SOLICITATION #:

2017000265

Appendix Z

Rocky Mountain Health Maintenance Organization Amendment 5

CONTRACT AMENDMENT NO. 5

Original Contract Number 14-68960
Amendment No. 14-68960A5

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Rocky Mountain Health Maintenance Organization, Inc., 2775 Crossroads Blvd., Grand Junction, Colorado, 81506, (hereinafter called "Contractor"), and the STATE OF COLORADO, acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called "Department" or "State.")

2. EFFECTIVE DATE AND ENFORCEABILITY

This Amendment shall not be effective or enforceable until it is approved and signed by the Colorado State Controller or designee (hereinafter called the "Effective Date.") The Department shall not be liable to pay or reimburse Contractor for any performance hereunder, including, but not limited to, costs or expenses incurred, or be bound by any provision hereof prior to the Effective Date.

3. FACTUAL RECITALS

The Parties entered into the Contract to create a new payment reform pilot program within the Accountable Care Collaborative. The purpose of this Amendment is to update language and the rates table to reflect the increase in the rate of Hepititis C treatment.

4. CONSIDERATION

The Parties acknowledge that the mutual promises and covenants contained herein and other good and valuable consideration are sufficient and adequate to support this Amendment.

5. LIMITS OF EFFECT

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments thereto, if any, remain in full force and effect except as specifically modified herein.

6. MODIFICATIONS

The Contract and all prior amendments thereto, if any, are modified as follows:

A. Exhibit A-3, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit A-4, Statement of Work, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit A-3 shall be deemed to reference Exhibit A-4.

B. Exhibit B-2, Covered Services, is hereby deleted in its entirety and replaced with Exhibit B-3, Covered Services, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit B-2 shall be deemed to reference Exhibit B-3.

C. Exhibit C-3, Rates, is hereby deleted in its entirety and replaced with Exhibit C-4, Rates, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit C-3 shall be deemed to reference Exhibit C-4.

D. Exhibit I, Covered Behavioral Health, is hereby deleted in its entirety and replaced with Exhibit I-1, Covered Behavioral Health, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit I shall be deemed to reference Exhibit I-1.

7. START DATE

This Amendment shall take effect on March 15, 2017. This Amendment shall terminate on the earlier of June 30, 2017 or the termination of the Contract for any reason unless specifically modified by a future amendment.

8. ORDER OF PRECEDENCE

Except for the Special Provisions and the HIPAA Business Associates Addendum, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The most recent version of the Special Provisions incorporated into the Contract or any amendment shall always control other provisions in the Contract or any amendments.

9. AVAILABLE FUNDS

Financial obligations of the state payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, or otherwise made available to the Department by the federal government, state government and/or grantor.

THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

Persons signing for Contractor hereby swear and affirm that they are authorized to act on Contractor's behalf and acknowledge that the State is relying on their representations to that effect.

CONTRACTOR:
Rocky Mountain Health Maintenance Organization, Inc., 2775 Crossroads Blvd., Grand Junction, Colorado, 81506,

By: _____
Signature of Authorized Officer

Date: 3-14-17

Michael E. Huotari
Printed Name of Authorized Officer

Vice President of Legal and Government Affairs
Printed Title of Authorized Officer

STATE OF COLORADO:
John W. Hickenlooper, Governor

By: _____
Susan E. Birch, MBA, BSN, RN
Executive Director
Department of Health Care Policy and Financing

Date: 3/17/17

LEGAL REVIEW:
Cynthia H. Coffman, Attorney General

By: NA

Date: _____

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contractor for such performance or for any goods and/or services provided hereunder.

STATE CONTROLLER:
Robert Jaros, CPA, MBA, JD

By: _____
Department of Health Care Policy and Financing

Date: 3/17/17

EXHIBIT A-3
STATEMENT OF WORK

SECTION 1.0 TERMINOLOGY

1.1. ADDITIONAL ACRONYMS, ABBREVIATIONS AND DEFINITIONS

1.1.1. Acronyms and abbreviations are defined at their first occurrence in this Statement of Work. The following list of acronyms, abbreviations and definitions is provided to assist the reader in understanding terminology used throughout this document.

1.1.1.1. "Accountable Care Collaborative" or "ACC" is the primary Medicaid program designed to improve Members' health and reduce costs. Medicaid Members in the ACC will receive the regular Medicaid benefit package, and will also belong to a Regional Care Collaborative Organization (RCCO). This contract is a pilot program within the ACC.

1.1.1.2. "Advance Directive" means a written instrument, such as a living will or durable power of attorney for health care, recognized under C.R.S. § 15-14-505(2), and defined in 42 CFR 489.100, relating to the provision of medical care when the individual is incapacitated.

1.1.1.3. "Alternative Benefit Plan" or "ABP" means the benefit plan that Expansion Members will receive pursuant to Section 1937 of the Social Security Act. The ABP is the regular Medicaid benefit package plus Habilitative therapies.

1.1.1.4. "CAHPS" means the Consumer Assessment of Healthcare Providers and Systems Health Plan Surveys.

1.1.1.5. "Care Coordination" means the process of identifying, screening and assessing Members' needs (medical and nonmedical), identification of and referral to appropriate services, and coordinating and monitoring an individualized care plan. This treatment plan shall also include a strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

1.1.1.6. "Clean claim" means a claims for payment with all required fields completed with correct and complete information, including all required documents.

1.1.1.7. "Client" means an individual eligible for and enrolled in the Colorado Medicaid Program.

1.1.1.8. "CMS" means the federal Centers for Medicare and Medicaid Services.

1.1.1.9. "Cold-Call Marketing" means any unsolicited personal contact by the MCO with a Potential Member for the purposes of marketing as defined at 42 CFR 438.104.

1.1.1.10. "Communication Disability" means an expressive or receptive impairment that creates a barrier to communication between a Member and a person not familiar with that Member.

1.1.1.11. "Contractor's Plan" means the Contractor's network or those Covered Services provided by the Contractor to eligible Clients in accordance with the terms and conditions of this agreement.

1.1.1.12. "Covered Drugs" means those drugs currently covered by the Medicaid program and includes those products that require prior authorization by the Colorado Medicaid program. Covered Drugs must be dispensed by a Participating Provider except for Emergency Services and must be prescribed by Participating Providers or requested by an authorized prescriber as a result of authorized Referral, Emergency Services, dental care, or obtained under the Medicaid Mental Health Capitation Program. Covered Drugs shall also mean drugs for which payments are made by the Contractor as a result of Appeal and External Review Processes.

1.1.1.13. "Covered Services" means those services described in Exhibit B, Covered Services, attached hereto and made part of this Contract, which the Contractor is required to provide or arrange to be provided to a Member. Covered Services shall also mean services for which payments are made by the Contractor as a result of Appeal and External Review Processes.

1.1.1.14. "Day(s)" means calendar days, unless otherwise specified.

1.1.1.15. "Desk Audit" means the review of materials submitted upon request to the Department or its agents for quality assurance activities.

1.1.1.16. "Designated Client Representative" means any person, including a treating health care professional, authorized in writing by the Member or the Member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services as defined at 10 C.C.R. 2505-10, Section 8.209.2.

1.1.1.17. "Disability" or "Disabilities" means, with respect to a Member, a physical or mental impairment that substantially limits one or more of the major life activities of such Member, in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101, *et seq.*

1.1.1.18. "Disenrollment" or "Disenroll" means the act of discontinuing a Member's Enrollment in the Contractor's Plan.

1.1.1.19. "DRAMS" means the Department's Drug Rebate Analysis Management System.

1.1.1.20. "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 responsibly expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

1.1.1.21. "Emergency Services" means covered inpatient and outpatient services that are: furnished by a provider that is qualified to furnish these services under this 42 CFR 438.114 (a) and that are needed to evaluate or stabilize an emergency medical condition.

1.1.1.22. "Encounter Claims Data" means claims data resulting from an occurrence of examination or treatment of a member by a medical practitioner or in a medical facility and includes pharmacy prescriptions. Mental health care is also included if provided under the auspices of this Contract.

1.1.1.23. "Enroll" or "Enrollment" means the act of entering a Client as a Member of the Contractor's Plan.

1.1.1.24. "Enrolled" means a Client who is a Member of the Contractor's Plan.

1.1.1.25. "Enrollee" means Member.

1.1.1.26. "EPSDT" means the Early, Periodic, Screening, Diagnosis and Treatment program that provides comprehensive health care to all Medicaid eligible children through periodic screenings, diagnostic and treatment services as defined at 10 CCR 2505-10, Section 8.280.1.

1.1.1.27. "Expansion Clients" means an individual eligible for and enrolled in the Colorado Medicaid Program, specifically childless adults 0-133% FPL and parents and caretaker relatives 69-133% FPL.

1.1.1.28. "Expansion Members" means any Expansion Client who is Enrolled in the Contractor's Plan. Any Expansion Client in the Contractor's service area is a potential Expansion Member.

1.1.1.29. "FDA" means the federal Food and Drug Administration.

1.1.1.30. "Federally Qualified Health Center" or "FQHC", means a hospital-based or free standing center that meets the FQHC definition found in Section 1905(1)(2)(C) of the Social Security Act.

1.1.1.31. "Federal Poverty Level" or "FPL" means the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. It is determined by the Department of Health and Human Services on an annual basis. Medicaid uses FPL to define eligibility income limits.

1.1.1.32. "Financial Reconciliation" means a reconciliation, as described in section 6.5 of this Statement of Work, necessary to comply with 42 C.F.R. 447.362.

1.1.1.33. "FFP" means Federal Financial Participation

1.1.1.34. "FQHC Encounter Rate" means the rate established by the Department to reimburse Federally Qualified Health Centers.

1.1.1.35. "Grievance" means an oral or written expression of dissatisfaction about any matter other than an action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights as defined at 10 CCR 2505-10, Section 8.209.2.

1.1.1.36. "Habilitative Services" means services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in the regular Medicaid benefit package. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.

1.1.1.37. "HEDIS" means the Healthcare Effectiveness Data and Information Set developed and maintained by the National Committee for Quality Assurance.

1.1.1.38. "Home Health Services" means those services described at 10 C.CR 2505-10, Section 8.520.

1.1.1.39. "Hospital Services" means those Medically Necessary Covered Services for members that are generally and customarily provided by acute care general Hospitals. Hospital Services shall also include services rendered in the emergency room and/or the outpatient department of any Hospital. Except for a Medical Emergency or Written Referral, Hospital Services are Covered Services only when performed by Participating Providers.

1.1.1.40. "Hospital" means an institution which:

1.1.1.40.1. Is licensed by the State as a Hospital;

1.1.1.40.2. Has a Utilization Review program that meets Medicare conditions of participation;

1.1.1.40.3. Is primarily engaged in providing medical care and treatment for sick and injured persons on an inpatient basis through medical, diagnostic and major surgical facilities, under the supervision of a staff of Physicians and with twenty-four-hour-a-day nursing service; and

1.1.1.40.4. Is certified by Medicare or, in the case of a specialty care center not eligible for Medicare certification, meets criteria established or recognized by the Department in accordance with any applicable state and federal statute or regulation.

1.1.1.41. "Independent Living" means the ability of a Member with a Disability to function at home, work and in the community-at-large to the greatest extent possible and in the least restrictive manner.

1.1.1.42. "I/T/U" means Indian Health Service, Tribally operated facility/program, and Urban Indian clinic.

1.1.1.43. "Key Personnel" means the individual filling the position of the Contract Manager, Financial Manager, and Medical Director.

1.1.1.44. "Marketing" or "Marketing Activities" means any communication, from the Contractor, to an individual enrolled in Medicaid who is not enrolled in the Contractor's Plan, that can reasonably be interpreted as intended to influence the individual to enroll in the Contractor's Medicaid product, or either to not enroll in, or to disenroll from, another Medicaid product.

1.1.1.45. "Marketing Materials" means materials that are produced in any medium by or on behalf of the Contractor and can be reasonably interpreted as intended to market to potential Members.

1.1.1.46. "Medical Home" means an approach to providing comprehensive primary-care that facilitates partnerships between individual members, their providers, and, where appropriate, the member's family, that meets the requirements described in Exhibit I, Medical Home Model Principles.

1.1.1.47. "Medical Loss Ratio" (MLR) means the amount of Medical Spend divided by the total capitation payments made to the Contractor annually.

1.1.1.48. "Medical Management" means activities related to ensuring clients receive necessary medical services. This may include traditional activities, such as integrating disease management into the care of members with multiple chronic illnesses, and non-traditional methods, such as using technology enhanced communication (e.g. texts) or delivering care in alternative formats (e.g. group visits).

1.1.1.49. "Medically Necessary" is defined in Exhibit B.

1.1.1.50. "Medical Record" means the collection of personal information, which relates an individual's physical or mental condition, medical history, or medical treatment, that is obtained from a single health care Provider, medical care institution, Member of the Contractor's Plan, or the spouse, parent or legal guardian of a Member.

1.1.1.51. "Medical Screening Examination" means screening of sick, wounded or injured persons in the emergency room to determine whether the person has an Emergency Medical Condition.

1.1.1.52. "Medical Spend" means the sum of the direct, indirect, and sub-contracted costs for providing all Covered Services provided under this Contract, verified through encounters submitted through the Medicaid Management Information System and supplemental financial information, subject to Department approval.

1.1.1.53. "Member" means any Client who is Enrolled in the Contractor's Plan.

1.1.1.54. "Modified Adjusted Gross Income" or "MAGI" refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act.

1.1.1.55. "Non-emergency" or "Non-emergent" means non-acute or chronic medical condition, wellness maintenance and/or prescription refills that require medical intervention, when the Member's condition is stable.

1.1.1.56. "Nursing Facility" means an institution that can meet state and federal requirements for participation as a Nursing Facility.

1.1.1.57. "Open Enrollment Period" means the two (2) months immediately preceding the month in which a Member's birthday occurs.

1.1.1.58. "Participating Provider" means a Provider who is in the employ of, or who has entered into an agreement with, the Contractor to provide medical services to the Contractor's Members. Primary care providers who are "Participating Providers" are referred to as "Primary Care Medical Providers."

1.1.1.59. "Persons with Special Health Care Needs" or "Special Health Care Needs" means persons as defined in 10 C.C.R. 2505-10, §8.205.9, *et seq.*

1.1.1.60. "Physician" means any doctor licensed to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered.

1.1.1.61. "Post Stabilization Services" means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or are provided to improve or resolve the Member's condition when the Contractor does not respond to a request for pre-approval within 1 hour, the Contractor cannot be contacted, or the Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a Contractor physician is unavailable for consultation.

1.1.1.62. "Potential Enrollee" means "Potential Member."

1.1.1.63. "Potential Member" means an individual enrolled in Medicaid who is subject to passive enrollment or may voluntary elect to enroll in the Contractor's Plan, but is not yet enrolled.

1.1.1.64. "Primary Care Medical Provider" or "PCMP" means a primary care provider who serves as a Medical Home for Members in the ACC. A PCMP may be a FQHC, RHC, clinic or other group practice that provides the majority of the Member's comprehensive primary, preventative and sick care. A PCMP may also be an individual or pods of PCMPs that are physicians, advanced practice nurses or physicians assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

1.1.1.65. "Provider" means a health care practitioner, institution, agency or supplier, which may or may not be a Participating Provider in the Contractor's Plan, but which furnishes or arranges for health care services with an expectation of receiving payment.

1.1.1.66. "Proprietary Information" means information relating to a Contractor's research, development, trade secrets, business affairs, internal operations and management procedures. It includes those of its customers, Members or affiliates, but does not include information lawfully obtained from third parties or that which is in the public domain.

1.1.1.67. "Psychiatric In Nature" means those occasions of service in which the Member has a diagnosis listed in Exhibit F, Covered Behavioral Health Procedure Codes, attached and incorporated herein by reference, and receives services listed in Exhibit F for the listed diagnosis.

1.1.1.68. "Qualified Interpreter" means an interpreter who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary.

1.1.1.69. "RCCO" means Regional Care Collaborative Organization.

1.1.1.70. "Referral" or "Written Referral" means any form of written communication or other permanent record by the Contractor and/or authorized Participating Provider that authorizes a Member to seek care from a Provider other than a Participating Provider.

1.1.1.71. "RHC Encounter Rate" means the rate established by the Department to reimburse Rural Health Centers.

1.1.1.72. "Rural Health Center" or "RHC", means a hospital-based or free standing center that meets the RHC definition found in Section 1905(1)(2)(B) of the Social Security Act.

1.1.1.73. "Serious Reportable Events" or "Never Events" means hospital acquired conditions that were not present on admission (POA) as an inpatient and that alter the condition or diagnosis of the individual receiving care.

1.1.1.74. "Service Area" means that area for which the Department and the Contractor have agreed that the Contractor will provide Covered Services to Members. The Service Area shall be the counties of Mesa, Montrose, Gunnison, Pitkin, Garfield, and Rio Blanco.

1.1.1.75. "Service Authorization" means the request by a Member for a Medically Necessary, Covered Service.

1.1.1.76. "Site Review" means the visit of Department staff or its designees to the site or the administrative office(s) of a Participating Provider and/or the Contractor and its Participating Providers.

1.1.1.77. "Subcontractor" means an individual or entity performing all or part of the services covered by this Contract, under a separate contract with the Contractor. The terms Subcontractor and Subcontractors mean Subcontractor(s) in any tier.

1.1.1.78. "Therapy" means high cost Hepatitis-C drugs found in the therapeutic classes W5Y, W0A, W0B, W0D, and W0E along with the supplementary drugs used in conjunction with the high cost drugs found in therapeutic class W5G.

1.1.1.79. "Triage" means the assessment of a Member's condition and direction of the Member to the most appropriate setting for Medically Necessary care.

1.1.1.80. "Urgently Needed Services" means Covered Services as defined at 42 C.F.R. §422.113(b)(1)(iii).

1.1.1.81. "Utilization Management" means the function wherein use, consumption and outcomes of services, along with level and intensity of care, are reviewed using Utilization Review techniques for their appropriateness.

1.1.1.82. "Utilization Review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, Referrals, procedures or settings.

1.1.1.83. "Work" means the tasks and activities Contractor is required to perform to fulfill its obligations under this Contract, including the performance of any services and delivery of any goods.

1.1.1.84. "Wrap Around Benefits" means those Medicaid services which either exceed coverage limitations the Contractor is required by this Contract to provide or, the Contractor is not obligated to provide coverage for under this Contract. Wrap Around Benefits are services reimbursable under the Medicaid fee-for-service and must be billed directly to the Department's fiscal agent by the Provider. Wrap Around Benefits include, but are not limited to, EPSDT Extraordinary Home Health Services, medical transportation, and private duty nursing.

SECTION 2.0 BACKGROUND

2.1. GENERAL PROGRAM BACKGROUND

2.1.1. House Bill 12-1281 of the Second Regular Session of the 68th General Assembly was passed in 2012, creating Section 25.5-5-415 of the Colorado Revised Statutes (C.R.S.), which allowed the Department of Health Care Policy and Financing (Department) to accept proposals for an innovative payment reform pilot that demonstrates new ways of paying for improved client outcomes while reducing costs in the Accountable Care Collaborative (ACC) program. The Department solicited proposals from the seven ACC Regional Care Collaborative Organizations (RCCOs) in the state. Rocky Mountain Health Plans' proposal was selected by the Department.

2.1.2. This managed care Contract is the result of C.R.S. 25.5-5-415 and operates within the ACC program. As the ACC program evolves, the Department intends to align this Contract with the program as a whole.

SECTION 3.0 CONTRACTOR AND SERVICE REQUIREMENTS

3.1. GENERAL CONTRACTOR REQUIREMENTS

3.1.1. Where policies, procedures, programs and plans are required by this Contract or Department regulations, the Contractor shall maintain and provide internal documents that clearly demonstrate all such requirements and the responsibilities of the Contractor. Where the Contractor is required to communicate to Providers, documentation may exist outside of the Contractor's internal policies and procedures, generally in the form of direct Provider correspondence or a Provider manual. Exception can be made for a single source for Provider and Contractor documents if the Contractor clearly specifies in the documents the role of the Contractor and the role of the Provider. Where the Contractor is required to communicate to Members, documentation may exist outside the Contractor's internal policies and procedures, generally in the form of direct Member correspondence or the Member handbook.

3.1.2. The Contractor shall submit all Encounter Claims Data and complete pay recovery costs for dates of service during which time this Contract was in effect, regardless of whether this Contract is terminated for any reason.

3.1.3. Subcontractual Relationships and Delegation

3.1.3.1. The Contractor shall be accountable for any functions and responsibilities that it delegates to any subcontractor, including:

3.1.3.1.1. All Subcontractors shall fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.

3.1.3.1.2. The Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.

3.1.3.1.3. The Contractor shall require a written agreement with the Subcontractor that specifies the activities and report responsibilities delegated to the Subcontractor; and provides for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

3.1.3.1.4. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.

3.1.3.1.5. The Contractor shall identify deficiencies or areas for improvement, and shall ensure that the Subcontractor takes corrective action.

3.1.3.2. Other than the Care Coordination and Covered Services provided by any PCMP, the Contractor shall not subcontract more than forty percent (40%) of its responsibilities under the Contract, based on the total annual Contract value, to any other entity and it shall not subcontract more than twenty percent (20%) of its responsibilities under the Contract, based on the total annual Contract value, to any single entity.

3.1.3.3. The Contractor shall not enter into any agreement with a Subcontractor or have any Subcontractor begin work in relation to the Contract until it has received the express, written consent of the Department to subcontract with the specific Subcontractor. This consent requirement shall only apply to subcontracts that relate to ten percent (10%) or more of the responsibilities under the Contract, based on the total annual Contract value.

3.1.3.4. Any agreement the Contractor has with a Subcontractor shall be in writing and shall require compliance with all of the terms in this Contract.

3.2. CONTRACTOR RESPONSIBILITIES AND REGULATORY COMPLIANCE

3.2.1. The Contractor shall provide administrative services under the terms set forth in this Contract. The Contractor shall be licensed pursuant to Section 10-16-401, et seq., C.R.S., as a Health Maintenance Organization.

3.2.2. The Contractor shall notify the Department, within two (2) business days, of any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, denying renewal, or notifying the Contractor of any noncompliance pursuant to Section 10-16-401, et seq, C.R.S. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, insurance, permits, etc. required for the Contractor to properly perform this Contract and/or failure to notify the Department as required by this section, may be grounds for the immediate termination of this Contract by the Department for default.

3.2.3. The Contractor shall meet the solvency standards set forth in Section 10-16-401, et seq, C.R.S. and its implementing regulations and any other applicable regulations. The Contractor shall notify the Department, within two (2) business days, of having knowledge or reason to believe that it does not meet the solvency standards specified herein. Failure to meet the solvency standards and/or failure to notify the Department as required by this section may be grounds for the immediate termination of this Contract by the Department for default.

3.3. PERSONNEL

3.3.1. The Contractor shall provide the following positions, defined as Key Personnel, in relation to the Contract:

3.3.1.1. Contract Manager

3.3.1.1.1. The Contract Manager shall devote one hundred percent (100%) of his or her time to this Contract.

3.3.1.1.2. The Contract Manager shall be the Department's primary point of contact for contract and performance issues and responsibilities.

3.3.1.1.3. All communication between the Department and the Contractor shall be facilitated by the Contract Manager.

3.3.1.1.4. The Contract Manager shall ensure that all Contract obligations are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.

3.3.1.2. Financial Manager

3.3.1.2.1. The Financial Manager shall devote at least twenty-five percent (25%) of his or her time to this Contract.

3.3.1.2.2. The Financial Manager shall be responsible for the implementation and oversight of the budget, accounting systems and all other financial operations of the Contractor.

3.3.1.2.3. The Financial Manager shall ensure that all financial operations of the Contractor are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.

3.3.1.3. Medical Director

3.3.1.3.1. The Medical Director shall devote at least thirty percent (30%) of his or her time to this Contract.

3.3.1.3.2. The Medical Director shall be a physician licensed by the State of Colorado and certified by the Colorado Board of Medical Examiners.

3.3.1.3.3. The Medical Director shall be responsible for the implementation of all clinical and/or medical programs implemented by the Contractor.

3.3.1.3.4. The Medical Director shall ensure that all clinical and/or medial programs implemented by the Contractor are implemented and operated in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.

3.3.2. Each Key Personnel position shall be filled by separate and distinct individuals. No individual shall be allowed to fulfill multiple Key Personnel positions simultaneously.

3.3.3. Each Key Personnel shall be available in person or by phone for meetings with the Department monthly or as often as determined by the Department.

3.3.4. The Contract Manager shall perform their responsibilities out of an office that is either located within the Contractor's Service Area or located in the Denver metro area.

3.3.5. Other Staff Functions

3.3.5.1. The Contractor shall provide staff necessary to ensure that the following functions are performed, in addition to those of the Key Personnel:

3.3.5.1.1. Outcomes and Performance Improvement Management, including overseeing Member and administrative outcomes, coordinating quality improvement activities across the Contractor's Service Area, ensuring alignment with federal and state guidelines, and setting internal performance goals and objectives.

3.3.5.1.2. Medical Management and Care Coordination Activities, including assisting providers and Members in rendering and accessing necessary and appropriate services and resources.

3.3.5.1.3. Communications Management, including organizing, developing, modifying and disseminating information, by way of written material and forums, to providers and Members.

3.3.5.1.4. Provider Relations and Network Management, including establishing agreements with Primary Care Medical Providers (PCMPs), establishing all other formal and informal relationships with providers, provider education, data-sharing, and addressing providers' questions and concerns.

3.3.6. The Contractor shall provide the Department with an organizational chart listing all positions within the Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure and the names of the individuals fulfilling each position, within thirty (30) days of the Contract's Effective Date. The organizational chart shall contain accurate and up-to-date telephone numbers and email addresses for each individual listed.

3.3.6.1. DELIVERABLE: Organizational Chart

3.3.6.2. DUE: Thirty (30) days from the Contract's Effective Date

3.3.7. Contractor shall provide the Department with the opportunity to approve new Key Personnel working on the Contract. Any new Key Personnel shall have, at a minimum, the same qualifications as the individual previously fulfilling that position. The Contractor shall deliver an updated Organizational Chart within five (5) days of any change in Key Personnel or request from the Department for an updated Organizational Chart. The Contractor shall deliver to the Department an interim plan for fulfilling any vacant position's responsibilities and the plan for filling the vacancy.

3.3.7.1. DELIVERABLE: Updated Organizational Chart

3.3.7.2. DUE: Five (5) days from any change in Key Personnel of from the Department's request for an updated Organizational Chart

3.3.8. The Contractor shall appoint any new Key Personnel only after a candidate has been approved by the Department to fill a vacancy.

3.3.9. The Department may request the removal from work on the Contract of employees or agents of the Contractor whom the Department justifies as being incompetent, careless, insubordinate, unsuitable or otherwise unacceptable, or who's continued employment on the Contract the Department deems to be contrary to the public interest or not in the best interest of the Department. For any requested removal of Key Personnel, the Department shall provide written notice to Contractor identifying each element of dissatisfaction with each Key Personnel, and Contractor shall have ten (10) business days from receipt of such written notice to provide the Department with a written action plan to remedy each stated point of dissatisfaction. Contractor's written action plan may or may not include the removal of Key Personnel from work on the Contract.

3.3.10. Training of Contractor Employees

3.3.10.1. The Contractor shall make appropriate staff available to participate in periodic training programs, sponsored by the Department, at the Department's direction. These programs will be designed to provide technical assistance to the Contractor with policy interpretation and coordination of services.

3.3.10.2. The Contractor shall be responsible for providing any necessary Plan- or Policy-related training to Participating Providers and any Subcontractors.

3.3.10.3. The Contractor shall provide cultural competency training to all of its new clinical staff members. The Contractor shall provide updated training to all staff members as needed to address changes in the training, to address issues that arise in relation to cultural competency or as requested by the Department.

3.4. CLIENT ENROLLMENT AND DISENROLLMENT

3.4.1. Clients in the following aid categories are eligible for enrollment under this Contract:

3.4.1.1. Elderly – Age 65+

3.4.1.2. Disabled Non Dual – Less than age 65 and disabled with no Medicare

3.4.1.3. Disabled Dual – Less than age 65 and disabled with Medicare

3.4.1.4. AFDC – Parents under 69% FPL age 19+

3.4.1.5. BC Women – Pregnant women age 19+

3.4.1.6. AwDC – Adults without dependent children. Under 133% FPL and age19+

3.4.1.7. Expansion Parents – Parents from 69-133% FPL age 19+

3.4.2. Enrollment

3.4.2.1. Enrollment Requirements

3.4.2.1.1. Enrollment in the Contractor's Plan shall be voluntary.

3.4.2.1.2. Members who are Disenrolled from the Contractor's Plan solely because the Member loses Medicaid eligibility for a period of two (2) months or less, shall be reenrolled with the Contractor's Plan upon regaining eligibility within the two (2) month period.

3.4.2.1.3. The Contractor shall not discriminate against Clients eligible to enroll on the basis of race, color or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin. The Contractor shall also not discriminate against Clients eligible to enroll on the basis of health status or need for health care services.

3.4.2.1.4. Once Enrolled in the Contractor's Plan a Member shall be enrolled until the Member's next Open Enrollment Period, at which time the Member shall receive an open enrollment notice. Subsequent enrollment shall be for twelve (12) months and a Member may not disenroll from the Contractor's Plan except as provided in section 3.4.3 Disenrollment.

3.4.2.1.5. All enrollment notices, informational materials and instructional materials relating to enrollment of Members shall be provided in a manner and format that may be easily understood and, wherever possible, at a sixth grade reading level, and must be shared with the Department's designated Contract manager for approval.

3.4.2.1.6. The Contractor may limit enrollment of new Clients by notifying the Department, in writing, that it will not accept new Clients as long as the enrollment limitation does not conflict with applicable statutes and regulations.

3.4.2.1.7. The Department will enroll Clients with the Contractor based on the Department's enrollment and reenrollment procedures.

3.4.2.1.7.1. The Department will passively enroll Members with the appropriate eligibility category and in the Contractor's Service Area.

3.4.2.1.7.2. Members will receive a notification letter that includes the Department's intent to enroll them into a program and instructions for opting out at least thirty (30) days before they are enrolled by the Department's enrollment broker.

3.4.2.1.7.3. After the date of effective enrollment, the Member has ninety (90) days to disenroll. Thus, all Members have a total of one hundred twenty (120) days to disenroll before they are locked into the program.

3.4.2.1.7.4. The initial lock in period starts ninety (90) days after the effective enrollment date and lasts until the beginning of the Member's birth month. The subsequent lock in periods start at the beginning of the Member's birth month and lasts for twelve (12) months. An open enrollment period begins sixty (60) days prior to the Members' birth month each year. If the Member disenrolls during the open enrollment period, the disenrollment will be effective at the beginning of their birth month.

3.4.2.1.8. The Contractor shall accept all Clients, that the Department enrolls, that are eligible for enrollment. The Contractor shall accept individuals eligible for enrollment in the order in which they are passively enrolled or apply without restriction. The Department may enroll any Client who is included in any of the eligibility categories listed in 3.4.1.

3.4.2.2. A Member shall be enrolled in the Contractor's Plan effective the first day of the month following the month in which the Client enrolled.

3.4.3. Disenrollment

3.4.3.1. The Contractor may only request disenrollment of a Member from the Contractor's Plan for cause. The Department shall review the Contractor's requests for disenrollment and may grant or reject the Contractor's request at its discretion. A disenrollment for cause may only occur under the following circumstances:

3.4.3.1.1. Admission of the Member to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institution.

3.4.3.1.2. Receipt of comprehensive health coverage, other than Medicaid, by the Member.

3.4.3.1.3. Enrollment in a Medicare MCO or capitated health plan other than such a plan offered by the Contractor.

3.4.3.1.4. Child welfare eligibility status or receipt of Medicare benefits.

3.4.3.1.5. Member moves out of the Contractor's service area.

3.4.3.1.6. The Contractor's Plan does not, because of moral or religious reasons, cover the service the Member seeks.

3.4.3.1.7. The Member needs related services to be performed at the same time, not all related services are available within the network and a physician determines that receiving the services separately would subject the Member to unnecessary risk.

3.4.3.1.8. Abuse or intentional misconduct consisting of any of the following:

3.4.3.1.8.1. Behavior of the Member that is disruptive or abusive to the extent that the Contractor's ability to furnish services to either the Member or other Members is impaired.

3.4.3.1.8.2. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.

3.4.3.1.8.3. Behavior of the Member that poses a physical threat to the provider, to other provider or Contractor staff or to other Members.

3.4.3.1.8.4. The Contractor shall provide one oral warning, to any Member exhibiting abusive behavior or intentional misconduct, stating that continuation of the behavior or misconduct will result in a request for disenrollment. If the Member continues the behavior or misconduct after the oral warning, the Contractor shall send a written warning that the continuation of the behavior or misconduct will result in disenrollment from the Contractor's Plan. The Contractor shall send a copy of the written warning and a written report of its investigation into the behavior, to the Department, no less than thirty (30) days prior to the disenrollment. If the Member's behavior or misconduct poses an imminent threat to the provider, to other provider or Contractor or to other Members, the Contractor may request an expedited disenrollment after it has provided the Member exhibiting the behavior or misconduct an oral warning.

3.4.3.1.8.4.1. DELIVERABLE: Copy of the Written Warning Sent to the Member and Written Documentation of the Member's Abusive Behavior or Intentional Misconduct.

3.4.3.1.8.4.2. DUE: No less than thirty (30) days prior to disenrollment unless the Department approves expedited disenrollment

3.4.3.1.9. The Member commits fraud or knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to the Contractor as part of the Member's enrollment in the Contractor's Plan.

3.4.3.1.10. Any other reason determined to be acceptable by the Department.

3.4.3.2. Disenrollment for cause shall not include disenrollment because of:

3.4.3.2.1. Adverse changes in the Member's health status.

3.4.3.2.2. Change in the Member's utilization of medical services.

3.4.3.2.3. The Member's diminished mental capacity.

3.4.3.2.4. Any behavior of the Member resulting from the Member's special needs, as determined by the Department, unless those behaviors seriously impair the Contractor's ability to furnish services to that Member or other Members.

3.4.3.3. The Department may disenroll any Member, who requests disenrollment, in its sole discretion.

3.4.3.4. The Department may disenroll a Member from the Contractor's Plan upon that Member's request. A Member (or his or her representative) may request disenrollment to the Department, either written or orally, and the Department may grant the Member's request:

3.4.3.4.1. For cause, at any time. A disenrollment for cause may occur under the following circumstances:

3.4.3.4.1.1. The Member moves out of the Contractor's service area.

3.4.3.4.1.2. The Contractor does not, because of moral or religious objections, cover the service the Member needs.

3.4.3.4.1.3. The Member needs related services to be performed at the same time, not all related services are available within the network and a physician determines that receiving the services separately would subject the Member to unnecessary risk.

3.4.3.4.1.4. Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error.

3.4.3.4.1.5. Poor quality of care, as documented by the Department.

3.4.3.4.1.6. Lack of access to covered services, as documented by the Department.

3.4.3.4.1.7. Lack of access to providers experienced in dealing with the Member's health care needs.

3.4.3.4.1.8. The Member Enrolled in the Contractor's Plan with his/her Physician and the Physician leave the Contractor.

3.4.3.4.1.9. The Member is a resident of long-term institutional care (e.g. hospice or skilled nursing facility).

3.4.3.4.1.10. The Member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than a Plan offered by the Contractor and Contractor cannot provide the Member with reasonable access to a Medicare approved Provider or, if the Member is enrolled in a Medicare managed care plan, Contractor cannot provide the Member with Providers participating in both Plans.

3.4.3.4.1.11. The Member is a foster child.

3.4.3.4.1.12. The Member is in long-term community based care (e.g. HCBS waiver programs).

3.4.3.4.2. Without cause, under the following circumstances:

3.4.3.4.2.1. A Member may request disenrollment at any time during the ninety (90) days following the date of the Member's initial enrollment with the Contractor.

3.4.3.4.2.2. A Member may request disenrollment at least once every twelve (12) months after the first ninety (90) day period.

3.4.3.4.2.3. A Member may request disenrollment upon automatic reenrollment under 42 CFR 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

3.4.3.4.2.4. A Member may request disenrollment if the Department imposes the intermediate sanction specified in 438.702(a)(3).

3.4.3.5. In the event that the Department grants a request for disenrollment, the effective date of that disenrollment shall be no later than the first day of the second month following the month in which the Member files the request. If the Department fails to either approve or deny the request in this timeframe, the request shall be considered approved.

3.4.3.5.1. In the event that a Member is disenrolled from the Contractor's Plan because the Member has become ineligible for Medicaid, then the effective date of disenrollment shall be the date on which the Member became ineligible.

3.4.3.5.2. If a current Member of a Contractor's Plan is an inpatient of a Hospital at 11:59 p.m. the day before that Member's disenrollment from the Contractor's Plan is scheduled to take effect, disenrollment shall be postponed until the Member is discharged from the hospital. If the Member is discharged from the hospital, the new disenrollment date for that Member shall be the last day of the month following discharge.

3.4.3.6. In the event that the Department denies a request for disenrollment, the Department will notify the Member of their right to request a State Fair Hearing.

3.4.4. The Contractor shall use reports and information from the Medicaid Management Information System (MMIS) to verify the Medicaid eligibility and enrollment in the Contractor's Plan for its Members. These reports may include some or all of the following:

3.4.4.1. Disenrollment Report (R0305) and (M0305).

3.4.4.2. Prepaid Health Plan (PHP) Enrollment Change Report (R0310).

3.4.4.3. PHP Current Enrollment Report (R0315).

3.4.4.4. PHP New Enrollee Report (R0325 and M0325).

3.4.4.5. Capitation Summary Report (R0360).

3.4.4.6. When available, Benefit Enrollment and Maintenance Transaction report (ANSI X 12N 834).

3.4.4.7. When available, Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction report (ANSI X 12N 820) for capitation.

3.5. COVERED SERVICES

3.5.1. Health Coverage

3.5.1.1. The Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit B. The Contractor shall provide Care Coordination, Utilization Management and Medical Management for Members to promote the appropriate and cost-effective utilization of Covered Services. The Contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

3.5.1.2. The Contractor shall provide the same standard of care for all Members regardless of eligibility category and shall make all Covered Services available in terms of timeliness, amount, duration and scope, to Members in an amount no less than those services are available to non-Member Medicaid recipients within the same area.

3.5.1.3. The Contractor shall 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 Member.

3.5.1.4. The Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service if the Contractor objects to the service on moral or religious grounds.

3.5.2. Coverage Limitations

3.5.2.1. The Contractor shall cover any service that is required under any State or Federal statute, regulation or rule, or is defined as Medically Necessary in Exhibit B.

3.5.2.1.1. The Contractor may use its quality committee to place appropriate limits on service so long as the limits allow for services furnished to reasonably be expected to achieve their purpose and the limits are in accordance with the Department's State Plan.

3.5.2.2. The Contractor shall not be liable for any Covered Services incurred prior to the Member's effective date of coverage under this Contract or after the date of termination of coverage.

3.5.2.3. The Contractor shall be authorized to impose and collect copayments in accordance with 10 CCR 2505-10 8.754.

3.5.2.4. The groups identified in 42 CFR 447.66(a) are exempt from co-pays.

3.5.3. Covered Services Through Participating Providers

3.5.3.1. Covered Services shall be made available in the Service Area only through Participating Providers or non-Participating Providers authorized by the Contractor. A Participating Provider is an organization or agency that has contracts or affiliations with the Contractor to render Covered Services.

3.5.3.2. Except for Emergency Services, Post Stabilization Services, and Urgently Needed Services, the Contractor shall have no liability or obligation to pay for any service or benefit sought or received by any Member from any non-Participating Provider unless:

3.5.3.2.1. Special arrangements or Referrals are made by a Participating Provider or the Contractor, as specified in the Member handbook.

3.5.4. Coverage of Specific Services and Responsibilities

3.5.4.1. Emergency Services

3.5.4.1.1. The Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a twenty-four (24) hour per day, seven (7) day per week basis.

3.5.4.1.2. Members temporarily out of the Service Area may receive out-of-area Emergency Services and Urgently Needed Services, as specified in Exhibit B.

3.5.4.1.3. The Contractor shall not require prior authorization for Emergency Services or Urgently Needed Services.

3.5.4.1.4. The Contractor may not deny payment for Emergency Services if a non-contracted provider provides the Emergency Services or when a representative of the Contractor instructs the Member to seek Emergency Services.

3.5.4.1.4.1. The Contractor shall pay non-contracted providers no more than the amount that would have been paid if the service had been provided under the Department's fee-for-service Medicaid program.

3.5.4.1.5. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor as responsible for coverage and payment.

3.5.4.1.6. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

3.5.4.1.7. The Contractor shall allow the emergency services provider a minimum of ten (10) calendar days to notify the Contractor of the Member's screening and treatment before refusing to cover the services based on a failure to notify.

3.5.4.2. Emergency Ambulance Transportation

3.5.4.2.1. The Contractor shall make reasonable efforts to ensure that Members within the Service Area shall have access to emergency ambulance transportation on a twenty-four (24) hours per day, seven (7) days per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.

3.5.4.3. Verification of Medical Necessity for Emergency Services

3.5.4.3.1. The Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services. The Contractor shall not deny benefits for conditions which a reasonable person outside of the medical community would perceive as Emergency Medical Conditions. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

3.5.4.4. Poststabilization Care Services

3.5.4.4.1. The Contractor shall provide coverage for Poststabilization Care Services in compliance with 42 C.F.R. § 438.114(e) and 42 CFR §422.113(c).

3.5.4.5. Newborn Services

3.5.4.5.1. The Contractor shall furnish Covered Services to newborns of mothers who are Members, who are determined Medicaid eligible, only for the period of the mother's hospitalization.

3.5.4.6. Coverage of Prescription Drugs

3.5.4.6.1. Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

3.5.4.6.1.1. The Contractor shall not provide drugs described in Medicare Part D to individuals eligible for both Medicare and Medicaid.

3.5.4.6.1.2. The Contractor shall comply with all federal and state statutes and regulations regarding prescription drug benefits described in Medicare Part D for individuals eligible for both Medicare and Medicaid.

3.5.4.6.1.3. The Contractor shall cover excluded Part D drugs as defined in 42 U.S.C. §1395w-101, *et seq.*, for individuals eligible for both Medicare and Medicaid in the same manner and to the same extent as they cover excluded Part D drugs for all other eligible Medicaid clients.

3.5.4.6.2. The Contractor shall provide coverage only for prescription drugs approved for use and reimbursed by the Medicaid Program, including those products that require prior authorization by the Medicaid Program. Such Covered Drugs must be prescribed and dispensed within the Contractor's parameters for pharmaceuticals, and as follows:

3.5.4.6.2.1. The Contractor shall only provide coverage for drugs that are rebateable in accordance with 42 U.S.C. Section 1396r-8.

3.5.4.6.2.2. The Contractor may establish a drug formulary, for all Medically Necessary Covered Drugs with its own prior authorization criteria provided the Contractor includes each therapeutic drug category in the Medicaid program.

3.5.4.6.2.3. The Contractor shall provide a Covered Drug if there is a Medical Necessity which is unmet by the Contractor's formulary product.

3.5.4.6.2.4. The Contractor may authorize at least a seventy-two (72) hour supply of outpatient Covered Drugs in an Emergency situation when the prior authorization request is incomplete or additional information is needed. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well-being.

3.5.4.7. Responsibility Regarding Psychiatric and Medical Diagnoses

3.5.4.7.1. Inpatient Hospital Services

3.5.4.7.1.1. The Contractor shall be responsible for inpatient hospital stays based on the primary diagnosis that requires inpatient care.

3.5.4.7.1.1.1. The Contractor shall be financially responsible for the hospital stay when the Member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric procedures.

3.5.4.7.1.1.2. The Contractor shall not be financially responsible for inpatient services when the Client's primary diagnosis is psychiatric in nature, even when the psychiatric hospitalization includes some medical conditions or procedures to treat a secondary medical diagnosis

3.5.4.7.1.1.3. The Contractor shall not be responsible for the hospital stay when the primary diagnosis is for substance abuse rehabilitation.

3.5.4.7.2. Coverage for Emergency Services

3.5.4.7.2.1. The Contractor shall be responsible for Emergency Services when the Member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures.

3.5.4.7.2.2. The Contractor shall not be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis.

3.5.4.7.3. The Contractor's responsibility for the Covered Services of outpatient Hospital Services is based on the diagnosis and the billing procedures of the Hospital.

3.5.4.7.3.1. For any procedure billed in a UB-92/ANSI 837I, Health Care Claim Institutional (ANSI 837I) format, the Contractor shall be responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

3.5.4.7.3.1.1. The procedure is billed on a UB-92/ANSI 837I claim form, and

3.5.4.7.3.1.2. The principal diagnosis is a medical diagnosis.

3.5.4.7.3.2. For any procedure billed in a HCFA-1500/ANSI 837P, Health Care Claim Professional Format, the Contractor shall be responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

3.5.4.7.3.2.1. The procedure is billed on a HCFA-1500/ANSI 837P claim form, and

3.5.4.7.3.2.2. The Covered Services are not listed as a required Behavioral Health Organization (BHO) Covered Service as defined in 10 C.C.R. 2505-10, Section 8.212.4.A. Diagnoses and procedures covered by the BHOs are listed in Exhibit F.

3.5.4.8. Wrap Around (Fee For Service) Benefits

3.5.4.8.1. The Contractor shall communicate to its Participating Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this Contract but are available to Members under Medicaid fee for service (FFS).

3.5.4.8.2. The Contractor shall instruct its Participating Providers on how to refer a Member for such services. The Contractor shall advise Participating Providers of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) support services that are available through other entities, including, but not limited to local public health departments and Healthy Communities. The Contractor shall also advise post-partum or breast-feeding or pregnant women of the special supplemental food program (Women, Infants, and Children), state's special assistance program for substance abusing pregnant women, and enhanced prenatal care services.

3.5.4.8.3. The Contractor shall inform its Home Health Services Providers and Members that Home Health Services after sixty (60) consecutive days are not Covered Services but are available to Members under FFS and require prior authorization. If Home Health Services after sixty (60) consecutive days are anticipated, the Contractor shall ensure that, at least thirty (30) days prior to the sixtieth (60th) day of Home Health Services, its Home Health Services Providers coordinate prior authorization with the Single Entry Point Agency for adult Members and with the Medicaid Fiscal Agent for children.

3.5.4.8.4. The Contractor shall inform its Participating Providers of the services provided by the Behavioral Health Organizations (BHOs).

3.6. SERVICE DELIVERY

3.6.1. Access

3.6.1.1. Access to Services

3.6.1.1.1. The Contractor shall comply with all requirements described in §10-16-704 C.R.S. The Contractor shall attempt to include both Essential Community Providers, as designated at 10 C.C.R. 2505-10, §8.205.5.A, and other Providers in its network of providers.

3.6.1.1.2. The Contractor shall maintain and monitor a network of Participating Providers that is sufficient to provide adequate access to all Covered Services. In order for the Contractor's network to be considered to provide adequate access, the Contractor shall ensure a minimum Provider to Member caseload ratio as follows:

3.6.1.1.2.1. 1:2000 Primary Care Medical Provider to Member ratio.

3.6.1.1.2.2. 1:2000 Physician specialist to Member ratio. Physician specialist includes Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.

3.6.1.1.2.3. Physician specialists designated to practice Gerontology, Internal Medicine, OB/GYN and Pediatrics shall be counted as either a PCMP or Physician specialist, but not both.

3.6.1.1.3. The Contractor shall have written agreements with all providers in its network.

3.6.1.1.4. The Contractor shall verify that all primary care providers in its network are contracted Primary Care Medical Providers (PCMPs) in the ACC.

3.6.1.1.5. The Contractor shall provide female Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated PCMP if that source is not a women's health specialist.

3.6.1.1.6. The Contractor shall ensure that Members in the Service Area have access to specialists and other Medicaid providers promptly without compromising the Member's quality of care or health.

3.6.1.1.7. The Contractor shall provide for a Member to receive a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the Member.

3.6.1.1.8. The Contractor shall ensure that all Members have appropriate access to certified nurse practitioners and certified nurse midwives, as set forth at 42 C.F.R. §438.102(a), as amended, through either Participating Provider agreements or Referrals. This provision shall not be interpreted as requiring the Contractor to provide any services that are not Covered Services under this Contract.

3.6.1.1.9. The Contractor shall not restrict any Member's choice of the Provider from which the Member receives family planning services or supplies.

3.6.1.1.10. The Contractor shall maintain, staff and publish the number for at least one (1) toll free telephone line that Members may call regarding customer service or Care Coordination issues.

3.6.1.1.10.1. The Contractor shall provide both English- and Spanish-speaking representatives to assist English- and Spanish-speaking Members and Clients, both through telephone conversations and in-person.

3.6.1.1.11. The Contractor shall develop and maintain its network so that it includes providers with the interest and expertise in serving the special populations that include, but are not limited to:

3.6.1.1.11.1. The physically or developmentally disabled.

3.6.1.1.11.2. Adults and the aged.

3.6.1.1.11.3. Non-English speakers.

3.6.1.1.11.4. Expansion population.

3.6.1.1.11.5. Members with complex behavioral or physical health needs.

3.6.1.1.11.6. Members with Human Immunodeficiency Virus (HI)

3.6.1.1.12. The Contractor's network shall provide the Contractor's Members with a meaningful choice selecting a PCMP.

3.6.1.1.12.1. If a Member within the Service Area selects a provider that has not entered into an agreement with the Contractor, the Contractor shall make an effort to enroll the provider.

3.6.1.1.12.1.1. The Contractor shall make an initial contact, through any method allowed by the Department and state and federal statues, regulations, policies, or procedures, with the provider to attempt to enroll the provider in the Contractor's network.

3.6.1.1.12.1.2. If the Contractor is unsuccessful in its initial contact, then the Contractor shall make one (1) follow-up contact to attempt to enroll the provider in the Contractor's network.

3.6.1.2. Out of Network Providers

3.6.1.2.1. In the event that the Contractor is unable to provide any Covered Service to a Member from a Participating Provider within its network, then the Contractor shall provide that service through a Provider that is not within its network promptly and without compromising the Member's quality of care or health.

3.6.1.2.2. The Contractor shall ensure that the cost to the Member for any service provided by the Contractor from a Provider that is not within the Contractor's network is not greater than the cost to that same Member if that Member had received the service from a Provider that was within the Contractor's network.

3.6.1.2.2.1. The Contractor shall work with any Provider that is not within its network with respect to any payment that the Contractor must make to the Provider to meet the requirements of this section 3.6.1.2. All payments from the Contractor to a Provider that is not within the Contractor's network shall be made in accordance with §25-4-401, C.R.S., unless otherwise negotiated between the Contractor and that Provider.

3.6.1.2.3. The Contractor shall pay I/T/U providers, whether participating in the network or not, for covered services provided to American Indian/Alaska Native Members who are eligible to receive services from the I/T/U.

3.6.1.2.3.1. The Contractor shall pay I/T/U providers at either a rate that has been negotiated between the Contractor and the I/T/U provider or, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider

3.6.1.3. Geographic Access

3.6.1.3.1. The Contractor shall establish and maintain adequate arrangements to ensure reasonable proximity of Participating Providers to the residence of Members so as not to result in unreasonable barriers to access and to promote continuity of care, taking into account the usual means of transportation ordinarily used by Members in accordance with 42 CFR 438.6(k)(2).

3.6.1.3.2. The Contractor's PCMP network shall have a sufficient number of PCMPs so that each Member has a PCMP and each Member has their choice of at least two (2) PCMPs within their zip code or within thirty (30) minutes of driving time from their location, whichever area is larger. For rural and frontier areas, the Department may adjust this requirement based on the number and location of available providers.

3.6.1.4. Service Availability

3.6.1.4.1. The Contractor's PCMP network shall offer hours of operation that are no less than the hours of operation offered to individuals enrolled in Medicaid fee-for-service.

3.6.1.4.2. The Contractor's PCMP network shall provide for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. The Contractor will determine the appropriate requirements for the number of extended hours and weekend availability based on the needs of the Contractor's Service Area, and submit these requirements to the Department for approval. The Contractor shall assess the needs of the Contractor's Service Area on a regular basis, no less often than quarterly, and submit a request to the Department to adjust its requirements accordingly.

3.6.1.4.2.1. DELIVERABLE: Documentation of Service Availability Requirements

3.6.1.4.2.2. DUE: Thirty (30) days from the Effective Date and any time that the Contractor requests a change to its requirements.

3.6.1.4.3. The Contractor shall ensure that Members, including Members with Disabilities, have a point of access to appropriate services available on a twenty-four (24) hours per day basis and have written policies and procedures for how the Contractor will meet this requirement. The Contractor shall communicate this information to Participating Providers and Members, and have a routine monitoring mechanism to ensure that Participating Providers promote and comply with these policies and procedures. These policies and procedures shall address, at a minimum, the following requirements:

3.6.1.4.3.1. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

3.6.1.4.3.2. The Contractor shall have a comprehensive plan for triage of requests for services on a twenty-four (24) hour seven (7) day per week basis, including all of the following:

3.6.1.4.3.2.1. Immediate Medical Screening Exam by the PCMP or Hospital emergency room.

3.6.1.4.3.2.2. Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service.

3.6.1.4.3.2.3. Practitioner backs up covering all specialties.

3.6.1.5. Scheduling and Wait Times

3.6.1.5.1. The Contractor shall establish clinically appropriate scheduling guidelines for various types of appointments necessary for the provision of primary and specialty care including, but not limited to:

3.6.1.5.1.1. Routine physicals.

3.6.1.5.1.2. Diagnosis and treatment of acute pain or injury.

3.6.1.5.1.3. Follow-up appointments for chronic conditions.

3.6.1.5.2. The Contractor shall ensure that its scheduling guidelines meet, at a minimum, all of the following standards:

3.6.1.5.2.1. Urgently Needed Services provided within forty-eight (48) hours of notification of the Member's need for those services to the Member's PCMP or the Contractor.

3.6.1.5.2.2. Non-urgent, symptomatic care scheduled within ten (10) days of the Member's request for services.

3.6.1.5.2.3. Adult, non-symptomatic well care physical examinations scheduled within forty five (45) days.

3.6.1.5.3. The Contractor shall make these scheduling guidelines available to the Department for the Department's review. In the event that the Department determines that the guidelines are unacceptable to the Department, then the Contractor shall work with the Department to modify those guidelines to create acceptable guidelines.

3.6.1.5.3.1. DELIVERABLE: Documentation of Scheduling Guidelines.

3.6.1.5.3.2. DUE: Thirty (30) days from the Effective Date.

3.6.1.5.4. The Contractor shall communicate all scheduling guidelines in writing to Participating Providers. The Contractor shall create and maintain an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and taking appropriate corrective action.

3.6.2. Service Area Standards

3.6.2.1. The Department shall make any final determination regarding the Contractor's suitability for providing Covered Services to Members within any specific Service Area.

3.6.2.2. The Contractor shall provide the Department with written notice and a service plan analysis when seeking to expand into a new Service Area or expand the eligibility categories served. Such written notice and analysis shall include, but not be limited to:

3.6.2.2.1. The name of the proposed county or counties in which the Contractor seeks to expand or the categories of populations to be served, and;

3.6.2.2.2. An analysis by the Contractor concerning whether its Provider network is adequate to serve Clients in the proposed county, able to provide the full scope of benefits, and can comply with the standards for access to care as specified in this Contract.

3.6.3. Selection and Assignment of Primary Care Medical Providers

3.6.3.1. The Contractor's network shall provide the Contractor's Members with a meaningful choice in selecting a PCMP. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a PCMP.

3.6.3.1.1. The Contractor shall not impose any limitation on a Member's ability to select or change that Member's PCMP that is more restrictive than the Member's right to disenroll from the Contractor's Plan.

3.6.3.1.2. The Contractor shall permit any American Indian/Alaska Native Member eligible to receive services from a participating I/T/U provider, to elect that I/T/U as his or her primary care provider, if that I/T/U participates in the Contractor's network as a primary care provider and has the capacity to provide the services.

3.6.3.1.3. The Contractor shall exempt any American Indian/Alaska Native Member who is eligible to receive or has received an item or Covered Service under this contract through an I/T/U provider or through referral from premiums and copays.

3.6.3.2. The Contractor shall in no way prohibit or restrict a Participating Provider, who is acting within the lawful scope of practice, from advising a Member about any aspect of his or her health status or medical care, advocating on behalf of a Member, advising about alternative treatments that may be self-administered, including the risks, benefits and consequences of treatment or non-treatment, the right to refuse treatment and to express preferences about future treatment decisions, so that the Member receives the information needed to decide among all available treatment options and can make decisions regarding the Member's own health care, regardless of whether such care is a Covered Service under this Contract. This section shall not be construed as requiring the Contractor to provide any service, treatment or benefit that is not a Covered Service under this Contract.

3.7. CARE COORDINATION AND MEDICAL MANAGEMENT

3.7.1. Medical management support

3.7.1.1. The Contractor shall use, and recommend to PCMPs, traditional and non-traditional medical management practices and tools to ensure optimal health outcomes and manage costs for the Department and the Contractor's Members. The Formal System of Care Coordination report shall include at least one planned method of Medical Management Support and an assessment of the efficacy or success of the last method tried. These practices and tools may include, but are not limited to, any of the following:

3.7.1.1.1. Traditional methods:

3.7.1.1.1.1. Integrating disease management into the care of Members with multiple chronic conditions.

3.7.1.1.1.2. Catastrophic case management.

3.7.1.1.1.3. Coordination of medical services for Members with serious, life-changing, and possibly life-threatening, illnesses and injuries.

3.7.1.1.2. Innovative and proven or promising practices:

3.7.1.1.2.1. Technologically enhanced communication, such as cell phone messages, email communication and text messaging.

3.7.1.1.2.2. Providing PCMPs with tools and resources to support informed medical decision-making with Members.

3.7.1.1.2.3. Alternate formats for delivering care.

3.7.1.1.2.4. Methods for diversion to the most appropriate care setting.

3.7.1.1.2.5. The Contractor shall use a method to detect inappropriate utilization of services and shall develop methods for diversion to the most appropriate care setting. Both shall be described in the Practice Support Plan.

3.7.1.2. The Department may review the Contractor's Medical Management practices and tools during the annual site review. In the event that the Department determines any practice or tool to be ineffective, inappropriate or otherwise unacceptable, the Contractor shall cease using or recommending that practice or tool immediately upon notification by the Department of its unacceptability. The Department may request that the Contractor devise a method to evaluate the tool's efficacy. In the event that the Department requests this, the Contractor shall develop a method for evaluation and implement that evaluation within thirty days of the request.

3.7.2. Care Coordination

3.7.2.1. The Contractor shall ensure Care Coordination is comprehensive, client and family centered, and integrated.

3.7.2.2. The Contractor shall ensure Care Coordination that reflects the needs of Members to achieve their desired health outcomes in an efficient and responsible manner. The Contractor shall document the Care Coordination care plan that includes documentation of the Member's desired health outcomes and identifies other members of that Member's Care Coordination team. The Department may request a sample of care plans at any time. The Contractor may allow the PCMPs with which it contracts or other Subcontractors to perform some or all of the Care Coordination activities, but the Contractor shall be responsible for the ultimate delivery of Care Coordination services.

3.7.2.2.1. In the event that the Contractor allows a PCMP or other Subcontractor to perform any Care Coordination activities, the agreement with that PCMP or other Subcontractor shall comply with all applicable requirements of this Contract.

3.7.2.3. Regardless of its relationships or contracts with PCMPs or Subcontractors, the Contractor shall:

3.7.2.3.1. Assess current Care Coordination services provided to each of its Members to determine if the providers involved in each Member's care are providing necessary Care Coordination services and which Care Coordination services are insufficient or are not provided. This assessment could be accomplished through random site reviews, in-practice activities conducted by Contractor's practice transformation personnel, collection of practice reporting, and similar Contractor oversight functions.

3.7.2.3.2. Provide all Care Coordination services that are not provided by another source.

3.7.2.3.3. Work with providers who are responsible for the Member's care to develop a plan for regular communication with the person(s) who are responsible for the Member's Care Coordination.

3.7.2.3.4. Reasonably ensure that all Care Coordination services, including those provided by other individuals or entities, meet the needs of the Member.

3.7.2.3.5. Ensure all members of the Care Coordination team have access to an integrated care plan elements across provider and community organizations, including a comprehensive psychosocial assessment and a multidimensional plan addressing social, physical and behavioral health needs.

3.7.2.4. The Contractor shall develop a formal system of Care Coordination for its Members. All elements of the formal system of Care Coordination shall be documented in the care plan. This formal system shall have comprehensive, client/family centered, integrated Care Coordination.

3.7.2.4.1. Comprehensive Care Coordination components include:

3.7.2.4.1.1. Assessing the Member's health and health behavior risks and medical and non-medical needs, including determining if a care plan exists and creating a care plan if one does not exist and is needed.

3.7.2.4.1.2. Linking Members both to medical services and to non-medical, community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance and other non-medical supports as necessary. Assessing support needs and responding appropriately from providing Members the necessary contact information for the service to arranging the services and acting as a liaison between medical providers, non-medical providers and the Member.

3.7.2.4.1.3. Providing assistance during care transitions from hospitals or other care institutions to home- or community-based settings or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. This assistance shall promote continuity of care and prevent unnecessary re-hospitalizations and document and communicate necessary information about the Member to the providers, institutions and individuals involved in the transition.

3.7.2.4.1.4. The Contractor shall provide, or work with community based organizations to arrange for, an individual to act as a care coordinator for each Member during any transitions in this section. This individual shall communicate with every member to which they are assigned, once while they are in the hospital and again within forty-eight (48) hours of that Member's discharge, to help the Member receive the assistance that Member needs during their transition.

3.7.2.4.1.5. Providing solutions to problems encountered by providers or Members in the provision or receipt of care.

3.7.2.4.1.5.1. The Contractor shall use its existing grievance process to document all problems presented by Members in the provision or receipt of care and the solutions given to the Member. The Contractor shall document problems presented by providers in the provision of care and the solutions provided to the provider. The Department may review any of the documented solutions and, should the Department determine the solution to be insufficient or otherwise unacceptable, may direct the Contractor to find a different solution or follow a specific course of action.

3.7.2.4.1.6. Informing the Members of the Department's Medicaid ombudsman to assist the Member in resolving health care issues and filing grievances.

3.7.2.4.1.7. Following up with Members to assess whether the Member has received needed services and if the Member is on track to reach their desired health outcomes.

3.7.2.5. Client/Family Centered characteristics include:

3.7.2.5.1. Ensuring that Members, and their families if applicable, are active participants in the Member's care, to the extent that they are able and willing.

3.7.2.5.2. Providing care and Care Coordination activities that are linguistically appropriate to the Member and are consistent with the Member's cultural beliefs and values.

3.7.2.5.3. Providing Care Coordination that is responsive to the needs of special populations, including, but not limited to:

3.7.2.5.3.1. The physically or developmentally disabled

3.7.2.5.3.2. Adults and the aged

3.7.2.5.3.3. Non-English speakers

3.7.2.5.3.4. All expansion populations, as defined in Colorado House Bill 09-1293, the Colorado Health Care Affordability Act

3.7.2.5.3.5. Members in need of assistance with medical transitions

3.7.2.5.3.6. Members with complex behavioral or physical health needs

3.7.2.5.4. Providing Care Coordination that aims to keep Members out of a medical facility or institutional setting and provide care in the Member's community or home to the greatest extent possible. The Contractor shall ensure that all Care Coordination activities comply with the Supreme Court decision in Olmstead v. L. C. (527 U.S. 581 (1999)).

3.7.2.6. Integrated Care Coordination characteristics include:

3.7.2.6.1. Ensuring that physical, behavioral, long-term care, social and other services are continuous and comprehensive and the service providers communicate with one another in order to effectively coordinate care.

3.7.2.6.2. Providing services that are not duplicative of other services and that are mutually reinforcing.

3.7.2.6.3. Implementing strategies to integrate member care such as:

3.7.2.6.3.1. Developing a knowledge base of care providers, case management agencies and available services, both within the Contractor's network and the Members' communities.

3.7.2.6.3.2. Becoming familiar with the Department's initiatives and programs.

3.7.2.6.3.3. Knowing the eligibility criteria and contact points for community-based service available to the Member's in the Contractor's Region, subject to the Department's direction.

3.7.2.6.3.4. Identifying and addressing barriers to health in the in the Contractor's region, such as member transportation issues or medication management challenges.

3.7.2.7. The Department may review the Contractor's formal system of Care Coordination at any time. The Department may direct changes in the Contractor's system of Care Coordination in the event that it determines any aspect of the system to be insufficient, inappropriate or otherwise unacceptable, for any reason. The Contractor shall immediately implement any changes directed by the Department and update its documentation of its formal system of Care Coordination accordingly.

3.7.2.7.1. The Contractor shall document its formal system of Care Coordination and deliver this documentation to the Department within sixty (60) days of the Contract's Effective Date.

3.7.2.7.2. DELIVERABLE: Documented Formal System of Care Coordination

3.7.2.7.3. DUE: Sixty (60) days from the Effective Date

3.7.2.8. The Contractor shall provide the Department with an updated documentation of its formal system of Care Coordination whenever it makes any significant change to its system, when a series of minor changes have combined into a significant change from the prior system or upon the Department's request. The Contractor shall deliver this documentation to the Department within sixty (60) days of the change has occurred or from any request by the Department for updated documentation.

3.7.2.8.1. DELIVERABLE: Updated Documentation of Formal System of Care Coordination.

3.7.2.8.2. DUE: Within sixty (60) days after the change or after the Department's request.

3.7.2.9. The Contractor shall attempt to contact Members who access a hospital's emergency room, or are otherwise hospitalized, within thirty (30) days of the Member's discharge or emergency room visit.

3.7.2.9.1. The Contractor shall explain the importance of the Medical Home concept, support transitions and follow-up in primary care settings, and help when necessary to schedule an appointment with the Member's PCMP.

3.7.2.10. The Contractor shall provide the Department with updated documentation of its System of Care Report including, at a minimum, the following information:

3.7.2.10.1. Number of Members contacted within seven (7) days of discharge.

3.7.2.10.2. Number of Members who received a clinic visit within thirty (30) days of discharge from a hospital.

3.7.2.10.3. Description of the agreements that the Contractor has with all of the hospitals in its Service Area, and if those hospitals are currently notifying the contractor when a Member presents at the emergency room or is admitted to the hospital.

3.7.2.10.4. Numbers of members receiving face-to-face Care Coordination and number of Care Coordination activities per member.

3.7.2.10.5. Number and description of integrated care activities, including, but not limited to, integration with local public health agencies, Community Centered Boards (CCBs), Single Entry Points (SEPs), and Community Mental Health Centers.

3.7.2.10.6. Number of Members accessing the Contractor's new workforce, behavior change and self-management supports.

3.7.2.10.6.1. DELIVERABLE: Systems of Care Report.

3.7.2.10.6.2. DUE: Semi-annually on November 1, reporting for the period of April 1 through September 30; and May 1, reporting for the period of October 1 through March 30.

3.7.2.11. The Contractor shall classify each member in the Contractor's Service Area, based on their care utilization, according to the Care Coordination Levels shown in Exhibit M. The Contractor shall assign or arrange for Care Coordinators for each Member pursuant to an assessment of his or her needs, and assist the Member in achieving the best health, functional and self-management status possible.

3.7.2.11.1. The Care Coordinator shall follow up with the Member at least:

3.7.2.11.1.1. Biweekly for any Member classified as Level 4

3.7.2.11.1.2. Monthly for any Member classified as Level 3a or 3b

3.7.2.12. The Contractor shall provide support, via telephone, as requested by any Member of any classification level.

3.7.2.13. The Contractor shall provide the services to each Member, based on that Member's Care Coordination Levels, as described in Exhibit M.

3.7.2.14. The Contractor shall arrange for training on poverty-related issues, such as the Contractor's Bridges out of Poverty training, to all of its Care Coordinators within three months of that staff member's placement as a Care Coordinator. The Contractor shall provide updated training to all staff members as needed to address changes in the training, to address issues that arise in relation to poverty-related issues or as requested by the Department.

3.7.2.15. The Contractor shall seek consent from all Members, in the Contractor's Service Area, who seek care in the mental health system so that it may share this information with that Member's Care Coordinator.

3.7.3. Persons with Special Health Care Needs

3.7.3.1. Continuation of Care for Persons with Special Health Care Needs

3.7.3.2. The Contractor shall develop and submit a plan to identify Persons with Special Health Care Needs based on the definition in 10 C.C.R. 2505-10 §8.205.9 for the Department's approval.

3.7.3.2.1. DELIVERABLE: Special Health Care Needs Plan

3.7.3.2.2. DUE: Within sixty (60) days of the effective date of this Amendment.

3.7.3.3. Once the Special Health Care Needs Plan is approved by the Department, the Contractor shall ensure that it uses the approved plan to identify Members with Special Health Care Needs.

3.7.3.3.1. The Contractor shall inform any new Member who is a Person with Special Health Care Needs as defined in 10 C.C.R. 2505-10, §8.205.9 that the Member may continue to receive Covered Services from the Member's current Provider for sixty (60) days from the date of Enrollment in the Contractor's Plan. The Member may only continue to receive Covered Services from the Member's current Provider if the Member is in an ongoing course of treatment with that Provider and the previous Provider agrees as specified in §25.5-5-406(1)(g), C.R.S.

3.7.3.3.2. The Contractor shall inform a new Member with Special Health Care Needs that the Member may continue to receive Covered Services from ancillary Providers at the level of care received prior to Enrollment in the Contractor's Plan, for a period of seventy-five (75) days, as specified in §25.5-5-406(1)(g), C.R.S.

3.7.3.3.3. The Contractor shall inform a new Member who is in her second or third trimester of pregnancy, that she may continue to see her current Provider until the completion of post-partum care directly related to the delivery, as specified in §25.5-5-406(1)(g), C.R.S.

3.7.3.4. The Contractor shall have sufficient experienced Providers with the ability to meet the unique needs of all Members who are Persons with Special Health Care Needs. If necessary primary or specialty care cannot be provided within the Contractor's network, the Contractor shall make arrangements for Members to access these Providers outside the network. The Contractor shall implement procedures to share the results of its identification and assessment of that Member's needs with other Providers serving the Member with Special Health Care Needs, in order to prevent duplication of those activities.

3.7.3.5. The Contractor shall implement mechanisms to assess each Member identified as a Person with Special Health Care Needs in order to identify any ongoing special conditions of the Member that require a course of treatment or regular care monitoring.

3.7.3.6. The Contractor shall allow Persons with Special Health Care Needs who use specialists frequently for their health care to maintain these types of specialists as PCMPs or be allowed direct access or a standing Referral to specialists for the needed care.

3.7.3.7. The Contractor shall establish and maintain procedures and policies to coordinate health care services for children with Special Health Care Needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, transportation, home and community based care, Developmental Disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates).

3.7.4. Accommodation of Members with Disabilities or Special Health Care Needs

3.7.4.1. The Contractor shall promote accessibility and availability of Medically Necessary Covered Services, either directly or through subcontracts, to ensure that appropriate services and accommodations are made available to Members with a Disability or any Members with Special Health Care Needs. Covered Services for Members with Disabilities or Special Health Care Needs must be provided in such a manner that will promote independent living and Member participation in the community at large.

3.7.4.2. To promote independent living, the Contractor shall:

3.7.4.2.1. Respond within twenty-four (24) hours, after written or oral notice to the Contractor by the Member, the Member's parents, guardian or Designated Client Representative, to any diminishment of the capacity of a Member with a Disability to live independently.

3.7.4.2.2. Deliver Covered Services that will restore the Member's ability to live independently as expediently as possible.

3.7.4.3. The Contractor shall facilitate culturally and linguistically appropriate care, by implementing the following requirements:

3.7.4.3.1. Establish and maintain policies to reach out to specific cultural and ethnic Members for prevention, health education and treatment for diseases prevalent in those groups.

3.7.4.3.2. Maintain policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation.

3.7.4.3.3. Make a reasonable effort to identify Members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Contractor of the language proficiency of Members during the Contractor's orientation calls or being served by Participating Providers, or improving access to health care through community outreach and Contractor publications.

3.7.4.3.4. Provide oral interpretation services available free of charge to Members.

3.7.4.3.5. Notify Members and potential members that oral interpretation services are available for any language and explain how to access those services.

3.7.4.3.6. Develop and provide cultural competency training programs, as needed, to the network Providers and Contractor staff regarding all of the following:

3.7.4.3.6.1. Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services.

3.7.4.3.6.2. The medical risks associated with the Client population's racial, ethical and socioeconomic conditions.

3.7.4.3.7. Make available written translation of Contractor materials, including Member handbook, correspondence and newsletters. Written Member information and correspondence shall be made available in languages spoken by prevalent non-English speaking Member populations within the Contractor's Service Area as directed by the Department or as required by 42 CFR 438.

3.7.4.3.8. Develop policies and procedures, as needed, on how the Contractor will respond to requests from Participating Providers for interpreter services by a Qualified Interpreter. This shall occur particularly in Service Areas where language may pose a barrier so that Participating Providers can:

3.7.4.3.8.1. Conduct the appropriate assessment and treatment of non-English speaking Members, including Members with a Communication Disability.

3.7.4.3.8.2. Promote accessibility and availability of Covered Services, at no cost to Members.

3.7.4.3.9. Develop policies and procedures on how the Contractor will respond to requests from Members for interpretive services by a Qualified Interpreter or publications in alternative formats.

3.7.4.3.10. Make a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse and culturally competent clinical Providers that represent the racial and ethnic communities being served.

3.7.4.3.11. Provide access to interpretative services by a Qualified Interpreter for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.

3.7.4.3.12. Develop and maintain written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

3.7.4.3.13. Arrange for Covered Services to be provided through agreements with non-Participating Providers when the Contractor does not have the direct capacity to provide Covered Services in an appropriate manner, consistent with Independent Living, to Members with Disabilities.

3.7.4.3.14. Provide access to TDD or other equivalent methods for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.

3.7.4.3.15. Make Member information available for Members with visual impairments, including, but not limited to, Braille, large print or audiotapes. For Members who cannot read, member information must be available on audiotape.

3.7.5. Preventative Health Services

3.7.5.1. The Contractor shall establish and maintain a comprehensive program of preventive health services for Members. The Contractor shall ensure that Members with a Disability have the same access to preventative health services as other Members. The program shall include written policies and procedures, involve Participating Providers and Members in their development and ongoing evaluation, and are a part of the Contractor's comprehensive quality assurance program as specified in Section 3.11 of this Statement of Work. The Contractor's program of preventive health services shall include, but is not limited to:

3.7.5.1.1. Risk assessment by a Member's PCMP, or other qualified professionals specializing in risk prevention who are part of the Contractor's Participating Providers or under contract to provide such services, to identify Members with chronic or high risk illnesses, a Disability or the potential for such conditions.

3.7.5.1.2. Health education and promotion of wellness programs, including the development of appropriate preventive services for Members with a Disability to prevent further deterioration. The Contractor shall also include the distribution of information to Members to encourage Member responsibility for following guidelines for preventive health.

3.7.5.1.3. Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk Members.

3.7.5.1.4. Procedures to identify priorities and develop guidelines for appropriate preventive services.

3.7.5.1.5. Processes to inform and educate Participating Providers about preventive services, involve Participating Providers in the development of programs and evaluate the effectiveness of Participating Providers in providing such services.

3.7.5.2. The Contractor shall comply with all requirements of EPSDT rules at 42 C.F.R. §§441.50 through 441.61, as amended, to ensure that Members have access to EPSDT benefits including such benefits which are not Covered Services pursuant to this Contract. The Contractor shall meet all of the following EPSDT requirements as part of the preventative health services it offers:

3.7.5.2.1. The Contractor shall inform all Medicaid-eligible persons through age 20 that EPSDT services are available.

3.7.5.2.2. The Contractor shall provide or arrange for the provision of all of the required screening, diagnostic and treatment components according to state and federal EPSDT standards and periodicity schedule. The Contractor may offer additional preventive services beyond these required standards.

3.7.5.3. The Contractor shall comply with all requirements of the Alternative Benefits Plan (ABP) rules at §1937 of the Social Security Act.

3.7.5.3.1. The Contractor shall provide all benefits included in the Alternative Benefit Plan to all Expansion Members, including benefits which may not be Covered Services pursuant to this Contract.

3.7.5.3.2. Expansion Members shall receive the ABP which is the regular Medicaid benefit package plus the addition of Habilitative therapies.

3.7.6. Services Delivered Only to Members

3.7.6.1. The Contractor shall ensure that Providers operating under the Contractor's Plan supply services only to Members. It is the responsibility of the Provider to verify that the individual receiving medical services is a Member on the date of service, whether the Contractor or the Department is responsible for reimbursement of the services provided and whether the Contractor has authorized a Referral or made special arrangements with a Provider, when appropriate. If a Provider has verified eligibility and enrollment as specified by the Department, the Department will reimburse the Contractor for the claim if the Department is responsible for the reimbursement of that claim.

3.7.6.2. The Department will identify the eligible Expansion Members for the Contractor.

3.7.6.2.1. The Contractor will advise all newly eligible Expansion Members enrolling in this plan of their benefit package, including regular Medicaid services as well as Habilitative therapy services.

3.8. PROVIDER SUPPORT

3.8.1. Administrative Support

3.8.1.1. The Contractor shall make all of the Participating Providers in its network aware of Colorado Medicaid programs, policies and processes.

3.8.1.1.1. This information shall include, but is not limited to, information regarding all of the following:

3.8.1.1.1.1. Benefit packages and coverage policies.

3.8.1.1.1.2. Prior authorization Referral requirements.

3.8.1.1.1.3. Claims and billing procedures.

3.8.1.1.1.4. Eligibility and enrollment processes.

3.8.1.1.1.5. Other operational components of service delivery.

3.8.1.2. This information shall be delivered to providers during direct contact at meetings, forums, training sessions or seminars, or through any method of mailing, as defined in 10 C.C.R. 2505-10 §8.050.

3.8.1.3. The Contractor shall make informational and educational materials available to providers regarding the roles that the Department, the Contractor and other Department contractors and partners play in the Colorado Medicaid system. These other Department contractors and partners shall include, at a minimum all of the following:

3.8.1.3.1. The Statewide Data Analytics Contractor (SDAC).

3.8.1.3.2. The Department's enrollment broker.

3.8.1.3.3. The Department's Medicaid fiscal agent.

3.8.1.3.4. The Department's utilization management contractor.

3.8.1.3.5. The Department's managed care ombudsman.

3.8.1.3.6. The county departments of human and social services for the counties in the Contractor's Region.

3.8.1.3.7. The Community-Centered Boards and Single Entry Point agencies.

3.8.1.3.8. Healthy Communities.

3.8.1.3.9. The Department's Dental Contractor.

3.8.1.4. The Contractor shall act as a liaison between the Department and its other contractors and partners and the providers. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:

3.8.1.4.1. Issues relating to Medicaid provider enrollment.

3.8.1.4.2. Prior authorization and Referral issues.

3.8.1.4.3. Member eligibility and coverage policies.

3.8.1.4.4. PCMP designation problems.

3.8.1.5. The Contractor shall submit written documentation of provider support activities to the Department for review. The Department may request changes to the provider support activities, and the Contractor shall make the changes and deliver the updated documents or plans to the Department.

3.8.1.5.1. DELIVERABLE: Documentation of Provider Support Activities.

3.8.1.5.2. DUE: Ten (10) days from the date the documents or plans are finalized for the original document, and ten (10) days from the request by the Department to make a change for updated documents.

3.8.2. Practice Support

3.8.2.1. The Contractor shall submit a Practice Support Plan, describing its annual activities, for Department review and approval. These practice support activities shall be directed at a majority of the PCMPs in the Contractor's Service Area and may range from comprehensive guidance on practice redesign to providing assistance with practice redesign and performance-enhancing activities. These activities shall include at least one activity relating to each of the following topics and address how each activity achieves the goals of practice/medical home transformation, client/family centered care, and team based care:

3.8.2.1.1. Operational practice support.

3.8.2.1.2. Clinical tools.

3.8.2.1.3. Client or Member materials.

3.8.2.1.4. Inappropriate utilization of services and methods for diverting Members to the most appropriate care setting.

3.8.2.1.5. Planned method of Medical Management Support and an assessment of the efficacy or success of the last method tried.

3.8.2.1.5.1. DELIVERABLE: Practice Support Plan

3.8.2.1.5.2. DUE: Annually, within the first three (3) months of the state fiscal year

3.8.2.2. The Contractor shall provide tools to the PCMPs that include the following:

3.8.2.2.1. Clinical Tools:

3.8.2.2.1.1. Clinical care guidelines and best practices

3.8.2.2.1.2. Clinical screening tools, such as depression screening tools and substance use screening tools.

3.8.2.2.1.3. Health and functioning questionnaires.

3.8.2.2.1.4. Chronic care templates.

3.8.2.2.1.5. Registries.

3.8.2.2.2. Client Materials:

3.8.2.2.2.1. Client reminders.

3.8.2.2.2.2. Self-management tools.

3.8.2.2.2.3. Educational materials about specific conditions.

3.8.2.2.2.4. Client action plans.

3.8.2.2.2.5. Behavioral health surveys and other self-screening tools.

3.8.2.2.3. Operational Practice Support:

3.8.2.2.3.1. Guidance and education on the principles of the Medical Home.

3.8.2.2.3.2. Training on providing culturally competent care.

3.8.2.2.3.3. Training to enhance the health care skills and knowledge of supporting staff.

3.8.2.2.3.4. Guidelines for motivational interviewing.

3.8.2.2.3.5. Tools and resources for phone call and appointment tracking.

3.8.2.2.3.6. Tools and resources for tracking labs, Referrals and similar items.

3.8.2.2.3.7. Referral and transitions of care checklists.

3.8.2.2.3.8. Visit agendas or templates.

3.8.2.2.3.9. Standing pharmacy order templates.

3.8.2.2.4. Data, Reports and Other Resources:

3.8.2.2.4.1. Expanded provider network directory.

3.8.2.2.4.2. Comprehensive directory of community resources.

3.8.2.2.4.3. Directory of other Department-sponsored resources, such as the managed care ombudsman and nurse advice line.

3.8.2.2.4.4. Link from main ACC Program website to the Contractor's website of centrally located tools and resources.

3.8.2.3. Provider Support Accessibility

3.8.2.3.1. The Contractor shall have an internet-accessible website that contains, at a minimum, all of the following:

3.8.2.3.1.1. General information about the ACC Program, the Contractor entity, the Contractor's role and purpose and the principles of a Medical Home.

3.8.2.3.1.2. A network directory listing providers and PCMPs with whom the Contractor has a contract, their contact information and provider characteristics such as gender, languages spoken, whether they are currently accepting new Medicaid clients and links to the provider's website if available.

3.8.2.3.1.3. A provider page or section that contains a description of the support the Contractor offers to providers, an online library of available tools, screenings, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled.

3.8.2.3.1.4. A listing of immediately available resources to guide providers and their Members to needed community-based services, such as child care, food assistance, services supporting elders, housing, utility assistance and other non-medical supports.

3.8.2.4. The Contractor shall use a health information exchange, such as Quality Health Network, to facilitate improved clinical information sharing, where such services are available, and only to the extent that data is accessible under the terms of any applicable HIPAA Business Associate agreements.

3.8.2.5. The Contractor shall provide interpreter services for all interactions with Members or Clients when there is no bilingual or multilingual Member of the Contractor available who speaks a language understood by a Member.

3.8.2.5.1. The Contractor may provide interpreter services for any PCMP in the Contractor's Region or any other provider with whom the Contractor has an agreement that the provider needs to interact with Members.

3.9. COMPLIANCE AND MONITORING

3.9.1. Utilization Management

3.9.1.1. The Contractor shall follow CMS regulations regarding Utilization Management in 42 C.F.R. Section 438, *et seq*.

3.9.1.2. The Contractor shall have a mechanism in effect to ensure consistent application of review criteria for authorization decisions and consultation with the requesting Provider when appropriate. The Contractor shall notify the requesting provider of any decision to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice to the Provider may be oral or in writing.

3.9.1.2.1. The Contractor, and its Subcontractors, shall have in place a set of written policies and procedures for processing requests for initial and continuing authorizations of services, and shall follow all policies and procedures.

3.9.1.3. The Contractor shall provide information to Members and Participating Providers, in appropriate formats, about how the Contractor's Utilization Management program functions and is utilized to determine the Medical Necessity of Covered Services. This information shall include appropriate points of contact with the program, contact persons or numbers for information or questions, and information about how to initiate appeals related to Utilization Management determinations.

3.9.1.3.1. The Contractor shall provide information to Members, at the time of the Member's Enrollment, which includes, but is not limited to, the purpose of the Contractor's Utilization Management program and how the program works.

3.9.1.3.2. The Contractor shall provide information to Participating Providers, at the time an agreement with that Provider is executed, that includes, but is not limited to, necessary information and guidelines to enable the Provider to understand and participate appropriately in the Utilization Management program.

3.9.1.4. The Contractor shall maintain data systems sufficient to support Utilization Management review program activities and to generate management reports that enable the Contractor to effectively monitor and manage Covered Services, grievances and appeals and Disenrollments for reasons other than loss of Medicaid eligibility.

3.9.1.5. The Contractor shall ensure 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 clinical expertise in treating the Member's condition or disease.

3.9.1.6. Utilization Management review shall be conducted under the direction of a qualified clinician.

3.9.2. Compliance Monitoring

3.9.2.1. The Contractor shall comply with requirements and limitations regarding abortions, hysterectomies and surgical sterilizations and shall maintain certifications and documentation specified in 42 C.F.R. §441, Subparts E and F. The certifications and documentations, as well as any summary reports, shall be available to the Department within ten (10) business days of the Department's request.

3.9.2.2. Upon the Department's request, the Contractor shall submit to the Department any appropriate information necessary for the Department to issue a Certificate of Creditable Coverage on behalf of a Member whose eligibility for Medicaid has ended as the Department is required to do under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320d – 1320d-8, and its implementing regulations.

3.9.3. Other Monitoring Activities

3.9.3.1. The Contractor shall participate in and respond to other Department compliance monitoring activities, including but not limited to:

3.9.3.1.1. Encounter Claims Data analysis and Encounter Claims Data validation (the comparison of Encounter Claims Data with Medical Records).

3.9.3.1.2. Appeals analysis to identify trends in the Medicaid program and among managed care organizations.

3.9.3.1.3. Other reviews determined by the Department.

3.9.3.2. The Department may determine Contractor compliance with individual requirements under this Contract based upon satisfactory review by recognized state agencies or private accreditation organizations.

3.9.4. Inspection, Monitoring and Site Reviews

3.9.4.1. Site Reviews

3.9.4.1.1. The Department may conduct Site Reviews of the Contractor's, Subcontractors' or Participating Providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in its sole discretion. The Department will conduct these Site Reviews for the purpose of determining compliance by the Contractor with applicable Department regulations and the requirements of this Contract. In the event that right of access is requested under this section, the Contractor and/or its Subcontractors or Participating Providers shall, provide and make available staff to assist in the audit or inspection effort. They shall provide adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of the Contractor's, Subcontractor's or Participating Providers' provision of care.

3.9.4.1.2. An emergency or unannounced review may be required in instances where Member safety, quality of medical care, potential fraud or financial viability is at risk. The Department may determine when an emergency review is required in its sole discretion.

3.9.4.1.3. For non-emergency Site Reviews, the Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted for mutually agreed upon dates for a Site Review. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to the Contractor at least three (3) weeks prior to the visit. The Contractor shall submit copies of policies, procedures, manuals, handbooks, reports, and other requested materials to facilitate the Department's Desk Audit prior to the Site Review. The Contractor shall have a minimum of thirty (30) days to submit the required materials for non-emergency reviews.

3.9.4.1.4. The Contractor shall make available, to the Department and its agents for Site Review, all records and documents related to the execution of this Contract, either on a scheduled basis as noted elsewhere in this section, or immediately on an emergency basis. Delays in the availability of such documents and records may subject the Contractor to remedial actions, as specified in this Contract. These records and documents shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records and documents.

3.9.4.1.5. A written report of the site visit will be transmitted to the Contractor within forty five (45) days of the Site Review. The Contractor shall be allowed thirty (30) days to review the preliminary report and respond to the findings. The final report will indicate areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response will be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.

3.9.4.1.6. The Contractor shall respond to any required actions, if necessary, with a corrective action plan within thirty (30) days of the final written report, specifying the action to be taken to remedy any deficiencies noted by the Department or its agents and time frames to implement these remedies. The corrective action plan is subject to approval by the Department. The Department will monitor progress on the corrective action plan until the Contractor is found to be in complete compliance. Department will notify the Contractor in writing when the corrective actions have been completed, accepted and the Contractor is considered to be in compliance with Department regulations and this Contract.

3.9.4.1.7. The Department may extend the time frame for corrective action in its sole discretion. The Department may also reduce the time frame for corrective action if delivery of Covered Services for Members is adversely affected or if the time reduction is in the best interests of Clients or Members, as determined by the Department. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.

3.9.4.1.8. Any data submitted by the Contractor to the Department or its agents after the last site visit day will not be accepted towards compliance with the visit in the written report. This data will only apply toward the corrective action plan.

3.9.4.1.9. The Site Review may include reviews of a sample of Participating Providers to ensure that Providers have been educated and monitored by the Contractor about the requirements under this Contract.

3.9.5. Contractor Review of Studies, Inspections, Site Reviews and Audits

3.9.5.1. The Department shall submit the results of any studies, inspections, Site Reviews or audits of the Contractor, or its Subcontractors or Participating Providers, to the Contractor for review. The Contractor shall have ten (10) business days to review the results of the study or audit prior to the Department releasing those results to the public. The Department may consider the Contractor's review or comments before releasing those results to the public.

3.9.6. Encounter Claims Data Provisions

3.9.6.1. The Contractor shall certify all Encounter Claims Data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

3.9.6.2. Contractor shall submit all Encounter Claims Data electronically, following the Colorado Medical Assistance Program policy rules found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). Encounter data shall be submitted in the current ANSI ASC X12N 837 version directly to the Department's fiscal agent using the Department's data transfer protocol. Contractor shall follow the guidelines for data submission set forth in the 837 X12N Companion Guide Specifications provided by the Department available at: http://www.colorado.gov/.

3.9.6.2.1. 837-format encounter claims, reflecting all medical, facility and supplier claims paid and/or adjusted by the Contractor, shall be submitted via a regular monthly batch process to the MMIS as follows:

3.9.6.2.1.1. All encounter claims shall be submitted in accordance with applicable HIPAA transaction guides posted at http://www.wpc-edi.com.

3.9.6.2.1.2. For Hospital, Ambulatory Surgery Center and Home Health Encounter Claims:

3.9.6.2.1.2.1. Both inpatient and outpatient Hospital and home health encounter claims include paid services provided by a Hospital, ambulatory surgery center or home health agency. These encounter claims shall contain revenue and procedure codes, as appropriate. One encounter claim shall be submitted for each hospitalization, outpatient visit or outpatient surgery. Multiple home health visits may be on one home health encounter claim. The encounter claim shall represent all services delivered to the Member during the billing episode billed.

3.9.6.2.1.2.2. Hospital, ambulatory surgery center and home health encounter claims shall be submitted using the ANSI 837I, Health Care Claim Institutional format.

3.9.6.2.1.2.3. Certain services, such as an infusion during home health, may be billed on an ANSI 837P, Health Care Claim Professional format rather than an ANSI 837I, Health Care Claim Institutional format. Such services may be submitted in the format received by the Contractor from the Provider.

3.9.6.2.1.3. For Pharmacy Encounter Claims:

3.9.6.2.1.3.1. Pharmacy encounter claims refer to all paid pharmaceuticals prescriptions. Paid pharmaceuticals prescriptions shall not include denied claims.

3.9.6.2.1.3.2. A pharmacy encounter Claim is a single prescription. If a single Member has multiple prescriptions filled from a single Provider a separate Pharmacy Encounter Claim should be submitted for each prescription.

3.9.6.2.1.3.3. All pharmacy encounters claims shall be submitted using the HIPAA compliant format approved by the National Council for Prescription Drug Program (NCPDP).

3.9.6.2.1.4. For Medical Encounter Claims:

3.9.6.2.1.4.1. Medical encounter claims include paid services delivered by any Provider. These claims may include, but are not limited to services delivered by medical groups, practices, clinics, Physicians, mid-level practitioners, medical equipment suppliers, family planning clinics, independent laboratories, optometrists, podiatrists, FQHCs, freestanding rehabilitation centers, or any other Providers.

3.9.6.2.1.4.2. When a Member receives services from multiple Providers in the same day, Contractor shall submit separate encounter claims for each visit for each Provider.

3.9.6.2.1.4.3. Medical encounters shall be submitted using the ANSI 837P, Health Care Claim professional format. The Contractor shall submit all claims in compliance with the Provider Billing Manual Guidelines, available at http://www.colorado.gov/hcpf.

3.9.6.2.1.4.4. The Contractor shall comply with the process for family planning documentation methodology and reporting, shown in Exhibit L, Family Planning Documentation Methodology and Reporting.

3.9.6.2.1.5. Each 837-format claim submitted shall identify provider types as follows:

3.9.6.2.1.5.1. The Billing Provider ID shall be the Medical Assistance Program Provider Pseudo ID assigned by the Department to the Contractor for each provider type that is billed using the 837P format. The Billing Provider ID shall be the Medical Assistance Program Provider Medicaid ID assigned by the Department for each provider type that is billed using the 837I format.

3.9.6.2.1.5.2. Rendering (and attending) Provider ID shall be Managed Care Plan's Medicaid ID assigned to the Contractor by the Department.

3.9.6.2.1.5.3. The Pay-to-Provider will not be submitted on Encounter claims.

3.9.6.2.2. For 837-format submissions, Contractor shall submit actual claim paid amounts

3.9.6.2.3. Contractor shall use the enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. Such data transmissions and enrollment reports shall include:

3.9.6.2.3.1. Medicaid Management Information System (MMIS) reports, which verify Medicaid eligibility

3.9.6.2.3.2. Daily generated Prepaid Health Plan (PHP) Manually Override of enrollment data changes (R0268)

3.9.6.2.3.3. Daily generated PHP Disenrollment Report (R0305)

3.9.6.2.3.4. Monthly generated PHP Disenrollment Report (M0305)

3.9.6.2.3.5. Monthly generated PHP Enrollment Change Report (R0310)

3.9.6.2.3.6. Monthly generated PHP Current Membership Report (R0315)

3.9.6.2.3.7. Daily generated PHP New Membership Report (R0325)

3.9.6.2.3.8. Monthly generated PHP New Membership Report (M0325)

3.9.6.2.3.9. Monthly generated PHP Capitation Summary Report (R0360)

3.9.6.2.3.10. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction

3.9.6.2.3.11. HIPAA compliant X12N 834 Health Care Enrollment and Maintenance standard transaction

3.9.6.2.4. Contractor, on a quarterly basis, shall electronically submit a flat file table that contains all encounters for that SFY year, with one record per encounter, which the Contractor shall certify is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

3.9.6.2.5. Flat file tables shall be submitted per the specifications listed in Exhibit D.

3.9.7. Cybersecurity

3.9.7.1. The Contractor shall ensure that all of its information technology systems and websites are operated and maintained in compliance with all state and federal statutes, regulations and rules and all State of Colorado Cyber Security Policies, in accordance with a reasonable implementation plan.

3.9.8. SDAC Access Compliance

3.9.8.1. The Contractor shall comply with the Department's SDAC Web Portal access policy.

3.10. SERIOUS REPORTABLE AND NEVER EVENTS

3.10.1. The Contractor shall track all Serious Reportable Events as described in Exhibit J, Serious Reportable Events or Never Events and any service with the Present on Admission (POA) indicator at the time of a hospital admission.

3.10.1.1. The Contractor or rendering Provider shall not bill the Client or Medicaid for POA related services.

3.10.1.2. Contractor shall not reimburse any Provider for the additional costs resulting from the hospital acquired conditions and Serious Reportable Events in Exhibit J.

3.11. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

3.11.1. The Contractor shall maintain an internal quality assessment and performance improvement program that complies with 42 C.F.R. §438.200 for all Covered Services.

3.11.2. The scope of the Contractor's internal quality assessment and performance improvement program shall be comprehensive and shall include, but not be limited to:

3.11.2.1. Practice Guidelines.

3.11.2.1.1. The Contractor shall develop practice guidelines for the following:

3.11.2.1.1.1. Perinatal, prenatal and postpartum care for women;

3.11.2.1.1.2. Conditions related to Persons with a Disability or Special Health Care Needs; and

3.11.2.1.1.3. Well child care.

3.11.2.1.2. The Contractor shall ensure that practice guidelines comply with the following requirements:

3.11.2.1.2.1. The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.

3.11.2.1.2.2. The guidelines consider the needs of the Member.

3.11.2.1.2.3. They are adopted in consultation with Participating Providers.

3.11.2.1.2.4. The Contractor reviews and updates the guidelines at least annually.

3.11.2.1.3. The Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to Members, Clients, the Department, other non-Members and the public at no cost.

3.11.2.1.4. The Contractor shall ensure that decisions regarding Utilization Management, Member education, Covered Services and other areas to which the guidelines apply are consistent with the guidelines to the extent that services set forth in the guidelines are Covered Services hereunder.

3.11.2.2. Performance Improvement Projects (PIPs)

3.11.2.2.1. The Contractor shall conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

3.11.2.2.2. PIPs shall follow requirements as outlined in External Quality Review Organization (EQRO) Protocol Validating Performance Improvement Projects and as directed by the Department.

3.11.2.2.3. The Contractor shall conduct PIPs on topics selected by the CMS when the Department is directed by CMS to focus on a particular topic.

3.11.2.2.4. The Contractor shall ensure that PIPs include the following:

3.11.2.2.4.1. Measurement of performance using objective quality indicators.

3.11.2.2.4.2. Implementation of system interventions to achieve improvement in quality.

3.11.2.2.4.3. Evaluation of the effectiveness of the interventions.

3.11.2.2.4.4. Planning and initiation of activities for increasing or sustaining improvement.

3.11.2.2.5. In addition to the standard PIP, the Contractor shall engage in a new PIP designed to demonstrate the uniqueness and value of this Contract as determined by the Department.

3.11.2.2.6. The Contractor shall complete performance improvement projects in a reasonable time period in order to facilitate the integration of project findings and information into the overall quality assessment and improvement program and to produce new information on quality of care each year.

3.11.2.2.7. The Contractor shall participate in an annual PIP learning collaborative hosted by the Department.

3.11.2.2.7.1. DELIVERABLE: Performance Improvement Projects.

3.11.2.2.7.2. DUE: To be determined by the Department.

3.11.2.3. Performance Measurement Data

3.11.2.3.1. Healthcare Effectiveness Data and Information Set (HEDIS)

3.11.2.3.1.1. The Contractor shall calculate and submit specified HEDIS measures. The Department will collaborate with the Contractor's quality improvement committee to designate the required measures.

3.11.2.3.1.2. The Contractor shall analyze and respond to results indicated in the HEDIS measures.

3.11.2.3.1.3. The Contractor shall contract with a NCQA (National Committee for Quality Assurance) certified individual entity to perform an external audit of the HEDIS measures according to HEDIS protocols.

3.11.2.3.1.4. Any failed audit that nullifies more than three (3) required HEDIS measures is considered non-compliant with this requirement.

3.11.2.3.2. Mandatory Federal Performance Measurements

3.11.2.3.2.1. The Contractor shall calculate additional performance measures when they are developed and required by CMS.

3.11.2.4. Member Satisfaction

3.11.2.4.1. The Contractor shall monitor Member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor shall use tools to measure these Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, grievance and appeals data and Enrollment and Disenrollment information.

3.11.2.4.2. The Contractor shall fund an annual Member satisfaction survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) with all Department directed supplemental questions, surveys and populations, administered by a certified survey vendor according to appropriate survey protocols. In lieu of a satisfaction survey conducted by an external entity, the Department, at the Department's discretion, may conduct the survey. The Contractor shall deliver any surveys to the Department for review and shall not administer any survey until it has received the Department's approval of that survey. The Contractor shall report to the Department or the Department's designated contractor results and all raw data of internal satisfaction surveys of Members designed to identify areas of satisfaction and dissatisfaction by June 30th of each fiscal year.

3.11.2.4.3. The Contractor shall develop a corrective action plan when Members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected or when a serious complaint is reported.

3.11.2.4.4. The Contractor shall implement and maintain a mechanism to assess the quality and appropriateness of care for Persons with Special Health Care Needs.

3.11.2.5. Mechanisms to Detect Over and Under Utilization

3.11.2.5.1. The Contractor shall implement and maintain a mechanism to detect overutilization and underutilization of services and to assess the quality and appropriateness of care furnished to Members, including Members with special health care needs. These mechanisms may incorporate those developed for the Contractor's Utilization Management program.

3.11.2.6. Quality of Care Concerns

3.11.2.6.1. The Contractor shall investigate any alleged quality of care concerns.

3.11.2.6.2. In response to a request from the Department in relation to any quality of care concern, the Contractor shall submit a letter to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue and the outcome of the review as determined by the Contractor. The outcome shall include whether or not the issue was found to be a quality of care issue and what action the Contractor intends to take with the Provider or Providers involved. The letter shall not include any names of the persons conducting the investigation or participating in any peer review process.

3.11.2.6.2.1. The letter shall be delivered to the Department within ten (10) business days of the Department's request. Upon request, the Department may allow additional time to investigate and report. If the Contractor refers the matter to a peer review process, it shall inform the Department of that referral.

3.11.2.6.2.2. Notwithstanding any other provision of this Contract, the Contractor may not disclose any information that is confidential by law. After the letter is received by the Department, if there is a request for public disclosure pursuant to the Colorado Open Records Act at Section 24-72-203, C.R.S., the Department will assert any applicable exemptions and, if none apply, will petition the court pursuant to Section 24-72-204(6)(a), C.R.S. to prohibit disclosure.

3.11.2.7. Quality Improvement Committee

3.11.2.7.1. The Contractor shall participate in the Department's Medical Quality Improvement Committee (MQuIC) to provide input and feedback regarding quality improvement priorities, performance improvement topics and measurements and specifics of reporting formats and time frames, and other collaborative projects.

3.11.2.8. Performance Improvement Advisory Committee (PIAC)

3.11.2.8.1. The Contractor shall create a Performance Improvement Advisory Committee to provide input into the Contractor's implementation of the ACC Program and the Contractor's own performance improvement program. The Performance Improvement Advisory Committee shall:

3.11.2.8.1.1. Be directed and chaired by one of Contractor's Key Personnel.

3.11.2.8.1.2. Have a formal, documented membership and governance structure.

3.11.2.8.1.3. Have a diverse membership, representative of the Contractor's Region, which includes members representing at least the following:

3.11.2.8.1.4. Members.

3.11.2.8.1.4.1. Member's families.

3.11.2.8.1.5. Advocacy groups and organizations.

3.11.2.8.1.6. The PCMP network.

3.11.2.8.1.7. Other Medicaid providers.

3.11.2.8.1.8. The Behavioral Health community.

3.11.2.8.1.9. Charitable, faith-based or service organizations within the community.

3.11.2.8.1.10. Hold regularly scheduled meetings, no less often than on a quarterly basis.

3.11.2.8.1.11. Open all scheduled meetings to the public.

3.11.2.8.1.12. Post the minutes of each meeting on the Contractor's website within ten (10) days of each meeting.

3.11.2.8.1.12.1. DELIVERABLE: Posted meeting minutes, meeting information for upcoming meetings, and the name and direct phone number of a contact person on the Contractor's website.

3.11.2.8.1.12.2. DUE: Ten (10) business days from the date of the meeting.

3.11.2.9. The ACC Program Improvement Advisory Committee

3.11.2.9.1. The Contractor shall provide one representative to serve as a member of the Department's ACC Program Improvement Advisory Committee. This individual shall be the Contractor's representative to the ACC Program Improvement Advisory Committee. The ACC Program Improvement Advisory Committee will solicit input and feedback on the ACC Payment Reform Pilot Program (this Contract) as one area of the ACC program.

3.11.2.10. Program Impact Analysis

3.11.2.10.1. The Contractor shall maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis.

3.11.2.10.2. Upon request, this information shall be made available to Providers and Members at no cost.

3.11.2.10.2.1. DELIVERABLE: Program Impact Analysis

3.11.2.10.2.2. DUE: Annually, by the last business day in September

3.11.2.11. Quality Improvement Plan

3.11.2.11.1. The Contractor shall provide a quality improvement plan to the Department. The plan shall delineate current and future quality assessment and performance improvement activities. The plan shall integrate findings and opportunities for improvement identified in HEDIS measurements, member satisfaction surveys, performance improvement projects and other monitoring and quality activities as required by the Department. The plan is subject to the Department's approval.

3.11.2.11.1.1. DELIVERABLE: Quality Improvement Plan

3.11.2.11.1.2. DUE: Annually, by the last business day in September

3.11.2.12. External Review

3.11.2.12.1. The Contractor shall participate in the annual external independent review of quality outcomes, timeliness of, and access to the services covered under this Contract. The external review may include but not be limited to all or any of the following:

3.11.2.12.1.1. Medical Record review.

3.11.2.12.1.2. Performance improvement projects and studies.

3.11.2.12.1.3. Surveys.

3.11.2.12.1.4. Calculation and audit of quality and utilization indicators.

3.11.2.12.1.5. Administrative data analyses.

3.11.2.12.1.6. Review of individual cases.

3.11.2.12.2. For external review activities involving Medical Record abstraction, the Contractor shall be responsible for obtaining copies of the Medical Records from the sites in which the services reflected in the encounter occurred.

3.11.2.12.3. The Contractor shall participate in the development and design of any external independent review studies to assess and assure quality of care. The final study specifications shall be at the discretion of the Department.

3.11.2.13. Health Information Systems

3.11.2.13.1. The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, encounters and Disenrollment.

3.11.2.13.2. The Contractor shall collect data on Member and Provider characteristics and on services furnished to Members.

3.11.2.13.3. The Contractor shall make all collected data available to the Department and to CMS upon request.

3.11.2.13.4. The Contractor shall ensure that the data received from providers is accurate and complete, by:

3.11.2.13.4.1. Verifying the accuracy and timeliness of reported data;

3.11.2.13.4.2. Screening the data for completeness; and

3.11.2.13.4.3. Collecting service information in standardized formats to the extent feasible and appropriate.

3.11.2.13.5. The Contractor shall make timely, good faith and reasonable efforts to work with the Department and any of the Department's contractors, as directed by the Department, in order to promote efficiency and the health and welfare of Clients and meet the requirements and timelines set forth in the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) and subsequent rules.

SECTION 4.0 MEMBER AND PROVIDER ISSUES

4.1. MEMBER ISSUES

4.1.1. Member Services, Rights and Responsibilities

4.1.1.1. The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with all the following rights, and shall follow all such policies and procedures:

4.1.1.1.1. Contractor shall comply with any applicable federal and state laws that pertain to Member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Members.

4.1.1.1.2. Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

4.1.1.1.3. Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

4.1.1.1.4. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

4.1.1.1.5. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

4.1.1.1.6. Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.

4.1.1.1.7. Each Member is guaranteed the right to be furnished with health care services in accordance with 42 CFR § 438.206 through § 438.210.

4.1.1.1.8. Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor, Subcontractors, providers or the Department treats the Member.

4.1.1.1.9. To receive, from the Provider and at the times specified in 42 C.F.R. Section 489.102, information concerning the implementation of Advance Directives, including a clear and precise statement of limitation if the Provider cannot implement an Advance Directive on the basis of conscience. The information shall include the Member's rights under this Contract, the Contractor's policies regarding the implementation of those rights and a statement regarding the fact that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment. Such information shall be provided in writing or an alternate format appropriate for the Member. Changes in state law shall be reflected in the Contractor's written material no later than ninety (90) days after the effective date of the change.

4.1.1.2. Member Responsibilities

4.1.1.2.1. The Contractor shall establish and maintain written requirements for Member participation and the responsibilities of Members in receiving Covered Services that are consistent with all responsibilities enumerated in 10 C.C.R. 2505-10, §8.205.2 and any amendments thereto.

4.1.1.3. Written Policies, Procedures and Information Relating to Members

4.1.1.3.1. The Contractor shall establish and maintain written policies and procedures regarding the rights and responsibilities of Members that incorporate the rights and responsibilities identified by the Department in this Contract. These policies and procedures shall include the components described in this section and address the elements listed in Exhibit K, Member Information.

4.1.1.3.2. The Contractor shall provide to all Members, including new Members, a Member handbook. This Member handbook shall include general information about services offered by the Contractor and complete statements concerning Member rights and responsibilities as listed in this section within a reasonable time after the Contractor is notified of the Enrollment. The Member handbook shall include all of the minimum requirements listed in Exhibit K. The Department may review the Member handbook upon request and the Contractor shall make any changes to the Member handbook directed by the Department within forty-five (45) days of the Department's request.

4.1.1.3.3. Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department. All materials shall be written in English and Spanish, or any other prevalent language, as directed by the Department or as required by 42 CFR 438. The Contractor shall notify all Members and potential Members of the availability of alternate formats for the information, as required by 42 CFR 438.10, and how to access such information.

4.1.1.3.4. The Contractor shall include in its Member handbook and Marketing Materials a provision clearly stating that Enrollment in the Contractor's Plan is voluntary. Contractor shall include information in its Member handbook about how to request disenrollment.

4.1.1.3.5. The Contractor may provide Members with similar information, in the same manner as that information is provided to private or commercial Members, but shall also provide Members with additional information as appropriate to promote compliance with this Contract.

4.1.1.3.6. The Contractor shall provide a copy of the policies on Members' rights and responsibilities to all Participating Providers and Subcontractors and ensure that Participating Providers and Subcontractors are aware of information being provided to Members including:

4.1.1.3.6.1. The Members' right to a state fair hearing, how to obtain a hearing, and the representation rules at a hearing.

4.1.1.3.6.2. The Members' right to file grievances and appeals and the requirements and timeframes for filing.

4.1.1.3.6.3. The availability of assistance with filing grievances and appeals and the toll-free number to file oral grievances and appeals.

4.1.1.3.6.4. The Members' right to request continuation of benefits during an appeal or State Fair Hearing and that the Member may be liable for the cost of any continued benefits if the action is upheld.

4.1.1.3.6.5. The Provider's appeal rights to challenge the failure of the Contractor to cover a service.

4.1.1.3.7. The Contractor and its representatives shall not knowingly provide untrue or misleading information, as defined at §10-16-413 (1)(a)-(c), C.R.S., regarding the Contractor's Plan or Medicaid eligibility, to Clients or Members.

4.1.1.4. Notices of Changes, Information and Actions

4.1.1.4.1. The Contractor shall notify all Members of their right to request and obtain the information listed in Exhibit K, at least once per year. The Contractor shall also notify Members of any significant changes in the following information at least thirty (30) days prior to the effective date of the change. Significant changes include, but are not limited to:

4.1.1.4.1.1. The amount, duration and scope of Covered Services available.

4.1.1.4.1.2. Procedures for obtaining Covered Services, including authorization requirements.

4.1.1.4.1.3. The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers.

4.1.1.4.1.4. The extent to which, and how, after-hours and Emergency Services are provided including:

4.1.1.4.1.4.1. What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services.

4.1.1.4.1.4.2. The fact that prior authorization is not required for Emergency Services.

4.1.1.4.1.4.3. The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local equivalent.

4.1.1.4.1.4.4. The locations of any emergency settings and other locations at which Providers and Hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract.

4.1.1.4.1.4.5. The fact that, subject to the provisions of this section, the Member has the right to use any Hospital or other setting for Emergency Services.

4.1.1.4.1.5. Policy on Referrals.

4.1.1.4.1.6. Any cost sharing or co-pays that the Member is responsible for in relation to the receipt of a Covered service.

4.1.1.4.1.6.1. All cost sharing and co-pays shall be implemented and imposed in accordance with 42 CFR 447.50 through 42 CFR 447.60.

4.1.1.4.1.7. How and where to access Wrap Around Benefits, including any cost sharing and how transportation is provided. For a counseling or Referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service the Department will provide this information.

4.1.1.4.2. The Contractor shall provide written notice to all Members affected by an adverse action within the timeframes described in Section 4.1.1.4.

4.1.1.4.2.1. An action is defined as the:

4.1.1.4.2.1.1. Denial or limited authorization of a requested service, including the type or level of service.

4.1.1.4.2.1.2. Reduction, suspension or termination of a previously authorized service.

4.1.1.4.2.1.3. Denial, in whole or in part, of payment for a service.

4.1.1.4.2.1.4. Failure to provide services in a timely manner.

4.1.1.4.2.1.5. Failure of the Contractor to act within the timeframes.

4.1.1.4.2.1.6. Denial of a rural area resident Member's request to obtain services outside the network:

4.1.1.4.2.1.6.1. From any other provider (in terms of training, experience, and specialization) not available within the network.

4.1.1.4.2.1.6.2. From a non-network provider who is the main source of a service to the recipient, as long as that provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the Contractor shall give the Member a choice of participating providers and the Member shall be transitioned to a participating provider within sixty (60) days.

4.1.1.4.2.1.6.3. Because the only plan or provider available does not provide the service due to moral or religious objections.

4.1.1.4.2.1.6.4. Because the Member's provider determines that the Member needs related services that would subject the Member to unnecessary risk if received separately and not all related services are available within the network.

4.1.1.4.2.1.6.5. Because the Department determines that other circumstances warrant out-of-network treatment.

4.1.1.4.2.2. All notices of adverse action shall contain, at a minimum, all of the following:

4.1.1.4.2.2.1. The action the Contractor or its Subcontractor has taken or intends to take.

4.1.1.4.2.2.2. The reasons for the action.

4.1.1.4.2.2.3. The Member's or the Provider's right to file an appeal.

4.1.1.4.2.2.4. The Member's right to request a State Fair Hearing.

4.1.1.4.2.2.5. Procedures for exercising Member's rights to appeal or grieve.

4.1.1.4.2.2.6. Circumstances under which expedited resolution is available and how to request it.

4.1.1.4.2.2.7. The Member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

4.1.1.4.3. The Contractor shall notify all affected Members, whenever the Contractor terminates, suspends or reduces any previously authorized Covered Service. The Contractor shall provide this notice at least ten (10) days prior to the termination, suspension or reduction, except:

4.1.1.4.3.1. The period of advanced notice is shortened to five (5) days if probable recipient fraud has been verified.

4.1.1.4.3.2. The notice shall be provided by the date of the termination, suspension or reduction for the following:

4.1.1.4.3.2.1. The death of a Member.

4.1.1.4.3.2.2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services, where the Member understands that this will be the result of supplying that information.

4.1.1.4.3.2.3. The Member's admission to an institution where the Member is ineligible for further services.

4.1.1.4.3.2.4. The Member's address is unknown and mail directed to him has no forwarding address.

4.1.1.4.3.2.5. The Member has been accepted for Medicaid services by another local jurisdiction.

4.1.1.4.3.2.6. The Member's physician prescribes the change in the level of medical care.

4.1.1.4.3.2.7. An adverse determination is made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989.

4.1.1.4.3.2.8. For adverse actions relating to a nursing facility transfer, the safety or health of individuals in the nursing facility where the Member is a resident would be endangered, the resident Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident Member's urgent medical needs, or a resident Member has not resided in the nursing facility for thirty (30) days.

4.1.1.4.4. The Contractor shall notify a Member of a denial of any payment for a claim made by that Member on the date of the denial, as required by 42 CFR 438.404.

4.1.1.4.5. The Contractor shall notify the Member of any standard Service Authorization denial within ten (10) days of the Member's request for the service.

4.1.1.4.5.1. In the event that the Department approves the Contractor's justifiable need for additional information in relation to a Service Authorization, or at the request of the Member or the member's provider, the due date for the notification may be extended for an additional fourteen (14) days.

4.1.1.4.5.2. If a Provider or the Contractor determine that the standard Service Authorization timeline would jeopardize a Member's life or health or ability to attain, maintain, or regain maximum function, then the Contractor shall notify that Member of a Service Authorization denial as expeditiously as required by the Member's condition, but not longer than three (3) business days from the Member's request for service.

4.1.1.4.5.3. When Service Authorization decisions are not reached within the applicable standard or expedited timeframes, the Contractor shall give notice on the date that the timeframes expire.

4.1.1.4.5.4. If the Contractor does not notify a Member of a Service Authorization decision within the timeframes in this section, the Contractor shall be deemed to have denied the Service Authorization and that Member shall have any rights relating to the Service Authorization that the Member would have if the Contractor had denied it.

4.1.1.4.6. The Contractor shall ensure that all information shown in Exhibit K, Member Information, is made available to every Member.

4.1.2. Grievance Process

4.1.2.1. The Contractor shall establish and maintain a grievance process through which Members may file any complaint they have that is not the result of an action subject to an appeal.

4.1.2.1.1. The Contractor shall ensure that information about the grievance process, including how to file a grievance, is available to all Members.

4.1.2.1.2. The Contractor shall only create a grievance process that provides a Member sufficient time to disenroll, no later than the first (1st) day of the second (2^{nd}) month following the month in which the Member or the Contractor files the request to disenroll, based on the timeframe specified in 42 CFR 438.56(e)(1) if the Contractor approves a disenrollment in response to a grievance.

4.1.2.1.3. The Contractor shall allow a Member to file a grievance either orally or in writing and shall acknowledge receipt of each grievance.

4.1.2.1.3.1. The Contractor shall give Members assistance in completing forms and other procedural steps in the grievance process, not limited to providing interpreter services and toll-free numbers with a Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability.

4.1.2.1.3.2. The Contractor shall ensure that decision makers on grievances were not involved in previous levels of review or decision-making.

4.1.2.1.3.2.1. The decision maker shall be a health care professional with clinical expertise in treating the Member's condition or disease if any of the following apply:

4.1.2.1.3.2.1.1. A grievance regarding denial of expedited resolutions of an appeal.

4.1.2.1.3.2.1.2. Any grievance involving clinical issues.

4.1.2.1.4. The Contractor shall make a decision regarding the grievance and provide notice to the Member of this decision within fifteen (15) business days of when the Member files the grievance.

4.1.2.1.4.1. This notice shall be made in a form and format approved by the Department.

4.1.2.1.5. If a Member is dissatisfied with the disposition of a grievance, the Member may bring the unresolved grievance to the Department. The Department's decision shall be final.

4.1.3. Appeal Process

4.1.3.1. The Contractor shall establish and maintain an internal appeal process under which a Member may challenge the denial of coverage of, or payment for, services in accordance with 42 C.F.R. §438.400 *et seq.*, as amended. In addition, the Contractor shall support the Department by attending and responding to State Fair Hearings notices regarding its Members.

4.1.3.2. The Contractor's appeal process shall comply with 10 C.C.R. 2505-10, §8.209, Medicaid Managed Care Grievance and Appeal Processes.

4.1.3.3. A Member's request for a review of any action, taken by the Contractor in relation to that Member, shall be considered an appeal.

4.1.3.3.1. A Member or a Provider shall be allowed to appeal any action by filing an appeal within thirty (30) days of when the Contractor has notified the Member or the Provider of the action.

4.1.3.3.2. A Member or a Provider shall be allowed to file an appeal either orally or in writing. If the Member or Provider files the appeal orally, the Contractor shall ensure that the Member or Provider is aware that they must file a signed, written appeal following the filing of oral appeal.

4.1.3.3.2.1. The Contractor shall give Members assistance in completing forms and other procedural steps in the appeal process, including, but not limited to, providing interpreter services and toll-free numbers with a Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability.

4.1.3.4. Within two (2) business days of Contractor receipt of the Member's or Provider's request for appeal, the Contractor shall send the Member a letter notifying the Member how they may receive a copy of the case file related to the appeal and how they can submit additional information wither in writing or in person to the Contractor.

4.1.3.5. The Contractor shall make its decision relating to all appeals within ten (10) business days of receipt of additional information from a Member for that appeal, or within ten (10) business days from when the Member notifies the Contractor that it will not submit any additional information for that appeal.

4.1.3.5.1. The Contractor may extend this timeframe by up to fourteen (14) calendar days if the Member requests the extension or if the Contractor can show that there is need for additional information and that the delay is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay and inform the Member of their right to file a grievance if he/she disagrees with the decision.

4.1.3.6. When conducting an appeal, the Contractor shall:

4.1.3.6.1. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Member or the Provider requests expedited resolution.

4.1.3.6.2. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

4.1.3.6.3. Allow the Member and the Member's representative opportunity, before and during the appeals process, to examine the Member's case file, including medical records, and any other documents and records.

4.1.3.6.4. Consider the Member, the Member's representative or the estate representative of a deceased Member as parties to the appeal.

4.1.3.7. The Contractor shall ensure that decision makers on appeals were not involved in previous levels of review or decision-making.

4.1.3.7.1. The decision maker shall be a health care professional with clinical expertise in treating the Member's condition or disease if any of the following apply:

4.1.3.7.1.1. A denial appeal based on lack of medical necessity.

4.1.3.7.1.2. Any appeal involving clinical issues.

4.1.3.8. The Contractor shall provide written notice of disposition of each appeal and shall make reasonable efforts to provide the Member oral notice of this disposition. This notice shall include:

4.1.3.8.1. The results and date of the appeal resolution.

4.1.3.8.2. For decisions not wholly in the Member's favor:

4.1.3.8.2.1. The right to request a State Fair Hearing,

4.1.3.8.2.2. How to request a State Fair Hearing,

4.1.3.8.2.3. The right to continue to receive benefits pending a hearing,

4.1.3.8.2.4. That the representative of a deceased Member's estate is a party to a State Fair Hearing,

4.1.3.8.2.5. How to request the continuation of benefits, and

4.1.3.8.2.6. Notice that if the Contractor's action is upheld in a State Fair Hearing, the Member may be liable for the cost of any continued benefits.

4.1.3.9. The Contractor shall continue the Member's benefits if all of the following are met:

4.1.3.9.1. The appeal is filed timely in accordance with the requirements of this Contract and is filed within ten (10) days after the Contractor mailed the notice of action or within ten (10) days before the intended effective date of the Contractor's proposed action.

4.1.3.9.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

4.1.3.9.3. The services were ordered by an authorized provider.

4.1.3.9.4. The authorization period has not expired.

4.1.3.9.5. The Member requests extension of benefits.

4.1.3.10. If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:

4.1.3.10.1. The Member withdraws the appeal.

4.1.3.10.2. The Member does not request a State Fair Hearing within ten (10) days from when the Contractor mails an adverse decision.

4.1.3.10.3. A State Fair Hearing decision adverse to the Member is made.

4.1.3.10.4. The authorization expires or authorization service limits are met.

4.1.3.11. If the final resolution of an appeal upholds the Contractor's action, the Contractor may recover the cost of the continuation of services furnished to the Member while that appeal was pending.

4.1.3.12. If the final resolution of an appeal reverses the Contractor's action, and the Contractor did not provide the services while the appeal was pending, then the Contractor shall provide the disputed services promptly after the final resolution and as expeditiously as the Member's health condition requires.

4.1.3.12.1. If the final resolution of an appeal reverses the Contractor's action and the Member received the services from another source because the Contractor did not provide the services, then the Contractor shall pay for those services in accordance with the Department's policy and regulations.

4.1.3.13. Notwithstanding the deadlines and due dates in any other section or provision of this Statement of Work, the Contractor shall establish and maintain an expedited appeal process for cases where the Contractor or the Member's Provider determines that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

4.1.3.14. Expedited Appeal Process

4.1.3.14.1. The Contractor shall accept a request for an expedited appeal either orally or in writing. The Member shall not be required to follow up any request for an expedited appeal.

4.1.3.14.2. When the Contractor receives a Member's request for an expedited appeal, the Contractor shall notify that Member of the limited time available for the Member to present evidence and allegations of fact or law, in person or in writing.

4.1.3.14.3. If an appeal meets the conditions for the expedited appeal process, the Contractor shall inform the Member that the Member is entitled to an expedited State Fair Hearing, in accordance with C.R.S. 25.5-5-406(1)(b).

4.1.3.14.4. The Contractor shall make a decision on all expedited appeals within three (3) business days of the request for that expedited appeal, provide written notice, and make reasonable efforts to provide oral notice of this decision.

4.1.3.14.4.1. The Contractor may extend this timeframe by up to fourteen (14) calendar days if the Member requests the extension or if the Contractor shows that there is need for additional information and that the delay is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.

4.1.3.14.5. The Contractor shall not take any punitive action against a Member, or a Provider, or a Provider supporting a Member's request, in response to the Member or Provider requesting an expedited appeal.

4.1.3.14.6. If the Contractor denies a Member's request for an expedited appeal, then the Contractor shall treat the appeal as a standard appeal and shall notify the Member of the denial of the expedited appeal within two (2) days in writing and shall make reasonable efforts to notify the Member promptly orally.

4.1.3.15. State Fair Hearing

4.1.3.15.1. A Member may request a State Fair Hearing during an appeal or once the Contractor has made a decision regarding an appeal.

4.1.3.15.1.1. A Member shall be allowed to request a State Fair Hearing within thirty (30) days from when the Contractor makes a decision regarding the appeal. If the Member requests the State Fair Hearing before the Contractor has made a decision regarding an appeal, then the Member shall be allowed to make the request within thirty (30) days from the action that lead to the appeal.

4.1.3.15.2. The Contractor shall ensure that each Member is aware of their right to a State Fair Hearing, how to obtain a State Fair Hearing and the representation rules for the hearing.

4.1.3.15.3. The Contractor, the Member, the Member's representative, and a representative of a deceased Member's estate, as applicable, shall be parties to the State Fair Hearing.

4.1.3.15.4. The Office of Appeals shall issue a Final Agency Decision within ninety (90) calendar days from the date the request for a hearing is received unless an extension has been granted to the applicant or recipient in which case the ninety (90) calendar day period shall be increased accordingly.

4.1.3.16. Expedited State Fair Hearing

4.1.3.16.1. When the appeal is heard first through the Contractor's appeal process, the Office of Appeals shall issue a Final Agency Decision for an expedited State Fair Hearing decision as expeditiously as the Member's health condition requires, but no later than three (3) working days from Department receipt of a hearing request for a denial of service that:

4.1.3.16.1.1. Meets the criteria for an expedited appeal process but was not resolved within the Contractor's expedited appeal timeframe, or

4.1.3.16.1.2. Was resolved wholly or partially adversely to the enrollee using the Contractor's expedited appeal timeframe.

4.1.3.16.2. When the appeal is made directly to the State Fair Hearing process without accessing the Contractor's appeal process, the Office of Appeals shall issue a Final Agency Decision for an expedited State fair Hearing decision as expeditiously as the Member's health condition requires, but no later than three (3) working days from the Department's receipt of a hearing request for a denial of a service that meets the criteria for an expedited resolution.

4.1.4. Member Confidentiality

4.1.4.1. Contractor shall protect the confidentiality of all Member records and other materials, in any form, including electronic that are maintained in accordance with this Contract. Except for purposes directly connected with the administration of the Medicaid program, no information about or obtained from any Member in possession of Contractor shall be disclosed in a form identifiable with the Member without the prior written consent of the Member or the parent or guardian of the Member if the Member is a minor, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals. Contractor shall have written policies governing access to, duplication and dissemination of, all such information. Contractor shall advise its employees, agents, Participating Providers and Subcontractors, if any, that they are subject to these confidentiality requirements. Contractor shall provide its employees, agents, Participating Providers and Subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

4.1.4.2. The Contractor shall maintain or make provisions for the maintenance of a Medical Record for each Member in compliance with 42 C.F.R. § 456.111. The Medical Record shall accurately represent the full extent of care provided to the Member. The record shall include, at a minimum, identification of the Member, physician name, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed under this Contract. The Contractor shall ensure that Hospital Medical Records include the date of admission and the dates of application for and authorization of Medicaid benefits, if application is made after admission, the plan of care, initial and subsequent continued stay review dates, reasons and plan for continued stay, if applicable. The Contractor shall ensure that non-mental hospital Medical Records include the date of operating room reservation and justification of emergency admission, if applicable. It may be reflected and noted in the record that an Advance Directive has been discussed with the Member, if one has been executed. Each Member's record must be legible and maintained in detail consistent with good medical and professional practices that facilitate effective internal and external peer review, medical audit and adequate follow-up treatment.

4.1.4.3. The Contractor shall conform to the requirements of 45 C.F.R 205.50, as amended, §10-16-423, C.R.S., as amended, 45 C.F.R. §§160 and 164, as amended, and 42 C.F.R 431.304 - 431.307, as amended, regarding confidentiality of health information about any Member for Covered Services hereunder.

4.1.4.4. The Contractor agrees to abide by 42 C.F.R. §431.301, as amended, and § 26-1-114, C.R.S., as amended, regarding the confidentiality of information concerning applicants for and Clients of medical assistance.

4.1.5. Marketing

4.1.5.1. The Contractor shall not distribute any marketing materials without the Department's approval.

4.1.5.1.1. The Contractor shall submit all materials relating to Marketing Activities to the Department's designee, and allow the Department's Night State Medical Assistance and Services Advisory Council and the Department to review any materials the Contractor proposes to use in relation to its Marketing Activities before distributing any such materials. Based on this review, the Department may require changes to any materials before the Contractor may distribute those materials, or may disallow the use of any specific materials in its sole discretion.

4.1.5.1.2. The Contractor shall specify methods of assuring the Department that Marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the Members or the Department.

4.1.5.1.3. The Contractor shall distribute all materials to the entire Service Area.

4.1.5.1.4. The Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

4.1.5.1.5. The Contractor and any Subcontractors shall not, directly or indirectly, engage in door-to-door, telephone, or other cold call marketing activities, as defined in 422 CFR 438.104(a).

4.1.5.1.6. Marketing materials shall not contain any assertion or statement, whether written or oral, that the potential Member must enroll with the Contractor to obtain benefits or not to lose benefits.

4.1.5.1.7. Marketing Materials shall not contain any assertion or statement, whether written or oral, that the Contractor is endorsed by the Centers for Medicare and Medicaid Services, the Federal or State government or similar entity.

4.1.5.1.8. The Contractor shall only engage in Marketing Activities in compliance with federal and state laws, regulations, policies and procedures.

4.1.6. Member notification of Provider Termination

4.1.6.1. Upon termination of a Provider's agreement or participation with the Contractor, for any reason, the Contractor shall notify any Member, who has selected that provider to be their Primary Care Medical Provider, of that provider's termination, as required in 42 CFR 438.10(f)(5).

4.1.6.1.1. DELIVERABLE: Notice to Members of Provider Termination

4.1.6.1.2. DUE: Fifteen (15) days from the notice of termination

4.1.7. Advance Directives

4.1.7.1. The Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all adult Members, as provided in 42 CFR §489. The Contractor shall provide all of the following information to those Members:

4.1.7.1.1. The Member's rights under the law of the State.

4.1.7.1.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

4.1.7.1.3. Contractor shall inform individuals that complaints concerning noncompliance with the Advance Directive requirements may be filed with the Colorado Department of Public Health and Environment.

4.1.7.2. The Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

4.1.7.3. The Contractor shall educate their staff concerning their policies and procedures on advance directives.

4.1.8. Incentives to Members

4.1.8.1. The Contractor shall not provide material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider. The Contractor shall also ensure that any agreements it has with its Participating Providers prohibit those Providers from providing material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider.

4.2. PROVIDER ISSUES

4.2.1. Participating Provider Requirements

4.2.1.1. Prior to the Contract's Effective Date, the Contractor shall:

4.2.1.1.1. Verify that all Participating Providers are Medicaid providers.

4.2.1.1.2. Verify that all Participating Physicians have a standard unique health identifier.

4.2.1.1.3. Verify that all primary care providers in its network are ACC PCMPs with an executed PCMP contract with their RCCO(s) and the Department.

4.2.1.1.4. Have a written agreement with all Participating Providers indicating that they are willing to take Medicaid FFS clients and ACC clients.

4.2.1.1.4.1. DELIVERABLE: List of All Participating Providers with Medicaid Provider IDs for the Department to Verify.

4.2.1.1.4.2. DUE: Prior to the Contract's Effective Date.

4.2.2. Licensure and Credentialing

4.2.2.1. The Contractor shall have written policies and procedures for the selection and retention of Providers.

4.2.2.2. The Contractor shall verify that all Participating Providers meet licensing and certification requirements.

4.2.2.3. The Contractor's credentialing program shall comply with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of Participating Providers. The Contractor may use information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to assist in meeting NCQA credentialing standards.

4.2.2.4. The Contractor's credentialing program shall include policies and procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.

4.2.2.5. The Contractor shall assure that all laboratory-testing sites providing services under this Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

4.2.2.6. The Contractor's Provider selection policies and procedures shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

4.2.3. Provider Insurance

4.2.3.1. The Contractor shall ensure that Participating Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this Contract. Minimum insurance requirements shall include, but are not limited to all the following:

4.2.3.1.1. Physicians participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000) per incident and one million five-hundred thousand dollars ($1,500,000) in aggregate per year.

4.2.3.1.2. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000) per incident and three million dollars ($3,000,000) in aggregate per year.

4.2.3.1.3. Sections 4.2.3.1.1 and 4.2.3.1.2 shall not apply to Physicians and facilities in the Contractor's network which meet any of the following requirements:

4.2.3.1.3.1. The Physician or facility is a public entity or employee pursuant to §24-10-103, C.R.S. of the Colorado Governmental Immunity Act, as amended.

4.2.3.1.3.2. The Physician or facility maintains any other security acceptable to the Colorado Commissioner of Insurance, which may include approved plan of self-insurance, pursuant to §13-64-301, C.R.S., as amended.

4.2.3.1.4. The Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such coverage, the Contractor shall notify the Department of such cancellation within two (2) business days of when the coverage is cancelled.

4.2.4. Provider Quality of Care Issues

4.2.4.1. For alleged quality of care concerns involving Participating Providers, the Contractor may use the process of its professional review committee, as set forth in §§ 12-36.5-104 and 12-36.5-104.4, C.R.S., when a quality of care concern is brought to its attention. This provision shall not be construed to require the Contractor to disclose any information that is confidential by law.

4.2.5. Program Integrity

4.2.5.1. The Contractor shall report all adverse licensure or professional review actions it has taken against any Participating Provider, in accordance with 45 C.F.R. Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank and to the appropriate State regulatory board.

4.2.5.2. The Contractor shall establish and maintain a compliance program designed to prevent, detect investigate and report fraud, waste and abuse.

4.2.5.2.1. The Contractor shall create a Compliance Program Plan documenting Contractor's written policies and procedures, standards and documentation of practices. The Compliance Program Plan shall be approved by Contractor's Chief Executive Officer and Compliance Officer. The Compliance Program Plan shall be submitted to the Department for review and approval and shall contain, at a minimum:

4.2.5.2.1.1. Provisions for internal monitoring and auditing.

4.2.5.2.1.2. Provisions for prompt response to detected offenses and for development of corrective action initiatives.

4.2.5.2.1.3. Provisions for monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.

4.2.5.2.1.4. Effective processes to screen all Provider claims, collectively and individually, for potential fraud, waste or abuse.

4.2.5.2.1.5. Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste and abuse.

4.2.5.2.1.6. Effective mechanisms to identify and report suspected instances of up-coding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided.

4.2.5.2.1.7. Effective processes to ensure that covered services billed by network providers were received by members and that the services received match the billing codes/descriptions.

4.2.5.2.2. The Contractor shall review, and update as necessary, the Compliance Program Plan at least annually. Upon completion of its review, the Contractor shall notify the Department of whether it has updated its Compliance Program Plan and, if it has made any updates to changes, deliver the updated plan to the Department for review and approval.

4.2.5.2.2.1. DELIVERABLES: Compliance Program Plan; Updated Compliance Program Plan

4.2.5.2.2.2. DUE: The Compliance Program Plan shall be due no later than thirty (30) days from the Contract's Effective Date; the Updated Compliance Program Plan or notification that the plan was not updated upon review shall be due annually, no later than July 30th

4.2.5.3. The Contractor shall suspend payments to any Participating Provider that is actively under investigation for a credible fraud allegation. The Department may suspend managed care capitation payments when an individual network provider is under investigation based upon credible allegations of fraud, depending on the allegations at issue.

4.2.5.4. The Department may suspend capitation payments to the Contractor should the Contractor be actively under investigation for credible fraud allegations. If the Department fails to suspend payments to such an entity for which there is a pending investigation of a credible allegation of fraud, without good cause, FFP may be disallowed with regard to such payments to the Contractor.

4.2.5.5. FFP is unavailable for any amounts paid to the Contractor if the Contractor is excluded from participation in Medicare or Medicaid for any of the following reasons:

4.2.5.5.1. The Contractor is controlled by a sanctioned individual.

4.2.5.5.2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Social Security Act.

4.2.5.5.3. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

4.2.5.5.3.1. Any individual or entity excluded from participation in Federal health care programs.

4.2.5.5.3.2. Any entity that would provide those services through an excluded individual or entity.

4.2.5.6. The Contractor shall establish written policies for employees requiring all employees to be informed of and detailing compliance with all of the following laws, rules and regulations:

4.2.5.6.1. The False Claims Act, 31 USC §§ 3729, et seq.

4.2.5.6.2. Administrative remedies for false claims and statements.

4.2.5.6.3. State laws relating to civil or criminal penalties for false claims and statements, if any.

4.2.5.6.4. Whistleblower protections under such laws.

4.2.5.6.4.1. DELIVERABLE: Written Policies for Employees Regarding False Claims

4.2.5.6.4.2. DUE: Thirty (30) days from the Contract's Effective Date

4.2.5.7. The Contractor shall create and maintain a training program for new and existing employees on the compliance program described in the Compliance Program Plan and the policies regarding false claims described in section 4.2.5.5. This training shall be conducted in a manner that allows the Department to verify that the training has occurred.

4.2.5.8. The Contractor shall designate a compliance officer and compliance committee that is accountable to the Contractor's senior management.

4.2.5.9. The Contractor shall have effective lines of communication between the compliance officer and the Contractor's employees for reporting violations.

4.2.5.10. The Contractor shall enforce its compliance program through well-publicized disciplinary guidelines.

4.2.5.11. The Contractor shall immediately report known confirmed intentional incidents of fraud and abuse to the Department and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU).

4.2.5.12. The Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department. The Contractor shall investigate its suspicions and shall submit its preliminary fraud report containing its findings and concerns to the Department. The Contractor shall continue its investigation and shall provide a final fraud report to the Department detailing the results of the investigation. The Department may approve an extension of time in which to complete the final fraud report upon a showing of good cause.

4.2.5.12.1. DELIVERABLES: Verbal fraud report; preliminary fraud report; final fraud report

4.2.5.12.2. DUE: The verbal fraud report is due within one (1) business day of when the contractor becomes aware of the fraud; the preliminary fraud report shall be due within three (3) business days of the verbal fraud report; the final fraud report shall be due within fifteen (15) business days of the verbal fraud report.

4.2.5.12.3. The Contractor shall provide all of the following information with each fraud report that warrants investigation:

4.2.5.12.3.1. Name and ID number.

4.2.5.12.3.2. Source of complaint.

4.2.5.12.3.3. Type of provider.

4.2.5.12.3.4. Nature of complaint.

4.2.5.12.3.5. Approximate dollars involved.

4.2.5.12.3.6. Legal & administrative disposition of the case.

4.2.6. Pharmacy Providers

4.2.6.1. The Contractor shall provide or enter into subcontracts with qualified pharmacy Providers for the provision of Covered Drugs as required, and in the manner specified, by Department regulations at 10 C.C.R. 2505-10, §8.205.8. All subcontracts with pharmacy Providers shall be subject to all standards set forth in this Contract.

4.2.7. Prompt Payment of Claims

4.2.7.1. The Contractor shall promptly pay claims submitted by Providers, including all I/T/U providers in its network, consistent with the claims payment procedures as required by §10-16-106.5, C.R.S., as amended.

4.2.7.2. In accordance with 42 CFR § 447.46 (c)(1-3), the Contractor shall adhere to the following alternative payment arrangement:

4.2.7.2.1. Clean claims shall be paid, denied, or settled within thirty (30) calendar days after receipt by the carrier if submitted electronically and within forty-five (45) calendar days after receipt by the carrier if submitted by any other means.

4.2.7.3. The Contractor shall ensure that (1) the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim; and (2) the date of the payment is the date of the check or other form of payment.

4.2.7.4. The Contractor shall promptly pay claims submitted by all Indian health care provider or I/T/U providers in its network, consistent with the procedures required in ARRA § 5006(d) and SMD letter 10-001.

4.2.8. Termination of Participating Provider Agreements

4.2.8.1. The Contractor shall notify the Department, in writing, of its decision to terminate any existing Participating Provider agreement where such termination will cause the delivery of Covered Services to be inadequate in a given area. The notice to the Department shall include a description of how the Contractor will replace the provision of Covered Services at issue. In the event that the Contractor is unable to adequately replace the affected services to the extent that accessibility will be inadequate in a given area, the Department may impose limitations on Enrollment in the area or eliminate the area from the Contractor's Service Area.

4.2.8.1.1. DELIVERABLE: Notification of Provider Agreement Termination

4.2.8.1.2. DUE: at least sixty (60) days prior to the effective date of the termination unless the termination is based upon quality or performance issues

4.2.9. Provider Applications

4.2.9.1. The Contractor shall not discriminate with regards to the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification. If the Contractor declines to include an individual Provider or group of Providers in its network, it shall give the affected Providers written notice of the reasons for its decision. In no event shall this provision be construed to:

4.2.9.1.1. Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members.

4.2.9.1.2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

4.2.9.1.3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

4.2.10. The Contractor shall monitor Covered Services rendered by Participating Providers for quality, appropriateness and Member outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting, and other applicable provisions of this Contract.

4.2.11. Prohibited Payments

4.2.11.1. The Contractor shall not make payments:

4.2.11.1.1. For an item or service, other than an emergency item or service, not including items or services furnished in an emergency room of a hospital, furnished:

4.2.11.1.1.1. Under the plan by an individual or entity during any time period when the individual or entity is excluded from participation under title V, XVII, or XX or under title XIX pursuant to § 1128, 1128A, 1156, or 1842(j)(2);

4.2.11.1.1.2. At the medical direction or on the prescription of a physician, during the period when the physician is excluded from participation under title V, XVIII, or XX or under title XIX pursuant to § 1128, 1128A, 1156, or 1842(j)(2), and when the person furnishing such item or service knew, or had reason to know, of the exclusion; or

4.2.11.1.1.3. By an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the Department determines there is a good cause not to suspend such payments; or

4.2.11.1.2. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;

4.2.11.1.3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; or

4.2.11.1.4. For home health care services provided by an agency or organization, unless the agency provides the Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

SECTION 5.0 REPORTING

5.1. GENERAL REPORTING REQUIREMENTS

5.1.1. For all reports described in this Contract, the Contractor shall meet the following requirements:

5.1.1.1. The Contractor shall deliver all reports to the Department and ensure that those reports are delivered in a timely manner.

5.1.1.2. The Contractor shall ensure that all reports are complete, contain all required elements and are presented in a Department-approved format.

5.1.1.3. The reports shall not contain any inaccuracies or present insufficient data.

5.1.2. Any report that does not meet the requirements of this section shall be considered improperly submitted.

5.1.3. For any improperly submitted report, the Contractor shall provide a corrective action plan to remedy any identified deficiencies in a report, as directed by the Department, within five (5) business days of notification by the Department of the improper submission of that report.

5.1.3.1. The Contractor shall remedy all identified deficiencies within five (5) business days of its submission of its corrective action plan to the Department unless the Department agrees to a longer period in writing.

5.1.4. Report Verification

5.1.4.1. The Department may, in its sole discretion, verify any information the Contractor reports to the Department for any reason. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:

5.1.4.1.1. Fact-checking

5.1.4.1.2. Auditing reported data

5.1.4.1.3. Requesting additional information

5.1.4.1.4. Performing site visits

5.1.4.2. In the event that the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated report, which corrects all errors and includes all omitted data or information, and submit the updated report to the Department within ten (10) days from the Department's request for the updated report.

5.1.4.2.1. DELIVERABLE: Updated reports.

5.1.4.2.2. DUE: Ten (10) days from the Department's request for an updated or corrected report.

5.1.5. Data Analysis and Reports

5.1.5.1. The Contractor shall share with the PCMPs, the SDAC and the Department any specific findings or important trends discovered through the Contractor's analysis of the available data and information.

5.1.5.2. The Contractor shall educate and inform the PCMPs and providers about the data reports and systems available to the providers and the practical uses of the available reports.

5.1.5.3. The Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern and apply the information to make changes and improve the health outcomes of its members.

5.1.5.3.1. The Department may request that the Contractor report the results of any analysis it performs. At the Department's request, the Contractor shall report the results of the analyses it performed to the Department and what steps it intends to take based on those analyses, within ten (10) days of the Department's request. The Department may request additional information, that the Contractor perform further analyses or that the contractor modify any steps it intends to take at the Department's sole discretion.

5.2. ENROLLMENT/DISENROLLMENT REPORTING

5.2.1. The Contractor shall submit a quarterly Enrollment/Disenrollment report to the Department. The report shall provide, at a minimum, all of the following:

5.2.1.1. A detailed summary and analysis of all Enrollment and Disenrollment activities.

5.2.1.2. Overall trends relating to Disenrollment and specific reasons for Disenrollment including, but not limited to:

5.2.1.2.1. Voluntary Disenrollment.

5.2.1.2.2. Members utilizing the Contractor's grievance process regarding requests for Disenrollment.

5.2.1.2.3. Involuntary Disenrollment information and trends.

5.2.1.3. The Enrollment/Disenrollment Report shall be submitted in a format approved by the Department.

5.2.1.3.1. DELIVERABLE: Enrollment/Disenrollment Report

5.2.1.3.2. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers.

5.2.2. The Contractor shall submit each quarter an enrollment attribution file of all client and provider relationships, including, at a minimum:

5.2.2.1. Month of Attribution;

5.2.2.2. Client Name;

5.2.2.3. Client Date of Birth;

5.2.2.4. Member ID;

5.2.2.5. Provider Identifier (NPI) of assigned primary care practice or physician;

5.2.2.6. Associated Medicaid Provider Identifier (or blank if not applicable);

5.2.2.7. Provider address; and

5.2.2.8. Provider specialty.

5.2.2.9. DELIVERABLE: Enrollment Attribution Flat File

5.2.2.10. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers

5.3. MEMBER OUTREACH AND STAKEHOLDER FEEDBACK REPORTING

5.3.1. The Member Outreach and Stakeholder Feedback Report shall contain:

5.3.1.1. A summary of the feedback received from Members and other stakeholders, through any advisory committee or through any other means.

5.3.1.2. A description of trends and themes in the feedback received.

5.3.1.3. A description of overarching issues to address or system-wide problems that must be solved and a proposal to address these issues or solve the problems.

5.3.1.4. A summary of the feedback and complaints from Members, providers and the community at large and any advice or views expressed by the Contractor's Performance Improvement Advisory Committee.

5.3.1.5. Challenges identified in serving the Expansion Population.

5.3.1.6. Lessons learned from the Expansion Population related to their health needs and behaviors.

5.3.2. The Contractor shall provide the Member Outreach and Stakeholder Feedback Report to the Department on a quarterly basis, within thirty (30) days from the end of the quarter that the report covers.

5.3.3. The Stakeholder feedback report may contain information that is not reflected in the Contractor's regular grievance process and the information contained in such a report is not indicative of a weakness or limitation of the Contractor of the Contractor's system.

5.3.3.1. DELIVERABLE: Member Outreach and Stakeholder Feedback Report.

5.3.3.2. DUE: Semi-annually on October 30th and April 30th of each year.

5.4. PROVIDER NETWORK REPORTING

5.4.1. The Contractor shall provide an annual Provider Network Strategic Plan to the Department. This Provider Network Strategic Plan shall contain, at a minimum, all of the following:

5.4.1.1. The Contractor's current and future strategic planning relating to its Provider network.

5.4.1.2. The Contractor's approach to meeting all access standards described in section 3.6.1.

5.4.1.3. All applicable metrics relating to the Provider network including, but not limited to:

5.4.1.3.1. PCMP to Member Ratio.

5.4.1.3.2. Physician Specialist to Member Ratio.

5.4.1.3.3. Number of Members who are more than thirty (30) miles or thirty (30) minutes travel time, whichever area is larger, from a Provider in the Contractor's Network.

5.4.1.3.4. Population demographics, as determined by the Department, of the Contractor's Providers and Members.

5.4.1.3.5. Number of PCMPs offering extended hours to Members.

5.4.1.3.6. Number of providers not accepting new Medicaid patients.

5.4.1.4. The Provider Network Strategic Plan shall be submitted in a format approved by the Department.

5.4.1.4.1. DELIVERABLE: Provider Network Strategic Plan.

5.4.1.4.2. DUE: Annually, within the first three (3) months of the state fiscal year.

5.4.2. The Contractor shall provide a semi-annual Provider Network Capacity and Services Report to the Department regarding the Contractor's capacity and services.

5.4.2.1. This Provider Network Capacity and Services report shall contain support showing that the Contractor meets, at a minimum, all of the following requirements:

5.4.2.1.1. The Contractor provides an appropriate range of preventive care, primary care and specialty services that is adequate for the anticipated number of Members.

5.4.2.1.2. The Contractor maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the Service Area.

5.4.2.1.3. The Contractor meets any other requirements described in 42 C.F.R. §438.207(c).

5.4.2.1.3.1. DELIVERABLE: Network Capacity and Services Report

5.4.2.1.3.2. DUE: Semi-annually, by January 31st and July 31st of each year.

5.4.2.1.3.3. DELIVERABLE: Updated Network Capacity and Services Report

5.4.2.1.3.4. DUE: Within thirty (30) days after a significant change in operations that, as defined by the Department, impact services.

5.4.2.2. The Contractor shall include the use of Electronic Health Records (EHR) by provider and provider specialty and stage of meaningful use (http://www.healthit.gov/providers-professionals/how-attain-meaningful-use), if applicable. For all providers, the Contractor shall indicate whether they are connected to the statewide Health Information Exchange (HIE) network (such as Quality Health Network or the Colorado Regional Health Information Organization).

5.4.2.3. In the event that the Provider Network Capacity and Services Report shows that the Contractor's Provider Network is insufficient to meet the access standards described in section 3.6.1., then the Contractor shall create and submit to the Department a corrective action plan on a schedule determined by the Department. The Department will review the corrective actions plan and may require changes to the plan before approving the plan. The Contractor shall not implement any corrective action plan until it has been approved by the Department.

5.4.2.3.1. DELIVERABLE: Network Capacity and Services Corrective Action Plan

5.4.2.3.2. DUE: As requested by the Department

5.4.3. The Contractor shall create and document a communication plan to communicate with all providers, behavioral health managed care organization and PCMPs in its network and other community resources with which it has relationships, and to promote communication amongst the providers.

5.4.3.1. The communication plan may include the following methods:

5.4.3.1.1. Assignment of providers to a specific provider relations consultant or point-of-contact with the Contractor's organization.

5.4.3.1.2. Holding information sessions for interested providers at practice association meetings or conferences.

5.4.3.1.3. Providing orientation sessions for providers that are new to the Contractor's network.

5.4.3.1.4. Hosting forums for ongoing training regarding the ACC program and services the contractor offers.

5.4.3.1.5. Posting provider tools, trainings, informational material and the Contractor's contact details on the internet in easily accessible formats.

5.4.3.1.6. Developing standard communication intervals at which the Contractor will contact providers to maintain connection and lines of communication.

5.4.3.1.7. Distributing written provider communications at least twice a year to promote continuous provider interest and involvement.

5.4.3.2. The Contractor shall submit its initials communication plan for the Department's review. The Contractor shall submit any significant changes to the Communication plan for the Department's review and approval.

5.4.3.2.1. DELIVERABLE: PCMP Communication Plan.

5.4.3.2.2. DUE: Ten (10) days from the Contract's Effective Date for the initial communication plan and thirty (30) days from the date of any change for an updated communication plan.

5.5. APPEAL AND GRIEVANCE REPORTING

5.5.1. The Contractor shall provide a quarterly Appeal and Grievance Report to the Department. This report shall meet the following requirements:

5.5.1.1. The Appeal and Grievance Report shall follow the format provided by the Department and contain any appeal and grievance information requested by the Department.

5.5.1.2. The Appeal and Grievance Report shall document Members' appeals and grievances and show how those appeals and grievances were tracked, resolved and assessed.

5.5.1.3. The Appeal and Grievance Report shall contain a written summary and a categorical analysis of the appeal and grievance data documented in the report. Based on this report, the Department may request a detailed report on any or all of the appeals and grievances shown on that report.

5.5.1.3.1. DELIVERABLE: Appeal and Grievance Report

5.5.1.3.2. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers.

5.6. CLINICAL REPORTING

5.6.1. HEDIS Report

5.6.1.1. The Contractor shall provide an annual HEDIS Report to the Department. This report shall meet the following requirements:

5.6.1.1.1. The HEDIS Report shall contain all HEDIS measures determined by the Department for that year.

5.6.1.1.2. The HEDIS Report shall follow the format approved by the Department

5.6.1.1.2.1. DELIVERABLE: HEDIS Report

5.6.1.1.2.2. DUE: Annually, by June 30th for the report covering the state fiscal year that ends on that day.

5.6.2. EPSDT Report

5.6.2.1. The Contractor shall complete and submit an annual EPSDT Report to the Department.

5.6.2.2. The EPSDT Report shall be provided to the Department on the Form CMS-416 and contain all information required for that form for the most recent period from October 1st through September 30th.

5.6.2.2.1. DELIVERABLE: EPSDT Report

5.6.2.2.2. DUE: Annually by February 1st for the prior period from October 1st through September 30th

5.6.3. Serious Reportable and Never Events and Provider Preventable Conditions Reporting

5.6.3.1. The Contractor shall provide a quarterly Serious Reportable and Never Events and Provider Preventable Conditions Report in a format as directed by the Department. This report shall contain all events described in Exhibit J-1, Serious Reportable or Never Events and Provider Preventable Conditions, attached and incorporated herein by reference for the Contractor and all Subcontracted facilities that provide inpatient services to Clients. The report shall also contain any service with the POA indicator at the time of a hospital admission.

5.6.3.1.1. DELIVERABLE: Serious Reportable and Never Events and Provider Preventable Conditions Report

5.6.3.1.2. DUE: Quarterly, within thirty (30) days of the end of the calendar quarter for which the report covers.

5.7. FINANCIAL REPORTING

5.7.1. The Contractor shall submit its annual financial statements prepared in accordance with Statutory Accounting Principles (SAP) certified by the Contractor's Chief Financial Officer or their designee to the Department or the Department's designee.

5.7.1.1. The financial information will be submitted in a template provided by the Department and modified as needed.

5.7.1.1.1. DELIVERABLE: Annual Financial Report.

5.7.1.1.2. DUE: Annually, on or before December 1st.

5.7.2. Health Insurance Providers Fee Reporting

5.7.2.1. In the event that the Contractor is subject to any Health Insurance Providers Fee under 26 CFR Part 57 and required to file a form 8963, then the Contractor shall create a Health Insurance Providers Fee Report to the Department that contains all of the following information:

5.7.2.1.1. A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).

5.7.2.1.2. The preliminary and final calculations of the fee from the IRS, even if the calculated fee was $0.00.

5.7.2.1.3. An allocation of the fee attributable to the Work under this Contract.

5.7.2.2. Any additional information related to the Health Insurance Providers Fee, as determined by the Department.

5.7.2.2.1. The Contractor shall deliver the Health Insurance Providers Fee Report for each year that it is required to file a form 8963 with the IRS.

5.7.2.2.1.1. DELIVERABLE: Health Insurance Providers Fee Report.

5.7.2.2.1.2. DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963.

5.7.3. The Contractor shall provide other financial reports as requested by the Department within 30 days following the request.

SECTION 6.0 REIMBURSEMENT

6.1. PAYMENT OF MONTHLY CAPITATION

6.1.1. For each Member Enrolled with the contractor, the Department shall pay the Contractor the Monthly Payment Rate specified in Exhibit C.

6.1.2. The Department shall remit payment of the Monthly Payment Rate to the Contractor, on or before the twentieth (20th) business day of each month.

6.1.3. The Department shall remit payment through an electronic transfer of funds to the bank account designated by the Contractor. The Department shall provide the Contractor with a monthly payment report through the MMIS.

6.1.4. The Contractor shall be responsible for the accuracy of direct deposit information provided to the Department and for updating such information as needed.

6.1.5. The Monthly Payment Rate shall be considered payment in full for all Covered Services set forth in Exhibit B.

6.1.6. In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Exhibit B and any other provision of the Contract, Exhibit B shall prevail over other provisions of this Contract, pages 1 to 22 and Exhibits A and C through P (see Section 19. 1., Order of Precedence).

6.1.7. The Department shall not make any payments to a provider other than the Contractor for services available under the Contract, except when these payments are specifically provided for in Title XIX of the Social Security Act, in 42 C.F.R., or when the Department has adjusted the capitation rates paid under the contract, in accordance with §438.6(c)(5)(v) to make payments for graduate medical education.

6.2. CALCULATION OF MONTHLY CAPITATION RATE

6.2.1. The Monthly Payment Rates set forth in Exhibit C are based on the costs of providing the Covered Services set forth in Exhibit B which shall not exceed one hundred percent (100%) of the direct health care cost of providing these same services to an actuarially equivalent Colorado Medicaid population group consisting of unassigned recipients and recipients in the Primary Care Physician Program. Rates will be set in accordance with all applicable state statutes, federal regulations and actuarial standards of practice. The actuarial basis for calculation of the Monthly Payment Rate is set forth in the actuarial certification which has been submitted to the Contractor and to CMS for review.

6.2.1.1. The actuarial calculation of the Monthly Payment Rate shall take into account additional medical expenditures that the Contractor reports on financials processed outside of the Contractor's encounter data, but incurred during the base data time period. These medical expenditures are for eligible members and include the following types of payments:

6.2.1.1.1. Contractor payments to the Department for services that the Department has paid for in error due to system issues.

6.2.1.1.2. Offline Contractor provider payments for contractual variances identified in the capitation payment.

6.2.1.1.3. Medically qualified quality expenses, such as Comprehensive Primary Care Initiative payments and shared savings.

6.2.1.1.4. Miscellaneous offline provider payments for doctors on call and case management services.

6.2.2. The Monthly Payment Rate may be adjusted during the performance period of this Contract pursuant to an executed amendment, upon approval of the State Controller or his/her designee.

6.2.3. The enrollment information, encounter data, and any other information submitted to the Department for the purpose of developing the Monthly Payment Rate must be certified by the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

6.2.4. The certification shall attest, based on best knowledge, information, and belief to the accuracy, completeness, and truthfulness of the data.

6.2.5. The Contractor must submit the certification concurrently with the certified data.

6.2.6. The Department retains the right to select a payment rate within the actuarially sound rate range based on performance and timeliness of deliverables within this Contract.

6.2.7. Risk Sharing

6.2.7.1. The Contractor and the Department will share the financial risk for medical expenditures for July 1, 2015 to June 30, 2016 based on a calculation of the adjusted medical expenditures for the enrollees of the Medicaid expansion population, by engaging in a risk sharing reconciliation for any amounts due from the Contractor as follows:

6.2.7.1.1. Adjusted Medical Expenditures shall be determined by the Department based on plan paid amounts found in Encounter Data for covered Services for the Contract period.

6.2.7.1.2. The Department reserves the right to audit and/or re-price the actual medical expenditures for external providers to ensure that the expenditures to providers are reasonable and reflective of arms-length transactions based on Encounter Data submitted by the Contractor. The Department will incur the cost of auditing plan encounter data for the re-pricing.

6.2.7.1.3. The data for services rendered, used for the reconciliation, is the routine Encounter Data sent by the Contractor.

6.2.8. Risk Corridor

6.2.8.1. As a result of the unknown risk level associated with the emerging adult expansion populations, the State has developed the following risk corridor as a risk-mitigation strategy:

Min	Max	MCO Share	Federal/State Share
0%	92.5%	5%	95%
92.5%	95%	20%	80%
95%	99%	50%	50%
99%	101%	100%	0%
101%	105%	50%	50%
105%	107.5%	20%	80%
107.5%	+	5%	95%

6.2.8.2. The risk corridor percentage is calculated as total adjusted medical expenditures divided by the medical portion of the total capitation payment for the same period.

6.2.8.3. The Contractor and the Department/Federal Government shall share risk as outlined in the table in section 6.2.7.1., including in the following scenarios:

6.2.8.3.1. Should the risk corridor percentage calculated as above, in the aggregate be greater than one hundred seven point five percent (107.5%) the Department/ Federal Government shall be responsible for ninety-five percent (95%) of the loss that is greater than one hundred seven point five percent (107.5%) of the medical portion of the total capitation rate or the Department/ Federal government shall be responsible for ninety-five percent (95%) of the gain that is less than ninety-two point five percent (92.5%) of the medical portion of the total capitation rate.

6.2.8.3.2. Should the risk corridor percentage in the aggregate be greater than or equal to ninety-nine percent (99%) or less than or equal to one hundred one percent (101%), the Department/ Federal Government shall have no financial responsibility.

6.2.8.3.3. To the extent that the actual experience is below the calculated medical loss ratio, the Federal Government will retain all profits below that threshold.

6.2.8.4. For the risk corridor calculations, the Department will use the encounter data priced at the Contractor plan paid amount.

6.2.8.5. Expansion population settlement plan for the rate period covered by this contract:

6.2.8.5.1. To complete the expansion adult service encounter identification and collection the Contractor shall:

6.2.8.5.1.1. Use the capitation file to identify the expansion populations

6.2.8.5.1.2. Use the same format as the regular MCO encounters

6.2.8.5.1.3. Send the data together with the quarterly MCO submission

6.2.8.5.1.4. The complete expansion adult encounters with at least four (4) months run-out

6.2.8.6. The Department or its authorized agent shall:

6.2.8.6.1. Calculate the adjusted medical expenditures

6.2.8.6.2. Calculate the actual rate and risk sharing amount based on the risk corridors and plan-wide MLR by May 2018.

6.2.8.6.3. Reconcile dollar amount with the Contractor by June 30, 2018.

6.3. RECOUPMENTS

6.3.1. The Department shall recoup Monthly Payment Rate amounts paid to the Contractor in error. Error may be either human or machine error on the part of the Department, the Contractor or otherwise. Error includes, but is not limited to, lack of eligibility, computer error, move by the Member outside the Contractor's Service Area, or situations where the Member cannot use the Contractor's facilities.

6.3.2. The Department shall recoup, from the Contractor, all claims for Covered Services paid by the Department, on behalf of Members who are retroactively Enrolled in the Contractor's Plan.

6.3.3. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) days, the Department shall deduct the overpayments from the next payment to the Contractor.

6.3.4. The Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, the Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within ninety (90) days of termination.

6.3.5. Payments made by the Department to the Contractor due to the Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

6.3.6. Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any Monthly Payment Rate amounts paid in error.

6.3.7. The Contractor's obligation to refund all calculated MLR rebates continues subsequent to the termination of the Contract.

6.4. HEALTH INSURANCE PROVIDERS FEE RATE SETTLEMENT

6.4.1. The Contractor and the Department shall engage in Health Insurance Providers Fee Rate Settlements based upon the Health Insurance Fee report provided by the Contractor to the Department each October. The Health Insurance Providers Fee Rate Settlement process shall include the following:

6.4.2. During the rate-setting cycle, the Department will calculate a prospective rate to account for the health insurance provider fee. This rate will be withheld from the Contractor's payment.

6.4.3. Upon receipt of the Health Insurance Providers Fee Report, the Department will calculate the actual rate to account for the health insurance provider fee. The Department will issue a notification letter by January 31st each year with the amount to be remitted to the Contractor.

6.5. THIRD PARTY PAYER LIABILITY

6.5.1. All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

6.5.2. The Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing Covered Services under this Contract.

6.5.2.1. Potential liable third parties shall include any of the sources identified in 42 C.F.R. Section 433.138 relating to identifying liable third parties. The Contractor shall coordinate with the Department to obtain information from other state and federal agencies and the Contractor shall cooperate with the Department in obtaining information from commercial third party resources.

6.5.2.2. The Contractor shall, on a monthly basis, notify the Department's fiscal agent, by telephone or in writing, of any third party payers, excluding Medicare, identified by the Contractor. If the third party payer is Medicare, the Contractor shall notify the Department and provide the Member's name and Medicaid identification along with the Medicare identification number. If the Member has health insurance coverage other than Medicare, the Contractor shall submit the following information:

6.5.2.2.1. Medicaid identification number;

6.5.2.2.2. Member's social security number;

6.5.2.2.3. Member's relationship to policyholder;

6.5.2.2.4. Name, complete address, and telephone number of health insurer;

6.5.2.2.5. Policy Member identification and group numbers;

6.5.2.2.6. Policy Member's social security number;

6.5.2.2.7. Policy Member's full name, complete address and telephone number; and

6.5.2.2.8. Daytime telephone number where Member can be reached.

6.5.2.3. The Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by the Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor.

6.5.2.4. The Contractor shall provide a quarterly report of all third party recovery efforts and amounts recovered by Medicaid client ID, category of assistance and date of service to the Department. The report shall be provided on compact disc (CD) or by encrypted email, no later than thirty (30) days following the end of each quarter.

6.5.2.5. In addition to compensation paid to the Contractor under the terms of this Contract, the Contractor may retain as income all amounts recovered from third party resources, up to the Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by the Contractor to Participating Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

6.5.2.6. The Contractor shall not restrict access to Covered Services due to the existence of possible or actual third party liability.

6.5.2.7. The Contractor shall inform Members, in its written communications and publications that Members shall comply with the Contractor's protocols, including using Providers within the Contractor's network, prior to receiving Non-emergency medical care. The Contractor shall also inform its Members that failure to follow the Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that the Contractor would have been liable to pay. If the Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to the Contractor or the Provider for payment or cost of the care or services.

6.5.2.8. The Contractor shall inform Members, in its written communications and publications, that when a third party is primarily liable for the payment of the costs of a Member's medical benefits, the Member shall comply with the protocols of the third party, including using Providers within the third party's network, prior to receiving Non-emergency medical care.

6.5.2.9. With the exception of Section 6.5.2.10 and except as otherwise specified in contracts between the Contractor and Participating Providers, the Contractor shall pay all applicable co-payments, coinsurance and deductibles for approved Covered Services for the Member from the third party resource using Medicaid lower-of pricing methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service:

6.5.2.9.1. The sum of reported third party coinsurance and/or deductible or

6.5.2.9.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

6.5.2.10. The Contractor shall pay, except as otherwise specified in contracts between the Contractor and Participating Providers, all applicable copayment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service.

6.5.2.11. The Contractor shall also inform its Members, in its written communications and publications, that failure to follow the third party's protocols will result in a Member being liable for the payment or the cost of any care or any service that the third party would have been liable to pay except that, if the third party or the service Provider substantively fails to communicate the protocols to the Member, the items or services the third party is liable for are non-reimbursable under the terms of this Contract and the Member is not liable to the Provider.

6.5.2.12. The Contractor shall include information in the Contractor's Member handbook regarding its rights and the Member's obligations under this section of the Contract and Section 25.5-4-301, C.R.S.

6.5.2.13. Benefits for Members shall be coordinated with third party auto insurance.

6.6. MEDICAL LOSS RATIO (MLR)

6.6.1. MLR Calculation

6.6.1.1. The Department or its agent will calculate a plan-wide Medical Loss Ratio (MLR) each SFY using medical and administrative cost data from encounter data, audited financial statements and reporting, and flat file submissions.

6.6.1.2. The MLR will be calculated by dividing the sum of the direct, indirect, and sub-contracted costs for providing all Covered Services provided under this Contract (Medical Spend) by total capitation payments made to the Contractor (i.e. Medical Spend / total capitation payments) for every annual measurement period, with supplemental information, subject to Department approval.

6.6.1.2.1. The first annual measurement period will begin upon execution of this Contract and end on June 30, 2015.

6.6.1.2.2. Subsequent annual measurement periods will align with the state fiscal year.

6.6.1.2.3. The Department will allow for four (4) months claims runout before calculating the Contractor's MLR. The calculation of the MLR may take an additional five (5) months.

6.6.1.2.4. The Department will calculate the MLR after any annual adjustments are made, including, at a minimum, any risk corridor rate calculations for the Medicaid expansion populations. The Department will provide documentation of the methodology it will use for the MLR and any adjustments, along with supporting data and documentation.

6.6.1.2.5. The Contractor must submit all encounters, audited financial statements and reporting, and flat files for the measurement period, before the Department can calculate the MLR. See section 3.9.6 Encounter Claims Data Provisions and Exhibit O Medical Loss Ratio (MLR) Calculation Template.

6.6.1.2.6. The Contractor's Medical Spend will be calculated and verified using both encounter data submitted through the State's Medicaid Management Information System (MMIS), as well as audited supplemental data provided in the Contractor's annual financial reporting.

6.6.1.2.7. The MLR shall be rounded to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.

6.6.1.3. MLR Target: The MLR Target is eighty-nine percent (89%).

6.6.1.4. Adjusted MLR Target: The MLR Target will be decreased by one percent (1%) for each quality measure target (MLR Quality Target) that the Contractor meets or exceeds (see 6.6.2.2. Quality Target Table). The lowest possible Adjusted MLR Target is four percent (4%) lower than the MLR Target, or eighty-five percent (85%). If the Contractor does not meet any MLR Quality Targets, then the Adjusted MLR Target is equal to the MLR Target, eighty-nine percent (89%).

6.6.1.5. If the Contractor's MLR does not meet or exceed the Adjusted MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:

6.6.1.5.1. Total amount of capitations payments received by the Contractor multiplied by the difference between the Contractor's MLR and the Adjusted MLR Target.

6.6.1.6. The Department will provide documentation of the methodology it will use for this calculation, along with supporting data and documentation.

6.6.1.7. The Contractor shall reimburse the Department within thirty (30) days of the Department finalizing the MLR calculation. The Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to the Contractor of the amount due, pursuant to 10 C.C.R. 2505-10, Section 8.050.3 A-C Provider Appeals, as well as Section 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

6.6.2. MLR Quality Targets

6.6.2.1. The Department will use the following four (4) quality metrics to measure the performance of the Contractor in relation to the Adjusted MLR Target through the end of SFY15-16. HEDIS measures utilized for the calculation will be based upon audited results produced by the Contractor for the 2016 NCQA and EQRO reporting cycle.

6.6.2.1.1. Adult Body Mass Index (BMI) Assessment (HEDIS - ABA)

6.6.2.1.1.1. Target: ninety-one point twenty-eight percent (91.28%).

6.6.2.1.2. HbA1c Poor Control (>9.0%) (HEDIS – CDC):

6.6.2.1.2.1. Target: twenty-nine point sixty-eight percent (29.68%).

6.6.2.1.3. Anti-depressant Medication Management (HEDIS - CDC)

6.6.2.1.3.1. Targets:

6.6.2.1.3.1.1.1. Effective Acute Phase Treatment: fifty-nine point thirty-five percent (59.35%).

6.6.2.1.3.1.1.2. Effective Continuation Phase Treatment: forty-two point twenty-nine percent (42.29%).

6.6.2.1.3.2. The Contractor must meet both targets in order to receive any credit for this quality metric.

6.6.2.1.3.3. The Contractor shall only include Members enrolled in this Contract when calculating the three (3) HEDIS quality metrics.

6.6.2.1.3.4. The three (3) HEDIS quality metrics must be third party verified by the Contractor's National Committee for Quality Assurance (NCQA) auditor and submitted to the Department's EQRO vendor by the end of the SFY that this contract covers.

6.6.2.1.4. Patient Activation Measure (PAM): Process Development and Screening Data Collection.

6.6.2.1.4.1. Targets:

6.6.2.1.4.1.1. At least eighty-five percent (85%) of the practices actively using the PAM tool will demonstrate use of the Coaching for Activation portion of the tool.

6.6.2.1.4.1.2. The Department will verify this target using the PAM Assessment Report.

6.6.2.1.4.2. The Contractor shall provide two (2) PAM reports to the Department annually, which include:

6.6.2.1.4.2.1. The PAM Assessment Report

6.6.2.1.4.2.1.1. The report shall be derived from Insignia Health's PAM software and shall be sent directly to the Department.

6.6.2.1.4.2.1.2. The report shall only include Members enrolled in this Contract.

6.6.2.1.4.2.1.3. The report shall contain, at a minimum, all of the following:

6.6.2.1.4.2.1.3.1. Client name;

6.6.2.1.4.2.1.3.2. Client Medicaid ID;

6.6.2.1.4.2.1.3.3. Survey type;

6.6.2.1.4.2.1.3.4. Survey date;

6.6.2.1.4.2.1.3.5. Activation Score;

6.6.2.1.4.2.1.3.6. PAM Level; and

6.6.2.1.4.2.1.3.7. Responses to all PAM assessment questions.

6.6.2.1.4.2.1.4. DELIVERABLE: PAM Assessment Report.

6.6.2.1.4.2.1.5. DUE: Annually, within thirty (30) days of the end of the SFY for which the report covers.

6.6.2.1.4.2.2. PAM Roadmap Report

6.6.2.1.4.2.2.1. The report shall include, at a minimum:

6.6.2.1.4.2.2.1.1. Year-end assessment of PAM and Coaching for Activation deployment;

6.6.2.1.4.2.2.1.2. Identification of successes, lessons learned and gaps; and

6.6.2.1.4.2.2.1.3. Roadmap for ongoing use of PAM data in further population analysis, stratification, and planning, and ongoing use of Coaching for Activation for population health planning.

6.6.2.1.4.2.2.2. DELIVERABLE: PAM Roadmap Report

6.6.2.1.4.2.2.3. DUE: Within thirty (30) days of the end of the SFY for which the report covers.

6.6.2.1.4.3. The Contractor must meet the PAM MLR Target, and submit both deliverables to the Department in order to receive any credit for this MLR Quality Measure.

6.6.2.2. Quality Targets Table:

Quality Measure	Target(s)/ Deliverable(s)	Adjustment Made to the MLR if the Contractor meets the Target
HEDIS: Adult Body Mass Index (BMI) Assessment	91.28%	Subtract one percent (-1%)
HEDIS: HbA1c Poor Control (>9.0%)	29.68%	Subtract one percent (-1%)
HEDIS: Anti-depressant Medication Management.	1. Effective Acute Phase Treatment: 59.35%. 2. Effective Continuation Phase Treatment: 42.29%	Subtract one percent (-1%)
Patient Activation Measure (PAM): Process Development and Screening Data Collection	1. Use of the Coaching for Activation tool in at least 85% of the practices using the PAM.	Subtract two percent (-1%)
Total		**Subtract four percent (-4%)**

6.6.2.3. In collaboration with the Contractor, the Department will set the MLR Quality Measure Targets for SFY16-17.

6.6.2.4. The Department intends to use the following four (4) quality metrics to measure the performance of the Contractor in relation to the Adjusted MLR Target for SFY15-16:

6.6.2.4.1. NQF #0421 (CQM29v2): Body Mass Index (BMI) Screening and Follow-Up

6.6.2.4.2. NQF #0418 (CQM2v3): Screening for Clinical Depression and Follow-Up Plan

6.6.2.4.3. NQF #0064 (CQM163v2): Low Density Lipoprotein (LDL) Management

6.6.2.4.4. PAM: Process Development and Screening Data Collection with Follow Up.

6.6.2.5. To the extent that the Contractor has access to identifiable, client-level clinical quality measure (CQM) data relevant to the MLR Quality Targets in an electronic format, the Contractor shall share this data with the Department. The Contractor will work with the Department to establish an appropriate format and method of data transfer.

6.7. PAYMENTS TO PHYSICIANS

6.7.1. Beginning on July 1, 2015, the Contractor shall reimburse physicians an enhanced payment. This enhanced payment shall be for eligible primary care services and vaccine administration furnished by a qualified physician, or under the personal direction of a physician.

6.7.1.1. The Contractor shall pay the enhanced payment to qualified physicians for eligible primary care services and vaccine administration rendered on and after July 1, 2015 through June 30, 2016.

6.7.1.2. The Contractor shall provide documentation to the Department, upon the Department's request, which provides assurances that physicians received the direct and full benefit of the enhanced payment described in this Section.

6.7.1.2.1. DELIVERABLE: Documentation that physicians received the direct and full benefit of the enhanced payment.

6.7.1.2.2. DUE: Within five (5) Business Days of the Department's request.

6.7.1.3. The primary care services and vaccine administration that qualify for this additional reimbursement are those listed in Exhibit Q, and have been approved as part of the Medicaid State Plan.

6.7.1.4. The Contractor may only operate a Physician Incentive Plan if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an incentive to reduce or limit medically necessary services to a Member.

6.7.1.5. The Contractor shall ensure that physicians or physician groups have adequate stop-loss protection if the Contractor puts them at financial risk for services not provided by the physician or physician group.

6.7.1.6. The Contractor shall not make payments to providers for provider-preventable conditions that:

6.7.1.6.1. Are identified in the State plan.

6.7.1.6.2. Have been found by the State, based on a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

6.7.1.6.3. Have a negative consequence for the Member.

6.7.1.6.4. Are auditable, and

6.7.1.6.5. Include, at a minimum:

6.7.1.6.5.1. The wrong surgical or other invasive procedure performed on a patient.

6.7.1.6.5.2. A surgical or other invasive procedure performed on the wrong body part.

6.7.1.6.5.3. A surgical or other invasive procedure performed on the wrong patient.

6.8. DISPROPORTIONATE SHARE HOSPITAL

6.8.1. The Contractor shall submit data according to the specifications in Exhibit N, Disproportionate Share and Graduate Medical Education Hospital Reporting, attached and incorporated herein by reference. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief

Financial Officer.

6.9. FQHC AND RHC ENCOUNTER REIMBURSEMENT

6.9.1. Payments from the Contractor to FQHC and RHC Facilities:

6.9.1.1. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505-10 8.700.6C.

6.9.1.1.1. The Department will notify the Contractor of the FQHC and RHC rates on a quarterly basis.

6.9.1.2. The Contractor shall reimburse the FQHC or RHC by at least the encounter rate in accordance with 10 CCR 2505-10 8.700.6 and the Medicaid State Plan for each FQHC or RHC visit, for services identified in 10 CCR 2505-10 8.700.3 for allowable costs identified in 10 CCR 2505-10 8.700.5. The Department will conduct quarterly accuracy audits with FQHCs and RHCs. Should the Department recognize any discrepancy in FQHC or RHC payments (less than the full encounter rate), then the Contractor shall be responsible for reimbursing the FQHC or RHC the difference of the encounter payment identified in 6.8.1.1. and the initial reimbursement amount. FQHC and RHC visits are defined in 10 CCR 2505-10 8.700.1.

6.9.1.3. If multiple services are provided by an FQHC or RHC within one visit, the Contractor will require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. The Contractor is required to pay the FQHC or RHC at least the encounter rate, less any third party payments and less any cost sharing, including Member co-payments as identified in the State Plan, regardless of whether or not the Contractor imposes or collects the Member co-payments for each visit.

6.9.2. The Contractor shall submit the encounter data for FQHC and RHC visits to the Department per the specifications provided in Exhibit H.

6.9.2.1. DELIVERABLE: FQHC and RHC Encounter Data

6.9.2.2. DUE: As described in Exhibit H

6.9.3. The Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs and is required to complete the documentation located at https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms upon the Department's request.

6.10. INSPECTION OF FINANCIAL RECORDS

6.10.1. In addition to the Financial Reporting as outlined in 5.7, the Contractor shall allow the Department and the Department of Health and Human Services to inspect and audit the financial records of the Contractor and its Subcontractors related to this Contract per 42 CFR 438.6(g).

6.11. MEDICAID PAYMENT IN FULL

6.11.1. Except as allowed in this Contract, the Contractor shall not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf, for Covered Services provided pursuant to this Contract.

6.11.2. Except as allowed in this Contract, the Contractor shall ensure that all of its Subcontractors and Participating Providers do not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or

any persons acting on a Member's behalf other than the Contractor, for Covered Services provided pursuant to this Contract.

6.11.3. This section shall not be construed to limit the ability of any of the Contractor's Subcontractors or Participating Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against the Contractor for any service provided pursuant to this Contract or any other agreement entered into between that Subcontractor or Participating Provider and the Contractor.

6.11.4. This provision shall survive the termination of this Contract, for authorized services rendered prior to the termination of this Contract, regardless of the reason for the termination. This provision shall be construed to be for the benefit of the Contractor's Members.

6.11.5. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 CFR Sections 95.1 and 95.7, the Department must file all claims for reimbursement of payments to the Contractor with CMS within 2 years after the calendar quarter in which the Department made the expenditure. The Contractor and the Department will work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file the Contractor's claims or capitation payments within 2 years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 CFR Section 95.19, no claims or capitations will be paid to the Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from the Contractor all claims and capitations paid to the Contractor for any period of time disallowed by CMS.

6.12. REIMBURSEMENT FOR HEPATITIS C MEDICATIONS

6.12.1. The Department shall reimburse the Contractor for the Therapies, described in Exhibit B, Covered Services, the lesser of the Contractor's paid amount or the fee-for-service rates beginning October 1, 2016, forward.

6.12.2. The Contractor shall use the MMIS to submit encounter claims to the Department for all Therapies and treatments provided to Members.

6.12.3. Prior to the implementation of interChange, the Contractor shall submit a flat file to the Department containing all Therapy encounter claims submitted to the MMIS on a quarterly basis, such flat file being formally submitted to the Department no later than thirty (30) days after the end of each quarter. This Section 6.12 shall become effective as of October 1st, 2016, and shall terminate on the date of successful implementation of the interChange.

6.12.3.1. The flat file submitted by the Contractor will contain the Contractor's paid amount as well as the Transaction Control Number for each corresponding submitted encounter claim.

6.12.3.2. The Department will have thirty (30) days after Contractor's submission of the flat file to validate the accuracy of the encounter data based on the MMIS submissions. The Department shall submit documentation of the proposed reimbursement to the Contractor, which will be based on the lesser of the paid amounts submitted in the flat file or the fee-for-service rates present in the MMIS encounter claims based on the State's most current published fee schedules, pursuant to 42 CFR 447.362.

6.12.3.3. If the Contractor objects to the Department's validation results of the claims data, the Contractor must submit written objection and analysis (the "Objection") to the Department

within ten (10) business days of receipt of the proposed reimbursement. Within ten (10) days from the receipt and review of the Objection, the Department will provide a final determination based on the review and analysis contained in the Objection.

6.12.3.4. The Department shall provide written notice of such findings if either party owes sums based on the final determination, and will either assess, or reimburse the Contractor accordingly. The owing party shall make payment of sums owed within thirty (30) days from the date of such written notice.

6.12.4. Post implementation of the interChange, the Contractor shall submit a flat file to the Department containing all Therapy encounter claims submitted to the MMIS on a quarterly basis, such a flat file being formally submitted to the Department no later than thirty (30) days after the end of each quarter.

6.12.4.1. The Department will have thirty (30) days after the Contractor's submission of the flat file to validate the accuracy of the encounter data based on MMIS submissions. The Department shall submit documentation of the proposed reimbursement to the Contractor, which will be based on the lesser of the paid amounts or the fee-for-service rates present in the MMIS encounter claims based on the State's most current published fee schedules, pursuant to 42 CFR 447.362.

6.12.4.2. If the Contractor objects to the Department's validation results of the claims data, the Contractor must submit the Objection to the Department within ten (10) business days of receipt of the proposed reimbursement. Within ten (10) days from the receipt and review of the Objection, the Department will provide a final determination based on the review and analysis contained in the Objection.

6.12.4.3. The Department shall provide written notice of such findings if either party owes sums based on the final determination, and will either assess, or reimburse the Contractor accordingly. The owing party shall make payment of sums owed within thirty (30) days from the date of such written notice.

6.12.5. Thirty (30) days after the close of the state fiscal year, the Department shall begin the process of reconciling all claims relating to the Therapies submitted for the previous state fiscal year. The Department shall complete the reconciliation and submit the results to the Contractor no later than thirty (30) days after the close of the previous state fiscal year.

6.12.5.1. If the Contractor wishes to object to the Department's reconciliation results, the Contractor must submit the Objection to the Department within ten (10) business days from the receipt of the Department's results.

6.12.5.2. The Department will provide a final determination on the reconciliation results within ten (10) business days after the receipt and review of the Objection.

6.12.6. The Department shall provide written notice of such findings if either party owes sums based on the final determination, and will either assess, or reimburse the Contractor accordingly. The owing party shall make payment of sums owed within thirty (30) days from the date of such written notice.

SECTION 7.0 ADDITIONAL FEDERAL REQUIREMENTS

7.1. FEDERAL DEBARRED ENTITIES

7.1.1. In addition to the Debarment and Suspension provisions in §21(C) of this Contract, the Contractor shall not knowingly have a relationship with any of the following entities:

7.1.1.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

7.1.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in the prior paragraph.

7.1.2. For the purposes of this section, a relationship is described as:

7.1.2.1. A director, officer or partner of the Contractor.

7.1.2.2. A person or entity with more than five percent (5%) beneficial ownership of the Contractor.

7.1.2.3. A Person with an employment, consulting or other arrangement with the Contractor that is responsible for any of the Contractor's obligations under this Contract.

7.1.3. The Contractor shall not employ or contract with any Provider that is excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

7.1.4. If the Department learns that the Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:

7.1.4.1. Must notify the Secretary of the Department of Health and Human Services of the noncompliance.

7.1.4.2. May continue an existing agreement with the Contractor unless the Secretary of the Department of Health and Human Services directs otherwise.

7.1.4.3. May not renew or extend the existing agreement with the Contractor unless the Secretary of the Department of Health and Human Services provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the Contract.

7.2. FEDERAL INTERMEDIATE SANCTIONS

7.2.1. The Department may implement any intermediate sanctions, as described in 42 CFR 438.702, if the Contractor:

7.2.1.1. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Contract with the Department, to a Member covered under the Contract.

7.2.1.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

7.2.1.3. Acts to discriminate among Members on the basis of their health status or need for health care services.

7.2.1.4. Misrepresents or falsifies information that it furnishes to CMS or to the Department.

7.2.1.5. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider.

7.2.1.6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.

7.2.1.7. Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

7.2.1.8. Has violated any of the other applicable requirements of sections 1903(m), 1932, or 1905(t) of the Act and any implementing regulations.

7.2.2. The Department may choose to impose any of the following intermediate sanctions:

7.2.2.1. Civil monetary penalties to a limit of twenty-five thousand dollars ($25,000.00) for each determination of failure to adhere to contract requirements as stated in Sections 7.2.1.1., 7.2.1.5., 7.2.1.6., and 7.2.1.7.

7.2.2.2. Civil monetary penalties to a limit of one hundred thousand dollars ($100,000.00) for each determination of a failure to adhere to contract requirements as stated in Sections 7.2.1.3. and 7.2.1.4.

7.2.2.3. Civil monetary penalties to a limit of fifteen thousand dollars ($15, 000.00) for each Member the Department determines was not enrolled because of a discriminatory practice under Section 7.2.1.3., up to a limit of one hundred thousand dollars ($100,000.00).

7.2.2.4. Civil monetary penalties to a limit of twenty-five thousand dollars ($25, 000.00), or double the amount of excess charges, whichever is greater, for excess charges under Section 7.2.1.2.

7.2.2.5. Imposition of temporary management, if the Contractor has repeatedly failed to meet substantive requirement in Section 1903(m) or Section 1932 of the Social Security Act. Temporary management will continue until it has been determined that the Contractor can ensure that the sanctioned behavior will not recur. Members will be granted the right to terminate enrollment without cause and notify the affected Members of their right to terminate enrollment.

7.2.2.6. Allow Members to right to terminate enrollment without cause with notification to the Members of their right to terminate enrollment, for each failure to adhere to contract requirements as stated in Sections 7.2.1.1., 7.2.1.2., 7.2.1.3., 7.2.1.4., 7.2.1.5., 7.2.1.6., and 7.2.1.8.

7.2.2.7. Suspension of all new enrollments, after the effective date of the sanction for each failure to adhere to contract requirements as stated in Sections 7.2.1.1., 7.2.1.2., 7.2.1.3., 7.2.1.4., 7.2.1.5., 7.2.1.6., and 7.2.1.8. until the necessary services or corrections in performance are satisfactorily completed as determined by the Department.

7.2.2.8. Suspension of payment for new enrollments, after the effective date of the sanction for each failure to adhere to contract requirements as stated in Sections 7.2.1.1., 7.2.1.2., 7.2.1.3., 7.2.1.4., 7.2.1.5., 7.2.1.6., and 7.2.1.8. until the necessary services or corrections in performance are satisfactorily completed as determined by the Department.

7.2.2.8.1. Only the sanctions specified in 7.2.2.6., 7.2.2.7., and7.2.2.8. may be imposed for failure to meet any of the requirements of sections 1903(m), 1932, or 1905(t) of the Social Security Act and any implementing regulations.

7.2.3. Before imposing any intermediate sanctions, the Department shall give the Contractor timely written notice that explains:

7.2.3.1. The basis and nature of the sanction.

7.2.4. Payments provided for under the contract shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

7.3. TERMINATION UNDER FEDERAL REGULATIONS

7.3.1. The Department may terminate this Contract for cause and enroll any Member enrolled with the Contractor in other Plan, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the Contractor has failed to:

7.3.1.1. Carry out the substantive terms of its contracts.

7.3.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

7.3.2. Before terminating the Contractor's Contract as described in this section, the Department shall:

7.3.2.1. Provide the Contractor a cure notice that includes, at a minimum, all of the following:

7.3.2.1.1. The Department's intent to terminate.

7.3.2.1.2. The reason for the termination.

7.3.2.1.3. The time and place for the pre-termination hearing

7.3.2.2. Conduct a pre-termination hearing.

7.3.2.3. Give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

7.3.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department shall send a written termination notice to the Contractor that contains the effective date of the termination.

7.3.2.4.1. Upon receipt of the termination notice, the Contractor shall give Members enrolled with the Contractor notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

7.3.3. Once the Department has notified the Contractor of its intent to terminate under this section, the Department may:

7.3.3.1. Give the Members enrolled with the Contractor written notice of the Department's intent to terminate the Contract.

7.3.3.2. Allow Members enrolled with the Contractor to Disenroll immediately, without cause.

7.4. TRANSITION AT TERMINATION REQUIREMENTS

7.4.1. Upon termination of the Contract for any reason, the Contractor shall do all of the following for a period not exceed sixty (60) days before termination of the Contract:

7.4.1.1. Provide the Department with all information related to the Contractor's PCMP Network, its Members and the services provided to those Members, for transition to the Department or

any other contractor of the Contractor's responsibilities.

7.4.1.2. Provide for the uninterrupted continuation of all network management, Care Coordination and administrative services until the transition of every member is complete and all requirements of the Contract are satisfied.

7.4.1.3. Designate an appropriate individual as the transition coordinator to work with the Department and any staff from the replacement contractor to ensure the transition does not adversely impact any member's care.

7.4.1.4. Provide to the Department all reports reasonably necessary for a transition.

7.4.1.5. Notify any Subcontractors of the termination of the Contract, as directed by the Department.

7.4.1.6. Notify all of the Members in the Contractor's Region that the Contractor will no longer be the RCCO for the region, in a form and manner approved by the Department.

7.4.1.7. Notify each PCMP in the Contractor's PCMP Network of the termination and the end date of the Contract and explain to the provider how the provider may continue participating in the ACC program.

7.4.1.8. Cooperate with the Department and any other replacement contractor during the transitions, including, but not limited to, using reasonable efforts to share and transfer Member information and following any instructions or preforming any required actions, as reasonably directed by the Department.

7.4.1.9. Provide the Department, in a format prescribed and approved by the Department:

7.4.1.9.1. A list of all PCMPs in the Contractor's PCMP Network.

7.4.1.9.2. A list of all Members in the Contractor's Region.

7.5. FEDERAL DISCLOSURES OF INFORMATION ON OWNERSHIP AND CONTROL

7.5.1. The Contractor shall provide all disclosures required by 42 CFR 455.104, as amended or hereinafter amended, in a form substantially similar to Exhibit G, Contractor Disclosure Template. These disclosures are:

7.5.1.1. The name and address of any person, either an individual or a corporation, with an ownership or control interest in the Contractor. For a corporate entity, the address shall include the primary business address, the address of each business location if there is more than one location and any applicable P.O. Box address.

7.5.1.1.1. The date of birth and social security number for any individual with an ownership or control interest in the Contractor.

7.5.1.1.2. The tax identification number of any corporate entity with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor has a five percent (5%) or greater interest.

7.5.1.2. Whether any person, either an individual or a corporation, with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

7.5.1.2.1. Whether any person, either an individual or a corporation, with an ownership or control interest in the any Subcontractor in which the Contractor has a five percent (5%) or greater interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

7.5.1.3. The name of any other entity required to disclose under 42 CFR 455.104 in which any owner of the Contractor has an ownership or control interest.

7.5.1.4. The name, address, date of birth and Social Security Number of any managing employee of the Contractor.

7.5.2. "Ownership interest" and "person with an ownership or control interest" shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended. "Subcontractor", for purposes of this subsection regarding Federal Disclosures of Information on Ownership and Control only, shall have the meaning specified in 42 CFR 455.101, as amended or hereinafter amended.

7.5.3. The Contractor shall complete these disclosures at the following times:

7.5.3.1. When the Contractor submits a proposal in accordance with the Department's procurement process.

7.5.3.2. Upon execution of the Contract or when the Department renews or extends the Contract.

7.5.3.3. Within thirty-five (35) days of any change in ownership of the Contractor.

7.6. FEDERAL FINANCIAL PARTICIPATION AND FINANCIAL SOLVENCY

7.6.1. The Contractor shall ensure that under no circumstance shall a Member be held liable for:

7.6.1.1. The Contractor's debts, in the event of the Contractor's insolvency.

7.6.1.1.1. The Contractor shall provide assurances to the Department that no Member will be held liable for the Contractor's debts, in the event of the Contractor's insolvency.

7.6.1.2. The Covered Services provided to the Member, for which the Department does not pay the Contractor.

7.6.1.3. The Covered Services provided to the Member, for which the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, Referral, or other arrangement.

7.6.1.4. The payments for Covered Services furnished under the Contract, Referral or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.

7.6.2. The Contractor shall ensure that no Member is billed by a Subcontractor or Referral Provider for any amount greater than would be owed if the Contractor provided the services directly.

7.6.3. The Contractor shall meet all solvency standards, established by the State of Colorado, for private health maintenance organizations.

7.6.4. In the event that the Contractor becomes insolvent, the Contractor shall cover continuation of services to Members for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

7.7. PHARMACY REBATES

7.7.1. The Department will collect pharmacy rebates when the Contractor submits pharmacy encounters into the Prescription Drug Card System (PDCS). The PDCS will adjudicate those pharmacy encounters submitted by the Contractor and feed all rebatable pharmacy claims into the Drug Rebate Analysis Management System (DRAMS). DRAMS will then collect the manufacturer information and generate quarterly invoices to the drug manufacturer. The drug manufacturers will pay all drug rebates to the Department, and the Contractor shall not be

responsible for any of these rebates. These amounts will be totaled quarterly and reported to CMS on the CMS-64 form.

7.8. OTHER FEDERAL REQUIREMENTS

7.8.1. Party In Interest Reporting

7.8.1.1. The Contractor shall report to the Department and, upon request, to the Secretary of the Department of Health and Human Services (DHHS), the Inspector General of the DHHS and the Controller General a description of transactions between the Contractor and a party in interest, as defined in section 1318(b) of the Social Security Act.

7.8.1.1.1. The Contractor shall report on the following transactions at a minimum:

7.8.1.1.1.1. Any sale, exchange or lease of any property between the Contractor and a party in interest.

7.8.1.1.1.2. Any furnishing for consideration of the following between the Contractor and a party in interest:

7.8.1.1.1.2.1. Goods.

7.8.1.1.1.2.2. Services, including management services.

7.8.1.1.1.2.3. Facilities.

7.8.1.1.1.2.3.1. Any lending of money or other extension of credit between the Contractor and a party in interest.

7.8.1.1.2. The Contractor's party in interest report shall not include salaries paid to employees for services provided in the normal course of their employment.

7.8.1.2. The Contractor shall allow the Secretary of DHHS and the Department, or their designees, to audit and inspect any books or records of the Contractor or its subcontractors pertaining to:

7.8.1.2.1. The ability of the Contractor to bear the risk of financial losses.

7.8.1.2.2. Services performed or payable amounts under the contract.

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Exhibit B-3
COVERED SERVICES

SECTION 1.0 DEFINITIONS

1.1.1. **Dialysis Treatment Center**: A health institution or a department of a licensed hospital, which is planned, organized, operated and maintained to provide outpatient treatment by means of dialysis and/or training for home use of dialysis equipment.

1.1.2. **Durable Medical Equipment (DME)** means Medically Necessary equipment prescribed by a physician that can withstand repeated use, serves a medical purpose, and is appropriate for use outside of a medical facility.

1.1.3. **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:

1.1.3.1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

1.1.3.2. Serious impairment to bodily functions.

1.1.3.3. Serious dysfunction of any bodily organ or part.

1.1.4. **Expanded EPSDT** shall mean those services that are not explicitly provided under this exhibit but which are Medically Necessary to correct or ameliorate defects and physical or mental illnesses or conditions discovered or shown to have increased in severity by an EPSDT screening. It does not include items or services that the Department determines are not safe and cost effective or which are considered experimental.

1.1.5. **Family Planning** are services and supplies furnished directly (or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active), which includes physical examinations, diagnosis, treatment, supplies and follow-up.

1.1.6. **Habilitative Therapy Services** are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration in accordance with 45 CFR 156.110(f) and 45 CFR156.115(a)(5).

1.1.6.1. Habilitative Therapy Services are only available to Expansion Members.

1.1.7. **Medically Necessary**, or Medical Necessity, shall be defined as described in 10 CCR 2505-10 §8.076.1.8. Medical Necessity means that a Medical Assistance program good or service:

1.1.7.1. Will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.

1.1.7.2. Is provided in accordance with professionally recognized standards for health care in the United States;

1.1.7.3. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

1.1.7.4. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;

1.1.7.5. Is delivered in the most appropriate setting(s) required by the client's condition;

1.1.7.6. Is not experimental or investigational; and

1.1.7.7. Is not more costly than other equally effective treatment options.

1.1.7.8. For EPSDT, Medical Necessity is defined in 10 CCR 2505-10 §8.280.1. For EPDST, all services described in Section 1905(a) of the Social Security Act are a covered benefit under EPSDT when medically necessary as defined at 10 CCR 2505-10, Section 8.076.1.8, regardless of whether such services are covered under the State Plan. For the purposes of EPSDT, medical necessity also includes a program good or service that will, or is reasonably expected to, assist the client to maintain maximum functional capacity in performing one or more Activities of Daily Living and meets the criteria set forth at Sections 1.1.7.2. through 1.1.7.7. above.

1.1.8. **Medical Screening Examination**: Screening of sick, wounded, or injured persons in the emergency room to determine whether the person has an Emergency Medical Condition. An appropriate Medical Screening Examination (including ancillary services routinely available to an emergency treatment facility) must be available to any individual who comes to the emergency treatment facility for examination or treatment of a medical condition and on whose behalf the examination or treatment is requested.

1.1.9. **Orthotic:** An orthopedic appliance used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

1.1.10. **Outpatient Services** are those diagnostic, therapeutic, rehabilitative, preventive and palliative items and services furnished by or under the direction of a physician to an eligible person who is an outpatient in a participating hospital that is not providing the patient room and board on a continuous twenty-four hour basis.

1.1.11. **Palliative Services** means any medical services recommended by a physician within the scope of his/her practice under state law, for the purpose of affording a recipient relief from the symptoms of a condition or disease.

1.1.12. **Poststabilization Care Services** means Covered Services, related to an Emergency Medical Condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition to improve or resolve the enrollee's condition, as set forth at 42 CFR §422.113.

1.1.13. **Preventive Services:** Services provided by a physician within the scope of his/her practice under state law to:

1.1.13.1. Prevent disease, disability, and other health conditions or their progression;

1.1.13.2. Prolong life; and,

1.1.13.3. Promote physical and mental health and efficiency.

1.1.14. **Prosthetic Device**: replacement, corrective or supportive devices prescribed by a doctor of medicine or a doctor of osteopathy to:

1.1.14.1. Artificially replace a missing portion of the body

1.1.14.2. Prevent or correct physical deformity or malfunction

1.1.14.3. Support a weak or malformed portion of the body

1.1.15. **Rehabilitative Services:** Any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

1.1.16. **Speech Pathologist**: Person specializing in the diagnostic evaluation and treatment of speech and language problems; the planning, directing or conducting of habilitative or rehabilitative treatment programs to restore communicative efficiency of communication problems or organic and non-organic etiology; provision of counseling and guidance for speech and language handicaps.

1.1.17. **Telemedicine** is defined as the delivery of medical services, and any diagnosis, consultation, treatment, transfer of medical data, or education related to health care services using interactive audio, interactive video, or interactive data communication instead of in-person contact.

1.1.18. **Therapeutic Services** means any medical service provided by a physician within the scope of his/her practice of medicine under state law, in the treatment of disease.

1.1.19. **Therapy** means high cost Hepatitis-C drugs found in the therapeutic classes W5Y, W0A, W0B, W0D, and W0E along with the supplementary drugs used in conjunction with the high cost drugs found in therapeutic class W5G.

SECTION 2.0 COVERED SERVICES

2.1. With the exception of EPSDT and preventive services as specified in this exhibit, covered services and supplies must be medically necessary and provided for the diagnosis or treatment of an illness, pregnancy, or accidental injury. A covered person and his or her physician decide which services and supplies are given, but contractors need only pay for the following covered services and supplies.

2.1.1. **Abortion**

2.1.1.1. Abortions are a Covered Service only in the following circumstances:

2.1.1.1.1. When a physician has found and certified in writing that in his or her professional judgment the life of the mother would be endangered if the fetus were carried to term, when documented in accordance with federal requirements. 42 C.F.R. § 441.203.

2.1.1.1.2. If the pregnancy is a result of rape or incest.

2.1.1.2. NOTE: For the purpose of this section, treatment for the following conditions is not considered to be an abortion:

2.1.1.2.1. Ectopic pregnancies (Pregnancy occurring in other than a normal position or place); and

2.1.1.2.2. Miscarriage (spontaneous abortion).

2.1.2. **Ambulance Services**

2.1.2.1. Covered ambulance services shall be provided to the nearest appropriate medical facility when any other form of transportation is not medically advisable and when the ambulance service is provided in conjunction with emergency medical care. Such covered ambulance services include the following situations:

2.1.2.2. Air ambulance

2.1.2.2.1. Air ambulance services, including rotary- and fixed-wing aircraft, are covered only if the client requires medical attention, the client is transported to the nearest appropriate medical facility, and

2.1.2.2.1.1. The point of pickup is inaccessible by land emergency transport vehicles,

2.1.2.2.1.2. Great distances or other obstacles are involved in transport to the nearest appropriate facility and prompt admission is essential; or

2.1.2.2.1.3. The client is suffering from an illness, injury, or psychiatric condition that makes all other forms of transport inadvisable.

2.1.2.2.2. Emergency Services which, due to the medical or psychiatric condition of the Client, are immediate in nature and cannot be arranged in advance.

2.1.2.2.3. Non-emergency Services that are preplanned but due to the medical or psychiatric condition of the Client are the only mode that can be utilized safely. Must be prior authorized.

2.1.2.3. If the Client is transported from home to hospital by ambulance for treatment of a condition which a prudent layperson would perceive as an emergency, as defined at 10 CCR 2505-10 Section 8.303, the ambulance shall be reimbursed, even if the healthcare services rendered are subsequently determined to be urgent or non-emergent in nature. 42 C.F.R. 438.114 (c) (1) (ii).

2.1.3. **Ambulatory surgical care**

2.1.3.1. The allowable surgical procedures identified for Medicare coverage are reimbursable and covered Medicaid benefits.

2.1.4. **Amniocentesis**

2.1.4.1. Amniocentesis performed for medical reasons other than sex determination.

2.1.5. **Anesthesia Services**

2.1.5.1. Administration of anesthetics to achieve general, regional or supplementation of local anesthesia related resuscitative and supportive procedures.

2.1.5.2. Administration of anesthesia or deep sedation in a hospital or outpatient facility when determined to be medically necessary for adults and children.

2.1.6. **Audiology and Speech Pathology**

2.1.6.1. Audiological services include medical/diagnostic ear testing using recognized diagnostic instrumentation/equipment in a clinical environment to assist or confirm in establishing a diagnosis.

2.1.6.2. Speech pathology services include performance of medical/diagnostic procedures including, but not limited to, those communicative problems resulting from medical conditions such as cerebral palsy, cleft palate/lip, or brain dysfunction.

2.1.6.3. NOTE: The EPSDT benefit covers screening and Medically Necessary ear exams and audiological testing.

2.1.7. **Autism**

2.1.7.1. Autism shall be treated as a physical disorder.

2.1.8. **Consultation**

2.1.8.1. Covered Services include medical services rendered by a provider whose opinion or advice is requested by a Client's primary care provider or the health plan medical director for further evaluation of an illness or injury. Clients shall be granted a second opinion when requested, subject to referral requirements. Consultations by non-participating providers may be subject to prior authorization.

2.1.9. **Detoxification**

2.1.9.1. Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

2.1.10. **Dialysis, Hemodialysis or Peritoneal Dialysis**

2.1.10.1. Coverage includes placement or repair of the dialysis route ("shunt" or "cannula").

2.1.10.2. The organization providing dialysis shall be responsible for the provision of all supplies and the maintenance of all equipment and necessary fixtures required for home dialysis.

2.1.10.2.1. Inpatient dialysis

2.1.10.2.1.1. Coverage is provided in those cases where hospitalization is required.

2.1.10.2.2. Outpatient dialysis

2.1.10.2.2.1. Coverage is provided when provided by a separate unit within a hospital or a freestanding Dialysis Treatment Center. Coverage is provided for any other medical condition for which the Medical Assistance Program provides payment when the eligible recipient receives regular Medically Necessary maintenance treatment on an outpatient dialysis program.

2.1.10.2.3. Home dialysis

2.1.10.2.3.1. The participating separate dialysis unit within a hospital or free-standing Dialysis Treatment Center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.

2.1.11. **Durable Medical Equipment and Disposable Supplies**

2.1.11.1. The following Durable Medical Equipment (DME) and supplies are Medicaid benefits for clients of all ages if Medical Necessity has been established and use outside of a medical facility is considered appropriate. DME shall be covered as described at 10 CCR 2505-10, Section 8.590.

2.1.11.1.1. Ambulation devices & accessories (canes, crutches, walkers),

2.1.11.1.2. Bath and bathroom equipment,

2.1.11.1.3. Bed and bedroom equipment and accessories, including specialized beds and mattress overlays,

2.1.11.1.4. Manual or power wheelchairs, seating system orthosis used for wheelchair positioning,

2.1.11.1.5. Diabetic monitoring equipment and related disposable supplies,

2.1.11.1.6. Elastic supports/stockings,

2.1.11.1.7. Monitoring equipment and supplies,

2.1.11.1.8. Oxygen Equipment for home use, including nursing facility residents, See Exclusions

2.1.11.1.9. Transcutaneous and/or neuromuscular electrical nerve stimulators (tens) and related supplies

2.1.11.1.10. Trapeze/traction/fracture frames,

2.1.11.1.11. Lymphedema pumps/compressors,

2.1.11.1.12. Rehabilitation equipment (specialized use),

2.1.11.1.13. Enteral formulas and supplies,

2.1.11.1.14. Parenteral equipment and supplies, and

2.1.11.1.15. Repairs and extensive maintenance as needed to keep the DME item functional.

2.1.11.2. The contractor shall provide an adequate number of disposable supplies when used in connection with approved DME and/or when related to one of the following categories:

2.1.11.2.1. Surgical, wound and burn care,

2.1.11.2.2. Syringes/needles,

2.1.11.2.3. Bowel and bladder care,

2.1.11.2.4. Antiseptics/solutions,

2.1.11.2.5. Gastric feeding sets and supplies,

2.1.11.2.6. Tracheostomy and endotracheal care supplies, or

2.1.11.2.7. Diabetic monitoring.

2.1.11.3. Covered Services include the rental or purchase of DME and supplies including repair, maintenance and delivery. The Contractor is only required to provide DME that is covered by Medicaid, but may provide other DME when medically appropriate. Preference should be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the equipment will be operated. Coverage in a particular case is subject to the requirement that the equipment be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. DME and supplies may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.

2.1.11.4. Medicaid clients for whom wheelchairs, wheelchair component parts, and other specialized equipment were authorized and ordered prior to enrollment in the Contractor's Plan, but for which delivery is delayed until after the HMO enrollment period begins, shall have those services provided by the Medicaid Program. The Contractor shall reimburse services approved and ordered by the Contractor providing the client remains Medicaid eligible, regardless of whether enrollment in the Plan continues. All other DME and disposable supplies approved by the Contractor shall be the responsibility of the Contractor.

2.1.12. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Benefits**

2.1.12.1. The Contractor must meet all state and federal requirements for EPSDT benefits under 42 C.F.R. Sections 441.50 through 441.61 and 10 C.C.R. 2505-10, Section 8.280. EPSDT services include comprehensive well child examinations, immunizations, assessment, diagnosis and treatment necessary to correct or ameliorate conditions, defects and illnesses discovered by EPSDT screening to all covered persons through the age of 20. EPSDT services also include provision benefit information, scheduling assistance and case management.

2.1.12.2. Information about EPSDT benefits must be provided to clients and parents, to include:

2.1.12.2.1. Information about the periodicity table,

2.1.12.2.2. Scheduling and transportation to make EPSDT appointments, and

2.1.12.2.3. Information about the full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid.

2.1.12.3. Additionally, maintenance of a coordinated system to follow the client through the entire range of screening and treatment (case management) and coordination with other providers to ensure that clients receive Covered Services, must be provided.

2.1.13. **Emergency Services**

2.1.13.1. Emergency Services means covered inpatient and Outpatient Services that are as follows:

2.1.13.1.1. Furnished by a provider that is qualified to furnish these services under this Contract; and

2.1.13.1.2. Needed to evaluate or stabilize an Emergency Medical Condition.

2.1.13.2. Emergency services are exempt from Primary Care Provider referral.

2.1.14. **Family Planning Services**

2.1.14.1. Family Planning counseling, examination, treatment and follow-up; information on birth control (including insertion and removal of approved contraceptive devices); measurement for contraceptive diaphragms; and male/female surgical sterilization (see Surgical Services, Sterilization) is included even if the Member goes out of network. The fees are included in the rates. The Contractor shall reimburse out-of-network family planning services at a rate equal to Medicaid fee-for-service reimbursement rates, or the Contractor's contractual reimbursement rates, whichever is higher. No referral is required.

2.1.15. **Federally Qualified Health Care (FQHC)**

2.1.15.1. Core services are provided in outpatient settings only, including a Member's place of residence. Core services means covered Outpatient Services that may include:

2.1.15.1.1. Physician services;

2.1.15.1.2. Physician assistant services;

2.1.15.1.3. Nurse practitioner services;

2.1.15.1.4. Nurse midwife services;

2.1.15.1.5. Licensed psychologist services;

2.1.15.1.6. Licensed social worker services;

2.1.15.1.7. Pneumococcal and influenza vaccines and administration;

2.1.15.1.8. Services and supplies incident to health professional services;

2.1.15.1.9. Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area that is determined to have a shortage of home health agencies; and

2.1.15.1.10. Any other reimbursable ambulatory services offered by the FQHC that are covered by the State Plan.

2.1.15.2. Notwithstanding a BHO primary diagnosis, services provided to Members by a physician (not a mental health practitioner) are covered (and have been included in the rates). The BHO diagnosis codes are attached as Exhibit F-1.

2.1.16. **Habilitative Health Services**

2.1.16.1. Habilitative therapy services shall have parity in amount, scope, and durations to rehabilitative therapies and will only consist of physical, occupational, and speech-language therapy services.

2.1.16.2. The procedure code set for Habilitative therapies is identical to that of Rehabilitative therapies.

2.1.16.3. All Habilitative Therapy Services require prior authorization.

2.1.16.4. Habilitative Therapy is only available to Expansion Members.

2.1.17. **Hepatitis-C Therapies**

2.1.17.1. The Contractor shall provide coverage for Members in accordance with the Department's criteria, outlined in the pharmacy billing manual.

2.1.17.2. Hepatitis-C therapies for Members shall include high cost Hepatitis-C drugs found in the therapeutic classes W5Y, W0A, W0B, W0D, and W0E along with the supplementary drugs used in conjunction with the high cost drugs found in therapeutic class W5G.

2.1.18. **Home Health Services**

2.1.18.1. Upon enrollment, the contractor shall provide Acute Home Health Services as defined in 10 CCR 2505-10. Section 8.520. Members eligible for Acute Home Health Services must be eligible for services as set forth at 10 CCR 2505-10, Section 8.520. The contractor is not required to cover more than one nurse, home health aide or therapist at one time except when two aides are required for transfers or more than one nurse is needed to perform a procedure.

2.1.18.2. Services provided by other kinds of providers (i.e. other than a Medicaid-certified Home Health agency) to Members in their own homes are also Covered Services and are included in the capitation rates. These kinds of Covered Services include:

2.1.18.2.1. Professional services of an RN, LPN or LVN on an intermittent basis

2.1.18.2.2. Home health aide services for purposes of providing skilled personal care, in conjunction with a nurse or therapist and under the supervision of a nurse or therapist

2.1.18.2.3. Physical evaluations and therapy, and speech/hearing evaluations and therapy, occupational therapy by licensed therapists.

2.1.18.2.4. Medical/surgical supplies delivered to the Member's home (e.g. DME, prosthetics, disposable supplies), but not other Wrap Around services.

2.1.18.2.5. Services provided when the Member's medical condition requires teaching (e.g. self-care management training), which is most effectively accomplished in the Client's home on a short-term basis.

2.1.18.2.6. Developmental therapies and EPSDT screenings (e.g. Neuromuscular reeducation, Sensory integration, Cognitive skills development).

2.1.18.3. Nurse Home Visitor Program services provided in the Member's home are Wrap Around services. These services are billed on the 1500 claim form using CPT codes G9006 or T1017.

2.1.19. **Imaging (Radiology or X-ray Services)** Services authorized by a licensed physician.

2.1.19.1.1. Services performed to diagnose conditions and illnesses with specific symptoms.

2.1.19.1.2. Services are performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.

2.1.19.1.3. Routine mammograms as described under Preventative Care Services.

2.1.20. **Inpatient Hospital**

2.1.20.1. Hospital services are a benefit of the Medicaid Program and include those items and services that are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a physician.

2.1.20.1.1. Semi-Private Room and Board

2.1.20.1.2. Private rooms must be covered:

2.1.20.1.2.1. When Medically Necessary

2.1.20.1.2.2. When furnished by the hospital as the only accommodation

2.1.20.1.2.3. If the hospital has no semi-private room available. Member must be moved to a semi-private room as soon as available.

2.1.20.1.3. Delivery and labor rooms, anesthesia, and equipment.

2.1.20.1.3.1. Limitations for a hospital stay following a normal vaginal delivery may be limited after 48 hours post delivery.

2.1.20.1.3.2. Limitations for a hospital stay following a cesarean delivery may be limited after 96 hours post delivery.

2.1.20.1.4. All other Medically Necessary services and supplies during the inpatient hospital stay including pharmacy, therapies, blood and blood products, anesthetics, Durable Medical Equipment (DME) and specialty care services.

2.1.20.1.5. Discharge oxygen

2.1.20.1.6. Routine Newborn care is limited to period of time that the mother remains hospitalized and is billed under the Mother's Medicaid Client ID. Inpatient newborn care following the mother's discharge is not a covered benefit under this Contract. The newborn will receive its own Medicaid Client ID retrospective to its date of birth and will be billed FFS.

2.1.20.1.7. Inpatient substance abuse rehabilitation DRG 772 is a wrap around. See Wrap Around Benefits Section.

2.1.21. **Laboratory (clinical/pathological)**

2.1.21.1. Services authorized by a licensed physician.

2.1.21.1.1. Services performed to diagnose conditions and illnesses with specific symptoms.

2.1.21.1.2. Services performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.

2.1.21.2. Services performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

2.1.21.3. LIMITATIONS

2.1.21.3.1. Collection, handling, and/or conveyance of specimens for transfer from the member's home, a nursing home or a facility other than the physician's office or place of practice is a benefit only if the member is homebound, bedfast, or otherwise non-ambulatory. However, when a specimen of this type could be reasonably mailed, the pickup is no longer considered Medically Necessary and therefore is non-reimbursable. The physician may be required to certify the Medical Necessity for the pick-up. Transfer of a specimen from one certified independent clinical laboratory to another is a benefit and reimbursable to the first certified laboratory only if the laboratory's equipment is not functioning or the laboratory is not certified to perform the tests ordered by the physician.

2.1.22. **Medical Services**

2.1.22.1. For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File as published in Provider bulletins or available on disc shall be considered the prevailing guide. The following is a general overview of such services.

2.1.22.1.1. Direct physical examination of the member's body and/or mental or cognitive status.

2.1.22.1.2. Examination of some aspect of the member's condition by means of radiological, non-radiological diagnostic imaging, pathology, laboratory or electronic monitoring procedures.

2.1.22.1.3. Procedures for prescribing, administering, directing or supervising medical treatment.

2.1.22.1.4. Manual manipulation. Department guidelines, which include manipulation by osteopathic physicians only, may be applied by the Plan.

2.1.22.1.5. Diagnosis and treatment of eye disease or injury.

2.1.22.1.6. Administration of injectables and allergens.

2.1.22.1.7. Counseling: Diet and/or nutritional counseling when the diagnosis indicates or includes a clinical problem that is or could be impacted by obesity.

2.1.22.1.8. Treatment for ear or hearing problems.

2.1.23. **Newborn Hospitalization**

2.1.23.1. Newborn hospitalizations shall extend only for the period of the mother's hospitalization unless Medical Necessity exists for the newborn to remain hospitalized. If Medical Necessity for the newborn to remain hospitalized exists, the additional days shall be billed FFS.

2.1.24. **Occupational/Physical Therapy**

2.1.24.1. A physician may prescribe occupational or physical therapy for clients when Medically Necessary.

2.1.25. **Outpatient Services**

2.1.25.1. Covered Services include diagnostic, Therapeutic, Rehabilitative, Preventive, and Palliative Services furnished by or under the direction of a physician.

2.1.26. **Outpatient Rehabilitation Services**

2.1.26.1. Covered Services include speech therapy, occupational therapy, physical therapy, pulmonary therapy and cardiac rehabilitation when ordered by the Covered Person's Primary Care or Referring Physician.

2.1.26.2. All Medically Necessary care and treatment of conditions discovered as a result of EPSDT medical screenings, including habilitation secondary to birth injury or developmental delay and rehabilitation services following illness or injury, shall be provided to Clients covered by the EPSDT Program.

2.1.27. **Oxygen and Oxygen Equipment**

2.1.27.1. Oxygen and oxygen equipment in a client's home, or place used as his/her home, and prescribed by the attending physician, is covered. Any form of oxygen for use by clients in an inpatient hospital setting must be provided by the hospital. The nursing facility must provide all forms of oxygen except for liquid or gaseous oxygen and the supplies and equipment necessary to administer each.

2.1.28. **Physical examinations**

2.1.28.1. Physical examinations for the purpose of:

2.1.28.1.1. Diagnostic evaluation of disease, and

2.1.28.1.2. Admission or placement in skilled nursing home care, intermediate nursing home care, residential care, or early and periodic screening, diagnosis and treatment.

2.1.29. **Physical/Occupational Therapy**

2.1.29.1. Occupational or physical therapy for clients when Medically Necessary and ordered by a physician.

2.1.30. **Physician Services**

2.1.30.1. Age 65 and over: All Medically Necessary services.

2.1.30.2. Under the age of 65: the following scope and range of benefits when Medically Necessary:

2.1.30.2.1. Inpatient hospital services

2.1.30.2.2. Inpatient surgery

2.1.30.2.3. Outpatient surgery

2.1.30.2.4. Outpatient diagnostic services

2.1.30.2.5. Physician services provided to residents in a skilled nursing facility

2.1.30.2.6. Home and physician office calls

2.1.30.2.7. Family Planning is considered in the same manner as for any other medical visit. Services provided in connection with medication and devices to be employed are supplied for the purpose of Family Planning, depending on the preference of the individual recipient/member. See Family Planning under Covered Services.

2.1.30.2.8. Dental care is a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones, including dental splints or other devices. With respect to these services, a doctor of dental surgery or dental medicine, appropriately licensed, is classified as a physician and entitled to payment.

2.1.30.2.9. Foot care services

2.1.30.2.10. Vision care services are included as benefits in accordance with the following general policies:

2.1.30.2.10.1. Services performed within the scope of the Medical and Optometrist Practice Acts

2.1.30.2.10.2. Services for the provision of eyeglasses and contact lenses following eye surgery.

2.1.30.2.10.3. Corneal transplants

2.1.30.2.11. Services in regard to laboratory testing in accordance with the Imaging and Laboratory sections of this exhibit

2.1.30.2.12. Immunizations

2.1.31. **Podiatry**

2.1.31.1. Foot care services are included as a benefit in the Medical Assistance Program whether provided by a physician or licensed podiatrist.

2.1.32. **Prescription Drugs**

2.1.32.1. The Contractor is responsible for prescription drugs.

2.1.33. **Preventive Medicine**

2.1.33.1. Examinations for the purpose of diagnosis and treatment of existing illness or injury are not included in this section. The client and the primary care physician will determine exam periodicity for members with a disability.

2.1.33.2. Physical exams

2.1.33.2.1. Under age 21, see Early Periodic Screening, Diagnosis and Treatment (EPSDT)

2.1.33.2.2. Age 21 - 35, at least once every 5 years but not more than once a year

2.1.33.2.3. Age 36 - 50, at least once every 2 years but not more than once a year

2.1.33.2.4. Over age 50, once every 12 months

2.1.33.3. Women's health

2.1.33.3.1. Routine yearly breast and pelvic examination with PAP smear, hematocrit and urinalysis

2.1.33.3.2. Routine mammograms as required by statute (Section 10-16-104 C.R.S.): a single baseline mammogram for women from age 35 to 39; at least once every two contract years for women from age 40 to 49, except women with risk factors to breast cancer, as determined by the primary care physician, shall be at least once per year; and at least once per contract year for women age 50 to 65 years.

2.1.33.4. Men's Health

2.1.33.4.1. Age 40 to 50 in high-risk categories (as determined by the primary care physician), in accordance with statute (Section 10-16-104 C.R.S.)

2.1.33.4.2. Age 50 years and older, screening for early detection of prostate cancer at least once per year.

2.1.33.5. Health education services

2.1.33.5.1. Instruction in personal health care measures, including those appropriate for clients with disabilities;

2.1.33.5.2. Instruction for a designated client representative, when the client is unable to receive or understand such services due to a disability;

2.1.33.5.3. Information about services, including recommendations on generally accepted medical standards for use and frequency of such service.

2.1.33.6. Contingent on Federal Approval from the Centers for Medicare & Medicaid, the contractor must provide preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults. Documentation is available to support claiming of FMAP for such services. As changes are made to the USPSTF and/or ACIP, coverage and billing codes will be updated to comply with the changes. Cost sharing cannot be applied to any of these services.

2.1.34. **Prosthetics and Orthotics**

2.1.34.1. The following Prosthetic Devices and Orthotics, including but not limited to the following list, are Medicaid benefits for clients of all ages if Medical Necessity has been established and use in the home setting has been determined to be appropriate. Medical Necessity shall be determined based on criteria established by the Department, and in accordance with 10 CCR 2505-10, Section 8.590.2A:

2.1.34.1.1. Ankle-foot/knee-ankle-foot Orthotics

2.1.34.1.2. Artificial limbs

2.1.34.1.3. Augmentative communication devices and communication boards

2.1.34.1.4. Colostomy (and other ostomy) bags and necessary accouterments required for attachment, including irrigation and flushing equipment and other items/supplies directly related to ostomy care

2.1.34.1.5. Facial prosthetics

2.1.34.1.6. Lumbar-sacral orthoses (LSO)

2.1.34.1.7. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements when an integral part of a leg or ankle brace

2.1.34.1.8. Recumbent ankle positioning splints

2.1.34.1.9. Rigid and semi-rigid braces

2.1.34.1.10. Specialized eating utensils and other Medically Necessary activities of daily living aids; and

2.1.34.1.11. Therapeutic shoes

2.1.34.1.12. Thoracic-lumbar-sacral orthoses (TLSO)

2.1.34.2. Covered Services include the rental or purchase of Prosthetic Devices and supplies including repair, maintenance and delivery. Preference will be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the devices will be operated. Coverage in a particular case is subject to the requirement that the devices be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. Prosthetic Devices may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.

2.1.35. **Radiology – see Imaging**

2.1.36. **Radiation Therapy**

2.1.37. **Rural Health Clinics (RHC)**

2.1.37.1. All of the following are benefits of the program when provided by a rural health clinic that has been certified in accordance with 10 CCR 2505-10 8.740 insofar as these services provided are otherwise reimbursable under the Program.

2.1.37.1.1. Services furnished by a physician.

2.1.37.1.2. Services furnished by a physician assistant, nurse practitioner, or nurse midwife, under the medical supervision of a physician.

2.1.37.1.3. Services and supplies that are furnished as an incident to professional services under (2.1.36.1.1.) and (2.1.36.1.2) above.

2.1.37.1.4. Part-time or intermittent visiting nurse care and related medical supplies (other than pharmaceuticals).

2.1.37.1.5. Other ambulatory service that are otherwise a benefit of the program that meets specific programmatic requirements for the furnishing of that service. Such services are not subject to physician supervision requirements unless such supervision is generally required for such services under the Medicaid program.

2.1.37.1.6. EPSDT services furnished by a rural health clinic that are not part of rural health clinic services. Such services may be provided only if the clinic meets any supervision or other requirements for EPSDT that are generally applicable wherever these services are furnished.

2.1.38. **Speech Pathology (see Audiology and Speech Pathology)**

2.1.39. **Substance Abuse**

2.1.39.1. Includes the medical treatment for withdrawal from the physiological effects of acute alcohol or drug abuse.

2.1.40. **Surgical Services**

2.1.40.1. For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File shall be considered the prevailing guide.

2.1.40.1.1. Reconstructive surgery

2.1.40.1.1.1. Medically Necessary reconstructive plastic surgery or surgery to correct disfigurement resulting from trauma or affecting function, regardless of when the injury, illness or defect occurred; or

2.1.40.1.1.2. Reconstructive services following mastectomy, subject to prior approval.

2.1.40.1.2. Male genital system

2.1.40.1.3. Female genital system

2.1.40.1.4. Oral Surgical Services (limited to treat certain conditions, as follows):

2.1.40.1.4.1. Accidental injury to jawbones or surrounding tissues;

2.1.40.1.4.2. Correction of non-dental pathophysiological condition which has resulted in a severe functional impairment, including temporomandibular disorder; or

2.1.40.1.4.3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, floor of mouth.

2.1.40.1.5. Sterilization

2.1.40.1.5.1. Stipulations: In order to receive sterilization services, the following criteria must be met:

2.1.40.1.5.1.1. The client must be at least 21 years of age;

2.1.40.1.5.1.2. The client may not be currently institutionalized for the care and treatment of mental illness;

2.1.40.1.5.1.3. He or she must be mentally competent;

2.1.40.1.5.1.4. The MED 178 consent form, as utilized by the Medicaid Program, must be properly signed at least 30 but no more than 180 days prior to performance of the procedure. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and (1) in the case of premature delivery, must state the expected date of delivery; or (2) in the case of abdominal surgery, must describe the emergency.

2.1.41. **Tobacco Cessation**

2.1.41.1. Includes all FDA approved prescription medications and over-the-counter tobacco cessation products for a maximum of two 90-day sessions in a 12-month period, commencing upon beginning the first session. The Tobacco Cessation benefit includes group or individual counseling services.

2.1.41.2. Limitations

2.1.41.2.1. Counseling is limited to five (5) sessions per calendar year.

2.1.42. **Telemedicine**

2.1.42.1. No Medicaid managed care organization, on or after January 1, 2002, may require face-to-face contact between a provider and a client for services appropriately provided through Telemedicine if the client resides in a county with a population with one hundred fifty thousand residents or fewer and if the county has the technology necessary for the provision of Telemedicine. The use of Telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance.

2.1.42.2. Any health benefits provided through Telemedicine shall meet the same standard of care as in-person care.

2.1.43. **Transplant Services**

2.1.43.1. Includes services received in connection with bone, bone marrow/stem cell, cornea, heart, lung, heart-lung, kidney, liver (including living donor or partial liver), pancreas after kidney, simultaneous pancreas-kidney, skin, or small bowel transplant:

2.1.43.1.1. Charges for retrieval or harvest of donor organs or bone marrow, if not provided by any other health care program or insurance, including any necessary compatibility testing and donor search.

2.1.43.1.2. Living donor transplant: Contractor is required to cover services to donor for costs directly related to the transplant. Services required due to complications or non-related care will be the responsibility of the donor's carrier.

2.1.43.1.3. Immunosuppressive drugs as supportive therapy for the transplant.

2.1.43.1.4. Organ Transplant services must be covered according to the written standards in section 3.1_E of the Medicaid State Plan.

2.1.44. **Vision Services**

2.1.44.1. Members ages 21 and older:

2.1.44.1.1. Annual medically necessary eye exams.

2.1.44.1.1.1. Clients with certain medical conditions and/or disabilities such as diabetes, retinal dysplasia or glaucoma may require more frequent exams, which shall be determined by the primary care physician.

2.1.44.1.2. Eyeglasses and contact lenses are benefits following eye surgery only, and do not require prior authorization. The surgery may have been performed at any time during the patient's life.

2.1.44.2. Members ages 20 and younger:

2.1.44.2.1. Ocular prosthetics are a benefit;

2.1.44.2.2. There is no yearly maximum for eye exams or eyeglasses.

2.1.44.2.3. See EPSDT for more information.

2.1.44.3. Members ages 20 and younger and members ages 21 and older following eye surgery:

2.1.44.3.1. Standard eyeglasses (one or two single or multifocal vision clear glass lenses with one standard frame);

2.1.44.3.2. Glasses dispensed by an optician are a benefit when ordered by an ophthalmologist or optometrist;

2.1.44.3.3. Replacement or repair of frames or lenses (standard eyeglasses), not to exceed the cost of replacement;

2.1.44.3.4. Contact lenses must be medically necessary and prior authorized. Contact lenses, supplies, and contact lens insurance are not benefits;

2.1.44.4. If a Member requests a deluxe frame, the provider must obtain written agreement from the Member to pay the non-covered costs. Allowable non-covered costs that can be charged to the Member are those representing the difference between the provider's retail usual and customary charges for the Colorado Medicaid Assistance Program allowable frames and the retail amount for the upgraded frames requested by the Member.

SECTION 3.0 EXCLUSIONS:

3.1. The following services are excluded from coverage:

3.1.1. **Acupuncture**

3.1.2. **Air ambulance services** when a Client could be safely transported by ground ambulance or by means other than ambulance.

3.1.3. **Ambulatory surgical procedures** not listed on the state approved list.

3.1.4. **Ambulance services** when a Client could be safely transported by means other than ambulance.

3.1.5. **Audiology and Speech Pathology:** With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids are not covered under this Contract but may be provided to children under the age of 21 through the Health Care Program for Children with Special Needs. Simple articulation or academic difficulties that are not medical or surgical in origin are also excluded.

3.1.6. **Autopsy charges**

3.1.7. **Biofeedback**, stress management, behavioral testing and training, and counseling for sexual dysfunction.

3.1.8. **Chiropractic services** unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.

3.1.9. **Cosmetic Procedures** or corrective plastic surgery performed solely to improve appearance. Cosmetic surgery exclusions include, but are not limited to, surgery for sagging or extra skin, any augmentation procedures, rhinoplasty and associated surgery, and any procedures utilizing an implant which does not alter physiologic functions, unless Medically Necessary and/or to correct disfigurement.

3.1.10. **Counseling** for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders or chronic situational reactions.

3.1.11. **Dental services**:

3.1.11.1. Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.

3.1.11.2. For adults, surgical correction of malocclusion, maxillofacial orthognathic surgery, oral surgery (except as otherwise provided under the Surgical Services), orthodontia treatment and procedures involving osteotomy of the jaw including hospital outpatient or ambulatory, anesthesia and related costs resulting from the services when determined by the Contractor to relate to a dental condition.

3.1.12. **Durable Medical Equipment** to include wheelchair lifts for vans or automobiles, hot tubs, Jacuzzis, exercise bikes or equipment, treadmills, stair glides, ramps for use with vehicles or homes, memberships in health clubs, or fees for swimming or other exercise or activities.

3.1.13. **EPSDT services** not provided under this Contract are:

3.1.13.1. Hearing aids and auditory training.

3.1.13.2. Psychiatric/psychological care that is included and covered through the Mental Health Capitation Program. Community Mental Health Centers formally known as Mental Health Assessment and Service Agencies (MHASAs) are required to cover diagnoses and services as described at 10 CCR 2505-10 §8.212.

3.1.13.3. Services that are experimental, not safe or cost effective, or services provided for the convenience of the caregiver need not be covered.

3.1.13.4. Expanded EPSDT services.

3.1.14. **Experimental** or investigational services or pharmaceuticals.

3.1.14.1. Any treatment, procedure, drug or device that has been reviewed and found by the Department to be experimental or investigational or the treatment, procedure, drug or device has been reviewed by the Contractor and found not to meet all of the eligible for coverage criteria below with respect to the particular illness or disease to be treated, or a treatment, procedure, drug or device. Eligible for coverage criteria include:

3.1.14.1.1. The treatment, procedure, drug or device must have final approval from the Food and Drug Administration (FDA), if applicable;

3.1.14.1.2. The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the treatment, procedure, drug or device on health outcomes;

3.1.14.1.3. The treatment, procedure, drug or device must improve or maintain the net health outcome;

3.1.14.1.4. The treatment, procedure, drug or device must be as beneficial as any established alternative; and

3.1.14.1.5. The improvements in health outcomes must be attainable outside the investigational settings.

3.1.14.1.6. Additionally, the treatment, procedure, drug or device must be Medically Necessary and not excluded by any other Contract exclusion.

3.1.15. **Government-sponsored care**

3.1.15.1. Items and services provided by federal programs, such as a Veteran's Hospital.

3.1.15.2. Services provided in facilities that serve a specific population, such as prisoners.

3.1.15.3. Care for conditions that federal, state, or local laws require to be treated in a public facility.

3.1.15.4. Services for which treatment is provided under any government law now existing or subsequently enacted or amended, including but not limited to Workmen's Compensation Act, Employer Liability Law or Colorado "No-Fault" automobile insurance.

3.1.16. **Fertility procedures or services** that render the capability to produce children, except when that capability is a side effect of Medically Necessary surgery for another purpose/diagnosis.

3.1.17. **FQHC Services**: Inpatient hospital stays are not covered under FQHC Services but may be a benefit under Inpatient Hospital Care.

3.1.18. **HCBS Services.** Includes wrap around services such as case management (for Model 200 children), home modification, electronic monitoring, personal care, non-medical transportation & all other waiver services.

3.1.19. **Hearing Aids** - With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids, repairs and batteries are not covered under this Contract but may be provided to children under the age of 21 as a Wrap Around Benefit. Simple articulation or academic difficulties that are not medical or surgical in origin are not covered under this Contract.

3.1.20. **High colonics**

3.1.21. **Holistic or homeopathic care** including drugs and ecological or environmental medicine.

3.1.22. **Home delivery:** Services associated with non-emergent home delivery, unless prior authorized by the Contractor are excluded.

3.1.23. **Home Health Services:** Services provided specifically as benefits of the Home and Community Based Services Programs (HCBS), which include unskilled personal care, home modification, electronic monitoring, adult day services, alternative care facility services, homemaker services and respite care are not included under this Contract.

3.1.23.1. Long Term Home as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.

3.1.23.2. Home Health Services provided by a person who ordinarily resides in the Client's home or is an immediate family member are not covered.

3.1.24. **Hospice services.** Clients need not be disenrolled from their HMO to receive hospice services, but may continue to get care not related to the terminal illness from the HMO. Clients may request disenrollment.

3.1.25. **Hypnosis**

3.1.26. **Immunizations** related to foreign travel.

3.1.27. **Imaging (Radiology or X-ray) Services** performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

3.1.28. **Infertility treatment,** including but not limited to embryo transplants, in vitro fertilization, and low tubal transfers, gamete interfallopian tube transfer and zygote interfallopian tube transfer.

3.1.29. **Inpatient hospital** excluded services include:

3.1.29.1. Psychiatric/psychological care included and covered through the Mental Health Capitation Program.

3.1.29.2. Discharge medications and experimental drugs.

3.1.29.3. Inpatient hospital services defined as experimental by the Medicare program.

3.1.29.4. For Medicaid approved benefits, Medicare patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities.

3.1.30. **Institutional care** when provided for the primary purpose of controlling or changing Client's environment, or if custodial care, domiciliary care, convalescent care (other than extended care) respite care, rest cures or hospice care.

3.1.31. **Isometric exercise**

3.1.32. **Expenses for medical reports**, including presentation and preparation.

3.1.33. **Laboratory services** performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

3.1.34. **Long Term Home Health** as defined at 10 CCR 2505-10, Sections 8.520 is excluded.

3.1.35. **Mental Health** inpatient or outpatient psychiatric or psychological care that is a benefit of the Mental Health Capitation Program (MHCP). Hospital inpatient or outpatient care with a principal diagnosis listed in Exhibit F is a benefit of the Mental Health Capitation Program (MHCP). All other mental health services are a benefit of the MHCP if both the diagnosis and procedure codes are listed in Exhibit F.

3.1.36. **Newborn hospitalizations**: Continued stay of healthy newborns for any other reason after the mother's discharge is not a benefit under the medical assistance program.

3.1.37. **Paternity Testing.** Such services shall be reimbursed by the Medicaid Program and recouped through the court system.

3.1.38. **Personal comfort or convenience items**. Includes items such as hospital television, telephone, private room (except as Medically Necessary), modifications and alterations in homes, vehicles, or place of residence.

3.1.39. **Physical examinations** of the following nature are excluded:

3.1.39.1. Examinations required by the county departments for the purpose of qualifying applicants for assistance or for the re-certification of recipients for assistance in the following categories: AND, AB, AFDC, or placement of children in Foster Care.

3.1.39.2. Physical examinations for employment, licensing, marriage, insurance, school, camp, sports, or adoption purposes or requests by any institution, agency, or person other than the recipient's county department or the state department. Examination or treatment ordered by a court except when such treatment may be Medically Necessary and is provided by a network provider and/or authorized by the primary care physician.

3.1.40. **Private Duty Nursing (PDN).** Private duty nursing services are a Wrap Around Benefit.

3.1.41. **Psychiatric/psychological care** as follows:

3.1.41.1. Milieu therapy

3.1.41.2. Play therapy

3.1.41.3. Day care

3.1.41.4. Electroshock treatment rehabilitation

3.1.41.5. Night care

3.1.41.6. Family therapy

3.1.41.7. Biofeedback

3.1.42. **Reversal** of surgically performed sterilization or subsequent re-sterilization.

3.1.43. Procedures, services and supplies relating to **sex change** or transformation.

3.1.44. **Skilled Nursing Facility Services are** a Wrap Around Benefit.

3.1.45. **Substance or alcohol abuse**, inpatient or residential rehabilitation.

3.1.46. **Surrogate Mother Services** or supplies received in connection with a Client acting as or utilizing the services of a surrogate mother.

3.1.47. **Transportation, non-emergent,** to medical appointments. This is a Medicaid benefit provided through the client's local county Department of Social Services, for the purpose of receiving covered medical services.

3.1.48. **Travel**, whether or not recommended or prescribed by a Physician or other medical practitioner.

3.1.49. **Vision correction procedures** for the purpose of vision correction that can be treated by corrective lenses, such as refractive keratoplasty, or radial and laser keratotomies.

3.1.50. **Wrap Around Benefits** are services that are Medicaid benefits not paid by the HMO. Wrap Around Benefits are paid for by the State of Colorado Medicaid program on a fee for service basis upon determination of Medical Necessity. Wrap-around services include, but may not be limited to the following:

3.1.50.1. Auditory Services for children. HMO Covered Services include screening and Medically Necessary ear exams and audiological testing. Wrap Around Benefits include hearing aids, auditory training, audiological assessment and hearing evaluation.

3.1.50.2. Comprehensive dental assessment, care and treatment for children.

3.1.50.3. Adult Dental services consisting of diagnostic procedures, preventative procedures, restorative procedures, periodontal care, endodontic treatment and oral surgery.

3.1.50.4. Drug/Alcohol Treatment for pregnant women, to include assessment and treatment, is covered through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only.

3.1.50.5. Extraordinary Home Health Services – Expanded EPSDT benefit which includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child's place of residence.

3.1.50.6. HCBS Services including case management (for Model 200 children); home modification, electronic monitoring, personal care and non-medical transportation.

3.1.50.7. Hospice services, however client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested.

3.1.50.8. Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470.

3.1.50.9. Inpatient substance abuse rehabilitation treatment for individuals aged 20 and under, DRG 772, as set forth in 10 CCR 2505-10, Section 8.300.4.5.

3.1.50.10. Intestinal Transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (i.e., liver); coordinated by Department & HMO Case Manager; provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai.

3.1.50.11. Non-emergency transportation to medical appointments for Covered Services only, through the client's county of residence.

3.1.50.12. Pediatric Behavioral Therapy.

3.1.50.13. Personal care benefit for children.

3.1.50.14. Private Duty Nursing (PDN), nursing services only.

3.1.50.15. Skilled Nursing Facility Services (skilled nursing and rehabilitation services) if client meets level of care certification. Wrap-around skilled nursing facility services include those services set forth at 10 CCR 2505-10, Section 8.440.1, notwithstanding the list of Covered Services set forth above. Wrap-around skilled nursing facility services also include any Medicare cross-over benefits.

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Exhibit C-4
Monthly Payment Rates

Monthly Payment Rates Table

Effective July 1, 2016 through September 30, 2016

Rates Adjusted for Date of Death Audit		
COHORT	Original Rate	Updated Rate
AFDC F	$362.81	$362.81
AFDC M	$273.91	$273.91
AWDC	$420.72	$420.72
BC WOMEN	$1,080.19	$1,080.19
EXPANSION PARENT F	$312.02	$312.02
EXPANSION PARENT M	$198.61	$198.61
OAP-A	$167.73	$170.22
OAP-B & AND/AB SSI DUAL	$155.38	$155.38
OAP-B & AND/AB SSI NONDUAL	$1,192.49	$1,192.49
TOTAL	$434.36	$434.47

Effective October 1, 2016 through June 30, 2017

Rates Adjusted of Hepatitis-C Coverage Changes		
COHORT	Original Rate	Updated Rate
AFDC F	$362.81	$362.81
AFDC M	$273.91	$249.67
AWDC	$420.72	$405.80
BC WOMEN	$1,080.19	$1,080.19
EXPANSION PARENT F	$312.02	$312.02
EXPANSION PARENT M	$198.61	$192.34
OAP-A	$170.22	$170.22
OAP-B & AND/AB SSI DUAL	$155.38	$155.38
OAP-B & AND/AB SSI NONDUAL	$1,192.49	$1,154.31
TOTAL	$434.47	$423.27

EXHIBIT I
MEDICAL HOME MODEL PRINCIPLES

SECTION 1.0 The Following are the Principles of the Medical Home Model

1.1. The care provided is:

1.1.1. Member/family-centered;

1.1.2. Whole-person oriented and comprehensive;

1.1.3. Coordinated and integrated;

1.1.4. Provided in partnership with the Member and promotes Member self-management;

1.1.5. Outcomes-focused;

1.1.6. Consistently provided by the same provider as often as possible so a trusting relationship can develop; and

1.1.7. Provided in a culturally competent and linguistically sensitive manner.

1.2. A PCMP that is:

1.2.1. Accessible, aiming to meet high access-to-care standards such as:

1.2.1.1. Twenty-four (24) hour, seven (7) days a week phone coverage with access to a clinician that can triage;

1.2.1.2. Extended daytime and weekend hours;

1.2.1.3. Appointment scheduling within:

1.2.1.3.1. 48 hours for urgent care,

1.2.1.3.2. 10 days for symptomatic, non-urgent care

1.2.1.3.3. 45 days for non-symptomatic routine care; and

1.2.1.4. Short waiting times in reception area.

1.2.1.5. Committed to operational and fiscal efficiency.

1.2.1.6. Able and willing to coordinate with its associated RCCO on medical management, Care Coordination, and case management of Members.

1.2.1.7. Committed to initiating and tracking continuous performance and process improvement activities, such as improving tracking and follow-up on diagnostic tests, improving care transitions, and improving Care Coordination with specialists and other Medicaid providers, etc.

1.2.1.8. Willing to use proven practice and process improvement tools (assessments, visit agendas, screenings, Member self-management tools and plans, etc.).

1.2.1.9. Willing to spend the time to teach Members about their health conditions and the appropriate use of the health care system as well as inspire confidence and empowerment in Members' health care ownership.

1.2.1.10. Focused on fostering a culture of constant improvement and continuous learning.

1.2.1.11. Willing to accept accountability for outcomes and the Member family experience.

1.2.1.12. Able to give Members and designated family members easy access to their medical records when requested.

1.2.1.13. Committed to working as a partner with the RCCO in providing the highest level of care to Members.

SECTION 2.0 COVERED BEHAVIORAL HEALTH PROCEDURE CODES

SECTION 1.0 **REQUIRED ELEMENTS** (in addition to member enrollment in a BHO)	**E&M Code**	**Laboratory**	**Emergency (CMS-1500)**	**Screening & Assessment**	**Prevention & Early Intervention**	**Crisis**
Primary Diagnoses	BHO MH or SUD	BHO MH or SUD	BHO MH or SUD	Any	Any	Any
Billing Provider Type	BHO Specialty Provider Types	Any	Any	BHO Specialty + FQHC & RHC Provider Types	BHO Specialty + FQHC & RHC Provider Types	Any

BHO MH Diagnoses Ranges	
Start Value	End Value
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F60.0	F63.9
F68.10	F69
F90.0	F99
R45.1	R45.2
R45.5	R45.82

SUD Diagnoses Ranges	
Start Value	End Value
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96
F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99

BHO Specialty Provider Types		
Provider Type (PT)	Spec Type	Provider Type Description
31	-	BHO- Atypical
35	360	CMHC
37	520	Psychologist- Doctorate

38	521	Psychologist- Master's (includes LCSW, LPC, and LMFT)
64	477	SUD Clinics
63	399	SUD Individual

FQHC & RHC Provider Types		
Provider Type (PT)	Spec Type	Provider Type Description
32	199	Denver Health and Other Hospital School-Based Clinics
32	150	FQHC- Freestanding
32	160	FQHC- Hospital-Based
45	398	RHC- Hospital Based
45	472	RHC- Freestanding

Proc Code	Full description of the procedure codes
00104	Anesthesia for electroconvulsive therapy
90785	Interactive complexity (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90837	Psychotherapy, 60 minutes with patient and/or family
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90870	Electroconvulsive therapy (includes necessary monitoring)
90875	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes

96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
99221	Initial Hospital Care Low Complexity
99222	Initial Hospital Care Moderate Complexity
99223	Initial Hospital Care High Complexity
99231	Subsequent Hospital Care Low Complexity
99232	Subsequent Hospital Care Moderate Complexity
99233	Subsequent Hospital Care High Complexity
99238	Hospital Discharge Day Management/30 minutes
99239	Discharge day management; more than 30 minutes
99251	Initial Inpatient Consultation/20 minutes
99252	Initial Inpatient Consultation/40 minutes
99253	Initial Inpatient Consultation/55 minutes
99254	Initial Inpatient Consultation/80 minutes
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional.
99367	Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by non-physician qualified health care professional
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion

G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).
*H0004	Behavioral health counseling and therapy, per 15 minutes
*H0005	Alcohol and/or drug services; group counseling by a clinician
*H0006	Alcohol and/or drug services; case management (targeted)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
*H0020	Medication Assisted Treatment
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem
*H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H2001	Rehabilitation program, per 1/2 day
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes. Long definition: The purpose of Comprehensive Community Support Services is to coordinate and provide services and resources to individuals/families necessary to promote recovery, rehabilitation and resiliency. Comprehensive Community Support Services identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community; as well as strengths, which may aid the individual or family in the recovery or resiliency process. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Comprehensive Community Support Services also include supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.
H2016	Comprehensive community support services, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem

H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2023	Supported employment, per 15 minutes
H2024	Supported employment, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psychoeducational service, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H2031	Mental health clubhouse services, per diem
H2032	Activity therapy, per 15 minutes
H2033	Multi-systemic therapy for juveniles, per 15 minutes
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders
*S3005	Safety assessment including suicidal ideation and other behavioral health issues
S5150	Unskilled respite care, not hospice; per 15 minutes
S5151	Unskilled respite care, not hospice; per diem
*S9445	Drug screening and monitoring
S9480	Intensive outpatient psychiatric services, per diem
T1005	Respite care services, up to 15 minutes
*T1007	Physical assessment of detoxification progression including vital signs monitoring
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes
*T1019	Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients
*T1023	Level of motivation assessment for treatment evaluation

Evaluation and Management codes are covered by the Contractor when they are billed by primary care providers including physicians, psychiatrist, FQHCs, and RHCs.

Evaluation and Management	
99201	Office or other outpatient visit, new patient/ 10 minutes
99202	Office or other outpatient visit, new patient/ 20 minutes
99203	Office or other outpatient visit, new patient/ 30 minutes
99204	Office or other outpatient visit, new patient/ 45 minutes
99205	Office or other outpatient visit, new patient/ 60 minutes
99211	Office or other outpatient visit, established patient/ 5 minutes
99212	Office or other outpatient visit, established patient/10 minutes
99213	Office or other outpatient visit, established patient/ 15 minutes
99214	Office or other outpatient visit, established patient/ 25 minutes
99215	Office or other outpatient visit, established patient/ 40 minutes
99217	Observation care discharge day management
99218	Initial observation / 30 minutes
99219	Initial observation care/ 50 minutes

99220	Initial observation care/ 70 minutes
99224	Subsequent observation care/ 15 minutes
99225	Subsequent observation care/ 25 minutes
99226	Subsequent observation care/ 35 minutes
99234	Observation or inpatient hospital care, patient admitted and discharged on same date of service, 40 minutes
99235	Observation or inpatient hospital care, patient admitted and discharged on same date of service/50 minutes
99236	Observation or inpatient hospital care, patient admitted and discharged on same date of service/ 55 minutes
99241	Office consultation/ 15 minutes
99242	Office consultation/ 30 minutes
99243	Office consultation/ 40 minutes
99244	Office consultation/ 60 minutes
99245	Office consultation/ 80 minutes
99255	Initial inpatient consultation/ 110 minutes.
99304	Initial nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99305	Initial nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99306	Initial nursing facility care/per day/ 45 minutes spent at bedside or on patient floor/unit
99307	Subsequent nursing facility care/per day/ 10 minutes spent at bedside or on patient floor/unit
99308	Subsequent nursing facility care/per day/ 15 minutes spent at bedside or on patient floor/unit
99309	Subsequent nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99310	Subsequent nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99315	Nursing facility discharge day management/ 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Annual nursing facility assessment/ 30 minutes spent at bedside or on patient floor/unit
99324	Domiciliary or rest home visit, new patient/ 20 minutes
99325	Domiciliary or rest home visit, new patient/ 30 minutes
99326	Domiciliary or rest home visit, new patient/ 45 minutes
99327	Domiciliary or rest home visit, new patient/ 60 minutes
99328	Domiciliary or rest home visit, new patient/ 75 minutes
99334	Domiciliary or rest home visit, established patient/ 15 minutes
99335	Domiciliary or rest home visit, established patient/ 25 minutes
99336	Domiciliary or rest home visit, established patient/ 40 minutes
99337	Domiciliary or rest home visit, established patient/ 60 minutes
99341	Home visit, new patient/20 minutes
99342	Home visit, new patient/30 minutes
99343	Home visit, new patient/45 minutes

99344	Home visit, new patient/60 minutes
99345	Home visit, new patient/75 minutes
99347	Home visit, established patient/15 minutes
99348	Home visit, established patient/25 minutes
99349	Home visit, established patient/40 minutes
99350	Home visit, established patient/60 minutes

Laboratory
80047 - 89398

Emergency (CMS-1500)	
31500	
31603	
99058	
99140	
99285	
S5160	
D7990	
D9110 **or** Emergency Indicator	

Screening & Assessment	
*H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H1011	Family assessment by licensed behavioral health professional for state defined purposes
H2000	Comprehensive multidisciplinary evaluation
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96101	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report.
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning

	and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing by a computer, with qualified health care professional interpretation and report.
98966	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

Prevention and Early Intervention	
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
S9453	Smoking cessation classes, non-physician provider, per session
S9454	Stress management classes, non-physician provider, per session

Crisis	
H2011	Crisis intervention service, per 15 minutes
S9485	Crisis intervention mental health services, per diem

***Denotes services that have been approved by the Joint Budget Committee (JBC) for inclusion in the substance use disorder benefit.**

Please Note: This list of covered procedures is to be used as a guideline rather than a contractual requirement. The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

RATES

Effective July 1, 2016 through September 30, 2016

Rates Adjusted for Date of Death Audit		
COHORT	Original Rate	Updated Rate
AFDC F	$362.81	$362.81
AFDC M	$273.91	$273.91
AWDC	$420.72	$420.72
BC WOMEN	$1,080.19	$1,080.19
EXPANSION PARENT F	$312.02	$312.02
EXPANSION PARENT M	$198.61	$198.61
OAP-A	$167.73	$170.22
OAP-B & AND/AB SSI DUAL	$155.38	$155.38
OAP-B & AND/AB SSI NONDUAL	$1,192.49	$1,192.49
TOTAL	$434.36	$434.47

Effective October 1, 2016 through June 30, 2017

Rates Adjusted of Hepatitis-C Coverage Changes		
COHORT	Original Rate	Updated Rate
AFDC F	$362.81	$362.81
AFDC M	$273.91	$249.67
AWDC	$420.72	$405.80
BC WOMEN	$1,080.19	$1,080.19
EXPANSION PARENT F	$312.02	$312.02
EXPANSION PARENT M	$198.61	$192.34
OAP-A	$170.22	$170.22
OAP-B & AND/AB SSI DUAL	$155.38	$155.38
OAP-B & AND/AB SSI NONDUAL	$1,192.49	$1,154.31
TOTAL	$434.47	$423.27