FFS Medicaid.		X				X
8.9.3. The State must ensure, through its contract with the TPA, that the TPA, within 90 days of the effective date of enrollment for all new enrollees, makes a best effort to conduct an initial assessment of each enrollee's needs, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful. The TPA shall be required to share with the State the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities.		X				X
8.9.4. The State must ensure, through its contract with the TPA, that the TPA shall ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.		X				X
8.10. Enrollee Health Record Requirements. The State must ensure, through its contract with the TPA, that the TPA shall ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards.	Y	X				X
9. Coverage and Authorization of Services Requirements						
9.1. The contract between the State and the TPA must do the following:	Y	X				X
9.1.1. Identify, define, and specify the amount, duration, and scope of each service that the TPA is required to offer. Amount, duration, and scope cannot be less than what is in the approved HELP Program TPA Alternative Benefit Plan.		X				X
9.1.2. Require that the TPA must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.		X				X

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
9.1.3. Require that the TPA may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.		X				X	
9.1.4. Permit the TPA to place appropriate limits on a service only on the basis of criteria applied under the State plan, such as medical necessity.		X				X	
9.1.5. Require that Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 C.F.R §441.20.		X				X	
9.2. Medically Necessary Services. The contract between the State and the TPA must specify what constitutes "medically necessary services" in a manner that:	Y	X				X	
9.2.1. Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and		X				X	
9.2.2. Meets the requirements for providing early and periodic screening and diagnosis of beneficiaries under age 21 to ascertain physical and mental defects, and treatment to correct or ameliorate defects and chronic conditions found (EPSDT).		X				X	
9.3. Processing Authorization of Services. For the processing of requests for initial and continuing authorizations of services, the contract with the TPA must require:	Y	X				X	
9.3.1. That the TPA and its subcontractors have in place, and follow, written policies and procedures. the contract with the TPA must require that the TPA:		X				X	
9.3.1.1. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.		X				X	
9.3.1.2. Consult with the requesting provider for medical services when appropriate.		X				X	
9.3.2. That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate expertise in addressing the enrollee's medical or behavioral health needs.		X				X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments	
		HCSC	DPHHS	Joint	POD 1	POD 2
9.3.3. That the TPA is to notify the requesting provider, and give the enrollee written notice of any decision by the TPA to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of §438.404of80 FR 31097 42CFR§ 438.404 (See 80 Fed. Reg. 31097 at 31283 (6/1/2015)) .		X				X
9.4. Decisions and Notification of Authorization of Services. The contract with the TPA must provide for the following decisions and notices:	Y	X				X
9.4.1. For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if:		X				X
9.4.1.1. The enrollee, or the provider, requests extension; or		X				X
9.4.1.2. The TPA justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.		X				X
9.4.2. For cases in which a provider indicates, or the TPA determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the TPA must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.		X				X
9.4.3. The TPA may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the TPA justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.		X				X
9.5. State Review of TPA Decisions to Deny, Limit, or Delay Services. The State and the TPA shall develop, in writing, a mechanism to exchange: 1) Enrollees' requests for appeals on decisions to deny, limit, or delay services; and 2) Outcomes and/or decisions from enrollees' appeals.		X				X
9.5.1. The exchange of information shall be as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date of a request, outcome1 or decision.		X				X

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
9.5.2. If a State fair hearing officer, or other State official, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the TPA must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		X				X	
9.6. Compensation for Individuals and Entities that Conduct Utilization Management. The contract between a State and the TPA must provide that, consistent with STC 6.4 and 42 C. F.R. §422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	Y	X				X	
10. Emergency and Post stabilization Services Requirements							
10.1. Definitions as used in this section:		X				X	
10.1.1. Emergency medical condition. Emergency medical condition means 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 the following:		X				X	Have BC use prudent def = was missing during RFP run. HCSC must ensure it uses / incorporates these definitions.
10.1.1.1. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.		X				X	HCSC must ensure it uses / incorporates these definitions.
10.1.1.2. Serious impairment to bodily functions.		X				X	HCSC must ensure it uses / incorporates these definitions.
10.1.1.3. Serious dysfunction of any bodily organ or part.		X				X	HCSC must ensure it uses / incorporates these definitions.
10.1.2. Emergency services. Emergency services means covered inpatient and outpatient services that are as follows:		X				X	HCSC must ensure it uses / incorporates these definitions.
10.1.2.1. Furnished by a provider that is qualified to furnish these services under this title.		X				X	HCSC must ensure it uses / incorporates these definitions.
10.1.2.2. Needed to evaluate or stabilize an emergency medical condition.		X				X	HCSC must ensure it uses / incorporates these definitions.

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
10.1.3. Post stabilization care services. Post stabilization care services means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in STC 10.2, to improve or resolve the enrollee's condition.		X				X	HCSC must ensure it uses / incorporates these definitions.
10.2. Coverage and Payment of Emergency Services and Post stabilization Care Services. The TPA is responsible for coverage and payment of emergency services and post stabilization care services. The TPA or the State:		X				X	
10.2.1. Must cover and pay for emergency services		X				X	
10.2.1.1. The State may require that the Emergency services provider is enrolled in Montana Medicaid or alternatively for a provider that is not enrolled in Montana Medicaid, that the TPA negotiates a rate with a non- enrolled provider that is no greater than the rate the provider would receive if enrolled in Montana Medicaid. These requirements cannot be used as basis for the TPA or State not providing an enrollee emergency services.		X				X	
10.2.2. May not deny payment for treatment obtained under either of the following circumstances:		X				X	
10.2.2.1. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition in this section.		X				X	
10.2.2.2. A representative of the TPA instructs the enrollee to seek emergency services.		X				X	
10.2.3. The TPA or the State may not:		X				X	
10.2.3.1. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.		X				X	
10.2.3.2. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, the TPA, or applicable State entity of the enrollee's screening and treatment within 365 calendar days of presentation for emergency services.		X				X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
10.2.3.3. Hold an enrollee who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.		X				X	
10.2.4. The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the TPA and the State as responsible for coverage and payment.		X				X	
10.2.5. Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). In applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act, and the states.		X				X	
11. Information and Communication Requirements							
11.1. Enrollee Assistance: General Requirements. The State through its contract with the TPA must:		X				X	
11.1.1. Have in place a mechanism to help enrollees and potential enrollees understand the requirements of the TPA for accessing services, benefits, and appeal rights.		X				X	
11.1.2. Provide all required information in these STCs to enrollees and potential enrollees in a manner and format that may be easily understood and readily accessible by enrollees.		X				X	
11.2. Requirements to Provide Information Electronically. Enrollee information required in this STC may not be provided electronically by either the State or the TPA, unless all of the following are met:		X				X	
11.2.1. The format is readily accessible.		X				X	
11.2.2. The information is placed in a location on the State or TPA website that is prominent and readily accessible.		X				X	
11.2.3. The information is provided in an electronic form which can be electronically retained and printed.		X				X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments	
		HCSC	DPHHS	Joint	POD 1	POD 2
11.2.4. The information is consistent with the content and language requirements of this STC.		X				X
11.2.5. The State or the TPA informs the enrollee that the information is available in paper form without charge upon request and provides it upon request within 5 calendar days.		X				X
11.3. Enrollee Handbook. The State through its contract with the TPA must provide each enrollee an enrollee handbook, either in paper or electronic form, at the time the enrollee first required to enroll in the TPA. The content of the member handbook must include information that enables the enrollee to understand how to effectively use the TPA. This information must include at a minimum:		X				X
11.3.1. Benefits provided by the TPA.		X				X
11.3.2. How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided.		X				X
11.3.2.1. In the case of a counseling or referral service that the TPA does not cover because of moral or religious objections, the TPA must inform enrollees that the service is not covered.		X				X
11.3.2.2. The TPA must inform enrollees how they can to obtain information from the State about how to access those services.		X				X
11.3.3. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.		X				X
11.3.4. Procedures for obtaining benefits, including any requirements, if any, for service authorizations or referrals.		X				X
11.3.5. The extent to which, and how, after-hours and emergency coverage are provided, including:		X				X
11.3.5.1. What constitutes an emergency medical condition and emergency services.		X				X
11.3.5.2. The fact that prior authorization is not required for emergency services.		X				X
11.3.5.3. The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.		X				X
11.3.6. Any restrictions on the enrollee's freedom of choice among network providers.		X				X
11.3.7. The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies, from out-of-network providers.		X				X

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments	
		HCSC	DPHHS	Joint	POD 1	POD 2
11.3.8. Cost sharing, if any is imposed under this waiver.		X				X
11.3.9. Enrollee rights and responsibilities, including the elements specified in STC 7.2 and 7.3.		X				X
11.3.10. The process of selecting and changing the enrollee's primary care provider.		X				X
11.3.11. Grievance, appeal, and fair hearing procedures and timeframes, consistent with subpart F of 42 CFR 438, in a State-developed or State-approved description. Such information must include:		X				X
11.3.11.1. The right to file grievances and appeals.		X				X
11.3.11.2. The requirements and timeframes for filing a grievance or appeal.		X				X
11.3.11.3. The availability of assistance in the filing process.		X				X
11.3.11.4. The right to request a State fair hearing after the TPA has made a determination on an enrollee's appeal which is adverse to the enrollee.		X				X
11.3.11.5. The fact that, when requested by the enrollee benefits that the TPA seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or State Fair Hearing is pending if the final decision is adverse to the enrollee.		X				X
11.3.12. How to access auxiliary aids and services, including additional information in in alternative formats or languages.		X				X
11.3.13. The toll-free telephone number for member services medical management and any other unit providing services directly to enrollees.		X				X
11.3.14. Information on how to report suspected fraud or abuse.		X				X
11.3.15. Any other content required by the State.			X			X
11.3.16. Information required by this paragraph to be provided by the TPA will be considered to be provided if the TPA:		X				X
11.3.16.1. Mails a printed copy of the information to the enrollee's mailing address;		X				X
11.3.16.2. Provides the information by email after obtaining the enrollee's agreement to receive the information by email;		X				X

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
11.3.16.3. Posts the information on the website of the TPA and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or		X				X	
11.3.16.4. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.		X				X	
11.4. Changes to the Enrollee Handbook. The TPA must give each enrollee notice of any change to the enrollee handbook that the State defines as significant at least 30 days before the intended effective date of the change.		X				X	
11.5. Enrollee Materials: General Requirements. Provide, and require the TPA to provide, all written materials for and enrollees consistent with the following:		X				X	
11.5.1. Use easily understood language and format;		X				X	
11.5.2. Use a font size no smaller than 12 point;		X				X	
11.5.3. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.		X				X	
11.5.4. Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 pt.		X				X	
11.6. Notifying Enrollees Communication Assistance. The State shall notify enrollees, and require the TPA to notify its enrollees:				X		X	
11.6.1. That oral interpretation is available for any language and written information is available in prevalent languages;		X				X	
11.6.2. That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and		X				X	
11.6.3. How to access those services.		X				X	
11.7. Assistance for Non-English Language Needs. The State through its contract with the TPA must:	Y			X		X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
11.7.1. Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in the TPA's service area.				X		X	
11.7.2. Make available oral and written information in each prevalent non-English language. All written materials for enrollees must include taglines in each prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services. Large print means printed in a font size no smaller than 18 pt.		X				X	
11.7.3. Make its written materials, including, at a minimum, provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services, available in the prevalent non-English languages in its particular service area. Written materials must also be made available in alternative formats and auxiliary aids and services should be made available upon request of the potential enrollee or enrollee at no cost. Written materials must also, include taglines in each prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the TPA's member/customer service unit.		X				X	
11.8. Notifying Enrollees of Provider Terminations. The State through its contract with the TPA must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	Y	X				X	
12. Provider Directory Information Requirements							
12.1. Provider Directory Information. The State through its contract with the TPA must make available, to enrollees, in electronic or paper form, the following information about its network providers:	Y	X			X		
12.1.1. The provider's name as well as any group affiliation.		X			X		
12.1.2. Street address(es).		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
12.1.3. Telephone number(s).		X			X		
12.1.4. Website URL as appropriate.		X			X		
12.1.5. Specialty, if appropriate.		X			X		
12.1.6. Whether the provider will accept new enrollees.		X			X		
12.2. Provider Directory: Provider Types. The provider directory must include the information for each of the following provider types covered under the contract:		X			X		
12.2.1. Physicians including specialists.		X			X		
12.2.2. Hospitals.		X			X		
12.2.3. Behavioral health providers.		X			X		
12.3. Future Requirements for Provider Directory Information. The State must ensure through its contract with the TPA that the TPA complies with any provider directory information in 42 CFR 438 that are more comprehensive than these STCs.		X			X		
13. Health Information Systems and Post-Adjudicated Claims Data Requirements							
13.1. Health Information Systems: General Requirements. The State must ensure, through its contracts that the TPA maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this waiver. The systems must provide information on areas including, but not limited to, utilization, claims, and grievances and appeals.	Y	X			X		
13.2. Health Information Systems: Specific Requirements. The State must require, at a minimum, that the TPA, and any subcontractors, comply with the following:		X			X		
13.2.1. Section 6504(a) of the Affordable Care Act, which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(l)(F) of the Act.		X			X		
13.2.2. Collect data on enrollee and provider characteristics as specified by the State, and on all services furnished to enrollees through a post-adjudicated claims data system or other methods as may be specified by the State.		X			X		
13.2.3. Ensure that data received from providers is accurate and complete by:		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
13.2.3.1. Verifying the accuracy and timeliness of reported data, including data from network providers the TPA is compensating on the basis of capitation payments.		X			X		
13.2.3.2. Screening the data for completeness, logic, and consistency.		X			X		
13.2.3.3. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.		X			X		
13.2.4. Make all collected data available to the State, and upon request to CMS.		X			X		
13.3. Post-Adjudicated Claims Data: General Requirement. The State must require the TPA to submit to the State post-adjudicated claims data that complies with the form, format and manner for data as required in in 42 CFR 438.242. Contracts between a State and the TPA must provide for:	Y	X			X		
13.3.1. Collection and maintenance of sufficient post-adjudicated claims data to identify the provider who delivers any item(s) or service(s) to enrollees.		X			X		
13.3.2. Submission of post-adjudicated claims data to the State at a frequency and level of detail to allow the submission of all post-adjudicated claims data that the State is required to report to CMS.		X			X		
13.4. Post-Adjudicated Claims Data and Availability of FFP. FFP is available for expenditures associated with the TPA contract and covered services provided under the TPA contract only if the State meets the following conditions for providing sufficient and timely post-adjudicated claims data to CMS:		X			X		
13.4.1. The State shall submit post-adjudicated claims data to CMS consistent with the data reporting requirements of the Medicaid Statistical Information System or any successor system.		X			X		
13.4.2. The State shall ensure that post-adjudicated claims data is validated for accuracy and completeness before each data submission.		X			X		
13.4.3. The State must require that the data, documentation and information that the TPA submits to the State related to post-adjudicated claims data be certified by either the TPA's Chief Executive Officer or Chief Financial Officer and that such data documentation and information is accurate, complete and truthful.		X			X		

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
13.4.4. The State shall require the TPA to submit the certification concurrently with the submission of the data, documentation, or information.		X			X		
13.5. CMS Review of Post-Adjudicated Claims Data. CMS will assess the State's submission to determine if it complies with current criteria for accuracy and completeness.				X			Joint - Based on DPHHS to communicate with CMS, HCSC to transfer files
13.5.1. If, after being notified of compliance issues the State is unable to make a data submission compliant, CMS will take appropriate steps to defer and/or disallow FFP on all or part of the TPA contract and covered services provided under the TPA contract in a manner based on the enrollee and specific service type of the noncompliant data.		X			X		Per RFP BCBSMT will be liable for disallowance. If CMS takes appropriate steps to disallowance for the federal portion of the match, then BCMSMT will be accountable.
14. Program Integrity Requirements							
14.1. Procedures to Detect Fraud Waste and Abuse. The State, through its contract with the TPA, must require that the TPA, or subcontractor to the extent that the subcontractor is delegated responsibility by the TPA for coverage of services and payment of claims under the contract between the State and the TPA, implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:	Y	X				X	
14.1.1. A compliance program that includes, at a minimum, all of the following elements:		X				X	
14.1.1.1. Written policies, procedures, and standards of conduct that articulate the TPA's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and State requirements.		X				X	
14.1.1.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors.		X				X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
14.1.1.3. The establishment of a Regulatory Compliance Committee at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.		X				X	
14.1.1.4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract.		X				X	
14.1.1.5. Effective lines of communication between the compliance officer and the organization's employees.		X				X	
14.1.1.6. Enforcement of standards through well-publicized disciplinary guidelines.		X				X	
14.1.2. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.		X				X	
14.1.3. Provision for prompt reporting of all improper payments identified or recovered, specifying the improper payments due to potential fraud, to the State or law enforcement.		X				X	
14.1.4. Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including all of the following:		X				X	
14.1.4.1. Changes in the enrollee's residence; or		X				X	
14.1.4.2. The death of an enrollee.		X				X	
14.1.5. Provision for notification to the State when it receives information about a change in a provider's circumstances that may affect the provider's eligibility to participate in the Medicaid program, including the termination of the provider agreement with the TPA.		X				X	
14.1.6. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.		X				X	

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments	
		HCSC	DPHHS	Joint	POD 1	POD 2
14.1.7. Written policies for all employees of the entity, and of any contractor or agent, providing detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers are in place.		X				X
14.1.8. Provision for the prompt referral of any potential fraud, waste, or abuse that the TPA identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.		X				X
14.1.9. Provision for the TPA's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR455.23.		X				X
14.2. Prohibited Relationships. The TPA, or a subcontractor of the TPA, may not knowingly have a relationship with 1) an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in no procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or 2) an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in this paragraph for any of the following:		X				X
14.2.1. A director, officer, or partner of the TPA.		X				X
14.2.2. A subcontractor of the TPA, as governed by§ 438.230.		X				X
14.2.3. A person with beneficial ownership of 5 percent or more of the TPA's equity.		X				X
14.2.4. A network provider or persons with an employment, consulting or other arrangement with the TPA for the provision of items and services that are significant and material to the TPA's obligations under its contract with the State.		X				X
14.2.5. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.		X				X
14.2.6. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(l) of this section.		X				X

Standards According to 1915b waiver	Contract Change Required	Responsibility			POD Assignments		
		HCSC	DPHHS	Joint	POD 1	POD 2	
14.3. Prohibition Relationship with Excluded Individuals and Entities. The TPA may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under section 1128 or 1128A of the Act.		X				X	
14.4. Non-Compliance with Prohibited Relationship. If a State finds that the TPA is not in compliance with the Prohibited Relationship STCs, the State:			X				
14.4.1. Must notify CMS of the noncompliance.			X				
14.4.2. May continue an existing agreement with the TPA entity unless CMS directs otherwise.			X				
14.4.3. May not renew or otherwise extend the duration of an existing agreement with the TPA.			X				
14.5. Other Program Integrity Requirements. The State must ensure, through its contracts, that the TPA, and any subcontractors:	Y		X				
14.5.1. Provides written disclosure of any prohibited relationships described in the STCs.		X					
14.5.2. Provides written disclosures of information on ownership and control required under 42 CFR 455.104.		X					
14.5.3. Reports to the State within 60 calendar days when it has identified any payments in excess of amounts specified in the contract.		X					
14.6. Other Remedies Available. Nothing in these STCs must be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Social Security Act.			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
d. The process by which beneficiaries remit payment, including ways individuals who cannot pay by check will be accommodated.		X				X	
e. The process by which the State operates the premium credit against copayments, including the list of services exempt from copayments.		X				X	
f. A description of the State's collection activities including the process by which the State assesses past due premiums.		X				X	
g. A description and assurance of how the State accurately tracks cost sharing and the aggregate cap.		X				X	Description of the TPA services only. EDX will be responsible to track aggregate.
h. Design for the beneficiary survey described in the Evaluation Section XII.		X				X	Relates to Beneficiary survey
i. A description of how State will comply with the requirements of 42 CFR 447.54 to implement a copayment for non-emergency use of the emergency department.		X				X	BC for TPA members.
8. Preventive Services Protocol. By December 11, 2015, the State will submit for approval, a protocol describing the process by which the State will ensure that certain beneficiaries are not charged for preventive health care services, including the list of services and drugs that will be exempted. This protocol will be included as Attachment C to these STCs.				X			DPHHS will submit protocol. BCMSMT is responsible to implement the preventive services protocol as described by DPHHS on 1/1/16.
VIII. CONTINUOUS ELIGIBILITY							
1. Duration. The State is authorized to provide a 12 month continuous eligibility period to the group of individuals specified in Table 1, regardless of the delivery system through which they receive Medicaid benefits.			X				
2. Exceptions. Notwithstanding subparagraph (a), if any of the following circumstances occur during an individual's 12 month continuous eligibility period, the individual's Medicaid eligibility shall, after appropriate process, be terminated:			X				
i. The individual cannot be located for a period of more than one month, after good faith			X				
ii. The individual is no longer a Montana resident.			X				
iii. The individual requests termination of eligibility.			X				
iv. The individual dies.			X				
v. The individual fails to provide, or cooperate in obtaining a Social Security Number, if otherwise required.			X				
vi. The individual provided an incorrect or fraudulent Social Security Number.			X				
vii. The individual was determined eligible for Medicaid in error.			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
a. The TPA and/or State may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies , place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The TPA and/or State also may not "sell" the debt for collection by a third-party.				X			
b. Beneficiaries described in 42 CFR 447.56(a) (including American Indians/Alaska Natives, as described therein) must be exempt from all copayments and premium contribution requirements, as applicable.			X				
c. Beneficiaries may not incur family cost sharing or premiums that exceeds 5 percent of the aggregate family's income, following rules established in 42 CFR 447.56(f).				X	X		BCBSMT will adjudicate according to the EDX
d. Copayment amounts will not exceed Medicaid cost sharing permitted by federal law and regulation.				X	X		BCBSMT will adjudicate according to the EDX
e. The State may not pass along the cost of any surcharge associated with processing payments to the beneficiary. Any surcharges or other fees associated with payment processing must be considered an administrative expense by the State.		X			X		
f. The State will ensure that all payments from the beneficiary, or on behalf of the individual, are accurately and timely credited toward unpaid premiums and related debt, and will provide the beneficiary an opportunity to review and seek correction of the payment history.		X			X		
6. Operations Protocol. By March 1, 2016 the State will submit for approval a protocol describing the State's policies and procedures for implementing the premiums and copayments and monitor operations of, and the effects of, the policy. This approval will be included as Attachment B to these STCs. As the operational protocol will be submitted after the State begins operating the demonstration, approval of the protocol may be contingent upon the State's agreement to make changes to any of the items included in the protocol. Compliance with the agreed upon protocol will be monitored via the processes described in section IX in paragraphs 2 and 3. The protocol shall include:			X				
a. A detailed description of the outreach campaign that the State conducts to explain the program policies.			X				
b. Copies of program, applicant and beneficiary communication materials.		X				X	
c. Copies of the notices beneficiaries receive regarding premiums and copayments and the schedule for such notices.		X				X	

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
2. Beneficiary Education. Program information, applicant information, and information shall be tested to ensure it is comprehensible by the target beneficiary audience and shall make clear:		X					BCBSMT Focus Group to test. Customer service input (e.g. Call logs, FAQs) will drive updates to the Administration manual and possibly the self-audit tool.
a. That eligibility will begin consistent with state plan rules.			X			X	
b. How premium payments should be made and the impact of change of income on premium payments owed.		X				X	
c. The income guidelines for each component of the program (above 100 percent of the FPL and at and below 100 percent of the FPL and the relevant monthly income dollar figures so that applicants can understand which group they are likely to be in).		X				X	
d. How the premium credit against copayments works.		X				X	
e. The consequences of non-payment of premiums for each income group.		X				X	
f. The consequences of non-payment of co-payments for each income group.		X				X	
g. How to re-enroll, if dis-enrolled for non-payment of premiums.						X	
3. Beneficiary Outreach. The State must conduct an outreach and education campaign to potential applicants and beneficiaries to ensure that they understand the program policies regarding premiums and associated consequences.			X				Materials are in place, DPHHS to follow up with their leadership
4. Copayments. Enrollees are subject to premiums and copayments up to 5 percent of income, calculated quarterly as described in 42 CFR 447.56(f) (both premiums and copayments count against the 5 percent aggregate cap). Copayment amounts shall be consistent with federal requirements regarding Medicaid cost		X			X		
a. Enrollees will receive a credit toward their copayment obligations in the amount of their premiums, such that they shall not accrue out of pocket expenses for copayments until accumulated copayments exceed 2 percent of aggregate household income.		X			X		
b. The following service categories are exempt from copayments:		X			X		
i. Preventive health care services, including primary, secondary and tertiary preventive services as described in the operational protocol;		X			X		
ii. Immunizations; and		X			X		
iii. Medically necessary health screenings ordered by a health care provider.		X			X		
c. Consistent with federal law, providers may not deny services for failure to receive beneficiary copayments from individuals at or below 100 percent of the FPL.		X			X		
5. Beneficiary Protections.							

BCBS Matrix 1115 STC

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
V. Benefits							
2. Minimum Essential Coverage		X					
VII. PREMIUMS AND COPAYMENTS							
1. Premiums. Authority to charge premiums is contingent upon the State demonstrating the ability to electronically track aggregate out-of-pocket costs (both premiums and copayments) for all household members, on a quarterly basis, and CMS’s approval of the preventive services protocol. The State is permitted to charge demonstration beneficiaries monthly premiums of 2 percent of aggregate household income. In families with two enrolled individuals, the total of both beneficiaries’ required premium contributions cannot exceed 2 percent of the household income. Notwithstanding the premium obligations, eligibility shall be determined consistent with State Plan rules.							
a. Premiums for Individuals with Income at or Below 100 percent of the FPL.							
i. Non-payment of premiums by individuals at or below 100 percent of the FPL shall not result in dis-enrollment. Unpaid premiums may be considered a collectible debt that may be assessed by the State, as the State must describe in the operational protocol.				X	X		
ii. All individuals shall receive a credit in the amount of their premium obligation towards the first 2 percent of copayments accrued.				X			The EDX transaction will come from DPHHS and dictates the credit amount
b. Premiums for Individuals with Income Above 100 percent of the FPL.							
i. After appropriate notice and a 90-day grace period, individuals with income above 100 percent of the FPL who fail to make a premium payment may be dis-enrolled.				X	X		BCBSMT will track paid and unpaid premiums.
ii. Re-enrollment shall be permitted upon payment of arrears or when the debt is assessed. Assessment occurs when the Department of Revenue sends notice of debt to the individual, as the State will describe in the Operations Protocol in Attachment B and described in section VII STC 7.			X		X		
iii. Assessment shall occur no less frequently than quarterly on a calendar basis; re-enrollment after assessment shall not require a new application for Medicaid.			X		X		
iv. The State shall establish a process to exempt individuals from disenrollment for good cause.			X				
v. All individuals shall receive a credit in the amount of their premium obligation towards the first 2 percent of copayments accrued.		X			X		

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
viii. The individual fails to provide the documentation of citizenship or immigration status required under federal law.			X				
ix. Consistent with section VII STC 1, the State may terminate individuals with incomes above 100 percent of the FPL due to nonpayment of premiums.			X				
3. Income for Purposes of Premium Calculation. If an individual’s income changes during the continuous eligibility period, the individual may report the change and the premium amount shall be recalculated for the following quarter.			X				
IX. GENERAL REPORTING REQUIREMENTS							
1. General Financial Requirements. The Sstate must comply with all general financial requirements under Title XIX outlined in Section XI of these STCs.			X				
2. Monthly Monitoring Calls. CMS will convene periodic conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Montana HELP Program beyond December 31, 2020. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls. Areas to be addressed may include, but are not limited to:			X				HCSC will assist the State with preparation for each such call, upon request.
a. Transition and implementation activities,			X				
b. Stakeholder concerns,			X				
c. Demonstration operations and performance,			X				
d. Enrollment,			X				
e. Copayments,			X				
f. Audits,			X				
g. Lawsuits,			X				
h. Financial reporting issues,			X				
i. Progress on evaluations,			X				
j. Legislative developments, and			X				
k. Any demonstration amendments the state is considering submitting.			X				
3. Quarterly Progress Reports. By December 15, 2015, the State will submit for approval a Quarterly Progress Report Format describing the States’ plan for submitting quarterly progress reports. This approval will be included as Attachment D to these STCs. The State shall submit progress reports in a format agreed upon by CMS and the State no later the State’s analysis and the status of the various operational areas. These quarterly reports shall include, but not be limited to:			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
a. A description of the population included in the demonstration (distribution of age, sex, racial/ethnic distribution, etc.).			X				
b. Completed Quarterly Report Template Workbook, included with Appendix D, with data on: enrollment and dis-enrollment stratified by premium experience and demographics associated with the demonstration populations. There should also be an accompanying brief narrative for each of these areas which address the pertinent issues outlined in Appendix D: Quarterly Report Format.			X				
c. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, or other operational issues.				X			
d. Summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. To the extent possible, the State should present this information to CMS in tables. The discussion should also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; and status of study participant recruitment, if applicable.				X			
e. A discussion of key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.				X			
f. Describe any additional events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and dis-enrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity. This should include action plans for any events identified as requiring corrective action.				X			
g. Oversight and monitoring conducted, such as TPA or provider site visits, reports, or requests for corrective actions plans pertaining to either the TPA or FFS demonstration population; complaints, grievances and appeals filed during the quarter by type, highlighting any patterns that are concerning; and actions being taken to address any significant issues evidenced by patterns of complaints or appeals.				X			
h. Enrollment figures for the quarter including enrollment figures for individuals by income level.			X				
i. The number of individuals reaching their cost sharing limitations.		X					
j. A summary of the post award forums and solicited comments from the public, when applicable.			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
k. Updated timeline for submitting monitoring and evaluation deliverables to CMS.			X				
l. The Sstate must provide a work plan included in each quarterly report, which outlines when monitoring activities occur. Each work plan should include:				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
i. Dates for the time periods that data collection will take place for all data sources, including data pulls, surveys collection, interview and focus groups conducting, as well as any other sources for collecting data that are not otherwise specified;				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
ii. Estimated time periods which data analyses will take place;				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
iii. Dates when the State will submit deliverables and reports;				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
iv. The individual responsible for each monitoring activity; and				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
v. Other relevant information associated with demonstration monitoring.				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
m. The data to be reported to CMS in quarterly reports includes, but is not limited the following:				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
i. The number of individuals subject to premium requirements (i.e., number of nonexempt individuals);				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
ii. The number of individuals with overdue premiums including those with premiums past due less than and greater than 90 days;				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
iii. The number of individuals who have premiums that have become collectible debt;				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
iv. The number and average amount of contributions from incorporated public or private third parties toward beneficiary premiums, by type of entity, and by beneficiary income level;				X			HCSC has the reporting requirement to DPHHS and DPHHS has to submit to CMS
v. The number of individuals who are dis-enrolled for failure to pay premiums, including;			X				
1. The number of individuals who have re-enrolled due to payment of full arrears;			X				
2. The number of individuals who have re-enrolled due to assessment, and;			X				
3. The number of individuals who have paid partial arrears.			X				
vi. The number of enrollees that are exempt from dis-enrollment due to good cause.			X				
4. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, delivery system and provider level, and segmentation by population) to support rapid cycle assessment in trends and for monitoring and evaluation of the demonstration.			X				
5. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.			X				
6. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The State shall submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the DY to CMS. A delay in submitting the draft or final annual report could subject the State to penalties described in paragraph 16 of section III.			X				
a. All items included in the quarterly report must be summarized to reflect the operation/activities throughout the DY;				X			
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;				X			
c. Yearly enrollment reports for demonstration beneficiaries for each DY (beneficiaries include all individuals enrolled in the demonstration); and				X			
d. Data related to the comprehensive quality strategy as described in paragraph 7 of this section.				X			

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
<p>7. Final Report. Within 60 days after the end of the demonstration, the State must submit a draft final report to CMS for comments. The final report should provide a comprehensive presentation of all key components of the demonstration that were addressed in quarterly and annual reports, and reflect the entire demonstration approval period from its inception until the final expiration date. The State must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments. A delay in submitting the draft final report or final report could subject the state to penalties described in paragraph 16 of section III. <i>(p. 8 of 34 of the Section 115 Waiver.)</i></p>			X				
X. GENERAL FINANCIAL REQUIREMENTS							
<p>1. Quarterly Expenditure Reports. The State must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.</p>			X				
<p>2. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures:</p>			X				
<p>a. Tracking Expenditures. In order to track expenditures under this demonstration, Montana must report demonstration expenditures through the Medicaid Budget and Expenditure System (MBES) and state Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning January 1, 2016, and ending December 31, 2016. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base.</p>			X				
<p>b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.</p>			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
<p>c. Use of Waiver Forms. The following one (1) waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expression in quotation marks is the waiver name to be used to designate these waiver forms in the MBES/CBES system.</p>			X				
<p>i. "Continuous Eligibility for New Adult Group" expenditures</p>			X				
<p>3. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name "ADM".</p>			X				
<p>4. Claiming Period. All claims for expenditures (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.</p>			X				
<p>5. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The State must estimate matchable demonstration expenditures (total computable and federal share) and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.</p>			X				
<p>6. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below:</p>			X				
<p>a. Administrative costs, including those associated with the administration of the demonstration.</p>			X				
<p>b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.</p>			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.			X				
7. Sources of Non-Federal Share. The State must certify that the matching non-federal share of funds for the demonstration are State/local monies. The State further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.			X				
a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.			X				
b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-federal share of funding.			X				
c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.			X				
d. Under all circumstances, health care providers must retain 100 percent of the Montana HELP Program reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.			X				
8. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:			X				
a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.			X				
c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (state or local) used to fund the non-federal share of demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State’s claim for federal match.			X				
d. The State may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.			X				
e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care				X			
9. Monitoring the Demonstration. The State shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe using continuous quality improvement approaches and that aligns with achieving the final goals and aims.				X			
10. Contributions from third parties. Third parties are permitted to contribute toward a beneficiary’s premium or copayments obligation. There are no limits on the amounts third parties can contribute toward a beneficiary’s premium obligation. Such third party contributions offset required beneficiary premium or copayment obligations only, and may not be used for any other purpose. Contributions that exceed such obligations will be returned to the contributing third party. The contribution must be used to offset the beneficiary’s required contributions only, not the Sstate’s share. Health care providers or provider-related entities making contributions on individuals’ behalf must have criteria for providing assistance that do not distinguish between individuals based on whether or not they receive or will receive services from the contributing provider(s) or class of providers. Providers may not include the cost of such payments in the cost of care for purposes of Medicare and Medicaid cost reporting and cannot be included or as part of a Medicaid shortfall or uncompensated care for any purpose.		X			X		BCBSMT to track and report to DPHHS policy. DPHHS to define the categories of third parties which are allowed to contribute towards a Participant's/Beneficiary's premiums or copayment obligations, and the circumstances under which such contributions may be made and continued.

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
XI. MONITORING BUDGET NEUTRALITY							
1. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 4 in this section, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the Sstate to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Sstate's compliance with these annual limits will be done using the Schedule C report from the CMS-64.			X				
2. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in section IV, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.			X				
3. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 4 below. In the event that there is more than one DY, the annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the composite federal share, which is defined in STC 4 in this section below.			X				
4. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the Sstate under the guidelines set forth in STC. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.			X				

Standards According to 1115 Waiver							Contract Change Required	Responsibility			POD Assignments		Comments
								HCSC	DPHHS	Joint	POD 1	POD 2	
MEG	TREND	DY 1- PMPM	DY 2- PMPM	DY 3- PMPM	DY 4- PMPM	DY 5- PMPM			X				
Continuous Eligibility - New Audit Group	4.1%	\$532.79	\$554.37	\$577.37	\$601.05	\$625.69							
<p>a. If the State’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the per member per month (PMPM) limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.</p>									X				
<p>b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.</p>									X				
<p>c. The State will not be allowed to obtain budget neutrality “savings” from this population.</p>									X				
<p>5. Composite Federal Share Ratio. The composite federal share is the ratio calculated by dividing the sum total of FFP received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see section III STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of composite federal share may be developed and used through the same process or through an alternative mutually agreed upon method.</p>									X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HSCC	DPHHS	Joint	POD 1	POD 2	
<p>6. Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group. CMS anticipates that states that adopt continuous eligibility for adults would experience a 2 percent increase in enrollment. Based on this estimate, CMS has determined that 97.4 percent of the member months for newly eligibility in the adult group will be made at the enhanced FMAP rate and 2.6 percent will be matched at the regular FMAP rate.</p>			X				
<p>7. State Reporting for the FMAP Adjustment. Newly eligible individuals in the Adult Group shall be claimed at the enhanced FMAP rate. The State must make an adjustment in the CMS-64W that accounts for the proportion of member months in which beneficiaries are enrolled due to continuous eligibility and could have been dis-enrolled due to excess income in absence of continuous eligibility (i.e. 2.6 percent). For the purposes of budget neutrality, the members for the adult group within the 2.6 percent of the population described in this STC will be treated as a hypothetical population.</p>			X				
<p>8. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.</p>			X				
<p>9. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, in the event that there is more than one demonstration year. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the State must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.</p>			X				

Standards According to 1115 Waiver			Contract Change Required	Responsibility			POD Assignments		Comments																	
				HCSC	DPHHS	Joint	POD 1	POD 2																		
<table border="1"> <thead> <tr> <th>Year</th> <th>Cumulative target definition</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>DY 1</td> <td>Cumulative budget neutrality limit plus:</td> <td>2.0%</td> </tr> <tr> <td>DY 2</td> <td>Cumulative budget neutrality limit plus:</td> <td>1.5%</td> </tr> <tr> <td>DY 3</td> <td>Cumulative budget neutrality limit plus:</td> <td>1.0%</td> </tr> <tr> <td>DY 4</td> <td>Cumulative budget neutrality limit plus:</td> <td>5.0%</td> </tr> <tr> <td>DY 5</td> <td>Cumulative budget neutrality limit plus:</td> <td>0%</td> </tr> </tbody> </table>			Year	Cumulative target definition	Percentage	DY 1	Cumulative budget neutrality limit plus:	2.0%	DY 2	Cumulative budget neutrality limit plus:	1.5%	DY 3	Cumulative budget neutrality limit plus:	1.0%	DY 4	Cumulative budget neutrality limit plus:	5.0%	DY 5	Cumulative budget neutrality limit plus:	0%			X			
Year	Cumulative target definition	Percentage																								
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DY 4	Cumulative budget neutrality limit plus:	5.0%																								
DY 5	Cumulative budget neutrality limit plus:	0%																								
<p>10. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.</p>					X																					
XII. EVALUATION																										
<p>1. Submission Evaluation Design. The State must submit to CMS for approval, by March 1, 2016, a draft evaluation design. At a minimum, the State must submit their draft evaluation design in accordance with the following criteria:</p>					X																					
<p>a. A discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations for the demonstration.</p>					X																					
<p>b. The evaluation design must include the research questions and proposed measures listed below. The State must use measures from nationally-recognized sources and those from national measures sets (including CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; and/or measures endorsed by National Quality Forum (NQF) where possible. At least one research question must be proposed for each waiver and expenditure authority approved by CMS. For questions that cover broad subject areas, the state may propose a more narrow focus for the evaluation.</p>					X																					
<p>i. How has the implementation of premiums affected program enrollment?</p>					X																					

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
ii. Have premiums and cost sharing made beneficiaries more likely to exhibit health-conscious consumption behavior?			X				
1. Percent of individuals accessing primary care		X					
2. Percent of individuals accessing behavior health services		X					
3. Pharmacy (overall costs, brand vs. generic dispensing rate)			X				
4. Percent of individuals using TPA Wellness Program services		X					
5. Percent of individuals using primary care for chronic disease management services (if chronic disease present)		X					
6. Percent of unique individuals accessing preventive services				X			
7. Percent of preventive care visits, total and average per person				X			
8. Percent of specialty care visits, total and average per person		X					
9. Percent of individuals taking brand name medications when generic medication is available			X				
iii. Does continuous eligibility promote better continuity of coverage for the new adult group?			X				
1. Enrollment rates;			X				
2. Churn rates.			X				
c. Addressing the research questions will require qualitative research methodologies. The State must develop a research plan for each research question, and provide a rationale for its selection. The research plan for each question must include the following:			X				
i. Proposed baseline and control comparison groups, where applicable. If randomization is not used, methods to adjust for the non-equivalence of the control and comparison group must be proposed.			X				
ii. Data sources, collection frequency, and process for demonstrating the accuracy and completeness of the data.			X				
iii. Sampling methodology for selecting the population being included in your analysis (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses). If an experimental design is selected, the state must ensure that a statistically reliable/significant sample size is selected.			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
iv. Draft of instruments used for collecting data, including survey designs, interview questions, and focus group questions.			X				
v. Analysis plan that describes the statistical methods that will be employed to evaluate differences between the demonstration and comparison groups in key outcomes. The evaluation design must also demonstrate how the state will analyze data.			X				
1. Description of statistics that will be utilized including whether the analysis will be at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.			X				
vi. Identify the contractor that will be conducting the evaluation. The State should describe the qualifications of the outside contractor and the process to ensure the contractor will be an independent evaluator with no conflict of interest.			X				
vii. Budget that details the estimated cost for staffing, data collection, and analysis over the course of the entire evaluation.			X				
viii. A diagram, process flow and logic model or driver diagram illustrating the specific quantifiable aims and how the State plans to meet the identified aims/outcomes of the demonstration.			X				
ix. Timeline for submitting evaluation and monitoring deliverables.			X				
2. Beneficiary Survey. Beginning in the first demonstration year, the State shall conduct at least one survey per year of individuals enrolled in the demonstration, individuals who have been dis-enrolled from the demonstration, and of individuals who are eligible but unenrolled. The survey size must produce statistically significant results, and the design will be described in the operations protocol. The purpose of the survey shall be to determine whether potential applicants and beneficiaries understand the program policies regarding premiums and associated consequences, and whether the premiums affect individuals' decisions about whether to apply for the program.		X				X	

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
3. Final Evaluation Design and Implementation. The State’s evaluation design may be subject to multiple revisions until a format is agreed upon by CMS. The State must submit the final evaluation design within 60 days after receipt of CMS’ comments. Upon CMS approval of the evaluation design, the State must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports as outlined in STC section 8 paragraph 2. The final evaluation design will be included as Attachment E to these STCs. Attachment E to these STCs.			X				
4. Draft Interim Evaluation Reports. The State must submit a draft Interim Evaluation Report at the midpoint of each demonstration approval period. The report should include the following criteria:			X				
a. An executive summary, including the programmatic goals, objectives, and hypotheses being tested;			X				
b. A description of the demonstration including interventions implemented appropriate to each population and/or condition, and resulting changes to the health care system			X				
c. A summary of the evaluation design, including, program benchmarks, outcomes, data sources, analysis, challenges, etc.			X				
d. A description of the population included in the evaluation (distribution of age, sex, racial/ethnic distribution, etc.)			X				
e. Preliminary evaluation findings including key outcome results and/or trends			X				
f. A discussion of the findings, including findings in quarterly and annual reports (including interpretation of findings and policy implications)			X				
g. Implementation successes, challenges and lessons learned			X				
h. A discussion of whether there would be any barriers to implementing any or all demonstration features under the state plan, and any advantages to doing so.			X				
In the event the State requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of its request for each subsequent renewal, as outlined in CFR 431.412 (c)(2)(vi).			X				
5. Final Interim Evaluation Report. The State must submit their final Interim Evaluation Report within 60 days after receipt of CMS’ comments on their draft Interim Evaluation report.			X				
6. Draft Final Evaluation Submission. The State must submit to CMS a draft of the final evaluation report within 120 days of expiration of the demonstration. The report must include the required criteria listed in section XI paragraph 3 of the STCs, including final evaluation findings.			X				
7. Final Evaluation Report. The State must submit the final evaluation report within 60 days after receipt of CMS’ comments on their draft submission.			X				

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
8. Cooperation with Federal Evaluators. Should CMS conduct an evaluation of any component of the demonstration; the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to CMS or the contractor at no cost to CMS or the contractor.			X				
9. Cooperation with Federal Learning Collaboration Efforts. The State will cooperate with improvement and learning collaboration efforts by CMS.			X				
10. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.			X				
11. Deferral for Failure to Provide Summative Evaluation Reports on Time. The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.			X				
XIII. HEALTH INFORMATION TECHNOLOGY							
1. Health Information Technology (HIT). The State shall use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.				X	X		
a. Montana must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (EHR) technology and the ability to exchange data through the State’s health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.				X	X		
b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing health information exchange (HIE) infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.				X	X		
c. All requirements must also align with Montana’s State Medicaid HIT Plan, as applicable, and other planning efforts such as the Office of National Coordinator HIE Operational Plan.				X	X		

Standards According to 1115 Waiver	Contract Change Required	Responsibility			POD Assignments		Comments
		HCSC	DPHHS	Joint	POD 1	POD 2	
XIV. T-MSIS REQUIREMENTS							
On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data," was released. It states that all states are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Montana against which the Montana HELP Program demonstration will be compared.		X					
Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and post adjudicated claims from the TPA consistent with the STCs under the 1915(b)(4) waiver, in accordance with requirements in the SMM Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.		X					

ATTACHMENT 5

SOURCES OF INFORMATION (HIPPA, HITECH)

**SOURCES OF INFORMATION
ON THE PRIVACY, TRANSACTIONS AND SECURITY REQUIREMENTS
PERTAINING TO HEALTH CARE INFORMATION OF THE FEDERAL HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND THE FEDERAL HEALTH
INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH),
ENACTED AS PART OF THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009**

The following are sources of information concerning the applicability of and implementation of the privacy, transactions and security requirements of HIPAA and HITECH. The Department Of Public Health & Human Services requires that contractors generating, maintaining, and using health care information in relation to recipients of State administered and funded services be compliant with the requirements of HIPAA and HITECH as applicable under the federal legal authorities and the status of the Department as a health care plan.

There can be difficulty in interpreting the applicability of the HIPAA and HITECH requirements to an entity and various circumstances. It is advisable to retain knowledgeable experts to advise concerning determinations of applicability and appropriate compliance.

Websites specified here may be changed without notice by those parties maintaining them.

FEDERAL RESOURCES

The following are official federal resources in relation to HIPAA and HITECH requirements. These are public sites. Implementation of the additional requirements under HITECH, due to the more recent date of enactment, is occurring on an ongoing basis.

- 1) U.S. Department Of Health & Human Services / Office Of Civil Rights

www.hhs.gov/ocr/hipaa

The federal Department Of Health & Human Services / Office Of Civil Rights (OCR) provides information pertaining to privacy and security requirements under HIPAA and HITECH including the adopted regulations and various official interpretative materials. This site includes an inquiry service. OCR is responsible for the implementation of the privacy and security aspects of HIPAA/HITECH and serves as both the official interpreter for and enforcer of the privacy requirements.

- 2) U.S. Department Of Health & Human Services / Centers For Disease Control & Prevention

<http://www.cdc.gov/od/science/regs/privacy/index.htm#>

The federal Department Of Health & Human Services / Centers For Disease Control & Prevention (CDC) provides information pertaining to the application of privacy requirements under HIPAA to public health activities and programs.

STATE RESOURCES

The Department Website For Medicaid Provider Information provides general information for providers of services on compliance with various state and federal requirements.

www.mtmedicaid.org

Further information concerning HIPAA/HITECH compliance in the delivery of services funded through the Department's various programs can be reviewed at the Department Website for DPHHS HIPAA Policies.

<http://www.dphhs.mt.gov/hipaa/policies/index.shtml>

Certain departmental programs may have more detailed guidance available in relation to particular programs of services. Inquiries may be directed at a program to determine if further information is available.

PROVIDER ASSOCIATIONS

Many national and state provider associations have developed extensive resources for their memberships concerning HIPAA/HITECH requirements. Those are important resources in making determinations as to the applicability and implementation of HIPAA/HITECH.

CONSULTANT RESOURCES

There are innumerable consulting resources available nationally. The Department does not make recommendations or referrals as to such resources. It is advisable to pursue references before retaining any consulting resource. Some consulting resources may be inappropriate for certain types of entities and circumstances.

ATTACHMENT 6

ASSURANCES NON-CONSTRUCTION PROGRAM

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions reducing this burden, to the Office of Management and Budget, Paperwork Reduction project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurance. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§ 4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
7. Will comply or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-66), which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§ 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
6. Will comply with all Federal statutes relating to nondiscrimination. These include, but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§ 1681-1683 and 1685-1686), which prohibit discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§ 6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§ 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. 290 dd-3 and 290 ee-3) as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. § 2601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§ 276a to 276a-7), the Copeland Act (40 U.S.C. § 276c and 18 U.S.C. § 874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§ 327-333, regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the

program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approval State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§ 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955k, as amended (42 U.S.C. § 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§ 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. 470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling and treatment of warm blooded animals held for research, teaching or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§ 4801 et seq.) Which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL <i>Michel E. Fiac</i>	TITLE <i>President</i>
APPLICANT ORGANIZATION <i>Blue Cross and Blue Shield of Montana</i>	DATE SUBMITTED <i>12/16/15</i>

ATTACHMENT 7

STANDARD FROM LLL – DISCLOSURE OF LOBBYING ACTIVITIES

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

Approved by OMB
0348-0046

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action: <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: Year _____ quarter _____ Date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known Congressional District, if known: _____	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime: Congressional District, if known: _____	
6. Federal Department/Agency: _____	7. Federal Program Name/Description: CFDA Number, if applicable: _____	
8. Federal Action Number, if known: _____	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Registrant (If individual, last name, first name, MI): _____	b. Individuals Performing Services (including address if different from No. 10a) (last name, first name, MI): _____	
11. Information requested through this form is authorized by Title 31 U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: <u>Michael E. Frank</u> Print Name: <u>Michael E Frank</u> Title: <u>President</u> Telephone No.: <u>406-437-5000</u> Date: <u>12/16/15</u>	
Federal Use Only:		Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawarded or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to Title 31 U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include, but are not limited to, subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award of loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number, the contract, grant or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".
9. For a covered Federal action, where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10.
 - (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in Item 4 to influence the covered Federal action.
 - (b) Enter the full names of the individual(s) performing services and include full address if different from 10(a). Enter Last Name, First Name and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.