

**CONTRACT AMENDMENT NO. 04**

Original Contract Number 2017MEDMCO001

**1. PARTIES**

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Denver Health and Hospital Authority dba Denver Health Medicaid Choice, a body corporate and political subdivision of the State of Colorado, 777 Bannock Street, Denver, CO, 80204, (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 have Denver Health and Hospital Authority perform as a Managed Care Organization for the Department. The purpose of this Amendment is to update the Statement of Work, and update various exhibits.

**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. Section 4, Definitions, Subsection C, Exhibits and other Attachments, is hereby deleted in its entirety and replaced with the following:

- C. Exhibits and other Attachments. The following documents are attached hereto and incorporated by reference herein:

- HIPAA Business Associate Addendum
- Exhibit A, Statement of Work
- Exhibit B, Rates
- Exhibit C, Sample Option Letter
- Exhibit D, Covered Services



Exhibit E, Disproportionate Share and Graduate Medicaid Education Hospital Reporting by Calendar Year Quarter  
Exhibit F, Member Handbook Requirements  
Exhibit G, Requirements for Physician Incentive Plans  
Exhibit H, Contractor Disclosure Template  
Exhibit I, Covered Behavioral Health Procedure Codes  
Exhibit J, Not Used  
Exhibit K, Serious Reportable Events or Never Events  
Exhibit L, Enrollment Retention Rate Disenrollment Codes  
Exhibit M, Procedure Codes for Enhanced Payments  
Exhibit N, Colorado Family Planning Methodology

**B.** Section 5, Term, Subsection A, is hereby deleted in its entirety and replaced with the following:

**5. TERM**

**A. Initial Term**

The Parties' respective performances under this Contract shall commence on July 1, 2017. This Contract shall expire on June 30, 2018, unless sooner terminated or further extended as specified elsewhere herein.

**C.** Section 16, Notices and Representatives, contacts For the State and For the Contractor, are hereby deleted in their entirety and replaced with the following:

**For the State:** Chris Tzortzis  
Department of Health Care Policy and Financing  
1570 Grant Street  
Denver, Colorado 80203  
Chris.Tzortzis@state.co.us

**For the Contractor:** Michael Robinson  
Denver Health and Hospital Authority  
777 Bannock Street  
Mailcode 6000  
Denver, CO 80204  
Michael.Robinson@dhha.org

**D.** Exhibit A1, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit A2, Statement of Work, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit A and A1 shall be deemed to reference Exhibit A2.

**E.** Exhibit B1, Rates, is hereby deleted in its entirety and replaced with Exhibit B2, Rates, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit B and B1 shall be deemed to reference Exhibit B2.



- F.** Exhibit D1, Covered Services, is hereby deleted in its entirety and replaced with Exhibit D2, Covered Services, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit D and D1 shall be deemed to reference Exhibit D2.
- G.** Exhibit I, Covered Behavioral Health Procedure Codes, is hereby deleted in its entirety and replaced with Exhibit I1, Covered Behavioral Health Procedure Codes, attached hereto and incorporated by reference in to the Contract. All reference within the Contract to Exhibit I shall be deemed to reference Exhibit I1.
- H.** Exhibit F1, Member Handbook Requirements, is hereby deleted in its entirety and replaced with Exhibit F2, Member Handbook Requirements, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit F and F1 shall be deemed to reference Exhibit F2.
- I.** Exhibit J, Medicaid Managed Care Grievance and Appeal Processes, is hereby deleted in its entirety and replaced with Exhibit J1, Not Used, attached hereto and incorporated by reference in to the Contract. All references within the Contract to Exhibit J shall be deemed to reference Exhibit J1.

**7. START DATE**

This Amendment shall take effect on July 1, 2017.

**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.

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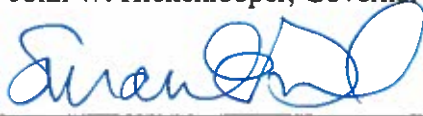
**THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT**

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:**  
Denver Health and Hospital Authority

**STATE OF COLORADO:**  
John W. Hickenlooper, Governor

By:   
Signature of Authorized Officer

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

Date: 6/9/17

Date: 6/14/17

Gregory McCarthy  
Printed Name of Authorized Officer

**LEGAL REVIEW:**  
Cynthia H. Coffman, Attorney General

Executive Director  
of Managed Care  
Printed Title of Authorized Officer

By: \_\_\_\_\_  
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: 6/28/17





**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 acronyms, abbreviations and terminology used throughout this document.
  - 1.1.1.1.        “Adjusted Medical Expenditures” means encounter data submitted by the Contractor that are priced for internal providers to reflect the State’s fee schedule and using the paid amount on the encounter data for external providers, and exclude any and all administrative costs and amounts equal to the Co-Payments in place for Medicaid FFS at the time, regardless of whether the Contractor collected on the Co-payments from enrollees or not. Actual Medical Expenditures must be reduced by any recoveries from other payers including those pursuant to coordination of benefits, third party liability, reinsurance, rebates, or adjustments in claims paid or from providers, including adjustments to claims paid.
  - 1.1.1.2.        “Administrative Services Fee” or “ASF” means the per member per month payment to Contractor to provide the range of administrative services contained in this Contract, as described in section 5.2 of this Statement of Work. The Administrative Services Fee shall not include the direct cost of medical care.
  - 1.1.1.3.        "Advance Directive" means a written instrument, such as a living will or durable power of attorney for health care, recognized under Section 15-14-505(2), C.R.S., and defined in 42 C.F.R. 489.100, relating to the provision of health care when the individual is incapacitated.
  - 1.1.1.4.        “Business Day” means any day in which the Department is open and conducting business, but shall not include weekend days or any day on which the Department observes one of the following holidays:
    - 1.1.1.4.1.        New Year's Day.
    - 1.1.1.4.2.        Martin Luther King, Jr. Day.
    - 1.1.1.4.3.        Washington-Lincoln Day (also referred to as President’s Day).
    - 1.1.1.4.4.        Memorial Day.
    - 1.1.1.4.5.        Independence Day.
    - 1.1.1.4.6.        Labor Day.
    - 1.1.1.4.7.        Thanksgiving Day.
    - 1.1.1.4.8.        Christmas Day.
  - 1.1.1.5.        “Care Coordination” means the process of identifying, screening and assessing Members’ needs, identification of and Referral to appropriate services, and coordinating and monitoring an individualized treatment 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 claim for payment with all required fields completed with correct and

complete information, including all required documents.

- 1.1.1.7. "Client" means a recipient of the Medicaid program.
- 1.1.1.8. "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.
- 1.1.1.9. "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.
- 1.1.1.10. "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 shall be dispensed by a Participating Provider except for Emergency Services and shall 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.
- 1.1.1.11. "Covered Services" means those services described in Exhibit D, attached hereto and made part of this contract, which the Contractor is required to provide or arrange to be provided to a Member in return for the Monthly Payment Rate.
- 1.1.1.12. "Department" means the Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado.
- 1.1.1.13. "Desk Audit" means the review of materials submitted upon request to the Department or its agents for quality assurance activities.
- 1.1.1.14. "Designated Client Representative" means the person as defined at 10 C.C.R. 2505-10, Section 8.209.2.
- 1.1.1.15. "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.
- 1.1.1.16. "Disenrollment" or "Disenroll" means the act of discontinuing a Member's Enrollment in the Contractor's Plan.
- 1.1.1.17. "EI" means the Early Intervention program that provides developmental supports and services to children birth through two years of age who have special developmental needs. It can help improve a child's ability to develop and learn. It can also help you and your family learn ways to support and promote your child's development, within your family activities and community life. The EI Colorado program provides EI services, such as occupational, speech or physical therapy, to help infants and toddlers grow and develop, and to help their family in this process. It is a voluntary program and does not discriminate based on race, culture, religion, income level, or disability.
- 1.1.1.18. "Emergency Medical Condition" means the sudden, and at the time, unexpected onset of a health condition that required immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Benefits cannot be denied for conditions which a prudent layperson would perceive as emergency medical conditions as specified by the Division of Insurance Regulation 4-2-17, Section 6.G.

- 1.1.1.19. "Emergency Medical Transportation" means those services as set forth 10 CCR 2505-10 8.018.
- 1.1.1.20. "Emergency Services" means those services as set forth at 42 C.F.R. Section 438.114(a).
- 1.1.1.21. "Encounter Data" means an occurrence of examination or treatment of a patient 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. Detailed data about individual services provided by a capitated managed care organization. The level of detail about each service reported is similar to that of a standard claim form.
- 1.1.1.22. "Enrollment", "Enroll" or "Enrolled" means that a Client becomes a Member of the Contractor's Plan.
- 1.1.1.23. "EPSDT" means the Early, Periodic, Screening, Diagnostic and Treatment program that provides comprehensive health care to all Medicaid eligible children through periodic screenings, diagnostic and treatment services.
- 1.1.1.24. "EPSDT Home Health Services" means home health services that are not listed under Exhibit D but are federally required to be available to an EPSDT child. The services shall be Medically Necessary and the child shall need a) Services that exceed the maximum allowable limit per day; b) Services to be provided away from home; or c) a Certified Nursing Assistant providing unskilled personal care. These services are covered by Medicaid as a Wrap Around Benefit and therefore, are not Covered Services under this contract.
- 1.1.1.25. "Experimental or Investigational Services" means 1) any treatment, procedure, drug or device that has been reviewed and found by the Department to be experimental or investigational or 2) 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: a. The treatment, procedure, drug or device shall have final approval from the Food and Drug Administration (FDA), if applicable; b. The scientific evidence as published in peer-reviewed literature shall permit conclusions concerning the effect of the treatment, procedure, drug or device on health outcomes; The treatment, procedure, drug or device must improve or maintain the net health outcome; The treatment, procedure, drug or device must be as beneficial as any established alternative; and e. The improvements in health outcomes must be attainable outside the investigational settings. Additionally, the treatment, procedure, drug or device shall be Medically Necessary and not excluded by any other contract exclusion.
- 1.1.1.26. "Federally Qualified Health Center" (FQHC) means a Provider defined at 10 C.C.R. 2505-10, Section 8.700.1.
- 1.1.1.27. "Home Health Services" means those services described at 10 C.C.R. 2505-10, Section 8.520, et seq.
- 1.1.1.28. "Hospital Services" means those Medically Necessary Covered Services for patients 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.
- 1.1.1.29. "Hospital" means an institution which: a. Is licensed by the state as a Hospital; b. Has a Utilization Review program that meets Medicare conditions of participation; c. 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, d. Is certified by Medicare; or e. 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.

- 1.1.1.30. "Incentive Arrangement" means any payment mechanism under which a MCO, PIHP, or PAHP may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.
- 1.1.1.31. "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.
- 1.1.1.32. Managed Care Organization (MCO) – An entity that has or is seeking to qualify for, a comprehensive risk contract and that is a federally qualified HMO that meets the advanced directives requirements; or any public or private entity that meets the advanced directives requirements and is determined by the Secretary to make the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity, and meets the solvency standards of 42 CFR 438.116 as defined in 42 CFR 438.2.
- 1.1.1.33. "Marketing" means any communication from the Contractor to a Medicaid recipient who is not enrolled in the plan that can reasonably be interpreted as intended to influence the recipient to enroll in the Contractor's Plan, or either not to enroll in, or to disenroll from, another contractor's Medicaid plan.
- 1.1.1.34. "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 enrollees.
- 1.1.1.35. "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.
- 1.1.1.36. "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.
- 1.1.1.37. "Medically Necessary" is defined in Exhibit D.
- 1.1.1.38. "Member" means any Client who is enrolled in the Contractor's Plan.
- 1.1.1.39. "Monthly Payment Rate" means the capitated rate, as specified in Exhibit B, Rates, attached and incorporated herein by reference, payable for each Member under this contract.
- 1.1.1.40. "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.
- 1.1.1.41. "Nursing Facility" means an institution that can meet state and federal requirements for participation as a Nursing Facility.
- 1.1.1.42. "Open Enrollment Period" means the two (2) months immediately preceding the month in which a member's birthday occurs.

- 1.1.1.43. "Passive Enrollment" or "Passively Enrolled" means enrollment of eligible fee-for-service (FFS) Medicaid clients within a geographical service area into a Contractor's Plan, subject to the Member's election not to accept enrollment and to "opt-out."
- 1.1.1.44. "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.
- 1.1.1.45. "Persons with Special Health Care Needs" or "Special Health Care Needs" means persons as defined in 10 C.C.R. 2505-10, Section 8.205.9.
- 1.1.1.46. "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.
- 1.1.1.47. "Primary Care Physician" or "Participating Primary Care Physician" means the Physician who has entered into a professional service agreement to serve the Contractor's Members.
- 1.1.1.48. "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.
- 1.1.1.49. "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 (1) lawfully obtained from third parties or (2) that which is in the public domain.
- 1.1.1.50. "Psychiatric In Nature" means those occasions of service in which the Member has a diagnosis listed in Exhibit I, Covered Behavioral Health Procedure Codes, attached and incorporated herein by reference, and receives services listed in Exhibit I.
- 1.1.1.51. "Qualified Interpreter" means an interpreter who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary.
- 1.1.1.52. "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 other than the Primary Care Physician.
- 1.1.1.53. "Re-pricing" means adjusting the claim payment to reflect not more than one hundred five percent (105%) of the State FFS reimbursement level.
- 1.1.1.54. "Rural Health Center" (RHC) means a Provider defined at 10 C.C.R. 2505-10, Section 8.740.1.
- 1.1.1.55. "Serious Reportable Events or Never Events" means hospital acquired conditions (HAC) that were not present on admission (POA) as an inpatient and that alter the condition or diagnosis of the recipient/Client receiving care.
- 1.1.1.56. "Service Area" means that area for which the Department and the Contractor have agreed that the Contractor shall provide Covered Services to Members. The Service Area shall be Adams, Arapahoe, Denver and Jefferson counties.
- 1.1.1.57. "Service Authorization Request" means a managed care enrollee's request for the provision of service.
- 1.1.1.58. "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.

- 1.1.1.59. "Skilled Nursing Care" means those services set forth at 10 CCR 2505-10 8.406.1.
- 1.1.1.60. "Subcontractor" means an individual or entity that has a contract with an MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO, PIHP, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, or PIHP as defined in 42 C.F.R. 438.2.
- 1.1.1.61. "Triage" means the assessment of a Member's condition and direction of the Member to the most appropriate setting for Medically Necessary care.
- 1.1.1.62. "Urgently Needed Services" means Covered Services as defined at 42 C.F.R. Section 422.113(b)(1)(iii).
- 1.1.1.63. "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.
- 1.1.1.64. "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.
- 1.1.1.65. "Wrap Around Benefits" are Medicaid services outside the scope of the Covered Services section of the Contract, and further defined in Exhibit D. Wrap Around Benefits are services reimbursable under the Medicaid fee-for-service and shall be billed directly to the Department's fiscal agent by the Provider.

## **SECTION 2.0 CONTRACTOR AND SERVICE REQUIREMENTS**

### **2.1. LICENSES, PERMITS AND RESPONSIBILITIES**

- 2.1.1. The Contractor shall be licensed as a hospital pursuant to Colorado law, and shall maintain accreditation from the Joint Commission on Accreditation of Healthcare Organizations.
- 2.1.2. The Contractor shall authorize the accrediting entity to provide the Department a copy of its most recent accreditation review, including: 1) accreditation status, survey type, and level; 2) accreditation results, including any recommended actions or improvements, corrective action plans, or summaries of findings; and 3) expiration date of the accreditation.
- 2.1.3. The Contractor shall notify the Department within two (2) Business Days, of any action on the part of the Colorado Department of Public Health and Environment or the Joint Commission on Accreditation of Healthcare Organizations of intent to suspend or revoke or modify licensure or full accreditation status. Any revocation, withdrawal or non-renewal of licensure or accreditation 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.
- 2.1.4. In order to maintain the ability to pay outside providers, and in place of usual Department of Insurance reserves, the Contractor shall hold in reserve one twelfth (1/12) of monthly paid (non-Denver Health and Hospital Authority) claims until such time as twelve (12) months of reserves have been accrued. Thereafter, on an ongoing basis, the reserve amount shall be a rolling balance based on the 12 most current months paid claims.
- 2.1.5. The Contractor shall provide the Department the opportunity to approve the contract manager assigned to manage this contract.

## **2.2. SUBCONTRACTS**

- 2.2.1. The Contractor shall be responsible for all work performed under this contract, but may enter into subcontracts for the performance of aspects of the scope of work required under this contract. Prior to entering into such subcontract, the Contractor shall evaluate the proposed Subcontractor's ability to perform the activities to be delegated. No subcontract, which the Contractor enters into with respect to performance under the contract, shall in any way relieve the Contractor of any responsibility for the performance of duties required under this contract.
- 2.2.2. Notwithstanding any relationship(s) that the Contractor may have with any subcontractor, Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Department. The Contractor shall ensure that all contracts or written arrangements between the Contractor and any subcontractor specify that any of the Contractor's activities or obligations under its contract with the State are delegated to a subcontractor, who agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.
- 2.2.3. The Contractor shall have a written agreement with each Subcontractor. The agreement shall specify the activities and reporting responsibilities delegated to the Subcontractor as specified in compliance with the Contractor's contract obligations. The agreement shall include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.
- 2.2.4. The Contractor shall develop and implement written procedures for monitoring Subcontractor performance on an ongoing basis. These procedures are subject to the approval of the Department.
- 2.2.5. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractors shall take corrective action.
- 2.2.6. The Contractor shall make available to the Department copies of any existing subcontracts and a full description of its procedures and policies in effect to accomplish the duties and responsibilities described herein, upon request by the Department.
- 2.2.7. The Contractor shall submit fully executed subcontracts to the Department, within five (5) Business Days of a written request from the Department.
- 2.2.8. Subcontracts shall meet the requirements of 42 C.F.R Section 434.6, as amended. All subcontracts shall provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, as specified in 45 C.F.R. Section 74, as amended.
- 2.2.9. The Contractor shall ensure that subcontractors and referral providers not bill enrollees, for covered services, any amount greater than would be owed if the entity provided the services directly.
- 2.2.10. The Contractor shall notify the Department, in writing, of its decision to terminate any existing subcontract. The written notice shall afford the Department at least sixty (60) calendar days prior to the services terminating unless the Contractor needs to terminate with less than sixty (60) calendar days' notice based upon quality or performance issues. The Contractor shall define how the replacement of these services shall be performed in the termination notice.

## **2.3. CLIENT ENROLLMENT AND DISENROLLMENT**

- 2.3.1. Clients in the following aid categories are eligible for enrollment under this contract:

- 2.3.1.1. Aid to Families with Dependent Children – Adults (AFDC – A) (Contingent on system updates, this category will be transitioning to MAGI Parents/Caretakers).
- 2.3.1.2. Aid to Families with Dependent Children – Children (AFDC – C).
- 2.3.1.3. Aid to the Needy Disabled/Aid to the Blind (AND/AB).
- 2.3.1.4. Baby Care/Kids Care – Adults (BCKC-A).
- 2.3.1.5. Baby Care/Kids Care – Children (BCKC-C).
- 2.3.1.6. Foster Care (FC).
- 2.3.1.7. Old Age Pensioners – Age 65+ (OAP-A).
- 2.3.1.8. Old Age Pensioners under Age 65 (OAP-B).
- 2.3.1.9. Refugee Medical Assistance – Adults (RMA-A).
- 2.3.1.10. Refugee Medical Assistance – Children (RMA-C).
- 2.3.1.11. Adult Buy-in.
- 2.3.1.12. MAGI Adults.
- 2.3.2. Enrollment
  - 2.3.2.1. Enrollment Requirements
    - 2.3.2.1.1. Members Enrollment in the Contractor’s Plan shall be voluntary.
    - 2.3.2.1.2. Residents of Denver, Colorado, who are eligible for Medicaid but do not enroll in Medicaid fee for service, shall be Passively Enrolled in Contractor’s Plan subject to performance requirements defined herein.
      - 2.3.2.1.2.1. Passive Enrollment excludes the following populations:
        - 2.3.2.1.2.1.1. Foster Care.
        - 2.3.2.1.2.1.2. Refugees that utilize Volunteer Agencies as their residential addresses.
        - 2.3.2.1.2.1.3. Clients with attribution with a non-DHMC provider.
      - 2.3.2.1.3. Members who are Passively Enrolled in Contractor’s Plan may Disenroll from Contractor’s Plan within ninety (90) days of the effective date of Passive Enrollment.
      - 2.3.2.1.4. Members who are Disenrolled from the Contractor’s Plan solely because he/she 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. The effective date of reenrollment shall be the first day of the month following the month in which the Member regained eligibility. The Department retains the right to review and retroactively enroll the Member.
      - 2.3.2.1.5. 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.
      - 2.3.2.1.6. The Contractor shall not discriminate against Clients eligible to Enroll on the basis of health status or need for health care services.
      - 2.3.2.1.7. 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 except as provided in this Contract.

- 2.3.2.1.8. 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.
- 2.3.2.1.9. The Contractor may limit Enrollment of new Clients, other than newborns, 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.
- 2.3.2.1.10. The Contractor shall demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers.
  - 2.3.2.1.10.1. The Contractor shall exempt from premiums any Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.
  - 2.3.2.1.10.2. The Contractor shall exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian health care provider through referral under contract health services.
  - 2.3.2.1.10.3. The Contractor shall meet the requirements of FFS timely payment for all I/T/U providers in its network, including paying ninety (90) percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt.
  - 2.3.2.1.10.4. The Contractor shall pay ninety-nine (99) percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt.
- 2.3.2.1.11. The Contractor shall pay I/T/U providers, whether participating in the network or not, for covered managed care services provided to American Indian/Alaska Native Members enrollees who are eligible to receive services from the I/T/U. 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.
- 2.3.2.1.12. The Contractor shall permit an out-of-network I/T/U provider to refer an Indian enrollee to a network provider.
- 2.3.2.2. Effective Date of Enrollment
  - 2.3.2.2.1. A Member, other than a newborn of a mother who is a Member, shall be enrolled in the Contractor's Plan as follows:
    - 2.3.2.2.1.1. If the Client has selected or been Passively Enrolled in the Contractor's Plan on or before the last day of the month, Enrollment shall be effective the first day of the next month.
    - 2.3.2.2.1.2. If the Client has selected the Contractor's Plan during the client's Open Enrollment Period, Enrollment shall be effective the first day of the month following the Client's Open Enrollment Period.
    - 2.3.2.2.1.3. Retroactive Enrollment of Members shall be limited to a period not to exceed ninety

(90) calendar days from the date of Disenrollment of the Member from Contractor's Plan.

**2.3.2.3. Enrollment of a Newborn**

2.3.2.3.1. The Contractor shall furnish Covered Services to newborns determined Medicaid eligible of Enrolled Members from the date of birth up to sixty (60) calendar days or until the last day of the first full month following birth, whichever is sooner (the "Initial Term").

2.3.2.3.2. Regardless of newborn's county of residence, upon receipt of the newborn's Medicaid identification number, newborn shall be retroactively enrolled into Contractor's plan from newborn's date of birth up to the end of the Initial Term.

2.3.2.3.2.1. If the newborn resides in Denver County, the newborn shall be passively enrolled into Contractor's Plan.

2.3.2.3.2.2. If the newborn resides outside of Denver County, the newborn shall be passively enrolled into a health plan in its respective county, upon receipt of newborn's Medicaid identification number, unless the mother or designated representative requested enrollment into the Contractor's plan on behalf of the newborn prior to passive enrollment.

2.3.2.3.3. The newborn's Mother or other designated representative shall have the right to request Disenrollment on behalf of the newborn during the ninety (90) days following the Enrollment of the newborn, or ninety (90) days after the Department sends the notice of Enrollment, whichever is later.

2.3.2.3.4. The Contractor shall ensure Covered Services are provided for a newborn beyond sixty (60) days from the date of birth when the newborn is either:

2.3.2.3.4.1. A Hospital inpatient on the last day of the month Enrollment is scheduled to expire, or

2.3.2.3.4.2. Enrolled in the Contractor's Plan within the Initial Term.

2.3.2.3.5. This Section shall govern the newborn's continued Enrollment in Contractor's Plan after the Initial Term.

**2.3.3. Enrollment Postponed Due to Inpatient Hospital Stay**

2.3.3.1. If a current Member of a Contractor's Plan or a Client, other than a newborn at birth, is an inpatient of a Hospital at 11:59 p.m. the day before his/her Enrollment into a new Contractor's Plan is scheduled to take effect, Enrollment shall be postponed. To postpone Enrollment of a current Member or Client, the new Contractor shall, within sixty (60) calendar days of the date the new Contractor discovers the Client's Hospital admission, request in writing to the Department that the Enrollment be delayed. The new Contractor's request shall include the name of the Hospital where the Client was inpatient and the date of admission. The Department shall respond to the Contractor in writing within five (5) Business Days of Contractor's request to postpone Enrollment or upon confirmation of the hospitalization, whichever is later.

2.3.3.2. If the Client is discharged from the Hospital before the fifteenth (15th) day of the month, the new Enrollment date shall be the first day of the month following discharge. If the Client is discharged from the Hospital on or after the fifteenth (15th) day of the month, the new Enrollment date shall be the first day of the month after the month following discharge.

- 2.3.3.3. If the Client was a Member of a Contractor's Plan at the time of admission to the Hospital and Enrollment into another Contractor's Plan, or the Medicaid Primary Care Physician Program, was postponed as set forth above, the Member shall not be Disenrolled from the Contractor's Plan of which he/she was a Member at the time of admission until after the Hospital discharge occurs.
- 2.3.4. **Disenrollment**
- 2.3.4.1. A Member may request Disenrollment without cause during the ninety (90) days following the date of the Member's initial Enrollment with the Contractor.
- 2.3.4.2. A Member may request Disenrollment without cause during the Open Enrollment Period. A Member may request Disenrollment upon automatic Reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity.
- 2.3.4.3. The Contractor shall notify a Member of his or her ability to terminate or change Enrollment at least sixty (60) calendar days before the end of the Open Enrollment Period. The Contractor shall bear all expenses of providing the required notice.
- 2.3.4.4. A newborn Member's mother or designated representative may request Disenrollment with cause of the newborn within ninety (90) days following Enrollment of the newborn. Said request must include mother's current address and a twenty-four (24) hour phone number both listed on file with the county. The Department may conduct reviews of the requests to determine HIPAA compliance and/ or compliance with the contract.
- 2.3.4.5. If the mother to a newborn, not being a member of the health plan, has a newborn that is passively enrolled as a member in to the health plan, the mother of the newborn, or the Contractor, may request the Department to disenroll the newborn from the health plan.
- 2.3.4.6. A Member may request Disenrollment when the Department imposes intermediate sanctions as set forth in this contract.
- 2.3.4.7. If the State restricts disenrollment, the State must ensure that any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment is given access to a state Fair Hearing.
- 2.3.4.8. A Member (or the Contractor on the Member's behalf) may request Disenrollment at any time for any of the following causes:
- 2.3.4.8.1. The Member moves out of the Contractor's Service Area.
- 2.3.4.8.2. The Contractor does not, because of moral or religious objections, cover the service the Member needs.
- 2.3.4.8.3. The Member needs related services (for example, a caesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Member's Primary Care Physician or another Physician determines that receiving the services separately would subject the Member to unnecessary risk.
- 2.3.4.8.4. Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error.
- 2.3.4.8.5. Poor quality of care, as documented by the Department.
- 2.3.4.8.6. Lack of access to Covered Services, as documented by the Department.
- 2.3.4.8.7. Lack of access to Providers experienced in dealing with the Member's health care needs,

as documented by the Department.

- 2.3.4.8.8. The Member Enrolled in the Contractor's Plan with his/her Physician and the Physician leaves the Contractor.
- 2.3.4.8.9. The Member is a resident of long-term institutional care (e.g. hospice or skilled nursing facility).
- 2.3.4.8.10. 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.
- 2.3.4.8.11. The Member is a foster child.
- 2.3.4.8.12. The Member is in long-term community based care (e.g. PACE, HCBS waiver programs).
- 2.3.4.8.13. Other reasons satisfactory to the Department. When allowing Disenrollment under this subclause, the Department or its enrollment broker shall inform the Contractor of the rationale for the decision. If a decision is based upon a policy or widely applicable practice, the Department will provide Contractor with the implementation criteria.
- 2.3.4.8.14. The Contractor shall retrieve or download and review the Disenrollment reports from the MMIS web portal.
- 2.3.4.8.15. After the Contractor is notified that the State intends to terminate the Contract, Members may disenroll immediately without cause.

#### 2.3.5. Effective Date of Disenrollment

- 2.3.5.1. When a Member voluntarily Disenrolls from the Contractor's Plan, the effective date of the Disenrollment shall be no later than the first day of the second month following the month in which the Member requested the Disenrollment.
- 2.3.5.2. If a decision regarding the Member's Disenrollment is not made by the Department, or its designee, by the first day of the second month following the month in which the Member requested the Disenrollment, the Disenrollment shall be considered approved.
- 2.3.5.3. Disenrollment Postponed Due to Inpatient Hospital Stay
  - 2.3.5.3.1. If a current Member of a Contractor's Plan is an inpatient of a Hospital at 11:59 p.m. the day before his/her Disenrollment from the Contractor's Plan is scheduled to take effect, Disenrollment shall be postponed until discharged from the Hospital.
  - 2.3.5.3.2. When the Member is discharged from the Hospital the new Disenrollment date shall be the last day of the month following discharge.
  - 2.3.5.3.3. The Department shall respond to the Contractor in writing within five (5) Business Days of Contractor's request to postpone Enrollment.
- 2.3.5.4. Member Moves Outside of Service Area
  - 2.3.5.4.1. When the Contractor determines a Member is no longer a permanent resident or has resided outside of its Service Area for ninety (90) consecutive days or more, the Contractor shall notify the Department.

- 2.3.5.4.2. When the Department is notified and confirms that a Member is no longer a permanent resident in the Contractor's Service Area or has resided outside of its Service Area for ninety (90) consecutive days or more, the Member shall be Disenrolled from the Contractor's Plan effective the first day of the next month.
- 2.3.5.5. Verification of Medicaid Eligibility and Member Enrollment
  - 2.3.5.5.1. The Contractor shall use the Medicaid Management Information System (MMIS) reports to verify Medicaid eligibility and Enrollment in the Contractor's Plan:
    - 2.3.5.5.1.1. Disenrollment Report (R0305) and (M0305).
    - 2.3.5.5.1.2. Prepaid Health Plan (PHP) Enrollment Change Report (R0310).
    - 2.3.5.5.1.3. PHP Current Enrollment Report (R0315).
    - 2.3.5.5.1.4. PHP New Enrollee Report (R0325 and M0325).
    - 2.3.5.5.1.5. Capitation Summary Report (R0360).
    - 2.3.5.5.1.6. When available, Benefit Enrollment and Maintenance Transaction report (ANSI X 12N 834).
    - 2.3.5.5.1.7. Benefit Eligibility Inquiry/Response (270/271).
  - 2.3.5.5.2. Until such time that the interChange goes live, the Contractor may rely on the above-referenced reports for purposes of making coverage determinations. After the Department has begun use of the interChange, Contractor shall use only the MMIS reports listed in the above Section 2.3.5.5.1.7. to verify Medicaid eligibility and Enrollment in the Contractor's Plan.
  - 2.3.5.5.3. The Contractor shall not be liable for any Covered Services incurred prior to a Member's effective date of coverage under this contract or after the date of termination of coverage.
- 2.3.5.6. Reporting
  - 2.3.5.6.1. The Contractor shall submit a quarterly Enrollment/Disenrollment report to the Department. The report shall provide a detailed summary and analysis of all Enrollment/Disenrollment activities, including overall trends and specific reasons for Disenrollment. The reports shall include voluntary Disenrollment, referrals to the Contractor's grievance process regarding requests for Disenrollment and involuntary Disenrollment information and trends. The report shall be submitted in a format specified by the Department and shall be submitted within thirty (30) calendar days following the end of the quarter being reported.
- 2.3.5.7. Contractor Requested Disenrollment
  - 2.3.5.7.1. The Contractor may request, and the Department may approve or initiate, Disenrollment for specific cases or persons where there is cause. The following are acceptable reasons for Disenrollment for cause:
    - 2.3.5.7.1.1. Admission to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institution.
    - 2.3.5.7.1.2. Receipt of Comprehensive Health Coverage other than Medicaid.
    - 2.3.5.7.1.3. A Member leaves the State of Colorado for ninety (90) consecutive days or more.
    - 2.3.5.7.1.4. Any other reason, as determined by the Department.

- 2.3.5.7.1.5. Enrollment in a Medicare MCO or capitated health plan other than such a plan offered by the Contractor.
- 2.3.5.7.1.6. Child welfare eligibility status or receipt of Medicare benefits.
- 2.3.5.7.1.7. Abuse or Intentional Misconduct
  - 2.3.5.7.1.7.1. Behavior which is disruptive or abusive to the extent that the Contractor's ability to furnish services to either the Member or other Members is impaired; an ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet other Member responsibilities described in this Contract.
- 2.3.5.8. The Contractor shall provide at least one oral warning regarding the activity in question. Where the misconduct continues, the Contractor shall send a written warning to the Member that continuation of his/her actions will result in termination of his/her Enrollment in the Contractor's Plan. The Contractor shall send a copy of the notification letter, along with a report of its investigation, to the Department thirty (30) calendar days prior to termination of the Member's Enrollment.
- 2.3.5.9. Fraud or Knowingly Furnishing Incomplete/ Incorrect Information
  - 2.3.5.9.1. A Member who knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to the Contractor incident to Enrollment under this contract shall be subject to Disenrollment by the Department.
  - 2.3.5.9.2. A Member who is an inpatient refuses a medically appropriate transfer to facility in Contractor's Plan with a twenty-four (24) notice to the client/guardian. Client's refusal to accept the transfer requires a notice of action filing and/or a grievance shall result in Member's Disenrollment.
  - 2.3.5.9.3. Disenrollment for cause shall not include adverse changes in a Member's health status, because of a change in the Member's utilization of medical services, because of diminished mental capacity, nor any behavior of the Member resulting from his or her special needs except those behaviors that seriously impair the Contractor's ability to furnish services to either this Member or other Members.
- 2.3.5.10. Contractor Requested Expedited Disenrollment
  - 2.3.5.10.1. The Contractor, after giving verbal warning, may request an expedited Disenrollment where a Member is Disenrolled promptly without an additional period to allow the actions or behaviors to be corrected. The following are acceptable reasons for expedited Disenrollment for cause:
    - 2.3.5.10.1.1. If the Member's actions or behaviors pose an imminent threat to the safety of Member(s) or Contractor.
    - 2.3.5.10.1.2. Fraud or knowingly furnishing incomplete or incorrect information.

## **2.4. COVERED SERVICES**

### **2.4.1. Health Coverage**

- 2.4.1.1. The Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit D. 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.

- 2.4.1.2. The Contractor shall provide the same standard of care for all Members regardless of eligibility category and shall make all Covered Services as accessible in terms of timeliness, amount, duration and scope, to Members, as those services are to non-Member Medicaid recipients within the same area.
- 2.4.1.3. 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.
- 2.4.1.4. A Contractor that would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the Contractor objects to the service on moral or religious grounds. However, the Contractor may not prohibit a health care professional from acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient for the following:
  - 2.4.1.4.1. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - 2.4.1.4.2. Any information the enrollee needs in order to decide among all relevant treatment options.
  - 2.4.1.4.3. The risks, benefits, and consequences of treatment and non-treatment.
  - 2.4.1.4.4. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 2.4.1.5. If the Contractor objects to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, Contractor must furnish information to the State about the services it does not cover with its application for a Medicaid contract, and whenever it adopts such a policy during the term of the contract to discontinue coverage of a counseling or referral service based on moral or religious objections, must notify enrollees at least thirty (30) days prior to the effective date of the policy for any particular service.
- 2.4.2. Coverage Limitations
  - 2.4.2.1. The Contractor shall not be required to cover any service that does not meet the definition of Medically Necessary.
  - 2.4.2.2. 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.
  - 2.4.2.3. The Contractor may place appropriate limits on a service:
    - 2.4.2.3.1. On the basis of criteria under the Medicaid State Plan, such as medical necessity.
    - 2.4.2.3.2. For utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
    - 2.4.2.3.3. For utilization control, provided that the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.
    - 2.4.2.3.4. For utilization control, provided that family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.
- 2.4.3. Covered Services Through Participating Providers

- 2.4.3.1. 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.
- 2.4.3.2. Except for Emergency 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:
  - 2.4.3.2.1. Special arrangements or Referrals are made by a Primary Care Physician or the Contractor, as specified in the Member handbook; or
  - 2.4.3.2.2. The Member is receiving a service as described in Section 2.5.5.1.
- 2.4.4. Coverage of Specific Services and Responsibilities
  - 2.4.4.1. Emergency Services
    - 2.4.4.1.1. 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.
    - 2.4.4.1.2. Members temporarily out of the Service Area may receive out-of-area Emergency Services and Urgently Needed Services.
    - 2.4.4.1.3. The Contractor shall not require prior authorization for Emergency Services or Urgently Needed Services.
    - 2.4.4.1.4. 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.
    - 2.4.4.1.5. 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.
    - 2.4.4.1.6. The Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
    - 2.4.4.1.7. The Contractor must allow the emergency services provider a minimum of ten (10) calendar days to notify the primary care provider, MCO, PIHP, PAHP, Contractor or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify.
    - 2.4.4.1.8. The Contractor must pay non-contracted providers for emergency services no more than the amount that would have been paid if the service had been provided under the State's FFS Medicaid program.
  - 2.4.4.2. Emergency Ambulance Transportation
    - 2.4.4.2.1. 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) hour per day, seven (7) day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.



2.4.4.3. Verification of Medical Necessity for Emergency Services

2.4.4.3.1. 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.

2.4.4.4. Post-stabilization Care Services

2.4.4.4.1. The Contractor shall provide coverage for Post-stabilization Care Services as follow:

2.4.4.4.1.1. An enrollee 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 patient.

2.4.4.4.2. The Contractor shall be financially responsible for:

2.4.4.4.2.1. Post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other representative.

2.4.4.4.2.2. Post-stabilization care services obtained within or outside the Contractor's network that are not pre-approved by the Contractor's provider or representative, but administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization care services.

2.4.4.4.2.3. Post-stabilization care services administered to maintain, improve, or resolve the enrollee's stabilized condition without preauthorization, and regardless of whether the enrollee obtains services within the Contractor's network:

2.4.4.4.2.3.1. When the Contractor did not respond to a request for pre-approval within one (1) hour,

2.4.4.4.2.3.2. Cannot be contacted for pre-approval, or

2.4.4.4.2.3.3. When the Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a network physician is not available for consultation.

2.4.4.4.3. The Contractor must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she obtained the services through the Contractor's network.

2.4.4.4.4. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when:

2.4.4.4.4.1. The network physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

2.4.4.4.4.2. The network physician assumes responsibility for the enrollee's care through transfer,

2.4.4.4.4.3. The Contractor and the treating physician reach an agreement concerning the enrollee's care, or

2.4.4.4.4.4. The enrollee is discharged.

2.4.4.5. Coverage of Prescription Drugs

- 2.4.4.5.1. Medicare Prescription Drug, Improvement, and Modernization Act (MMA)
- 2.4.4.5.1.1. The Contractor shall not provide drugs described in Medicare Part D to individuals eligible for both Medicare and Medicaid.
- 2.4.4.5.1.2. 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.
- 2.4.4.5.1.3. 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.
- 2.4.4.5.2. The Contractor shall provide coverage 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:
- 2.4.4.5.2.1. The Contractor shall 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. The Contractor shall ensure that the formulary requires the following:
- 2.4.4.5.2.1.1. Information in electronic or paper form about which generic and name brand medications are covered, as well as which tier each medication is on.
- 2.4.4.5.2.1.2. The formulary drug list on the Contractor's website in a machine readable file and format as specified by the State.
- 2.4.4.5.2.2. The Contractor shall develop and maintain a prior authorization program to provide Covered Drugs for any Medically Necessary conditions unmet by the Contractor's formulary product. The Contractor shall ensure that the program includes the following criteria:
- 2.4.4.5.2.2.1. Provision of a telephonic or telecommunication response within 24 hours of a request for prior authorization; and
- 2.4.4.5.2.2.2. Prescription of at least a seventy-two (72) hour supply of outpatient Covered Drugs in an Emergency situation, with the exception of drugs referred to in section 42 USC 1396r-8(d)(2) of the Act. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well-being.
- 2.4.4.5.3. If a Member requests a brand name drug for a prescription that is included on the Contractor's drug formulary in generic form, the Member may receive the brand name drug by paying the cost difference between the generic and brand name drug. In this event, the Member must sign the prescription stating that the member will pay the difference in price, between the generic and the brand name drug, to the pharmacy.
- 2.4.4.5.4. Outpatient Drug Coverage & Drug Utilization
- 2.4.4.5.4.1. The Contractor shall develop and maintain a Drug Utilization Review (DUR) program that complies with the requirements described in Sections 1927(g) and 1927(d)(5)(A) of the Act, and 42 CFR part 456, subpart K no later than July 1, 2017.

The Contractor's DUR program shall perform the following functions:

- 2.4.4.5.4.1.1. Prospective drug review,
- 2.4.4.5.4.1.2. Retrospective drug use review,
- 2.4.4.5.4.1.3. Establish and operate a DUR Board, and
- 2.4.4.5.4.1.4. An educational program
- 2.4.4.5.4.2. The Contractor shall exclude encounters for Covered Drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization data reports submitted to the Department.
- 2.4.4.5.4.3. The Contractor shall provide the Department with a detailed report of its drug utilization review program activities on an annual basis, within forty-five (45) days after receiving a written request from the Department. The Contractor shall ensure that the report includes information as required by the CMS Medicaid Drug Utilization Review report, and the Department.
- 2.4.4.5.4.3.1. DELIVERABLE: DUR Program Activities Report
- 2.4.4.5.4.3.2. DUE: Within forty-five (45) days after receiving a written request from the Department.
- 2.4.4.5.4.4. The Contractor shall cover all outpatient drugs as defined in 42 USC 1396r-8 and section 1927(k)(2) of the Act based on medical necessity.
- 2.4.4.5.4.5. The Contractor shall not cover any outpatient drugs not eligible for rebate, except for outpatient drugs acquired through the 340B Drug Pricing Program pursuant to 42 USC 1396r-8
- 2.4.4.5.4.6. The Contractor shall not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.
- 2.4.4.5.4.7. The Contractor shall provide a formulary for covered outpatient drugs that is no more restrictive than the Department's formulary for coverage, pursuant to 42 CFR 438.210.
- 2.4.4.5.4.8. The Contractor shall report the following drug utilization data and information necessary for the Department to bill manufacturers for rebates no later than forty-five (45) calendar days after the end of each quarterly rebate period:
  - 2.4.4.5.4.8.1. Total number of units of each dosage form, strength, and package size by National Drug Code of all outpatient drugs covered and dispensed by the Contractor.
  - 2.4.4.5.4.8.1.1. DELIVERABLE: Outpatient Drug Utilization Report
  - 2.4.4.5.4.8.1.2. DUE: No later than forty-five (45) calendar days following the end of each quarterly rebate period.
- 2.4.4.6. Coverage of New Services and Items
  - 2.4.4.6.1. The Contractor shall not be responsible for providing any new health care services or new technology that is authorized, approved or adopted as a covered benefit under Medicaid fee-for-service during the term of this Contract. New prescription drugs shall be a Covered Service subject to the Contractor's formulary.
  - 2.4.4.6.2. The Contractor may submit a written request to the Department, requesting the

Department to review the appropriateness of including a prescription drug as a Covered Service. The Department reserves the right to make the final decision.

**2.4.4.7. Responsibility Regarding Psychiatric and Medical Diagnoses**

**2.4.4.7.1. Inpatient Hospital Services**

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

**2.4.4.7.1.1.1. 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.**

**2.4.4.7.1.1.2. 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**

**2.4.4.7.1.1.3. The Contractor shall not be responsible for the hospital stay when the primary diagnosis is for substance abuse rehabilitation, unless the stay is for short-term, substance detoxification.**

**2.4.4.7.2. Coverage for Emergency Services**

**2.4.4.7.2.1. 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.**

**2.4.4.7.2.2. 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.**

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

**2.4.4.7.3.1. 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:**

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

**2.4.4.7.3.1.2. The principal diagnosis is a medical diagnosis.**

**2.4.4.7.3.2. 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:**

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

**2.4.4.7.3.2.2. 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 I.**

**2.4.4.8. Additional Benefits and Services**

- 2.4.4.8.1. The Contractor may offer to Members additional benefits and services beyond Covered Services. These benefits and services shall be identified in the Member handbook and a written description provided to the Department in a format and on a schedule to be determined in consultation with the Contractor. The Contractor shall submit written notification to the Department at least thirty (30) calendar days prior to the targeted effective date for offering the additional benefits and services.
- 2.4.4.9. **Wrap Around (Fee For Service) Benefits**
- 2.4.4.9.1. 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).
- 2.4.4.9.2. The Contractor shall instruct its Participating Providers on how to refer a Member for such services. The Contractor shall advise Participating Providers of EPSDT support services that are available through local public health departments. 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.
- 2.4.4.9.3. The Contractor shall inform its Home Health Services Providers and Members that Home Health Services after sixty (60) consecutive calendar days are not Covered Services but are available to Members under FFS and require prior authorization. If Home Health Services after sixty (60) consecutive calendar days are anticipated, the Contractor shall ensure that, at least thirty (30) calendar days prior to the sixtieth (60<sup>th</sup>) 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.
- 2.4.4.10. **Assurance of Adequate Capacity and Services**
- 2.4.4.10.1. The Contractor shall submit documentation to the State, in the format specified by the State, to demonstrate that it complies with the following requirements:
- 2.4.4.10.1.1. Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.
- 2.4.4.10.1.2. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.
- 2.4.4.10.2. The Contractor shall submit documentation described in the above section 2.4.4.10.1 as specified by the State, but no less frequently than the following: (1) at the time it enters into a contract with the State. (2) At any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services, including:
- 2.4.4.10.2.1. Changes in the Contractor's services, benefits, geographic service area or payments;  
or
- 2.4.4.10.2.2. Enrollment of a new population in the Contractor's programs.
- 2.4.4.11. **Coverage of Hepatitis-C Therapies**
- 2.4.4.11.1. The Contractor shall provide coverage for Members in accordance with the Department's criteria, outlined in the pharmacy billing manual.

- 2.4.4.11.1.1. 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 (the “Therapies” or “Therapy”).

## **2.5. SERVICE DELIVERY**

### **2.5.1. Access**

#### **2.5.1.1. Access to Services**

- 2.5.1.1.1. The Contractor shall comply with the following timely access requirements:
  - 2.5.1.1.1.1. Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
  - 2.5.1.1.1.2. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
  - 2.5.1.1.1.3. Make services included in the contract available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.
  - 2.5.1.1.1.4. Establish mechanisms to ensure compliance by providers.
  - 2.5.1.1.1.5. Monitor providers regularly to determine compliance.
  - 2.5.1.1.1.6. Take corrective action if there is a failure to comply.
- 2.5.1.1.2. 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.
- 2.5.1.1.3. The Contractor shall maintain and monitor a network of 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:
  - 2.5.1.1.3.1. 1:2000 Primary Care Physician to Member ratio. Primary Care Physician includes Physicians designated to practice Family Medicine and General Medicine.
  - 2.5.1.1.3.2. 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.
  - 2.5.1.1.3.3. Physician specialists designated to practice Gerontology, Internal Medicine, OB/GYN and Pediatrics shall be counted as either a Primary Care Physician or Physician specialist, but not both.
- 2.5.1.1.4. The Contractor shall have written agreements with all Providers in its network.
- 2.5.1.1.5. The Contractor shall consider the following when establishing and maintaining the Provider network:
  - 2.5.1.1.5.1. The anticipated Medicaid Enrollment.
  - 2.5.1.1.5.2. The expected utilization of Covered Services.

- 2.5.1.1.5.3. The numbers and types of Providers required to furnish the Covered Services.
- 2.5.1.1.5.4. The number of network Providers who are not accepting new Medicaid patients.
- 2.5.1.1.5.5. The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members and whether the location provides physical access to Members with Disabilities.
- 2.5.1.1.6. 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 Primary Care Physician if that source is not a women’s health specialist.
- 2.5.1.1.7. The Contractor shall provide for a second opinion from a qualified health care professional within the network or arrange for the Member to obtain one outside the network at no cost to the Member.
- 2.5.1.1.8. 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, and §26-4-202(1)(j), C.R.S., as amended, through either 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.
- 2.5.1.1.9. The Contractor shall demonstrate that the organization maintains a sufficient number, mix, and geographic distribution of Providers of services.
- 2.5.1.2. Out of Network Providers
  - 2.5.1.2.1. In the event that the Contractor is unable to provide any Covered Service to a Member from a 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.
  - 2.5.1.2.2. 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. The Contractor shall coordinate with the out-of-network Provider with respect to payment.
- 2.5.1.3. Geographic Access
  - 2.5.1.3.1. 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. The Contractor shall have Providers located throughout the Contractor’s Service Area within thirty (30) miles or thirty (30) minutes travel time to the extent such services are available.
- 2.5.1.4. Service Availability
  - 2.5.1.4.1. The Contractor shall ensure that Members, including Members with Disabilities, have a point of access to appropriate services available on a 24-hour 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:

- 2.5.1.4.1.1. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.
- 2.5.1.4.1.2. 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:
  - 2.5.1.4.1.2.1. Immediate Medical Screening Exam by the Primary Care Physician or Hospital emergency room.
  - 2.5.1.4.1.2.2. Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service.
  - 2.5.1.4.1.2.3. Practitioner backs up covering all specialties.
- 2.5.1.5. Language Methodology
  - 2.5.1.5.1. The State must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State and provide that information to the Contractor.
- 2.5.1.6. Scheduling and Wait Times
  - 2.5.1.6.1. 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:
    - 2.5.1.6.1.1. Routine physicals.
    - 2.5.1.6.1.2. Diagnosis and treatment of acute pain or injury.
    - 2.5.1.6.1.3. Follow-up appointments for chronic conditions.
  - 2.5.1.6.2. The Contractor shall ensure that its scheduling guidelines meet, at a minimum, all of the following standards:
    - 2.5.1.6.2.1. Non-urgent health care, non-symptomatic well care physical examinations scheduled within thirty (30) days.
    - 2.5.1.6.2.2. Urgently Needed Services provided within forty-eight (48) hours of notification of the Primary Care Physician or Contractor.
  - 2.5.1.6.3. 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.
  - 2.5.1.6.4. 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.
- 2.5.2. Service Area Standards
  - 2.5.2.1. The Department shall make any final determination regarding the Contractor's suitability for providing Covered Services to Members within any specific Service Area.



- 2.5.2.2. 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:
  - 2.5.2.2.1. The name of the proposed county or counties in which the Contractor seeks to expand or the categories of populations to be served.
  - 2.5.2.2.2. 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.
- 2.5.2.3. The Contractor shall, within thirty (30) Business Days following the close of each fiscal year quarter and as required by 42 C.F.R. Section 438.207(c), submit to the Department, a detailed written report regarding the Contractor's capacity and services. The report shall be in the format specified by the Department and shall demonstrate that the Contractor meets the following:
  - 2.5.2.3.1. Provides an appropriate range of preventive care, primary care and specialty services that is adequate for the anticipated number of Members.
  - 2.5.2.3.2. 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.
- 2.5.2.4. Subject to approval by the Department, the Contractor may discontinue providing Covered Services to Members within an entire county within the Contractor's Services Area, upon Contractor's submission of its intent to discontinue providing such services, as well as an exit strategy for discontinuance. Such discontinuance of the provision of Covered Services shall be effective on the first day of the month following conclusion of the sixty (60) calendar days after approval.
- 2.5.3. Selection and Assignment of Primary Care Providers
  - 2.5.3.1. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a Primary Care Physician.
  - 2.5.3.2. If a Member does not select a Primary Care Physician, the Contractor shall assign the Member to a Primary Care Physician or a Primary Care Facility and notify the Member, by telephone or in writing, of his/her Facility's or Primary Care Physician's name, location, and office telephone number.
  - 2.5.3.3. 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 so that the Member receives the information needed to decide among all available treatment options and can make decisions regarding his/her 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.
- 2.5.4. Coordination of Care
  - 2.5.4.1. The Contractor shall have written policies and procedures to ensure timely coordination with any of a Member's other Providers of the provision of Covered Services to that Member. The Contractor shall implement these procedures in a manner that promotes and assures

service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living. The policies and procedures shall also address the coordination and provision of Covered Services in conjunction with other medical and behavioral health plans that may be providing services to the Member and ensure that, in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. Sections 160 and 164.

- 2.5.4.2. The Contractor shall coordinate with the Member's mental health Providers, if the Member has mental health Providers, to facilitate the delivery of mental health services in conjunction with the provision of Covered Services, as appropriate.
- 2.5.4.3. In addition to efforts made as part of the Contractor's internal quality assessment and improvement program, the Contractor's Care Coordination system shall include, but is not limited to:
  - 2.5.4.3.1. Procedures for and the capacity to:
    - 2.5.4.3.1.1. Provide an individual needs assessment within 90 days after enrollment, and at any other necessary time, that includes the screening for Special Health Care Needs. Special Health Care Needs may include, but are not limited to, mental health, high risk health problems, functional problems, language or comprehension barriers and other complex health problems.
      - 2.5.4.3.1.1.1. The Contractor shall authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.
    - 2.5.4.3.1.2. Develop an individual treatment plan as necessary based on the needs assessment.
    - 2.5.4.3.1.3. Establish treatment objectives, treatment follow-up, the monitoring of outcomes and a process to ensure that treatment plans are revised as necessary.
    - 2.5.4.3.1.4. These procedures must be designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and shall allow Members with Special Health Care Needs direct access to a specialist as appropriate for the Member's condition and medical needs.
  - 2.5.4.3.2. Procedures designed to address those Members who may require services from multiple Providers, facilities and agencies and who require complex coordination of benefits and services.
  - 2.5.4.3.3. Procedures designed to address those Members who require ancillary services, including social services and other community resources.
  - 2.5.4.3.4. A strategy to ensure that all Members, and those Members' authorized family members or guardians, are involved in treatment planning and consent to any medical treatment.
  - 2.5.4.3.5. Procedures and criteria for making Referrals and coordinating care by specialists, subspecialists and community-based organizations that will promote continuity as well as cost-effectiveness of care.
  - 2.5.4.3.6. Procedures to provide continuity of care for newly Enrolled Members to prevent disruption in the provision of Medically Necessary services. These procedures may include, but are not limited to, the following:
    - 2.5.4.3.6.1. Appropriate Care Coordination staff trained to evaluate and handle individual case transition and care planning.

- 2.5.4.3.6.2. Assessment for appropriate technology and equipment available.
- 2.5.4.3.6.3. Procedures for evaluating adequacy of Participating Providers.
- 2.5.4.3.6.4. Clearly written criteria and procedures that are made available to all Participating Providers, staff and Members regarding how to initiate case planning, including information on how the Member can contact the person or entity primarily responsible for coordinating services.
- 2.5.4.3.6.5. Procedures for coordinating the care of newly enrolled Members recently released from the Department of Corrections.
- 2.5.4.3.7. The Contractor must also implement procedures to deliver care to and coordinate services for all enrollees for the following:
  - 2.5.4.3.7.1. The services between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;
  - 2.5.4.3.7.2. The services the enrollee receives from any other MCO, PIHP, or PAHP;
  - 2.5.4.3.7.3. The services the enrollee receives in FFS Medicaid; and
  - 2.5.4.3.7.4. The services the enrollee receives from community and social support providers.
- 2.5.4.4. The Department may review any of the Contractor's procedures relating to care coordination and work with the Contractor to make changes to the procedures that it determines to be in the best interest of the Department or the Members.
- 2.5.4.5. The Contractor shall implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity, formally designated, as primarily responsible for coordinating their health care services, as well as coordinating between the services it provides and the services the enrollee receives from any third party provider.
- 2.5.5. Persons with Special Health Care Needs
  - 2.5.5.1. Continuation of Care for Persons with Special Health Care Needs
    - 2.5.5.1.1. 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) calendar 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.
    - 2.5.5.1.2. 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) calendar days, as specified in §25.5-5-406(1)(g), C.R.S.
    - 2.5.5.1.3. 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.
  - 2.5.5.2. 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 the Department and other Providers, MCOs, PIHPs or PAHPs serving the Member with Special Health Care Needs, in order to prevent duplication of those activities.

- 2.5.5.2.1. The Contractor shall ensure each Provider furnishing services to the Member maintains and shares an enrollee health record in accordance with professional standards.
- 2.5.5.3. 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.
- 2.5.5.4. The Contractor shall produce a treatment plan for enrollees with Special Health Care Needs who are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan must be:
  - 2.5.5.4.1. Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
  - 2.5.5.4.2. Approved by the Contractor in a timely manner, if this approval is required by the Contractor, and
  - 2.5.5.4.3. Any treatment plans produced by the Contractor shall be in accordance with any applicable State quality assurance and utilization review standards.
- 2.5.5.5. 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 Primary Care Physicians or be allowed direct access or a standing Referral to specialists for the needed care.
- 2.5.5.6. 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).
- 2.5.6. Accommodation of Members with Disabilities or Special Health Care Needs
  - 2.5.6.1. 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.
  - 2.5.6.2. To promote independent living, the Contractor shall:
    - 2.5.6.2.1. 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.
    - 2.5.6.2.2. Deliver Covered Services that will restore the Member's ability to live independently as expeditiously as possible.

- 2.5.6.3. The Contractor shall facilitate culturally and linguistically appropriate care, by implementing the following requirements:
- 2.5.6.3.1. 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.
  - 2.5.6.3.2. Maintain policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation.
  - 2.5.6.3.3. 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.
  - 2.5.6.3.4. Develop and provide cultural competency training programs, as needed, to the network Providers and Contractor staff regarding all of the following:
    - 2.5.6.3.4.1. Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services.
    - 2.5.6.3.4.2. The medical risks associated with the Client population's racial, ethical and socioeconomic conditions.
  - 2.5.6.3.5. 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 438.10.
  - 2.5.6.3.6. 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:
    - 2.5.6.3.6.1. Conduct the appropriate assessment and treatment of non-English speaking Members, including Members with a Communication Disability.
    - 2.5.6.3.6.2. Promote accessibility and availability of Covered Services, at no cost to Members.
  - 2.5.6.3.7. 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.
  - 2.5.6.3.8. 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.
  - 2.5.6.3.9. 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.
  - 2.5.6.3.10. 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.
  - 2.5.6.3.11. 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.

2.5.6.3.12. 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.

2.5.6.3.13. 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.

## 2.5.7. Preventative Health Services

2.5.7.1. 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 2.7 of this Statement of Work. The Contractor's program of preventive health services shall include, but is not limited to:

2.5.7.1.1. Risk assessment by a Member's Primary Care Provider, 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.

2.5.7.1.2. 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.

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

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

2.5.7.1.5. 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.

## 2.5.7.2. EPSDT Program Requirements

2.5.7.2.1. The Contractor shall ensure the delivery of EPSDT services for Contractor Covered Services. The Contractor shall have written policies and procedures for providing EPSDT services including lead testing and immunizations to the eligible population.

2.5.7.2.2. The Contractor shall comply with all EPSDT regulations set forth in 1905(a), 42 USC 1396d(r)(5) and 42 USC 1396d(a), 42 C.F.R. Sections 441.50 through 441.62, as amended and performance will be verified by paid claims, CAP audits and ad hoc reporting.

2.5.7.2.3. The Contractor shall assure the provision of all required components of periodic health

screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. At a minimum, such efforts shall include:

- 2.5.7.2.3.1. Education and outreach to eligibles of the importance of EPSDT services.
- 2.5.7.2.3.2. A proactive approach to ensure eligibles obtain EPSDT services including but not limited to EPSDT exceptions to all care limitations and must be determined on a case by case basis. Prior authorization is allowed for services but must not impede the delivery of necessary services.
- 2.5.7.2.3.3. Systematic communication process with network providers regarding the Department's EPSDT requirements.
- 2.5.7.2.3.4. Process to measure and assure compliance with the EPSDT schedule.
- 2.5.7.2.3.5. Per 42 C.F.R 438.210 a process to assure that the medically necessary services not covered by the Contractor are referred to the correct provider with the appropriate referral information for action. Any services where a provider cannot be located should be referred to the local Accountable Care case management office or the Healthy Communities office.
- 2.5.7.2.3.6. Comply with all reporting requirements and data needs for federal reporting. All data required, including but not limited to raw data, shall be given to the Department no later than February 1st of each year for the October 1st through September 30th period of the previous contract year.
- 2.5.7.2.3.7. Contractor must apply the Department's definition of Medical Necessity to all members ages 20 and under.
- 2.5.7.2.4. Thirty (30) days after the close of each quarter, the Contractor must provide the Department with EPSDT data, by age and by basis of eligibility, on child health screening services, referrals for corrective treatment, and dental services.
- 2.5.7.2.5. All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions, with the exception of services expressly excluded in this Contract, are covered for EPSDT-eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act. Any excluded EPSDT services shall be covered as a wrap- around benefit by the State.
- 2.5.7.3. EI Program Requirements
  - 2.5.7.3.1. The Contractor shall provide Early Intervention (EI) Services and Supports as described in CRS 27-10.5 part 7. If Contractor does not meet the requirements specified in CRS 27-10.5-709, the Contractor shall develop a process in coordination with the Department and CDHS to ensure EI Services and Supports are provided in accordance with CRS 27-10.5 part 7. The Contractor must contract with providers who meet the qualifications for early intervention providers, as defined in CCR 2509-10-7.951, as outlined in Appendix F of the Qualified Personnel Standards as noted on the EI Colorado Website.
  - 2.5.7.3.2. EI is a federally and state funded and regulated program for children from birth through two years who have been identified with a developmental delay or have been diagnosed with a condition that has a high probability of resulting in a delay. In Colorado, Early Intervention Colorado is coordinated through the Colorado Department of Human Services (CDHS), Office of Early Childhood.

- 2.5.7.3.3. The Contractor shall provide a list of their credentialed qualified providers to the Department annually by October 30th and assure that there are adequate providers to serve the eligible children. The Department will provide a template for this report.
- 2.5.7.3.4. EI services are family-centered. Families work together as a team with professionals to develop an Individualized Family Service Plan (IFSP). This plan identifies the strategies, supports and services necessary to reach developmental outcomes identified by the family and the rest of the IFSP team. An Early Interventionist's work with young children and families is guided by this plan. The Individual Family Service Plan (IFSP) is considered the document for medical necessity of services.
  - 2.5.7.3.4.1. EI services are independent of the home health program and therefore the rule in which at sixty (60) days payment for services be shifted to the Fee-For-Service program is not applicable.
  - 2.5.7.3.4.2. The Contractor shall be responsible for the EI services through the duration of the services being received, subject to the member's eligibility and enrollment in the plan.
  - 2.5.7.3.5. EI services are provided where the child lives, plays and learns. Service settings may include the child's home, a childcare center, a relative's home, or other community settings. The IFSP team identifies learning opportunities that occur within the family's typical, daily routines. Early Intervention professionals provide support and guidance to families to enhance those natural learning opportunities and to help their child achieve the identified developmental outcomes.
  - 2.5.7.3.6. Services provided in a clinic or provider office do not qualify as Early Intervention services and should not be offered as a replacement for services provided in the members community.
- 2.5.7.4. Training on Department Policies and Member Populations
  - 2.5.7.4.1. The Contractor shall ensure that appropriate staff participates in periodic training programs sponsored by the Department designed to provide technical assistance to the Contractor with policy interpretation and coordination of services to maximize compliance with requirements.
  - 2.5.7.4.2. The Contractor shall be responsible for training Participating Providers and any Subcontractors.
- 2.5.8. Services Delivered Only to Members
  - 2.5.8.1. 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.

## **2.6. COMPLIANCE AND MONITORING**

### **2.6.1. Utilization Management**



- 2.6.1.1. The Contractor shall follow CMS regulations regarding Utilization Management in 42 C.F.R. Section 438, *et seq.*
- 2.6.1.2. 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.
- 2.6.1.3. 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.
  - 2.6.1.3.1. The Contractor shall provide information to Members, at the time of the Member's Enrollment that includes, but is not limited to, the purpose of the Contractor's Utilization Management program and how the program works.
  - 2.6.1.3.2. 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.
- 2.6.1.4. 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.
- 2.6.1.5. 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 medical, behavioral health, or long-term services and supports needs.
- 2.6.1.6. Utilization Management review shall be conducted under the direction of a qualified clinician.
- 2.6.2. Compliance Reporting
  - 2.6.2.1. The Contractor shall be deemed out of compliance with reporting requirements under any of the following conditions:
    - 2.6.2.1.1. Late or absent submission of report.
    - 2.6.2.1.2. Report(s) does not contain all required elements as stated in Department format.
    - 2.6.2.1.3. Report(s) contains inaccuracies or insufficient data.
  - 2.6.2.2. The Contractor shall provide, upon the Department's request, a corrective action plan to eliminate identified deficiencies.
  - 2.6.2.3. 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. Section 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.

- 2.6.2.4. 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 (HIPAA), Pub.L. 104-191.
- 2.6.2.5. The Contractor shall ensure that either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer shall certify the submission of the following data, documentation or information:
  - 2.6.2.5.1. Encounter data submission, as described in Section 2.6.7.1. of this Agreement.
  - 2.6.2.5.2. Data on which the Department certifies the actuarial soundness of the capitation rates.
  - 2.6.2.5.3. Data on which the Department determines the Contractor's compliance with the medical loss ratio requirement described in 42 CFR §438.8.
  - 2.6.2.5.4. Data on which the Department determines that the Contractor has made adequate provision against the risk of insolvency.
  - 2.6.2.5.5. Data on which the Department bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network.
  - 2.6.2.5.6. The annual report of overpayment recoveries in 42 CFR §438.608(d)(3).
  - 2.6.2.5.7. Information on ownership and control, as described in Section 5.2.1. of this Agreement.
- 2.6.2.6. Network Adequacy Report
  - 2.6.2.6.1. The Contractor shall submit a quarterly Network Adequacy report. The report shall contain the total number of Providers by type of provider, county, and the number of Providers who are accepting new Members.
    - 2.6.2.6.1.1. DELIVERABLE: Quarterly Network Adequacy Report.
    - 2.6.2.6.1.2. DUE: Thirty (30) days after the end of the reporting quarter.
  - 2.6.2.6.2. Contractor shall annually conduct a needs assessment to identify unmet service needs in its service delivery area. The needs assessment shall be completed at least sixty (60) calendar days prior to the end of the contract year.
  - 2.6.2.6.3. Thirty (30) calendar days prior to the end of the contract year, Contractor shall submit to the Department a copy of its need assessment report and shall provide written assurance that Contractor's Network is adequate in number, mix and geographic distribution and in accordance with Department standards, for the expected level of Membership in the Service Area for the following year.
    - 2.6.2.6.3.1. DELIVERABLE: Need Assessment and Network Adequacy Report.
    - 2.6.2.6.3.2. DUE: Thirty (30) calendar days prior to the end of the contract year.
  - 2.6.2.6.4. If the needs assessment report indicates that the network is not adequate to meet the population of the Contractor's service area or if the Department determines that the

network is not adequate, the Contractor shall submit an action plan outlining how and when the unmet needs will be addressed. Action plans are subject to Departmental review and approval.

- 2.6.2.6.4.1. DELIVERABLE: Adequacy Action Plan.
- 2.6.2.6.4.2. DUE: Thirty (30) calendar days prior to the end of the contract year.
- 2.6.2.6.5. The Contractor shall provide to the Department an annual Provider Network Strategic Plan. The report is to be submitted not later than September 30, and is subject to the Department's approval. The plan shall reflect current and future network planning and include, at a minimum:
  - 2.6.2.6.5.1. Access to Service standards.
  - 2.6.2.6.5.2. Geographic access standards.
  - 2.6.2.6.5.3. Provider network standards.
  - 2.6.2.6.5.4. Population demographics.
- 2.6.3. Other Monitoring Activities
  - 2.6.3.1. In consultation with the Department, the Contractor shall participate in and respond to other Department compliance monitoring activities, including but not limited to:
    - 2.6.3.1.1. Encounter Data analysis; Encounter Data validation (the comparison of Encounter Data with Medical Records).
    - 2.6.3.1.2. Appeals analysis to identify trends in the Medicaid program and among managed care organizations.
    - 2.6.3.1.3. Risk-adjusted rate studies.
    - 2.6.3.1.4. Other reviews determined by the Department.
  - 2.6.3.2. The Department reserves the right to determine Contractor compliance with individual requirements under this contract based upon satisfactory review by recognized state agencies or private accreditation organizations.
- 2.6.4. Inspection, Monitoring and Site Reviews
  - 2.6.4.1. Inspections and Acceptance
    - 2.6.4.1.1. The Contractor shall permit duly authorized agents of the Department and of the state and federal government to access the Contractor's, Subcontractors' or Participating Providers' premises, during normal business hours. These agents may inspect, audit, monitor or otherwise evaluate the quality, appropriateness, timeliness or any other aspect of the performance of the Subcontractors' or Participating Providers' contractual services. Services as used in this clause include Covered Services performed or tangible material produced or delivered in the performance of Covered Services. If any of the Covered Services do not conform to the Contract's requirements, the Department may require the Contractor to perform the services again in order to conform to contract requirements, with no additional payment. When defects in the quality or quantity of Covered Services cannot be corrected by repeat performance, the Department may require the Contractor to take the necessary action to ensure that the future performance conforms to the Contract's requirements. These remedies in no way limit the remedies available to the Department in the Termination and Remedies provisions of this contract, or remedies

otherwise available by law.

2.6.4.2. Site Reviews

- 2.6.4.2.1. 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.
- 2.6.4.2.2. An emergency or unannounced review may be required in instances where patient 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.
- 2.6.4.2.3. 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) calendar days to submit the required materials for non-emergency reviews.
- 2.6.4.2.4. 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.
- 2.6.4.2.5. A written report of the site visit will be transmitted to the Contractor within thirty (30) calendar 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.
- 2.6.4.2.6. The Contractor shall respond to any required actions, if necessary, with a corrective action plan within thirty (30) calendar 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.

2.6.4.2.7. 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.

2.6.4.2.8. 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.

2.6.4.2.9. 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.

#### 2.6.5. Contractor Review of Studies, Inspections, Site Reviews and Audits

2.6.5.1. 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.

#### 2.6.6. Audits and Maintenance of Records

2.6.6.1. The Contractor shall permit the Department, federal government, or any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and/or transcribe Contractor's records concerning its performance under this contract during the term of this contract. This right shall extend for a period of six (6) years following termination of this contract or final payment hereunder, whichever is later, to assure compliance with the terms hereof, or to evaluate the Contractor's performance hereunder. The Contractor shall also permit these same entities to monitor all activities conducted by the Contractor pursuant to the terms of this contract. As the monitoring agency may, in its sole discretion, deem necessary or appropriate, such monitoring may consist of internal evaluation procedures, examination of program data, special analyses, on-site check, formal audit examinations, or any other reasonable procedure. All such monitoring shall be performed in a manner that will not unduly interfere with contract work.

2.6.6.2. The Department, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services Office of Inspector General, the Comptroller General and their designees shall have the right to inspect and audit any records or documents of the Contractor or its Subcontractors and may at any time inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted. Notwithstanding any other provision in this contract, the right of the Department, CMS, the US Department of Health and Human Services Office of Inspector General, the Comptroller General and their designees shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

2.6.6.3. The Contractor and all Subcontractors shall maintain a complete file of all records,

documents, communications, and other materials which pertain to the operation of the program/project or the delivery of services under this contract sufficient to disclose fully the nature and extent of services/goods provided to each Member. These records shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records. Such files shall be sufficient to properly reflect all direct and indirect costs of labor, materials, equipment, supplies and services, and other costs of whatever nature for which contract payments was made and shall include but are not limited to:

- 2.6.6.3.1. All Medical Records, service reports, and orders prescribing treatment plans.
- 2.6.6.3.2. Records of goods, including such things as drugs and medical equipment and supplies, and copies of original invoices for such goods.
- 2.6.6.3.3. Records of all payments received for the provision of such services or goods.
- 2.6.6.4. The Contractor shall maintain records or shall have a system in place to retrieve information sufficient to identify the Physician who delivered services to the patient.
- 2.6.6.5. All such records, documents, communications, and other materials shall be maintained by the Contractor, for a period of six (6) years from the date of any monthly payment under this contract, or for such further period as may be necessary to resolve any matters which may be pending, or until an audit has been completed with the following qualification: if an audit by or on behalf of the federal and/or state government has begun but is not completed at the end of the six (6) year period, or if audit findings have not been resolved after a six (6) year period, the materials shall be retained until the resolution of the audit finding.
- 2.6.6.6. The Department will conduct a readiness review to assess the Contractor's readiness to provide services to new eligibility groups at least three (3) months prior to the effective date of the Department's implementation and arrangement for the provision of services to new eligibility groups.
  - 2.6.6.6.1. The readiness review conducted by the Department must include a desk review of documents and may, at the Department's option, include an on-site review. On-site reviews must include interviews with the Contractor's staff and leadership that manage key operational areas.
  - 2.6.6.6.2. The Department's readiness review will assess the ability and capacity of the Contractor to perform satisfactorily for the following areas:
    - 2.6.6.6.2.1. Operations and Administration, including:
      - 2.6.6.6.2.1.1. Administrative staffing and resources.
      - 2.6.6.6.2.1.2. Delegation and oversight of the Contractor's responsibilities.
      - 2.6.6.6.2.1.3. Enrollee and provider communications.
      - 2.6.6.6.2.1.4. Grievance and appeals
      - 2.6.6.6.2.1.5. Member services and outreach.
      - 2.6.6.6.2.1.6. Provider Network Management.
      - 2.6.6.6.2.1.7. Program integrity and compliance.
    - 2.6.6.6.2.2. Service delivery, including:

- 2.6.6.6.2.2.1. Case management, care coordination, and service planning.
- 2.6.6.6.2.2.2. Quality improvement
- 2.6.6.6.2.2.3. Utilization review.
- 2.6.6.6.2.3. Financial Management, including:
  - 2.6.6.6.2.3.1. Financial reporting and monitoring.
  - 2.6.6.6.2.3.2. Financial solvency.
- 2.6.6.6.2.4. Systems management, including:
  - 2.6.6.6.2.4.1. Claims management.
  - 2.6.6.6.2.4.2. Encounter data and enrollment information management.
- 2.6.6.7. Contractor and Contractor's subcontractors shall retain the following information for a period of no less than ten (10) years:
  - 2.6.6.7.1. Enrollee grievance and appeal records, as specified in §438.416,
  - 2.6.6.7.2. Base data, as specified in §438.5(c),
  - 2.6.6.7.3. MLR Reports, as specified in §438.8(k), and
  - 2.6.6.7.4. Any data, information, and documentation, as specified in §438.604, §438.606, §438.608, and §438.610.
- 2.6.7. Encounter Claims Data Provisions
  - 2.6.7.1. The Contractor shall certify all Encounter Data and Financial Template information submitted are accurate, complete and truthful based on the Contractor's best knowledge, information and belief. These certifications 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. The data shall be sent quarterly based on the contract year (July 15, October 15, January 15, and April 15 for the previous three months of data submitted). The Contractor shall send the financial template annually on December 15 for the previous fiscal year.
  - 2.6.7.2. Encounter Data for Current Rate Setting and Quality Assurance
    - 2.6.7.2.1. Paid Encounter Data Submissions
      - 2.6.7.2.1.1. For purposes of rate setting and quality assurance, the Contractor shall submit paid Encounter Data to the Department. Paid encounters types shall include claims that were paid initially, adjusted claims and resubmissions, within the requested reporting periods.
    - 2.6.7.2.2. Encounter Data Submission Schedule
      - 2.6.7.2.2.1. The Contractor shall submit Encounter Data to the Department based on paid dates from a twelve (12) month interval, on January 15th, April 15th, July 15th, and October 15th as follows:
        - 2.6.7.2.2.1.1. July 15th submission reporting shall include encounters with paid dates between April 1st and June 30th of the prior fiscal year.
        - 2.6.7.2.2.1.2. October 15th submission reporting shall include encounters with paid dates between July 1st and September 30th of the same calendar and fiscal year.

- 2.6.7.2.2.1.3. January 15th submission reporting shall include encounters with paid dates between October 1st and December 31st of the prior calendar year.
- 2.6.7.2.2.1.4. April 15th submission reporting shall include encounters with paid dates between January 1st and March 31st of the same calendar and fiscal year.
- 2.6.7.2.2.2. For the purposes of rate setting, the Contractor shall observe all deadlines provided by the Department for encounter data submissions.
- 2.6.7.2.3. Encounter Data Submission Categories
  - 2.6.7.2.3.1. Encounter Data submitted to the Department shall include the following categories: EPSDT; Hospital inpatient and outpatient; medical group practices/clinics; Physicians, non-Physician practitioners; medical equipment; ambulatory surgical centers; family planning clinics; independent laboratories; optometrists; podiatrists; home health; dialysis centers; FQHCs; freestanding rehabilitation centers, pharmacies; and skilled nursing facilities.
- 2.6.7.2.4. Data Set Format Requirements
  - 2.6.7.2.4.1. The Contractor shall submit Encounter Data in the format prescribed and approved by the Department following consultation with the managed care organizations. Data set format requirements are available from the Department.
- 2.6.7.2.5. Encounter Data Transmissions
  - 2.6.7.2.5.1. The Contractor shall submit Encounter Data to the Department by compact disc (CD) or by encrypted email electronically.
- 2.6.7.2.6. Encounter Data Processing and Reporting
  - 2.6.7.2.6.1. The Department will process all submissions for Encounter Data for rate setting and quality assurance.
  - 2.6.7.2.6.2. The Department will send the Contractor a report within thirty (30) calendar days, providing the number of records received for the requested reporting period and the number of encounters that were unreadable.
- 2.6.7.2.7. Financial Template for Current Rate Setting and Quality Assurance
  - 2.6.7.2.7.1. For purpose of rate setting and quality assurance, the Contractor shall submit completed financial template to the Department by December 15 for the previous fiscal year based on the requirements provided by the Department.
- 2.6.7.3. Quality review of Encounter Data and Financial Template Report
  - 2.6.7.3.1. In addition to financial template submission, the Contractor shall allow the Department to inspect and audit the financial records of the Contractor and its Subcontractors related to this contract per C.R.F. 438.3(h).
  - 2.6.7.3.2. The Contractor shall participate in annual, external independent site reviews, and Performance Measure Validation in order to review compliance with Department standards and contract requirements.
  - 2.6.7.3.3. External quality review activities shall be conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols.
  - 2.6.7.3.4. The Contractor shall also participate in an annual 411 audit conducted by the External Quality



Review Organization (EQRO) and the Department. The Contractor shall submit all data and records necessary for the performance of a 411 audit to the Department or its designee. The Department will inform the Contractor of all other steps necessary to complete the 411 audit.

**2.6.7.4. Encounter Claims Data for MMIS Submissions**

**2.6.7.4.1.** In addition to the direct submission of Encounter Data to the Department for purposes of rate setting and quality assurance, the Contractor shall submit encounter claims data directly to the Department's fiscal agent, via the Medicaid Management Information System (MMIS).

**2.6.7.4.2. Encounter Claims Data Submission Schedule**

**2.6.7.4.2.1.** The Contractor shall submit encounter claims data to the MMIS on a monthly basis.

**2.6.7.4.3. Encounter Claims Submission Requirements**

**2.6.7.4.3.1. Hospital, Ambulatory Surgery Center and Home Health Encounter Claims**

**2.6.7.4.3.1.1.** Hospital (both inpatient and outpatient) and home health encounter claims include paid and denied 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.

**2.6.7.4.3.1.2.** Hospital, ambulatory surgery center and home health encounter claims shall be submitted electronically directly to MMIS, using the ANSI 837I, Health Care Claim Institutional format.

**2.6.7.4.3.1.3.** 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 Provider.

**2.6.7.4.3.2. Pharmacy Encounter Claims**

**2.6.7.4.3.2.1.** Pharmacy claims refer to all paid pharmaceuticals prescriptions.

**2.6.7.4.3.2.2.** A pharmacy claim encounter is a single prescription. Example: A Member who goes to one Provider and has two prescriptions filled would have two encounters.

**2.6.7.4.3.2.3.** Pharmacy encounters shall be submitted electronically directly to the MMIS, using the National Council for Prescription Drug Program (NCPDP) version 5.1 format.

**2.6.7.4.3.3. Medical Encounter Claims**

**2.6.7.4.3.3.1.** Medical encounter claims include paid and denied services delivered by medical groups practices/clinics, Physicians, non-practitioners, medical equipment suppliers, family planning clinics, independent laboratories, optometrists, podiatrists, FQHCs, and freestanding rehabilitation centers, and all other Providers not listed in sections a and b above.

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

- 2.6.7.4.3.3.3. Medical encounters shall be submitted electronically directly to the MMIS, using the ANSI 837P, Health Care Claim professional format.
- 2.6.7.4.4. Encounter Edits and Types
  - 2.6.7.4.4.1. Encounter Data Edits
    - 2.6.7.4.4.1.1. The MMIS will edit encounter claims for accuracy and reasonableness of data. The edits used will change as the volume and accuracy of data increases. The Contractor can obtain a current list of edits by contacting the Department.
  - 2.6.7.4.4.2. Encounter Types
    - 2.6.7.4.4.2.1. Adjudicated encounter claims are encounters that have been accepted by the system edits as provisionally correct. If the Department discovers errors with previously adjudicated claims resulting from a federal or state mandate or request that requires the completeness and accuracy of the Encounter Data, the Contractor shall be required to correct the error.
    - 2.6.7.4.4.2.2. Rejected encounter claims are encounters that fail electronic claims capture (ECC) edits. These claims are not allowed into MMIS and will be reported to the Contractor upon failure of ECC.
    - 2.6.7.4.4.2.3. Level 1 denied encounter claims are encounters that have been denied by the Contractor. Encounter claims denied by the Contractor shall be submitted to the MMIS edits as described in Section 2.6.7.4.1 of this contract. Level 2 denied encounter claims are encounter claims that fail to process correctly in the MMIS because of missing or erroneous data. These claims are not allowed into MMIS and will be reported to the Contractor on a routine basis.
- 2.6.7.4.5. Data Set Format Requirements
  - 2.6.7.4.5.1. The Contractor shall submit all Encounter Data for MMIS in a format to be specified by the Department.
    - 2.6.7.4.5.1.1. Detailed format information for the ASC 837 transaction is available at <http://www.wpc-edi.com>. HIPAA transaction data guides to prepare systems to work with the Colorado Medicaid program and detail acceptable Colorado Program values can be found at [www.chcpf.state.co.us](http://www.chcpf.state.co.us).
    - 2.6.7.4.5.1.2. A detailed format for Pharmacy submissions has been emailed to the Contractor. Additional copies are available from the Department's Information Systems Section.
    - 2.6.7.4.5.1.3. The Department reserves the right to change format requirements at any time, following consultation with the Contractor and will make a good faith effort to provide advanced written notice of such changes. The Department, however, retains the right to make the final decision regarding format submission requirements.
  - 2.6.7.4.5.2. The Contractor shall take necessary measures to ensure the:
    - 2.6.7.4.5.2.1. Accuracy of all required fields.
    - 2.6.7.4.5.2.2. Completeness of encounter claims submitted.
    - 2.6.7.4.5.2.3. Presence of Medical Record documentation and each encounter claim.

- 2.6.7.4.5.2.4. Submitted data include paid and denied claims identified in this section of the contract (paid only for Pharmacy encounter claims).
- 2.6.7.4.5.2.5. Submitted data excludes interim, serial, duplicate and late billings or claims in appeal status.
- 2.6.7.4.5.2.6. Submitted data include the most current version of adjusted claims.
- 2.6.7.4.5.3. The Contractor shall review compliance with these criteria each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.
- 2.6.7.4.6. **Encounter Data Transmissions**
  - 2.6.7.4.6.1. The Contractor shall submit all encounter claims data directly to the MMIS, via electronic transmission. Expanded privileges to submit encounter claims can be obtained through the Department's Information Systems Section.
- 2.6.7.4.7. **Processing and Reporting**
  - 2.6.7.4.7.1. The Department will process all encounter claims received through the MMIS.
  - 2.6.7.4.7.2. The Department will provide a weekly report to the Contractor of all encounter claims received via electronic transmission.
- 2.6.7.5. **Client Services**
  - 2.6.7.5.1. The Contractor shall ensure that Providers supply services only to those eligible Colorado Medicaid Clients assigned as Members to the Contractor's Plan. It is the responsibility of the Provider to verify that the individual receiving medical services is Medicaid eligible 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.
- 2.6.7.6. **Contract Termination and Encounter Data**
  - 2.6.7.6.1. Termination of the contract does not relieve the Contractor of its obligation to submit all required Encounter Data for dates of service during which time the contract was in effect, nor does it relieve the Contractor of the obligation to complete pay recovery costs.
- 2.6.8. The Contractor shall track and report quarterly Provider Preventable Conditions as described in Exhibit K, Serious Reportable Events or Never Events, attached and incorporated herein by reference, for all subcontracted facilities that provide inpatient services to Clients. The report shall contain any service with the Present on Admission (POA) indicator at the time of a hospital admission. The Department will provide a detailed report template. The Contractor or rendering provider cannot bill the Client or Medicaid for POA related services.
  - 2.6.8.1. The Contractor shall not reimburse any provider for the additional costs resulting from the hospital acquired conditions and Serious Reportable Events per Exhibit K.
  - 2.6.8.2. The Contractor shall not reimburse the professional nor the hospital for the following occurrences of associated inpatient charges:
    - 2.6.8.2.1. Surgery performed on the wrong body part.
    - 2.6.8.2.2. Surgery performed on the wrong patient.
    - 2.6.8.2.3. Wrong surgical procedure on a patient.

## 2.6.9. Health Insurance Providers Fee Reporting

- 2.6.9.1. 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:
  - 2.6.9.1.1. A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).
  - 2.6.9.1.2. The preliminary and final calculations of the fee from the IRS, even if the calculated fee was \$0.00.
  - 2.6.9.1.3. An allocation of the fee attributable to the Work under this Contract.
  - 2.6.9.1.4. Any additional information related to the Health Insurance Providers Fee, as determined by the Department.
- 2.6.9.2. 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.
  - 2.6.9.2.1. DELIVERABLE: Health Insurance Providers Fee Report
  - 2.6.9.2.2. DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963

## 2.7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

- 2.7.1. The Contractor shall maintain an internal quality assessment and performance improvement program that complies with 42 C.F.R. §438.330 for all Covered Services.
- 2.7.2. The scope of the Contractor's internal quality assessment and performance improvement program shall be comprehensive and shall include, but not be limited to:
  - 2.7.2.1. Practice Guidelines.
    - 2.7.2.1.1. The Contractor shall develop practice guidelines for the following:
      - 2.7.2.1.1.1. Perinatal, prenatal and postpartum care for women;
      - 2.7.2.1.1.2. Conditions related to Persons with a Disability or Special Health Care Needs; and
      - 2.7.2.1.1.3. Well child care.
    - 2.7.2.1.2. The Contractor shall ensure that practice guidelines comply with the following requirements:
      - 2.7.2.1.2.1. The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
      - 2.7.2.1.2.2. The guidelines consider the needs of the Member.
      - 2.7.2.1.2.3. They are adopted in consultation with Participating Providers.
      - 2.7.2.1.2.4. The Contractor reviews and updates the guidelines at least annually.
  - 2.7.2.1.3. 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.
  - 2.7.2.1.4. 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.

#### 2.7.2.2. Performance Improvement Projects

2.7.2.2.1. The Contractor shall conduct performance improvement projects 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.

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

2.7.2.2.3. The Contractor shall conduct performance improvement projects on topics selected by the CMS when the Department is directed by CMS to focus on a particular topic.

2.7.2.2.4. 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.

2.7.2.2.5. At least once per year, the Department will review the impact and effectiveness of the quality assessment and performance improvement program of the Contractor, including 1) the Contractor's performance on the measures on which it is required to report; 2) the outcomes and trended results of each Contractor's performance improvement projects; and 3) the results of any efforts by the Contractor to support community integration for enrollees using long-term services and supports.

#### 2.7.2.3. Performance Measurement Data

##### 2.7.2.3.1. Healthcare Effectiveness Data and Information Set (HEDIS)

2.7.2.3.1.1. 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.

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

2.7.2.3.1.3. The Contractor shall contract with an individual entity to perform an external audit of the HEDIS measures according to HEDIS protocols.

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

##### 2.7.2.3.2. Mandatory Federal Performance Measurements

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

#### 2.7.2.4. Member Satisfaction

2.7.2.4.1. 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.

- 2.7.2.4.2. The Contractor shall fund an annual Member satisfaction survey, the Consumer Assessment of Health Plans Study (CAHPS), 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 results of internal satisfaction surveys of Members designed to identify areas of satisfaction and dissatisfaction by June 30<sup>th</sup> of each fiscal year.
- 2.7.2.4.3. 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.
- 2.7.2.4.4. The Contractor shall implement and maintain a mechanism to assess the quality and appropriateness of care for Persons with Special Health Care Needs.
- 2.7.2.5. Mechanisms to Detect Over and Under Utilization
- 2.7.2.5.1. The Contractor shall implement and maintain a mechanism to detect over and underutilization of services. These mechanisms may incorporate those developed for the Contractor's Utilization Management program.
- 2.7.2.6. Quality of Care Concerns
- 2.7.2.6.1. The Contractor shall investigate any alleged Quality of Care (QOC) concerns, which are defined as concerns raised by the Department or providers, or concerns discovered by the Contractor. Member complaints about care are not considered QOC concerns and should be processed as grievances, unless the Department instructs otherwise.
- 2.7.2.6.2. The Contractor shall have a system for identifying and addressing all alleged QOC concerns.
- 2.7.2.6.3. When a QOC concern is raised, the Contractor shall investigate, analyze, track, trend and resolve QOC concerns by doing the following:
- 2.7.2.6.3.1. Send an acknowledgment letter to the originator of the QOC concern,
- 2.7.2.6.3.2. Investigate the QOC issue(s),
- 2.7.2.6.3.3. Follow-up with the Member to determine if the Member's immediate health care needs are being met,
- 2.7.2.6.3.4. Send a QOC resolution letter to the originator of the QOC concern. This letter shall include, at a minimum:
- 2.7.2.6.3.4.1. Sufficient detail to foster an understanding of the QOC resolution
- 2.7.2.6.3.4.2. A description of how the Member's health care needs have been met
- 2.7.2.6.3.4.3. A contact name and telephone number or call for assistance or to express any unresolved concerns
- 2.7.2.6.3.5. Refer QOC issues to the Contractor's peer review committee, when appropriate,
- 2.7.2.6.3.6. Refer or report the QOC issue to the appropriate regulatory agency and Child or Adult

- Protective Services for further research, review or action, when appropriate
- 2.7.2.6.3.7. Notify the appropriate regulatory or licensing board or agency when the affiliation of a Network Provider is suspended or terminated due to QOC concerns.
- 2.7.2.6.3.8. Document the incident in a QOC file. This file shall include, at a minimum:
- 2.7.2.6.3.8.1. The name and contact information of the originator of the QOC concern
- 2.7.2.6.3.8.2. A description of the QOC concern including issues, dates and involved parties
- 2.7.2.6.3.8.3. All steps taken during the QOC investigation and resolution process
- 2.7.2.6.3.8.4. Corrective action(s) implemented and their effectiveness
- 2.7.2.6.3.8.5. Evidence of the QOC resolution
- 2.7.2.6.3.8.6. A Copy of the acknowledgement and resolution letters
- 2.7.2.6.3.8.7. Any referral made by the Contractor to a regulatory or licensing agency or board.
- 2.7.2.6.4. For QOC concerns involving Network Providers, the Contractor may use the process of its professional review committee, as set forth in Sections 12-36.5-104 and 12-36.5-104.4, C.R.S.
- 2.7.2.6.5. 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.
- 2.7.2.6.5.1. The letter shall be delivered to the Department within fourteen (14) 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.
- 2.7.2.6.6. 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.
- 2.7.2.6.7. The Contractor shall submit a quarterly report, accompanying its Network Adequacy Reports, to the Department using an agreed upon format that includes a brief description of each QOC concern identified during the previous quarter, and the outcome of each review.
- 2.7.2.7. Quality Improvement Committee
- 2.7.2.7.1. The Contractor shall participate in the Department's Quality Improvement Committee (QuIC) 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.

**2.7.2.8. Program Impact Analysis and Annual Report**

**2.7.2.8.1.** 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.

**2.7.2.8.2.** The Contractor shall submit an annual report to the Department, detailing the findings of the program impact analysis. The report shall describe techniques used by the Contractor to improve performance, the outcome of each performance improvement project and the overall impact and effectiveness of the quality assessment and improvement program. The report shall be submitted by the last Business Day of September for the preceding year's quality activity or at a time the contract has been terminated.

**2.7.2.8.3.** The Program Impact Analysis and Annual Report shall provide sufficient detail for Department staff to validate the Contractor's performance improvement projects, which involve the following:

**2.7.2.8.3.1.** Measurement of performance using objective quality indicators.

**2.7.2.8.3.2.** Implementation of system interventions to achieve improvement in quality.

**2.7.2.8.3.3.** Evaluation of the effectiveness of the interventions.

**2.7.2.8.3.4.** Planning and initiation of activities for increasing or sustaining improvement.

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

**2.7.2.9. Quality Improvement Plan**

**2.7.2.9.1.** 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.

**2.7.2.9.1.1.** DELIVERABLE: Quality Improvement Plan

**2.7.2.9.1.2.** DUE: Annually, by the last Business Day in September

**2.7.2.10. External Review**

**2.7.2.10.1.** 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:

**2.7.2.10.1.1.** Medical Record review.

**2.7.2.10.1.2.** Performance improvement projects and studies.

**2.7.2.10.1.3.** Surveys.

**2.7.2.10.1.4.** Calculation and audit of quality and utilization indicators.

**2.7.2.10.1.5.** Administrative data analyses.

**2.7.2.10.1.6.** Review of individual cases.

**2.7.2.10.2.** 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.

2.7.2.10.3. 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.

2.7.2.11. **Health Information Systems**

2.7.2.11.1. 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.

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

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

2.7.2.11.4. The Contractor shall ensure that the data received from Providers is accurate and complete, in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

2.7.2.11.5. 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.

2.7.2.11.6. The Contractor shall ensure that data received from provider is accurate and complete by:

2.7.2.11.6.1. Verifying the accuracy and timeliness of reported data;

2.7.2.11.6.2. Screening the data for completeness, logic, and consistency; and

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

**SECTION 3.0 MEMBER AND PROVIDER ISSUES**

**3.1. MEMBER ISSUES**

**3.1.1. Member Services, Rights and Responsibilities**

3.1.1.1. 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:

3.1.1.1.1. 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.

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

3.1.1.1.3. 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.

- 3.1.1.1.4. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- 3.1.1.1.5. 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.
- 3.1.1.1.6. 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.
- 3.1.1.1.7. 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.
- 3.1.1.1.8. 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) calendar days after the effective date of the change.
- 3.1.1.1.9. The Contractor shall provide general information to potential enrollees at the time they first become eligible in a voluntary program or are first required to enroll in a mandatory program and within a timeframe that enables the potential enrollee to use the information in choosing among available plans.
  - 3.1.1.1.9.1. The Contractor shall provide general information to potential enrollees about:
    - 3.1.1.1.9.1.1. Basic features of managed care,
    - 3.1.1.1.9.1.2. Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program, and
    - 3.1.1.1.9.1.3. The MCO's responsibilities for coordination of enrollee care.
- 3.1.1.2. Member Responsibilities
  - 3.1.1.2.1. 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.
- 3.1.1.3. Written Policies, Procedures and Information Relating to Members
  - 3.1.1.3.1. 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 F, Member Handbook Requirements, attached hereto and incorporated herein.

- 3.1.1.3.2. For each of the following provider types covered under this Contract - physicians, including specialists; hospitals; pharmacies; behavioral health providers; and Long-Term Services and Supports (LTSS) providers, as appropriate, the Contractor shall make the following information on the Contractor's network providers available to the enrollee in paper form upon request and electronic form:
  - 3.1.1.3.2.1. Names, as well as any group affiliations,
  - 3.1.1.3.2.2. Street addresses,
  - 3.1.1.3.2.3. Telephone numbers,
  - 3.1.1.3.2.4. Website URLs, as appropriate,
  - 3.1.1.3.2.5. Specialties, as appropriate,
  - 3.1.1.3.2.6. Whether network providers will accept new enrollees,
  - 3.1.1.3.2.7. The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training,
  - 3.1.1.3.2.8. Whether network provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.
- 3.1.1.3.3. The Contractor shall ensure that its provider network information includes the following:
  - 3.1.1.3.3.1. A paper provider directory must be updated at least monthly.
  - 3.1.1.3.3.2. An electronic provider directory must be updated no later than 30 calendar days after the Contractor receives updated provider information
- 3.1.1.3.4. The Contractor shall make the provider directory available on the Contractor's website in a machine readable file and format as specified by the State.
- 3.1.1.3.5. The Contractor and its subcontractors must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services.
- 3.1.1.3.6. 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 F. 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.
  - 3.1.1.3.6.1. The handbook information provided to the enrollee is considered to be provided if the Contractor:
    - 3.1.1.3.6.1.1. Mails a printed copy of the information to the enrollee's mailing address.
    - 3.1.1.3.6.1.2. Provides the information by email after obtaining the enrollee's agreement to receive the information by email.
    - 3.1.1.3.6.1.3. Posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable

Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. OR

- 3.1.1.3.6.1.4. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.
- 3.1.1.3.7. Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department. Written information shall be translated into other non-English languages prevalent in the Service Area, and provided in alternative formats as required in this Contract. The Contractor shall inform Members and potential Members that oral interpretation services are available for any language, that written information is available in prevalent languages and how the Member may access interpretation services free of charge. Prevalent population shall consist of 500 or more Members speaking each language.
- 3.1.1.3.8. The Contractor may provide Members with similar information, in the same manner as that information is provided to private or commercial enrollees, but shall also provide Members with additional information as appropriate to promote compliance with this Contract.
- 3.1.1.3.9. The Contractor shall provide periodic updates to the Member handbook when needed to explain changes to the above policies. Prior to printing, the Contractor shall submit the updates to the Department for review and approval, at least thirty (30) calendar days prior to the targeted printing date.
- 3.1.1.3.10. The Member handbook shall be approved or disapproved by the Department in writing within forty-five (45) calendar days of receipt by Department. If the Member handbook is disapproved by the Department, the Department shall specify the reason(s) for disapproval in the written notice to Contractor.
- 3.1.1.3.11. The Contractor shall provide a copy of the policies on Members' rights and responsibilities to all Participating Providers and ensure that Participating Providers are aware of information being provided to Members.
- 3.1.1.3.12. 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.
- 3.1.1.4. Notices of Changes, Information and Actions
  - 3.1.1.4.1. The Contractor shall notify all Members of their right to request and obtain the information listed in Section 3.1.2.1. through Section 3.1.2.8, at least once per year.
  - 3.1.1.4.2. If the Contractor chooses to provide required information electronically, it must observe the following requirements:
    - 3.1.1.4.2.1. It must be in a format that is readily accessible.
    - 3.1.1.4.2.2. The information shall be placed in a location on the Contractor's website that is prominent and readily accessible.
    - 3.1.1.4.2.3. The information shall be provided in an electronic form which can be electronically retained and printed.
    - 3.1.1.4.2.4. The information in consistent with content and language requirements.

- 3.1.1.4.2.5. The Contractor shall notify the enrollee that the information is available in paper form without charge upon request
- 3.1.1.4.2.6. The Contractor shall provider, upon request, information in paper form within five (5) business days.
- 3.1.1.4.3. The Contractor shall also notify Members of any significant changes in the following information at least thirty (30) calendar days prior to the effective date of the change. Significant changes include, but are not limited to:
  - 3.1.1.4.3.1. The amount, duration and scope of Covered Services available in sufficient detail to ensure that Members understand the benefits to which they are entitled.
  - 3.1.1.4.3.2. Procedures for obtaining Covered Services, including authorization requirements.
  - 3.1.1.4.3.3. The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers.
  - 3.1.1.4.3.4. The extent to which, and how, after-hours and Emergency Services are provided including:
    - 3.1.1.4.3.4.1. What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services.
    - 3.1.1.4.3.4.2. The fact that prior authorization is not required for Emergency Services.
    - 3.1.1.4.3.4.3. The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local equivalent.
    - 3.1.1.4.3.4.4. 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.
    - 3.1.1.4.3.4.5. 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.
  - 3.1.1.4.3.5. Policy on Referrals for specialty care and for other benefits not furnished by the Member's Primary Care Physician.
  - 3.1.1.4.3.6. Any changes of cost sharing or co-payments that the Member is responsible for in relation to the receipt of a Covered service.
    - 3.1.1.4.3.6.1. All cost sharing and co-payments, if greater than zero, shall be implemented and imposed in accordance with 42 CFR 447.50 through 42 CFR 447.82.
    - 3.1.1.4.3.6.2. The Contractor shall not charge a deductible, cost sharing or copayment charge upon the following categorically or medically needy individuals:
      - 3.1.1.4.3.6.2.1. Children
      - 3.1.1.4.3.6.2.2. Pregnant women
      - 3.1.1.4.3.6.2.3. Institutionalized individuals
      - 3.1.1.4.3.6.2.4. Emergency Services
      - 3.1.1.4.3.6.2.5. Family planning
      - 3.1.1.4.3.6.2.6. Indians
  - 3.1.1.4.3.7. How and where to access Wrap Around Benefits, including any cost sharing and how

transportation is provided.

3.1.1.4.3.8. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall furnish information on how and where to obtain the service.

3.1.1.4.4. Notice of Adverse Action

3.1.1.4.4.1. Any notice of adverse action by the Contractor must be in writing, use easily understood language and format, and be made available in the state-established prevalent non-English languages in its service area.

3.1.1.4.4.2. Any notice of adverse action must be made available in alternative formats an in an appropriate manner for persons with special needs.

3.1.1.4.4.3. Contractor must inform all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

3.1.2. Grievance and Appeals Process

3.1.2.1. Generally

3.1.2.1.1. The Contractor shall maintain an internal Grievance and Appeal process to handle Grievances about any matter related to this Contract, and Appeals of an adverse benefit determination for Covered Services, in accordance with 42 C.F.R. § 438.400 *et seq.* The Contractor shall also maintain a processes to collect and track information about all grievances and appeals.

3.1.2.1.2. The Contractor shall ensure its appeal process complies with 10 CCR 2505-10, §8.209, Medicaid Managed Care Grievance and Appeal Process.

3.1.2.1.3. The Contractor shall assist Members in following the Department's procedures for handling Appeals of physical health adverse benefit determinations.

3.1.2.1.4. The Contractor shall use the reporting format provided by the Department to document and maintain an organized system for recording, tracking, resolving, and assessing Members' appeals. The Contractor shall submit a completed data reporting form to the Department, on a quarterly basis, within thirty (30) calendar days following the end of the quarter being reported.

3.1.2.1.5. The Contractor shall use the Department's reporting format to provide a written analysis of the appeal data. The Contractor shall submit the written report to the Department on a quarterly basis, within thirty (30) calendar days following of the end of the quarter being reported.

3.1.2.1.6. The Contractor shall not be responsible for any grievance or appeal associated with a Wrap Around Benefit.

3.1.2.1.6.1. From time to time, the Department may conduct reviews of the Contractor and its providers and subcontractors to ensure that they are notifying enrollees in a timely manner, pursuant to the notice requirements for grievances and appeals set forth in Section 3.1.2.2. and Section 3.1.2.4 of this Agreement.

3.1.2.1.7. The Contractor shall give Members assistance in completing forms and other procedural steps in the Grievance and Appeals 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.

- 3.1.2.1.8. The Contractor shall, at the time they enter into a contract, inform Providers and subcontractors about:
  - 3.1.2.1.8.1. The Member’s right to file grievances and appeals.
  - 3.1.2.1.8.2. The requirements and time frames for filing.
  - 3.1.2.1.8.3. The availability of assistance with filing.
  - 3.1.2.1.8.4. The toll-free number to file orally.
  - 3.1.2.1.8.5. The Member’s right to request a continuation of benefits during an appeal or state fair hearing filing, although the member may be liable for the cost of any continued benefits if the action is upheld.
  - 3.1.2.1.8.6. The right to request a State fair hearing, how Members obtain a hearing, and the representation rules at a hearing, after the Contractor has made a determination on an enrollee’s appeal which is adverse to the enrollee.
  - 3.1.2.1.8.7. Information on how to report suspected fraud or abuse.
  - 3.1.2.1.8.8. Any other content required by the Colorado Medicaid Managed Care Grievance and Appeals Process.
  - 3.1.2.1.8.9. How to access auxiliary aids and services, including additional information in alternative formats or languages.
  - 3.1.2.1.8.10. How to exercise an advanced directive
- 3.1.2.2. **Grievance Process**
  - 3.1.2.2.1. The Contractor shall establish and maintain a Grievance process through which Members may express dissatisfaction about any matter related to this Contract other than an adverse benefit determination.
  - 3.1.2.2.2. The Contractor shall ensure that information about the Grievance process, including how to file a Grievance, is available to all Members and is given to all providers and subcontractors.
  - 3.1.2.2.3. The Contractor shall allow a Member to file a Grievance either orally or in writing at any time and shall acknowledge receiving the Grievance.
  - 3.1.2.2.4. The Contractor shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making nor were a subordinate of anyone who was. The decision maker shall be a health care professional with clinical expertise in treating the Member’s condition or disease for any Grievance or Appeal involving:
    - 3.1.2.2.4.1. A grievance regarding a denial of expedited resolution of an appeal.
    - 3.1.2.2.4.2. A grievance involving clinical issues.
    - 3.1.2.2.4.3. A Member appealing a denial that is based on lack of medical necessity.
  - 3.1.2.2.5. The Contractor shall ensure that decision makers on Grievance and Appeals of Adverse Benefit Determinations take into account all comments, documents, records, and other information submitted by the enrollee of their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
  - 3.1.2.2.6. 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.

- 3.1.2.2.7. 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 is final.
- 3.1.2.2.8. The Contractor shall document problems a Network Provider submits to the Contractor, and the solutions the Contractor has offered to the provider. The Department may review any of the documented solutions. If the Department determines the solution to be insufficient or otherwise unacceptable, it may direct the Contractor to find a different solution or follow a specific course of action.
  - 3.1.2.2.8.1. If the Department is contacted by a Member, family members or caregivers of a Member, advocates, the Ombudsman for Medicaid Managed Care, and other individuals/entities with a Grievance regarding concerns about the care or lack of care a Member is receiving, the Contractor shall address all issues as soon as possible after the Department has informed the Contractor of the concerns. The Contractor shall keep the Department informed about progress on resolving concerns in real time, and shall advise the Department of final resolution.
- 3.1.2.3. Notice of Adverse Benefit Determination
  - 3.1.2.3.1. If the Contractor denies coverage of or payment for a Covered Service to a Member, the Contractor shall send the Member a notice of adverse benefit determination approved by the Department that meets the following requirements:
    - 3.1.2.3.1.1. Is in writing.
    - 3.1.2.3.1.2. Is available in the state-established prevalent non-English languages in its region.
    - 3.1.2.3.1.3. Is available in alternative formats for persons with special needs.
    - 3.1.2.3.1.4. Is in an easily understood language and format.
    - 3.1.2.3.1.5. Explains the adverse benefit determination the Contractor or its subcontractor has taken or intends to take.
    - 3.1.2.3.1.6. Explains the reasons for the adverse benefit determination, including the right of the Member to be provided with reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination upon request and free of charge.
    - 3.1.2.3.1.7. Provides information about the Member's right to file an Appeal, or the Provider's right to file an Appeal when the Provider is acting on behalf of the Member as the Member's designated representative.
    - 3.1.2.3.1.8. Explains the Member's right to request a State Fair Hearing.
    - 3.1.2.3.1.9. Describes the procedures for the Member to exercise their Appeal or Grievance rights.
    - 3.1.2.3.1.10. Describes the circumstances under which expedited resolution of an Appeal is available and how to request it.
    - 3.1.2.3.1.11. Explains the Member's right 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 continued services.
    - 3.1.2.3.1.12. A member's right to the appeals process available under the CMHTA, when applicable.
  - 3.1.2.3.2. The Contractor shall give notice according to the following schedule:



- 3.1.2.3.2.1. At least ten (10) days before the date of action, if the adverse benefit determination is a termination, suspension or reduction of previously authorized Medicaid-covered services.
- 3.1.2.3.2.2. As few as five (5) days prior to the date of adverse benefit determination if the Contractor has verified information indicating probable beneficiary fraud.
- 3.1.2.3.2.3. By the date of adverse benefit determination when any of the following occur:
  - 3.1.2.3.2.3.1. The recipient has died.
  - 3.1.2.3.2.3.2. The Member submits a signed written statement requesting service termination.
  - 3.1.2.3.2.3.3. The Member submits a signed written statement including information that requires termination or reduction and indicates that the Member understands that service termination or reduction will occur.
  - 3.1.2.3.2.3.4. The Member has been admitted to an institution in which the Member is ineligible for Medicaid services.
  - 3.1.2.3.2.3.5. The Member's address is determined unknown based on returned mail with no forwarding address.
  - 3.1.2.3.2.3.6. The Member is accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.
  - 3.1.2.3.2.3.7. A change in the level of medical care is prescribed by the Member's physician.
  - 3.1.2.3.2.3.8. The notice involves an adverse determination with regard to preadmission screening requirements.
  - 3.1.2.3.2.3.9. The transfer or discharge from a facility will occur in an expedited fashion.
- 3.1.2.3.2.4. On the date of adverse benefit determination when the adverse benefit determination is a denial of payment.
- 3.1.2.3.2.5. As expeditiously as the Member's health condition requires, within ten (10) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.
  - 3.1.2.3.2.5.1. The Contractor may extend the ten (10) calendar day service authorization notice timeframe of up to fourteen (14) additional days if the Member or the Provider requests extension; or if the Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.
  - 3.1.2.3.2.5.2. If the Contractor extends the ten (10) day service authorization notice timeframe, it must give the Member written notice of the reason for the extension and inform the Member of the right to file a Grievance if he/she disagrees with the decision.
- 3.1.2.3.2.6. On the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.
- 3.1.2.3.2.7. For cases in which a Provider, or the Contractor, determine that following the standard authorization timeframe could seriously jeopardize the Member's life or health or his/her ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

- 3.1.2.3.2.7.1. The Contractor may extend the seventy-two (72) hour expedited service authorization decision time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest.
- 3.1.2.3.2.8. 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.
- 3.1.2.4. Appeal Process
  - 3.1.2.4.1. A Member's request for a review of any action, taken by the Contractor in relation to that Member, shall be considered an appeal.
    - 3.1.2.4.1.1. The Contractor shall allow Members, Providers acting on behalf of a member and with the Member's written consent, or a Designated Client Representative, to file an appeal within sixty (60) days from the date of the Contractor's notice of adverse benefit determination.
    - 3.1.2.4.1.2. 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, unless an expedited appeal is requested.
    - 3.1.2.4.2. 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.
    - 3.1.2.4.3. The Contractor shall resolve each Appeal and provide notice as expeditiously as the Member's health condition requests, and not to exceed ten (10) working days from the day the Contractor receives the appeal.
      - 3.1.2.4.3.1. The Contractor may extend the timeframe for processing an Appeal by up to fourteen (14) calendar days if the Member requests; or the Contractor shows that there is a need for additional information and that the delay is in the Member's best interest, upon state request.
      - 3.1.2.4.3.2. The Contractor shall provide the Member with written notice within two (2) calendar days of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member.
    - 3.1.2.4.4. When conducting an appeal, the Contractor shall:
      - 3.1.2.4.4.1. Ensure that oral inquires seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Member or the Provider requests expedited resolution
      - 3.1.2.4.4.2. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.
      - 3.1.2.4.4.3. 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.

- 3.1.2.4.4.4. Consider the Member, the Member's representative or the estate representative of a deceased Member as parties to the appeal.
- 3.1.2.4.5. The Contractor shall ensure that decision makers on appeals were not involved in previous levels of review or decision-making.
  - 3.1.2.4.5.1. 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:
    - 3.1.2.4.5.1.1. A denial appeal based on lack of medical necessity.
    - 3.1.2.4.5.1.2. Any appeal involving clinical issues.
- 3.1.2.4.6. The Contractor shall provide written notice of the disposition of the appeal and shall make reasonable efforts to provide the Member oral notice of this disposition. The notice shall include:
  - 3.1.2.4.6.1. The results and data of the Appeal resolution.
  - 3.1.2.4.6.2. For Appeal decisions not wholly in the Member's favor, the Contractor shall include the following:
    - 3.1.2.4.6.2.1. Right to request a State Fair Hearing,
    - 3.1.2.4.6.2.2. How to request a State Fair Hearing,
    - 3.1.2.4.6.2.3. The right to continue to receive benefits pending a hearing,
    - 3.1.2.4.6.2.4. How to request the continuation of benefits, and
    - 3.1.2.4.6.2.5. Notice that the Member may be liable for the cost of any continued benefits if the Contractor's adverse benefit determination is upheld in the hearing.
- 3.1.2.5. Expedited Appeals Process
  - 3.1.2.5.1. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines - for a request from the Member - or when the provider indicates, in making the request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
  - 3.1.2.5.2. 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.
  - 3.1.2.5.3. 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.
  - 3.1.2.5.4. 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).
    - 3.1.2.5.4.1. If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the standard timeframe for appeal resolution and give the Member prompt oral notice of the denial and a written notice within two (2) calendar days of receiving the request for expedited resolution.
    - 3.1.2.5.4.2. The Contractor shall resolve each expedited Appeal and provide notice as expeditiously as the Member's health condition requires, within seventy-two (72)

hours after the Contractor receives the expedited Appeal request.

- 3.1.2.5.4.3. The Contractor may extend timeframe for processing an expedited Appeal by up to fourteen (14) calendar days if the Member requests the extension; or the Contractor shows that there is need for additional information and that the delay is in the Member's best interest.
- 3.1.2.5.4.4. The Contractor shall provide the Member with written notice within two (2) calendar days of the reason for any extension to the timeframe for processing an expedited Appeal that is not requested by the Member.
- 3.1.2.5.4.5. The Contractor shall provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited Appeal.
- 3.1.2.5.5. 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.
- 3.1.2.6. Continuation of Benefits and Services During an Appeal
  - 3.1.2.6.1. The Contractor shall continue the Member's benefits while an appeal is in the process if all of the following are met:
    - 3.1.2.6.1.1. The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice.
    - 3.1.2.6.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
    - 3.1.2.6.1.3. The Member's services were ordered by an authorized Provider;
    - 3.1.2.6.1.4. The authorization period has not expired; and
    - 3.1.2.6.1.5. The Member requests continuation of benefits:
      - 3.1.2.6.1.5.1. Within ten (10) calendar days of the Contractor sending the notice of adverse benefit determination, or
      - 3.1.2.6.1.5.2. On or before the intended effective date of the Contractor's proposed adverse benefit determination.
  - 3.1.2.6.2. 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:
    - 3.1.2.6.2.1. The Member withdraws the request for the appeal or state fair hearing.
    - 3.1.2.6.2.2. The Member does not request a State Fair Hearing with continuation of benefits within ten (10) days from the date the Contractor mails an adverse Appeal decision.
    - 3.1.2.6.2.3. A State Fair Hearing decision adverse to the Member is made.
    - 3.1.2.6.2.4. The service authorization expires or the authorization limits are met.
  - 3.1.2.6.3. The Contractor may recover the cost of the continued services furnished to the Member while the appeal was pending if the final resolution of the appeal upholds the Contractor's adverse benefit determination.
  - 3.1.2.6.4. If the Contractor or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor shall

authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date of notice reversing the determination.

3.1.2.6.5. If the Contractor or State Fair Hearing Officer reverses a decision to deny authorization of the services, the Contractor shall pay for disputed services received by the Member while the appeal was pending, unless State policy and regulations provide for the State to cover the cost of such services.

3.1.2.6.6. The Contractor shall notify the requesting Provider and give the Member written notice 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.

3.1.2.7. State Fair Hearing

3.1.2.7.1. The Contractor shall allow a Member to request a State Fair Hearing. The Member must exhaust the Contractor Appeal process before requesting a State Fair Hearing. The Member has one hundred twenty (120) calendar days from the date of a notice of an adverse Appeal resolution to request a State Fair Hearing. The parties to the State Fair Hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.

3.1.2.7.2. If the Contractor does not adhere to the notice and timing requirements regarding a Member's Appeal, the Member is deemed to have exhausted the Appeal process and may request a State Fair Hearing.

3.1.2.7.3. The parties to the State Fair Hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.

3.1.2.7.4. The State's standard timeframe for reaching its decision on a state fair hearing request is within ninety (90) days of the date the Member filed the appeal with the Contractor if the Member filed initially with the Contractor, excluding the days the Member took to subsequently file for a State Fair Hearing, or the date the Member filed for direct access to a State Fair Hearing.

3.1.2.7.5. The Contractor shall participate in all State Fair Hearings regarding Appeals and other matters arising under this contract.

3.1.2.8. Expedited State Fair Hearing

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

3.1.2.8.1.1. Meets the criteria for an expedited appeal process but was not resolved with the Contractor's expedited appeal timeframes; or

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

3.1.2.9. Recordkeeping Process for Grievances and Appeals

3.1.2.9.1. The Contractor must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and

revisions to the Department's quality strategy.

- 3.1.2.9.2. The record of each grievance or appeal must contain, at a minimum, all of the following information:
  - 3.1.2.9.2.1. A general description of the reason for the appeal or grievance.
  - 3.1.2.9.2.2. The date received.
  - 3.1.2.9.2.3. The date of each review or, if applicable, review meeting.
  - 3.1.2.9.2.4. Resolution at each level of the appeal or grievance, if applicable.
  - 3.1.2.9.2.5. Date of resolution at each level, if applicable.
  - 3.1.2.9.2.6. Name of covered person for whom the appeal or grievance was filed.
- 3.1.2.9.3. The Contractor must accurately maintain the record in a manner accessible to the Department and available upon request to CMS.

### 3.1.3. Patient Confidentiality

- 3.1.3.1. The 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 a minor's parent or guardian, 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.
- 3.1.3.2. The Contractor shall maintain or make provisions for the maintenance of a Medical Record for each Member according to state and federal laws and regulations. The Medical Record shall accurately represent the full extent of care provided to the Member. The record shall include, at a minimum, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed under this contract. 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.
- 3.1.3.3. The Contractor shall conform to the requirements of 45 C.F.R Section 205.50, as amended, Section 10-16-423, C.R.S., as amended, 45 C.F.R. Sections 160 and 164, as amended, and

42 C.F.R Sections 431.304 - 431.307, as amended, regarding confidentiality of health information about any Member for Covered Services hereunder.

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

#### 3.1.4. Marketing

3.1.4.1. The Contractor shall not distribute any Marketing Materials without first obtaining the Department's approval which shall include a review by a medical care advisory committee. The Department shall inform the Contractor of its decision on the materials, within three (3) Business Days of the medical care advisory committee's review. This includes materials that are produced in any medium, by or on behalf of the Contractor, which can reasonably be interpreted as intended to market to potential Members. All materials, including the Contractor's Member handbook, shall be submitted to the Department at least thirty (30) calendar days prior to the targeted release date.

3.1.4.2. The Contractor shall assure the Department, in writing, upon submission of any written material for the Department's approval that any marketing plans and materials are accurate and do not mislead, confuse or defraud the Clients, Members or the Department.

3.1.4.3. The Contractor's written materials or oral presentations shall not contain any assertion that the Client must Enroll in the Contractor's Plan or any other Managed Care Organization in order to obtain benefits or in order not to lose benefits.

3.1.4.4. The Contractor's written materials or oral presentations shall not contain any assertion that the Contractor's Plan is endorsed by the Centers for Medicare and Medicaid Services, the federal or state government or similar entity.

3.1.4.5. The Contractor shall not, directly or indirectly, engage in door-to-door, telephone, or cold-call marketing activities. Cold call marketing includes any unsolicited personal contact by the Contractor, its Subcontractors or Participating Providers with a potential Member for the purpose of marketing as defined at 42 C.F.R. Section 438.104(a).

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

3.1.4.7. Should the Contractor distribute Marketing Materials, it shall distribute the materials to its entire Service Area.

3.1.4.8. Any final copy of written education materials developed by the Department, which describes the Contractor or the Contractor's Plan, shall be submitted to the Contractor at least ten (10) Business Days prior to the release.

### 3.2. PROVIDER ISSUES

#### 3.2.1. Licensure and Credentialing

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

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

3.2.1.2.1. The Contractor shall require that each physician providing services to enrollees have a standard unique health modifier.

- 3.2.1.3. 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.
- 3.2.1.4. 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.
- 3.2.1.5. 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. Those laboratories with Certificates of Waiver will provide only the nine (9) types of tests permitted under the terms of the Waiver. Laboratories with Certificates of Registration may perform a full range of laboratory tests.
- 3.2.1.6. 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.
- 3.2.1.7. The Contractor shall not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
- 3.2.1.8. The Contractor shall comply with any additional requirements established by the State.
- 3.2.2. **Provider Insurance**
  - 3.2.2.1. 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:
    - 3.2.2.1.1. Physicians participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars (\$500,000.00) per incident and one million five-hundred thousand dollars (\$1,500,000.00) in aggregate per year.
    - 3.2.2.1.2. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars (\$500,000.00) per incident and three million dollars (\$3,000,000.00) in aggregate per year.
    - 3.2.2.1.3. Sections 3.2.2.1.1 and 3.2.2.1.2 shall not apply to Physicians and facilities in the Contractor's network which meet any of the following requirements:
      - 3.2.2.1.3.1. 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.
      - 3.2.2.1.3.2. 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.
    - 3.2.2.1.4. 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.
- 3.2.3. **Provider Quality of Care Issues**



- 3.2.3.1. For alleged quality of care concerns involving Physician 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.
- 3.2.4. **Provider Incentive Plans**
  - 3.2.4.1. No specific payment can be made directly or indirectly under a Provider incentive plan to a Provider as an inducement to reduce or limit Medically Necessary services furnished to a Member.
  - 3.2.4.2. The Contractor shall disclose to the Department or any Member or Member's Designated Client Representative, at the Department's request, information on any Provider incentive plan.
  - 3.2.4.3. The Contractor shall ensure that agreements containing Physician incentives comply with 42 C.F.R. Section 438.6, as described in Exhibit G, Requirements for Physician Incentive Plans, attached and incorporated herein by reference. Please see 42 C.F.R. Section 438.6 for the current version of the regulations.
- 3.2.5. **Program Integrity**
  - 3.2.5.1. The Contractor shall disclose information on individuals or corporations with an ownership or control interest in the Contractor to the State at the following times:
    - 3.2.5.1.1. When the Contractor submits a proposal in accordance with the State's procurement process.
    - 3.2.5.1.2. Upon the managed care organization executing the contract with the State.
    - 3.2.5.1.3. Upon renewal or extension of the contract.
    - 3.2.5.1.4. Within 35 days after any change in ownership of the Contractor.
  - 3.2.5.2. The Contractor shall report to the National Practitioner Data Bank and to the appropriate state regulatory board 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.
  - 3.2.5.3. The Contractor shall establish and maintain a compliance program designed to prevent, detect investigate and report fraud, waste and abuse.
  - 3.2.5.4. The Contractor shall implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
  - 3.2.5.5. 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:
    - 3.2.5.5.1. Provisions for internal monitoring and auditing of compliance risks.
    - 3.2.5.5.2. Provisions for prompt response to detected compliance offenses as they are raised, and for development of corrective action initiatives.
    - 3.2.5.5.3. Provisions for monitoring Members for improper prescriptions for controlled substances,

inappropriate emergency care or card-sharing.

- 3.2.5.5.4. Effective processes to screen all Provider claims, collectively and individually, for potential fraud, waste or abuse.
- 3.2.5.5.5. Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste and abuse.
- 3.2.5.5.6. 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.
- 3.2.5.5.7. Effective processes to ensure that covered services billed by network providers were received by clients and that the services received match the billing codes/descriptions.
- 3.2.5.6. The Contractor shall establish and maintain a Regulatory Compliance Committee on the Board of Directors accountable to the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this contract.
- 3.2.5.7. The Contractor, its providers and subcontractors, are subject to the False Claims Act, §§ 3729 through 3733 of Title 31, United States Code.
- 3.2.5.8. The Contractor shall establish written policies for employees, within thirty (30) days of the effective date of this contract, requiring all employees to be informed of and detailing compliance with:
  - 3.2.5.8.1. The False Claims Act, 31 USC §§ 3729, et seq.
  - 3.2.5.8.2. Administrative remedies for false claims and statements.
  - 3.2.5.8.3. State laws relating to civil or criminal penalties for false claims and statements. if any.
  - 3.2.5.8.4. Whistleblower protections under such laws.
- 3.2.5.9. The Contractor shall establish a process for training existing and new employees on the compliance program and on the items in Sections 3.2.5.6.1 through 3.2.5.6.4 above. All training shall be conducted in such a manner that it can be verified by the Department.
  - 3.2.5.9.1. Employee Education About False Claims
    - 3.2.5.9.1.1. In accordance with 42 U.S.C. 1396a(a)(68), the Contractor shall establish written policies for all employees (including management) and for any contractor or agent that include detailed information about the False Claims Act, 31 USC §§ 3729, et seq., administrative remedies for false claims and statements established under chapter 38 or title 31, United States Code, the Colorado Medicaid False Claims Act, Section 25.5-4-304 C.R.S. et seq., detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse, whistleblower protections and the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs.
    - 3.2.5.9.1.2. The Contractor shall provide upon request by the Department written assurances and submit its written policies and procedures. The written assurances are:
      - 3.2.5.9.1.2.1. The Contractor has the policy and procedures required by 42 U.S.C. 1396a(a)(68).
      - 3.2.5.9.1.2.2. The Contractor has incorporated language required by statute into the employee

handbook, if one exists.

- 3.2.5.9.1.2.3. The policy and procedures have been disseminated to all employees including management and employees of any contractor or agent.
- 3.2.5.9.1.2.4. The Contractor understands that failure to comply within thirty (30) calendar days from the date of the request by the Department for assurances and submissions may result in suspension or termination.
- 3.2.5.9.1.2.5. DELIVERABLE: Written assurances, policies and procedures and employee handbook, if one exists.
- 3.2.5.9.1.2.6. DUE: Annually, within thirty (30) days of the date of written request by the Department's Program Integrity Section.
- 3.2.5.10. The Contractor shall have effective lines of communication between the compliance officer and the Contractor's employees for reporting violations.
- 3.2.5.11. The Contractor shall enforce its compliance program through well-publicized disciplinary guidelines.
- 3.2.5.12. The Contractor shall immediately report known confirmed intentional incidents of fraud and abuse to the Department's contract manager and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU).
- 3.2.5.13. The Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department's contract manager. The Contractor shall investigate its suspicions and shall submit its written findings and concerns to the contract manager within three (3) Business Days of the verbal report. If the investigation is not complete in three (3) Business Days, the Contractor shall continue to investigate. A final report shall be submitted within fifteen (15) Business Days of the verbal report. The contract manager may approve an extension of time in which to complete the final report upon a showing of good cause.
- 3.2.5.14. The Contractor shall not knowingly have a relationship of the type described below and specified in 42 CFR 438.610 with the following:
  - 3.2.5.14.1. 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.
    - 3.2.5.14.1.1. If the State finds 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 State: (1) must notify the Secretary of the noncompliance; (2) may continue an existing agreement with the Contractor unless the Secretary directs otherwise; and (3) may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.
  - 3.2.5.14.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in II.F.5.m.1. This section applies to the following types of individuals:
    - 3.2.5.14.2.1. A director, officer, subcontractor, or partner of the Contractor.
    - 3.2.5.14.2.2. A person with beneficial ownership of five (5) percent or more of the Contractor's

equity.

- 3.2.5.14.2.3. A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the Department.
- 3.2.5.14.3. For all providers who do not have an independent Medicaid provider identification number, Contractor will comply with and perform all of the State's obligations identified in State Medicaid Director Letter #08-003, dated June 12, 2008, and State Medicaid Director Letter #09-001, dated January 16, 2009 (collectively, Letters) provided by the Department.
- 3.2.5.14.4. The Contractor shall provide a list of excluded providers to the Department on a monthly basis.
- 3.2.5.15. The Contractor shall suspend payments to any network provider that is actively under investigation for a credible fraud allegation. The State 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.
- 3.2.5.16. The Contractor acknowledges that the State may suspend capitation payments to Medicaid managed care organizations should the managed care organization be actively under investigation for credible fraud allegations. Accordingly, if the State 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 managed care organization.
- 3.2.6. Pharmacy Providers
  - 3.2.6.1. 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, Section 8.205.8. The Contractor may limit pharmacy Providers to its owned and operated pharmacies so long as the limitation does not adversely affect the delivery of pharmaceutical products in nursing facilities as required by 10 C.C.R. 2505-10, Section 8.205.8.A and B. All subcontracts with pharmacy Providers shall be subject to all standards set forth in this Contract.
- 3.2.7. Advance Directives
  - 3.2.7.1. Advance Directives are defined in 42 C.F.R. Section 489.100, and Section 15-14-505(2), C.R.S.
  - 3.2.7.2. The Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all adult individuals receiving medical care by or through the Contractor, as provided in 42 C.F.R. Section 489.
  - 3.2.7.3. The Contractor shall provide written information to those individuals with respect to the following:
    - 3.2.7.3.1. Their rights under the law of the state.
    - 3.2.7.3.2. 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.
    - 3.2.7.3.3. The 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.

3.2.7.4. 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.

3.2.7.5. The Contractor shall educate staff concerning its policies and procedures on advance directives.

3.2.8. Prompt Payment of Claims

3.2.8.1. The Contractor shall promptly pay claims submitted by Providers, consistent with the claims payment procedures as required by §10-16-106.5, C.R.S., as amended.

3.2.8.2. The Contractor shall meet the requirements of FFS timely payment, including paying ninety (90) percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt, and paying ninety-nine (99) percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt.

3.2.8.3. 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 payment is the date of the check or other form of payment.

3.2.9. Termination of Participating Provider Agreements

3.2.9.1. 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.

3.2.9.2. The Contractor shall make a reasonable effort to provide written notice of the termination of Participating Provider agreements to Members. This shall occur within fifteen (15) calendar days after receipt, issuance of, or notice of such termination to all Members receiving Covered Services on a regular basis from or through a Provider whose agreement is terminating with the Contractor, regardless of whether the termination is for cause or without cause. Where a termination involves a Primary Care Physician, all Members that receive Covered Services through that Primary Care Physician shall also be notified. Such notice shall describe how services provided by the Participating Provider will be replaced, and inform the Members of Disenrollment procedures. The Contractor shall allow Members to continue receiving care for sixty (60) calendar days from the date a Participating Provider is terminated without cause when proper notice as specified in this section has not been provided to the Members.

3.2.10. Incentive to Members

3.2.10.1. The Contractor and Participating Providers are prohibited 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.

### **3.2.11. Provider Applications**

- 3.2.11.1. 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:**
  - 3.2.11.1.1. Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members.**
  - 3.2.11.1.2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.**
  - 3.2.11.1.3. 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.**
- 3.2.12. The Contractor shall monitor Covered Services rendered by Participating Providers for quality, appropriateness and patient outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting, and other applicable provisions of this contract.**

## **SECTION 4.0 REIMBURSEMENT**

### **4.1. PAYMENT OF MONTHLY PAYMENT RATE**

- 4.1.1. For each Member Enrolled with the Contractor, the Department will pay the Contractor the Monthly Payment Rate specified in Exhibit B.**
- 4.1.2. The Department will remit payment of the Monthly Payment Rate to the Contractor, on or before the twentieth (20th) business day of each month.**
- 4.1.3. The Contractor shall receive and retain capitation payments only for Medicaid-eligible enrollees.**
- 4.1.4. The Department will remit to the Contractor a prorated Monthly Capitation Rate for any Member whose enrollment begins after the first (1st) of the month, including Members retroactively enrolled and newborns, based on the Rates as specified in Exhibit B. The prorated Monthly Capitation Rate is calculated by the MMIS. The MMIS converts the Monthly Capitation Rate into a per diem rate by dividing the Monthly Capitation Rate by the number of days in the month. The Contractor is reimbursed by the MMIS for the number of days that the Member is enrolled in the month.**
- 4.1.5. The Department will remit payment through an electronic transfer of funds to the bank account designated by the Contractor. The Department will provide the Contractor with a monthly payment report through the MMIS.**
- 4.1.6. The Contractor shall be responsible for the accuracy of direct deposit information provided to the Department and for updating such information as needed.**
- 4.1.7. The Monthly Payment Rate shall be considered payment in full for all Covered Services set forth in Exhibit D.**
- 4.1.8. The Department will provide the Contractor with capitation claim payment information through the following codes:**

4.1.8.1. Payroll Deducted and Other Group Premium Payment for Insurance Products Transactions (ANSI X 12N 820) for capitation.

4.1.8.2. Health Care Claim Payment/Advice (835).

## 4.2. CALCULATION OF MONTHLY PAYMENT RATE

4.2.1. The State will pay the Contractor capitation rates effective July 1, 2017 – June 30, 2018. The capitation rates for this time period are appropriately certified by a qualified actuary. The rate table is part of and incorporated herein as Exhibit B.

4.2.2. 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.

4.2.2.1. The Department retains the discretion to select a payment rate within the actuarially sound rate range based on performance and timeliness of deliverables in this Contract.

4.2.3. Medical Loss Ratio (MLR)

4.2.3.1. MLR Calculation

4.2.3.1.1. The MLR will be calculated according to the instructions provided on the MLR template and the guidance provided in 42 CFR §438.8(a).

4.2.3.1.2. All data provided by the Contractor for the purposes of MLR calculation shall use actual costs.

4.2.3.1.2.1. The first annual measurement period began upon execution of the FY 16-17 Contract and ended on June 30, 2017.

4.2.3.1.2.2. Subsequent annual measurement periods will align with the state fiscal year; beginning on July 1, and ending on June 30 of the subsequent calendar year.

4.2.3.1.2.3. The Contractor will allow for three (3) months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five (5) months.

4.2.3.1.2.4. The Contractor shall calculate the Medical Loss Ratio (MLR) for its expansion and non-expansion clients separately.

4.2.3.1.2.5. The Contractor must submit the calculated internally certified MLR template along with supporting data and documentation, including, but not limited to, all encounters, financial information and reporting, and flat files for the measurement period, before the Department can validate the submitted MLR for the Contractor. The submission date is March 1, 2018. See Section 2.6.7. Encounter Claims Data Provisions and the Medical Loss Ratio (MLR) Calculation Template, as provided by the Department.

4.2.3.1.2.5.1. The Contractor must submit the externally certified financial template to the Department by May 1, 2018, based on the requirements provided by the Department.

4.2.3.1.2.5.2. The MLR reporting process shall comply with the CMS' two-year timely filing requirement in 45 CFR 95.7. If the Department does not receive the above listed deliverables in Section 4.2.3.1.2.5. within one and a half years after the calendar quarter in which the underlying claims for the deliverables were incurred, the Department shall thereafter process the reporting on a quarterly basis.

4.2.3.1.2.6. The Contractor's Medical Spend and audited supplemental data provided in the

Contractor's annual financial reporting will be verified using encounter data submitted through flat file submissions on a secure server, until such time that the Department deems it appropriate for such encounter data submissions to be sent through the State's Colorado interChange.

- 4.2.3.1.2.7. MLR Target: The Contractor shall have a Medical Loss Ratio (MLR) of eighty-five percent (85%). The Contractor will calculate a cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department in Appendix X.
- 4.2.3.1.2.8. The MLR is 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%.
- 4.2.3.1.2.9. 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:
  - 4.2.3.1.2.9.1. Reimbursement amount shall equal the total amount of capitations payments received by the Contractor multiplied by the difference between the Contractor's MLR and the Adjusted MLR Target.
  - 4.2.3.1.2.9.2. The Contractor shall reimburse the Department within thirty (30) days of the Department finalizing the MLR validation. 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.
- 4.2.3.1.3. The MLR will be calculated as the ratio of the numerator (as defined below) to the denominator (as defined below).
  - 4.2.3.1.3.1. The numerator is the sum of the Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's fraud reduction activities.
    - 4.2.3.1.3.1.1. Incurred claims must include the following:
      - 4.2.3.1.3.1.1.1. Direct claims that Contractor paid to external providers and the cost of internal staff for services or supplies covered under the contract and services meeting the requirements of 42 CFR 438.3(e) provided to enrollees.
      - 4.2.3.1.3.1.1.2. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.
      - 4.2.3.1.3.1.1.3. Withholds from payments made to network providers.
      - 4.2.3.1.3.1.1.4. Claims that are recoverable for anticipated coordination of benefits.
      - 4.2.3.1.3.1.1.5. Claims payments recoveries received as a result of subrogation.
      - 4.2.3.1.3.1.1.6. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.
      - 4.2.3.1.3.1.1.7. Changes in other claims-related reserves.



- 4.2.3.1.3.1.1.8. Reserves for contingent benefits and the medical claims portion of lawsuits.
- 4.2.3.1.3.1.2. Amounts that must be deducted from incurred claims include the following:
  - 4.2.3.1.3.1.2.1. Overpayment recoveries received from network providers.
  - 4.2.3.1.3.1.2.2. Prescription drug rebates received and accrued.
- 4.2.3.1.3.1.3. Expenditures that must be included in incurred claims include the following:
  - 4.2.3.1.3.1.3.1. The amount of incentive and bonus payments made, or expected to be made, to network providers.
  - 4.2.3.1.3.1.3.2. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses.
- 4.2.3.1.3.1.4. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.
- 4.2.3.1.3.1.5. Amounts that must be excluded from incurred claims:
  - 4.2.3.1.3.1.5.1. Non-claims costs. Those expenses for administrative services that are not: Incurred claims as defined in section 4.2.3.1.3.1.1.; expenditures on activities that improve health care quality, as defined in section 4.2.3.1.3.1.5.6. or licensing and regulatory fees, or Federal and State taxes, as defined in section 4.2.3.2.
    - 4.2.3.1.3.1.5.2. Non-claims costs include the following:
      - 4.2.3.1.3.1.5.2.1. Amounts paid to third party vendors for secondary network savings.
      - 4.2.3.1.3.1.5.2.2. Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.
      - 4.2.3.1.3.1.5.2.3. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 CFR 438.3(e) and provided to an enrollee.
      - 4.2.3.1.3.1.5.2.4. Fines and penalties assessed by regulatory authorities.
    - 4.2.3.1.3.1.5.3. Amounts paid to the Department as remittance under section 42 CFR 438.8(j).
    - 4.2.3.1.3.1.5.4. Amounts paid to network providers under 42 CFR 438.6(d).
    - 4.2.3.1.3.1.5.5. Incurred claims paid by the Contractor that are later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the Contractor.
  - 4.2.3.1.3.1.5.6. Activities that improves health care quality must be in one of the following categories:
    - 4.2.3.1.3.1.5.6.1. Activities that meet the requirements of 45 CFR 158.150(b), and are not excluded under 45 CFR 158.150(c)
    - 4.2.3.1.3.1.5.6.2. Activities related to any EQR-related activity as described in CFR 438.358(b) and (c).

- 4.2.3.1.3.1.5.6.3. Any expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in section 4.2.3.1.3.1.1.
- 4.2.3.1.3.1.5.7. Expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in section 4.2.3.1.3.1.3.2.
- 4.2.3.2. Denominator
  - 4.2.3.2.1. The denominator of the Contractor's MLR for a MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the Contractor's premium revenue (as defined below) minus the Contractor's Federal, State, and local taxes and licensing and regulatory fees (as defined below) and is aggregated in accordance with 42 CFR 438.8(i).
  - 4.2.3.2.2. Premium revenue includes the following for the MLR reporting year:
    - 4.2.3.2.2.1. State capitation payments, developed in accordance with 42 CFR 438.4, to the Contractor for all enrollees under a risk contract approved under 42 CFR 438.3(a), excluding payments made under to 42 CFR 428.6(d).
    - 4.2.3.2.2.2. State-developed one time payments, for specific life events of enrollees.
    - 4.2.3.2.2.3. Other payments to the Contractor approved under 42 CFR 438.6(b)(3).
    - 4.2.3.2.2.4. Unpaid cost-sharing amounts that the Contractor could have collected from enrollees under the contract, except those amounts the Contractor can show it made a reasonable, but unsuccessful, effort to collect.
    - 4.2.3.2.2.5. All Changes to unearned premium reserves.
    - 4.2.3.2.2.6. Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 CFR 438.5 or 438.6
  - 4.2.3.2.3. Federal, State, and local taxes and licensing and regulatory fees for the MLR reporting year include:
    - 4.2.3.2.3.1. Statutory assessments to defray the operating expenses of any State or Federal department.
    - 4.2.3.2.3.2. Examination fees in lieu of premium taxes as specified by State law.
    - 4.2.3.2.3.3. Federal taxes and assessments allocated to the Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.
  - 4.2.3.2.4. State and local taxes and assessments including:
    - 4.2.3.2.4.1. Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
    - 4.2.3.2.4.2. Guaranty fund assessments.
    - 4.2.3.2.4.3. Assessments of State or locality industrial boards or other boards for operating expense or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

- 4.2.3.2.4.4. State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
- 4.2.3.2.4.5. State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.
- 4.2.3.2.5. Payment made by the Contractor that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:
  - 4.2.3.2.5.1. Three percent of earned premium; or
  - 4.2.3.2.5.2. The highest premium tax rate in the State for which the report is being submitted, multiplied by the Contractor's earned premium in the State
- 4.2.3.3. The total amount of the denominator for the Contractor, which is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no amount under this section for that year may be reported by the ceding entity.
- 4.2.3.4. The Department will recoup payment from the Contractor for missing the MLR target using the MLR calculation methodology as expressed above.
- 4.2.3.5. Allocation of Expense
  - 4.2.3.5.1. General
    - 4.2.3.5.1.1. The Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition or, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.
    - 4.2.3.5.1.2. The Contractor shall report expenditures that benefit multiple contracts or populations, or contracts other than those being reported, on a pro rata basis.
  - 4.2.3.5.2. Expenditures
    - 4.2.3.5.2.1. The Contractor shall ensure that expense allocations are based on a generally accepted accounting method that is expected to yield the most accurate results.
    - 4.2.3.5.2.2. The Contractor shall ensure that shared expenses, including expenses under the terms of a management contract, are apportioned pro rata to the contract incurring the expense.
    - 4.2.3.5.2.3. The Contractor shall ensure that expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, are borne solely by the reporting entity and are not apportioned to the other entities.
  - 4.2.3.5.3. Credibility Adjustment
    - 4.2.3.5.3.1. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances.
    - 4.2.3.5.3.2. The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.
    - 4.2.3.5.3.3. If the Contractor's experience is non-credible, it is presumed to meet or exceed the

MLR calculation standards.

4.2.3.5.4. Aggregation of Data

4.2.3.5.4.1. The Contractor will aggregate data for all Medicaid eligibility groups covered under this Contract.

4.2.3.5.5. Reporting Requirements

4.2.3.5.5.1. The Contractor shall submit an MLR report to for each MLR reporting year, that includes:

4.2.3.5.5.1.1. Total incurred claims.

4.2.3.5.5.1.2. Expenditures on quality improving activities.

4.2.3.5.5.1.3. Expenditures related to activities compliant with program integrity requirements.

4.2.3.5.5.1.4. Non-claims costs.

4.2.3.5.5.1.5. Premium revenue.

4.2.3.5.5.1.6. Taxes.

4.2.3.5.5.1.7. Licensing fees.

4.2.3.5.5.1.8. Regulatory fees.

4.2.3.5.5.1.9. Methodology(ies) for allocation of expenditures.

4.2.3.5.5.1.10. Any credibility adjustment applied.

4.2.3.5.5.1.11. The calculated MLR.

4.2.3.5.5.1.12. Any remittance owed to the Department, if applicable.

4.2.3.5.5.1.13. A comparison of the information reported with the audited financial report.

4.2.3.5.5.1.14. A description of the aggregation method used to calculate total incurred claims.

4.2.3.5.5.1.15. The number of member months.

4.2.3.5.5.2. The Contractor shall require any subcontractors providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

4.2.3.5.6. Recalculation of MLR

4.2.3.5.6.1. In any instance where the Department makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the Department, the Contractor shall:

4.2.3.5.6.1.1. Re-calculate the MLR for all MLR reporting years affected by the change.

4.2.3.5.6.1.2. Submit a new MLR report meeting the requirements in 42 CFR 438.8(k).

**4.2.4. Risk Corridor:**

**4.2.4.1.** As a result of the unknown risk level associated with the emerging MAGI childless adults population, the State has developed the following risk corridor as a risk-mitigation strategy:

Min	Max	MCO Share	Federal/State Share
0%	98%	50%	50%
98%	102%	100%	0%
102%	+	50%	50%

**4.2.4.2.** 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.

**4.2.4.3.** Should the risk corridor percentage calculated as above, in the aggregate be greater than one hundred two percent (102%) the Department/Federal Government shall be responsible for fifty percent (50%) of the loss that is greater than one hundred two percent (102%) of the medical portion of the total capitation rate or the Department/Federal Government shall be responsible for fifty percent (50%) of the gain that is less than ninety-eight percent (98%) of the medical portion of the total capitation rate.

**4.2.4.4.** Should the risk corridor percentage in the aggregate be greater than or equal to ninety-eight percent (98%) or less than or equal to one hundred two percent (102%), the Department/Federal Government shall have no financial responsibility.

**4.2.4.5.** To the extent that the actual experience is below an eighty five percent (85%) medical loss ratio, the Federal Government will retain all profits below that threshold. On the top end of the corridor, the Federal Government will not provide financial participation above the fee-for-service-equivalent (FFSE), which will be calculated during the risk corridor process.

**4.2.4.6.** For the risk corridor calculations, the Department will use the encounter data priced at the Medicaid fee schedule for internal DH providers and will benchmark DH's actual costs for external providers to the Medicaid fee schedule to ensure reasonable provider contracting.

**4.2.4.7.** MAGI childless adults settlement plan for the rate period from July 2017 to June 2018:

**4.2.4.7.1.** To complete the MAGI childless adults service encounter identification and collection the Contractor shall:

**4.2.4.7.1.1.** Use the capitation file to identify the MAGI childless adults clients.

**4.2.4.7.1.2.** Use the same format as the regular MCO encounters.

**4.2.4.7.1.3.** Send the data together with the quarterly MCO encounter submission.

**4.2.4.7.1.4.** The complete MAGI childless adults encounters with at least three (3) months run-out.

**4.2.4.7.1.5.** Calculate the actual rate and risk sharing amount based on the risk corridors, and capped values in May 2019.

**4.2.4.7.1.6.** Reconcile dollar amount with DHHAs by June 30th, 2019.

**4.2.4.7.1.6.1.** The risk corridor reconciliation process shall comply with CMS' two-year timely filing requirement in 45 CFR 95.7. If the Department does not receive the

Contractor's complete claims within one and a half years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, the Department shall thereafter process the reconciliation on a quarterly basis.

- 4.2.4.7.1.7. The above due dates of this Section are subject to receiving Contractor's complete, timely, and accurate encounter data.

### **4.3. THIRD PARTY PAYER LIABILITY**

- 4.3.1. 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.
- 4.3.2. The Contractor shall be responsible for collection of any third party liability. The Contractor shall submit an annual Third Party Recovery Report of all amounts recovered from third parties. The Department will remove the amount submitted in the annual Third Party Recovery Report from the calculation of the Monthly Capitation Rates
- 4.3.3. 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.
- 4.3.3.1. 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.
- 4.3.3.2. 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:
- 4.3.3.2.1. Medicaid identification number.
- 4.3.3.2.2. Member's social security number.
- 4.3.3.2.3. Member's relationship to policyholder.
- 4.3.3.2.4. Name, complete address, and telephone number of health insurer.
- 4.3.3.2.5. Policy Member identification and group numbers.
- 4.3.3.2.6. Policy Member's social security number.
- 4.3.3.2.7. Policy Member's full name, complete address and telephone number.
- 4.3.3.2.8. Daytime telephone number where Member can be reached.
- 4.3.3.3. The Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor. The Contractor, as a duly licensed hospital, shall have the lien rights provided in Article 27 of Title 38 of the

Colorado Revised Statutes.

- 4.3.3.4. 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) calendar days following the end of each quarter.
- 4.3.3.5. 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 this Contract and state and federal laws.
- 4.3.3.6. The Contractor shall not restrict access to Covered Services due to the existence of possible or actual third party liability.
- 4.3.3.7. 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.
- 4.3.3.8. 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.
- 4.3.3.9. With the exception of Section 4.3.3.10 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 the 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:
  - 4.3.3.9.1. The sum of reported third party coinsurance and/or deductible or
  - 4.3.3.9.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.
- 4.3.3.10. The Contractor shall pay, except as otherwise specified in contracts between the Contractor and Participating Providers, all applicable co-payment, 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.
- 4.3.3.11. 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.

4.3.3.12. 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.

4.3.3.13. Benefits for Members shall be coordinated with third party auto insurance.

#### **4.4. DISPROPORTIONATE SHARE HOSPITAL**

4.4.1. The Contractor shall submit data according to the specifications in Exhibit E, 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.

#### **4.5. FQHC & RURAL HEALTH CENTER (RHC) REIMBURSEMENT**

4.5.1.1. The Department provided FQHC and RHC encounter rates effective for SFY14. As the Department is transitioning into building in the FQHC/RHC APM rate into the capitation rate to eliminate additional reconciliation, these rates were applied to each FQHC and RHC visit.

4.5.2. FQHC & Rural Health encounter reimbursement:

4.5.2.1. Payments from Contractor to FQHC or RHC Facilities

4.5.2.1.1. Each FQHC or RHC has an encounter rate calculated in accordance with 10 CCR 2505-10 8.7006C.

4.5.2.1.2. The Department shall notify the Contractor of the current FQHC or RHC rates on a quarterly basis.

4.5.2.1.3. 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 Contractor shall submit information to inform the Department's quarterly accuracy audit with FQHCs and RHCs in the format indicated on the Department's website (<https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms>). 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 and the initial reimbursement amount.

4.5.2.1.4. FQHC visits are defined in 10 CCR 2505-10 8.700.1, and a RHC visit is defined in 10 CCR 2505-10 8.740.1. The alternative prospective payment system methodology is in accordance with the approved Medicaid State Plan.

4.5.2.1.5. 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 identified in



the state plan, regardless of whether or not the Contractor imposes or collects the co-payments on enrollees for each visit.

- 4.5.2.2. The encounter data for FQHC and/or RHC visits are included in the routine encounter data submission to the Department.
- 4.5.2.3. FQHC or RHC payment is included in HMO capitation rate. No further wrap payment and/or reconciliation will be performed on FQHC or RHC payment.

#### **4.6. DELIVERIES REIMBURSEMENT**

- 4.6.1. The Contractor shall receive payment for delivery services provided to Members through a supplemental payment. The payment, which is set forth in Exhibit B, includes facility and professional service costs related to the delivery and post-partum care. One payment shall be made for each delivery regardless of the number of births associated with that delivery.
- 4.6.2. In order to receive payment for deliveries, the Contractor shall submit, to the Department, a cover letter and an electronic Excel spreadsheet in the format designated by the Department. Documentation of the delivery, e.g., a claim record of delivery, must accompany the request for payment. The request for payment shall be submitted to the Department no later than one hundred and fifty (150) days following the delivery.
- 4.6.3. 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.
- 4.6.4. The Department shall adjudicate the Contractor's request for payment within thirty-five (35) days of receipt of all documentation of the delivery.

#### **4.7. ADDITIONAL REQUIREMENTS FOR REIMBURSEMENT**

- 4.7.1. 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 the Centers for Medicare and Medicaid Services (CMS) within two (2) years after the calendar quarter in which the Department made the expenditure. Therefore, if the Department is unable to file any claim(s) for an adjustment for prior year costs related to the Contractor's claims or capitation payments within two (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 paid to the Contractor for any period of time disallowed by CMS due to inadequate or inaccurate records on the part of the Contractor.
- 4.7.2. **Payments to Primary Care Physicians**
  - 4.7.2.1. 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.
    - 4.7.2.1.1. The Contractor shall pay the enhanced payment to qualified physicians for eligible primary care services and vaccine administration rendered on and after July 1, 2016 through June 30, 2017.
    - 4.7.2.1.2. 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.

- 4.7.2.1.2.1. DELIVERABLE: Documentation that physicians received the direct and full benefit of the enhanced payment
- 4.7.2.1.2.2. DUE: Within five (5) Business Days of the Department's request
- 4.7.3. The Contractor is prohibited from paying any amount expended 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:
  - 4.7.3.1. Under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2), [203].
  - 4.7.3.2. At the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 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 (after a reasonable time period after reasonable notice has been furnished to the person); or
  - 4.7.3.3. By any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments.
  - 4.7.3.4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
  - 4.7.3.5. With respect to any amount expended for roads, bridges, stadiums, or any item or service not covered under the Medicaid State Plan.
  - 4.7.3.6. For home health care services provided by an agency provides the state with a surety bond as specified in Section 1861(o)(7) of the Act.
- 4.7.4. Covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the Contractors shall be subject to the same rebate requirements as the State is subject under section 1927 and that the State shall collect such rebates from manufacturers.
- 4.7.5. The Department will ensure that no payment is made to a provider other than the Contractor for services available under the contract between the Department and the Contractor, except when these payments are specifically provided for in Title XIX of the Act, in 42 CFR, or when the

Department has adjusted the capitation rates paid under the contract, for graduate medical education.

#### **4.8. REIMBURSEMENT FOR HEPATITIS-C THERAPIES**

- 4.8.1. The Department shall reimburse the Contractor for the Therapies, described in Exhibit D, Covered Services, the lesser of the Contractor's paid amount or the fee-for-service rates.
- 4.8.2. The Contractor shall use the MMIS to submit encounter claims to the Department for all Therapies and treatments provided to Members.
- 4.8.3. 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 4.8.3 shall become effective as of October 1<sup>st</sup>, 2016, and shall terminate on the date of successful implementation of the interChange.
  - 4.8.3.1. 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.
  - 4.8.3.2. 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, pursuant to the terms of 42 CFR 447.362, 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 on the State's most current published fee schedules.
  - 4.8.3.3. 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.
  - 4.8.3.4. 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.
- 4.8.4. 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.
  - 4.8.4.1. 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, pursuant to the terms of 42 CFR 447.362, based on the lesser of the paid amounts or the fee-for-service rates present in the MMIS encounter claims on the State's most current published fee schedules.
  - 4.8.4.2. 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.

- 4.8.4.3. 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.
- 4.8.5. 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 Contractor shall submit a flat file containing any claims relating to the Therapies not previously reconciled under the above sections 2.3 and 2.4 within thirty (30) days. The Department will reconcile the submitted encounters in the MMIS against the flat files provided by the Contractor in order to ensure completeness. Any encounter claims relating to the Therapies not previously reconciled or reimbursed will be included in the following reconciliation; any claims not adjudicated in the MMIS, but found in the flat file, will not be reimbursed. The Department shall complete the reconciliation and submit the results to the Contractor no later than ninety (90) days after the close of the previous state fiscal year.
  - 4.8.5.1. 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.
  - 4.8.5.2. The Department will provide a final determination on the reconciliation results within ten (10) business days after the receipt and review of the Objection.
  - 4.8.5.3. The Department shall provide written notice of such findings based on the final determination, and if necessary, will reimburse the Contractor accordingly. The Department shall make payment of any sums owed within thirty (30) days from the date of such written notice.

## **SECTION 5.0 ADDITIONAL REQUIREMENTS**

### **5.1. REMEDIAL ACTIONS AND SANCTIONS**

- 5.1.1. The Contractor shall comply with all provisions of this contract and its amendments, if any, and shall act in good faith in the performance of the provisions of said contract. The Contractor agrees that failure to comply with the Contract provisions may result in the application of remedial actions and/or termination of this contract.
- 5.1.2. In addition to any other remedies available under this contract, and without limiting its remedies otherwise available at law, the Department may exercise the other remedial actions and intermediate sanctions, described in this section, if the Contractor substantially fails to:
  - 5.1.2.1. Provide medically necessary services that the Contractor is required to provide, under law or this contract, to a Member.
  - 5.1.2.2. Provide Medical Records and other requested documents for Non-emergency review within thirty (30) calendar days of the date of the written request as stated in Section 5.1.4.9.
  - 5.1.2.3. Satisfy the scope of work found in this contract, as determined by the results of monitoring activities or audits.
  - 5.1.2.4. Comply with the requirements for physician incentive plans, as stated in Exhibit G.
- 5.1.3. In addition to any other remedies available under this contract, and without limiting its remedies

otherwise available under law, the Department may exercise the other remedial actions and intermediate sanctions, described in this section, if the Contractor:

- 5.1.3.1. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- 5.1.3.2. Discriminates among Members on the basis of their health status or need for health care services including termination of Enrollment or refusal to reenroll a recipient, except as permitted under the Medicaid program or any other practice that would reasonably be expected to discourage Enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.
- 5.1.3.3. Misrepresents or falsifies information furnished to the Department or the Centers for Medicare and Medicaid Services.
- 5.1.3.4. Misrepresents or falsifies information furnished to Members, potential Members, or Providers.
- 5.1.3.5. Distributes directly or indirectly, through any agent or independent contractor, any Marketing Materials that have not been approved by the Department or that contain false or materially misleading information.
- 5.1.3.6. Violates any applicable requirements of sections 1903(m) or 1932 of the Social Security Act and its implementing regulations.
- 5.1.3.7. Prohibits or otherwise restricts a health care professional acting within the scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:
  - 5.1.3.7.1. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - 5.1.3.7.2. Any information the enrollee needs in order to decide among all relevant treatment options.
  - 5.1.3.7.3. The risks, benefits, and consequences of treatment or non-treatment.
  - 5.1.3.7.4. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 5.1.4. The Department may choose to impose any of the following intermediate sanctions:
  - 5.1.4.1. 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 5.1.2.1, 5.1.2.4, 5.1.3.4, and 5.1.3.5.
  - 5.1.4.2. 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 5.1.3.2 and 5.1.3.3.
  - 5.1.4.3. Civil monetary penalties to a limit of fifteen thousand dollars (\$15,000.00) for each Client the State determines was not Enrolled because of a discriminatory practice under Section 5.1.3.2., up to a limit of one hundred thousand dollars (\$100,000.00).
  - 5.1.4.4. 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 5.1.3.1.
    - 5.1.4.4.1. If the State imposes a civil monetary penalty on the Contractor for premiums or charges

in excess of the amounts permitted under the Medicaid program, the maximum amount of the penalty shall be the greater of twenty-five thousand dollars (\$25,000.00) or double the amount of the excess charges, however, the State must deduct the amount of the overcharge from the penalty and return it to the affected enrollee.

- 5.1.4.5. Imposition of temporary management, if the Contractor has repeatedly failed to meet substantive requirements 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. Enrollees will be granted the right to terminate Enrollment without cause and notify the affected enrollees of their right to terminate Enrollment.
- 5.1.4.6. Allow Members the 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 Section 5.1.3.6.
- 5.1.4.7. Suspension of all new Enrollments, after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section 5.1.3.6 until the necessary services or corrections in performance are satisfactorily completed as determined by the Department.
- 5.1.4.8. Suspension of payment for Enrollments after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section 5.1.3.6 until the necessary services or corrections in performance are satisfactorily completed as determined by the Department
- 5.1.4.8.1. Only the sanctions specified in 5.1.4.6, 5.1.4.7, and 5.1.4.8, of this section may be imposed for failure to meet any of the requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.
- 5.1.4.9. The Contractor shall be subject to the requirements and sanctions of 42 C.F.R. Section 438.730. Payment provided under this contract for new Members will be denied when and for so long as payment for these same Members is denied by the Centers for Medicare and Medicaid pursuant to 42 C.F.R. Section 438.730(e).
- 5.1.4.10. The Department may terminate this Contract and enroll the Contractor's enrollees in other MCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the Contractor has failed to do either of the following:
  - 5.1.4.10.1. Carry out the substantive terms of its contract; or
  - 5.1.4.10.2. Meet the applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.
- 5.1.5. Notice of Sanction and Pre-Termination Hearing
  - 5.1.5.1. Before imposing any of the intermediate sanctions specified in this Section 5, the State must give the affected entity timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.
  - 5.1.5.2. Before terminating any contracts with the Contractor, the State must provide the Contractor a pre-termination hearing.
  - 5.1.5.3. Prior to a pre-termination hearing, the State must provide Contractor with the following:
    - 5.1.5.3.1. Written notice of its intent to terminate, the reason for termination, and the time and place of the hearing,
    - 5.1.5.3.2. After the hearing, the State must provide the Contractor written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming

decision, the effective date of termination, and

5.1.5.3.3. For an affirming decision, give enrollees of the Contractor notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

5.1.6. Termination of Contract

5.1.6.1. After a State notifies the Contractor that it intends to terminate the Contract, the enrollees shall have the option to disenroll immediately without cause.

5.1.7. Liquidated Damages

5.1.7.1. Time is of the essence in the performance of this contract. The parties agree that the damages from breach of this contract are difficult to prove or estimate, and the amount of liquidated damages specified herein represents a reasonable estimation of damages that will be suffered by the Department from late performance, including costs of additional inspection and oversight, and lost opportunity for additional efficiencies that would have attended on-time completion of performance. Assessment of liquidated damages shall not be exclusive of or in any way limit remedies available to the Department at law or equity for Contractor's breach of contract.

5.1.7.2. If the Contractor fails to satisfactorily perform the services required under this contract, the Contractor shall, in place of actual damages, pay the Department liquidated damages as follows:

5.1.7.2.1. For each calendar day beyond the date: 1) specified in a corrective action plan approved by the Department by which Contractor compliance is to be achieved; or 2) the date that a corrective action plan is due but not submitted to the Department, the amount of three hundred dollars (\$300.00) per calendar day until the compliance is achieved or an acceptable correction action plan is submitted. If the Contractor notifies the Department that it will not be able to achieve compliance by the date specified in the corrective action plan, and explains in writing its reasonable efforts to achieve compliance, the Department may grant in writing an extension of the deadline for Contractor compliance. No more than fifteen thousand dollars (\$15,000.00) in such damages for failure to comply with corrective action plans shall be assessed during any contract year.

5.1.7.2.2. For each calendar day beyond the date that all requested documents, including but not limited to policies, procedures, reports, manuals and handbooks are required to be produced either by the contract or specified in a written request of the Department, the amount of three hundred dollars (\$300.00) per calendar day until the documents are produced. A written request of the Department will allow the Contractor a minimum of thirty (30) calendar days to produce documents. No more than fifteen thousand dollars (\$15,000.00) in such damages shall be assessed during any contract year. If the Contractor notifies the Department that it will not be able to produce the documents within the specified timeframe and explains its reasonable efforts to produce the documents, if the Department determines, in its sole discretion, that an emergency or unannounced visit is necessary, the said documents shall be produced immediately, or on a schedule determined by the Department. Failure to produce the said documents may result in the assessment of liquidated damages as set forth herein.

5.1.7.2.3. For failure to issue and report notice of action when required by Colorado Code of Regulations (CCR) Section 2505-10, Section 8.209, and federal regulations at 42 CFR §

438.400 and §438.404, a fine of five hundred dollars (\$500.00) for each occurrence shall be assessed.

- 5.1.7.2.4. For failure to process and report grievances when required by C.C.R. 2505-10, Section 8.209 and federal regulations at 42 CFR § 438.400, a fine of one hundred dollars (\$100.00) for each occurrence shall be assessed.
- 5.1.7.2.5. For failure to comply with the Department's request for information, response to site visit requests or other reports by the defined timelines specified in the written request, the Department will assess five hundred dollars (\$500.00) for each calendar day for which the request is late.
- 5.1.7.2.6. All Medical Records shall be produced by the date specified in the Department's (or its designee's) written request, which shall allow a minimum of thirty (30) calendar days for the Contractor to produce the records for Non-emergency reviews. For each record specified in the Department's written request that is not produced within the timeframe specified in the Department's written request or any extensions granted, liquidated damages of three hundred dollars (\$300.00) per calendar day may be assessed against the Contractor. No more than fifteen thousand dollars (\$15,000.00) in such damages for failure to produce Medical Records shall be assessed during any contract year.
  - 5.1.7.2.6.1. If the Contractor notifies the Department (or designee) that it will not be able to meet the due date for the production of Medical Records, and explains in writing its reasonable efforts to produce the records, the Department may grant an extension of time for production of records in writing. If the Contractor notifies the Department that it cannot produce Medical Records due to the inability or unwillingness of a Participating Provider to produce the records, the Department may require exclusion of that Participating Provider from the Contractor's Medicaid network. If the Department determines, in its sole discretion, that an emergency review is required, the Contractor shall have five (5) Business Days from the date of the request to produce the Medical Records to the Department. In the case of a Provider site visit, the Contractor shall submit the Medical Records to the Department within two (2) Business Days of the site visit, or on a schedule determined by the Department. Failure to produce the said Medical Records may result in the assessment of liquidated damages as set forth herein.
- 5.1.7.3. Notwithstanding any other provision of this Section, if the Contractor is provided notice of termination for breach of contractual obligations pursuant to Section 15, Remedies, and the Contractor fails to cure the alleged breach in the time specified, in addition to any other damages that are applicable as the result of the termination, the Contractor shall be liable for three hundred dollars (\$300.00) per calendar day from the date set for cure until either the purchasing agency reasonable obtains similar supplies or services. If the Contractor is not terminated for default, liquidated damages shall not be due to the Department. The Contractor will not be required to pay liquidated damages when the delay in performance is beyond the control and without the fault or negligence of the Contractor.
- 5.1.7.4. If liquidated damages are imposed under this contract, the department may reduce the amount of any payments otherwise due to the Contractor by withholding the amount of such damages. Exercise of any of the remedial actions set forth in this section shall not relieve the Contractor from performance of any of its duties and obligations under this contract.
- 5.1.7.5. The Contractor will not be required to pay liquidated damages when the delay in performance



is beyond the control and without the fault or negligence of the Contractor.

- 5.1.7.6. The remedies available to the Department set forth above are in addition to all other remedies available to the Department by law or equity, are joint and several and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any remaining remedies. The Department's exercise of any of the remedies set forth in this section shall not excuse the Contractor from performance of its obligations and duties under this Contract.
- 5.1.7.7. Failure to produce statistically meaningful results for ninety five percent (95%) of CAHPS program survey questions within timelines as described in contract Section 2.7.2.4.2 shall result in liquidated damages of five thousand dollars (\$5,000.00). Statistically meaningful results lower than ninety percent (90%) of CAHPS program survey questions within described timelines shall result in liquidated damages of an additional five thousand dollars (\$5,000.00) plus one thousand dollars (\$1,000.00) per each individual survey question where statistically meaningful results were not reported.

## **5.2. DISCLOSURES**

- 5.2.1. The Contractor shall disclose the following information as set forth in Exhibit H, Contractor Disclosure Template, attached and incorporated herein by reference:
- 5.2.1.1. The Contractor shall submit an annual list of the names and addresses of each person with an ownership or control interest in Contractor.
- 5.2.1.2. The Contractor shall disclose, annually, the identity of each subcontractor that provides material and significant items or services to Contractor, and where the subcontractor is owned, in whole or in part, directly or indirectly, by any directors, officers, partners, owners, or employees of Contractor. The disclosure must identify the ownership person and contain a description of the magnitude of the beneficial ownership interest. An indirect ownership interest may be established by the ownership of a spouse, parent, child, or sibling of a director, officer, partner, owner or employee of Contractor.
- 5.2.1.3. The Contractor shall disclose, annually, the identity of each subcontractor that provides material and significant items and services to Contractor, and where the subcontractor is controlled, in whole or in part, directly or indirectly, by any directors, officers, partners, owners, or employees of Contractor. The disclosure must identify the person with control and contain a description of the kind of control interest. An indirect control interest may be established by the control exercised by a spouse, parent, child, or sibling of a director, officer, partner, owner or employee of Contractor.
- 5.2.1.4. The Contractor shall disclose, annually, the identity of the directors, officers, partners, owners, employees and contractors who have, and who have not, been surveyed in the prior twelve months about their relationships to individuals who have been disbarred, 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 federal Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Upon Department request, survey documentation shall be copied and delivered to the Department.
- 5.2.1.5. The Contractor shall disclose, annually, to the Department the identity of any directors, managing employees, officers, partners, owners, employees or contractors who have an Ownership or control interest in Contractor and who have been convicted of a criminal

offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

- 5.2.2. The Contractor shall provide written disclosure to the Department within sixty (60) calendar days of identification of any prohibited affiliation, ownership or control, or capitation payments or other payments in excess of amounts specified in the Contract.
- 5.2.3. Any Contractor that is subject to periodic survey and certification of its compliance with Medicaid standards shall supply the information specified in paragraph 1 above to the Department or its survey agency at the time it is surveyed. The Department or its survey agency shall promptly furnish the information to the Secretary of Health and Human Services and the Department.
- 5.2.4. Any Contractor that is not subject to periodic survey and certification and has not supplied the information specified in paragraph 1 above to the Secretary of Health and Human Services within the prior 12-month period, shall submit the information to the Department before entering into a contract or agreement with the Department. The Department shall promptly furnish the information to the Secretary of Health and Human Services.
- 5.2.5. Updated information shall be furnished to the Secretary of Health and Human Services, the Department or its survey agency at intervals between contract renewals, within thirty-five (35) days of a written request.
- 5.2.6. Before the Department enters into or renews an agreement, or at any time upon written request by the Department, Contractor shall disclose to the Department the identity of any person who:
  - 5.2.6.1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor.
  - 5.2.6.2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
- 5.2.7. The Contractor shall disclose to the Department certain business transactions to include:
  - 5.2.7.1. Any sale, exchange or lease of any property between the Contractor and a party in interest.
  - 5.2.7.2. Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.
  - 5.2.7.3. Any lending of money or other extension of credit between the Contractor and a party in interest.
  - 5.2.7.4. Parties of interest include:
    - 5.2.7.4.1. Any director, officer, partner, or employee responsible for management or administration of Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law.
    - 5.2.7.4.2. Any organization in which a person described in Section 5.2.6.4.1 is a director, officer or partner; has a direct or indirect beneficial interest of more than five percent (5%) in the

equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the Contractor.

- 5.2.7.4.3. Any person directly or indirectly controlling, controlled by, or under common control with a Contractor.
- 5.2.7.4.4. Any spouse, child, or parent of an individual described in Sections 5.2.6.4.1, 5.2.6.4.2, or 5.2.6.4.3.
- 5.2.8. The Contractor shall report to the State, on a timely and periodic basis specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to enrollees for which the entity is responsible for coverage of such drug (other than outpatient drugs) and such other data as the Secretary determines necessary.

**EXHIBIT B, RATES****SFY2017-2018 DHHA Capitation Rate**

<b>Eligibility Category</b>	<b>SFY18 Capitation Rate</b>
AFDC-A-F	<b>\$220.19</b>
AFDC-A-M	<b>\$172.33</b>
BCKC-A	<b>\$591.34</b>
CHILD-C	<b>\$88.67</b>
CHILD-U	<b>\$376.17</b>
FC	<b>\$208.38</b>
OAP-A	<b>\$287.65</b>
OAP-B/AND - N	<b>\$816.75</b>
OAP-B/AND - T	<b>\$149.04</b>
MAGI childless adults (formerly AwDC)	<b>\$291.82</b>
AFDC Expansion Adults - F	<b>\$183.95</b>
AFDC Expansion Adults - M	<b>\$107.87</b>
Delivery	<b>\$5,459.88</b>

## EXHIBIT D, COVERED SERVICES

### DEFINITIONS

**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.

**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.

**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) 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.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.

**Expanded EPSDT** shall mean those services that are not provided under Exhibit D 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.

**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.

**Medically Necessary, or Medical Necessity,** shall be defined as described in 10 CCR 2505-10 § 8.076.1.8.

**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.

**Orthotic:** An orthopedic appliance used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

**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 24-hour basis.

**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.

**Post stabilization 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, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition, as set forth at 42 CFR §422.113.

**Preventive Services:** Services provided by a physician within the scope of his/her practice under state law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and, (3) promote physical and mental health and efficiency.

**Prosthetic Device:** replacement, corrective or supportive devices prescribed by a doctor of medicine or a doctor of osteopathy to:

- Artificially replace a missing portion of the body
- Prevent or correct physical deformity or malfunction
- Support a weak or malformed portion of the body

**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.

**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.

**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.

**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.

## **COVERED SERVICES**

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.

### **Abortion**

Abortions are a Covered Service only in the following circumstances:

If the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed, pursuant to 42 C.F.R. § 441.202 and 42 C.F.R. § 441.203.

**NOTE:** For the purpose of this section, treatment for the following conditions is not considered to be an abortion:

- Ectopic pregnancies (Pregnancy occurring in other than a normal position or place)
- Miscarriage (spontaneous abortion)

### **Ambulance Services**

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:

- Air ambulance
  - 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
    - The point of pickup is inaccessible by land emergency transport vehicles,
    - Great distances or other obstacles are involved in transport to the nearest appropriate facility and prompt admission is essential; or
    - The client is suffering from an illness, injury, or psychiatric condition that makes all other forms of transport inadvisable.
- Emergency Services which, due to the medical or psychiatric condition of the Client, are immediate in nature and cannot be arranged in advance.
- 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.

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).

### **Ambulatory surgical care**

The allowable surgical procedures identified for Medicare coverage are reimbursable and covered Medicaid benefits.

### **Amniocentesis**

Amniocentesis performed for medical reasons other than sex determination.

### **Anesthesia Services**

Administration of anesthetics to achieve general, regional or supplementation of local anesthesia related resuscitative and supportive procedures.

### **Audiology and Speech Pathology**

- Audiological services include medical/diagnostic ear testing using recognized diagnostic instrumentation/equipment in a clinical environment to assist or confirm in establishing a diagnosis.
- 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.
- The EPSDT benefit covers screening and Medically Necessary ear exams and audiological testing.

### **Autism**

Autism shall be treated as a physical disorder.

## **Behavioral Health Services**

The contractor covers all behavioral health procedure codes listed on Exhibit I.

## **Consultation**

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.

## **Detoxification**

- Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

## **Dialysis, Hemodialysis or Peritoneal Dialysis**

- Coverage includes placement or repair of the dialysis route ("shunt" or "cannula").

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.

- Inpatient dialysis  
Coverage is provided in those cases where hospitalization is required.
- Outpatient dialysis  
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.
- Home dialysis  
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.

## **Durable Medical Equipment and Disposable Supplies**

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.

- Ambulation devices & accessories (canes, crutches, walkers),
- Bath and bathroom equipment,
- Bed and bedroom equipment and accessories, including specialized beds and mattress overlays,
- Manual or power wheelchairs, seating system orthosis used for wheelchair positioning,
- Diabetic monitoring equipment and related disposable supplies,
- Elastic supports/stockings,
- Monitoring equipment and supplies,
- Oxygen Equipment for home use, including nursing facility residents, See Exclusions
- Transcutaneous and/or neuromuscular electrical nerve stimulators (tens) and related supplies
- Trapeze/traction/fracture frames,
- Lymphedema pumps/compressors,
- Rehabilitation equipment (specialized use),



- Enteral formulas and supplies,
- Parenteral equipment and supplies, and
- Repairs and extensive maintenance as needed to keep the DME item functional.

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:

- Surgical, wound and burn care,
- Syringes/needles,
- Bowel and bladder care,
- Antiseptics/solutions,
- Gastric feeding sets and supplies,
- Tracheostomy and endotracheal care supplies, or
- Diabetic monitoring.

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.

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.

#### **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits**

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.

Information about EPSDT benefits must be provided to clients and parents, to include:

- Information about the periodicity table,
- Scheduling and transportation to make EPSDT appointments, and
- Information about the full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid.

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.

#### **Emergency Services**

Emergency Services means covered inpatient and Outpatient Services that are as follows:

- (1) Furnished by a provider that is qualified to furnish these services under this contract; and
- (2) Needed to evaluate or stabilize an Emergency Medical Condition. Emergency services are exempt from Primary Care Provider referral.

### **Family Planning Services**

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. Contractor shall reimburse out-of-network family planning services at a rate equal to or better than fee-for-service reimbursement rates, or Contractor's internal reimbursement rates, whichever is higher. No referral is required.

### **Federally Qualified Health Care (FQHC)**

Core services are provided in outpatient settings only, including a patient's place of residence. Core services means covered Outpatient Services that may include:

- Physician services;
- Physician assistant services;
- Nurse practitioner services;
- Nurse midwife services;
- Licensed psychologist services;
- Licensed social worker services;
- Pneumococcal and influenza vaccines and administration;
- Services and supplies incident to health professional services;
- 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
- Any other reimbursable ambulatory services offered by the FQHC that are covered by the State Plan.

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 code is attached as Exhibit I.

### **Hepatitis-C Therapies**

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.

### **Home Health Services**

Acute Home Health and Long Term with Acute Episode Home Health services provided pursuant to 10 CCR 2505-10 8.520.K.3.b are Covered services. Long Term Home Health is excluded.

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:

- Professional services of an RN, LPN or LVN on an intermittent basis

- 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
- Physical evaluations and therapy, and speech/hearing evaluations and therapy, by licensed therapists
- Medical/surgical supplies delivered to the Member's home (e.g. DME, prosthetics, disposable supplies), but not other Wrap Around services (e.g. Oxygen)
- 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
- Developmental therapies and EPSDT screenings (e.g. Neuromuscular reeducation, Sensory integration, Cognitive skills development)

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.

**Imaging (Radiology or X-ray Services)** Services authorized by a licensed physician.

- Services performed to diagnose conditions and illnesses with specific symptoms.
- Services are performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.
- Routine mammograms as described under Preventative Care Services.

### **Inpatient Hospital**

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.

- Semi-Private Room and Board
- Private rooms must be covered:
  - When Medically Necessary
  - When furnished by the hospital as the only accommodation
  - If the hospital has no semi-private room available. Patient must be moved to a semi-private room as soon as available.
- Delivery and labor rooms, anesthesia, and equipment.
  - Limitations for a hospital stay following a normal vaginal delivery may be limited after 48 hours post-delivery.
  - Limitations for a hospital stay following a cesarean delivery may be limited after 96 hours post-delivery.
- 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.
- Discharge oxygen
- Routine Newborn care is limited to period of time that the mother remains hospitalized. Inpatient newborn care following the mother's discharge is a covered benefit only when the child's medical condition necessitates ongoing inpatient care.

**Laboratory (clinical/pathological)** Services authorized by a licensed physician.

- Services performed to diagnose conditions and illnesses with specific symptoms.
- Services performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.
- Services performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

**Limitations**

- Collection, handling, and/or conveyance of specimens for transfer from the patient's home, a nursing home or a facility other than the physician's office or place of practice is a benefit only if the patient 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.

**Medical Services**

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.

- Direct physical examination of the patient's body and/or mental or cognitive status.
- Examination of some aspect of the patient's condition by means of radiological, non-radiological diagnostic imaging, pathology, laboratory or electronic monitoring procedures.
- Procedures for prescribing, administering, directing or supervising medical treatment.
- Manual manipulation. Department guidelines, which include manipulation by osteopathic physicians only, may be applied by the Plan.
- Diagnosis and treatment of eye disease or injury.
- Administration of injectables and allergens.
- Counseling: Diet and/or nutritional counseling when the diagnosis indicates or includes a clinical problem that is or could be impacted by obesity.
- Treatment for ear or hearing problems.

**Newborn Hospitalization**

Newborn hospitalizations shall extend only for the period of the mother's hospitalization unless Medical Necessity exists for the infant to remain hospitalized. When Medical Necessity for the infant to remain hospitalized exists, the additional days shall be covered.

**Occupational/Physical Therapy**

A physician may prescribe occupational or physical therapy for clients when Medically Necessary.

**Outpatient Services**

Covered Services include diagnostic, Therapeutic, Rehabilitative, Preventive, and Palliative Services furnished by or under the direction of a physician.

### **Outpatient Rehabilitation Services**

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.

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.

### **Oxygen and Oxygen Equipment**

Oxygen generating equipment prescribed for use in any inpatient setting, or as discharge oxygen, is a covered service if inpatient services are included within the scope of this contract.

Oxygen in canisters, whether in gaseous or liquid form, prescribed for use in any inpatient setting is a covered service if inpatient services are included within the scope of this contract. Contractor is responsible for nursing facility charges. All other prescribed uses of oxygen in canisters, whether in gaseous or liquid form, are covered wrap-around services paid by the Department through fee-for-service reimbursement. See Exclusions for portable and liquid oxygen.

### **Physical examinations**

Physical examinations for the purpose of:

- Diagnostic evaluation of disease, and
- Admission or placement in skilled nursing home care, intermediate nursing home care, residential care, or early and periodic screening, diagnostic and treatment.

### **Physical/Occupational Therapy**

Occupational or physical therapy for clients when Medically Necessary and ordered by a physician.

### **Physician Services**

- Age 65 and over: All Medically Necessary services.
- Under the age of 65: the following scope and range of benefits when Medically Necessary:
- Inpatient hospital services
- Inpatient surgery
- Outpatient surgery
- Outpatient diagnostic services
- Physician services provided to residents in a skilled nursing facility
- Home and physician office calls
- 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/patient. See Family Planning under Covered Services.
- 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.
- Foot care services
- Vision care services are included as benefits in accordance with the following general policies:
  - Services performed within the scope of the Medical and Optometrist Practice Acts

- Services for the provision of eyeglasses and contact lenses following eye surgery.
- Corneal transplants
- Services in regard to laboratory testing in accordance with the Imaging and Laboratory sections of this exhibit
- Immunizations

### **Podiatry**

Foot care services are included as a benefit in the Medical Assistance Program whether provided by a physician or licensed podiatrist.

### **Prescription Drugs**

The Contractor is responsible for prescription drugs.

### **Preventive Medicine**

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.

- Physical exams
  - Under age 21, see Early Periodic Screening, Diagnostic and Treatment (EPSDT)
  - Age 21 - 35, at least once every 5 years but not more than once a year
  - Age 36 - 50, at least once every 2 years but not more than once a year
  - Over age 50, once every 12 months
- Women's health
  - Routine yearly breast and pelvic examination with PAP smear, hematocrit and urinalysis
  - 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.
- Men's Health
  - 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.)
  - Age 50 years and older, screening for early detection of prostate cancer at least once per year.
  - Health education services
  - Instruction in personal health care measures, including those appropriate for clients with disabilities;
  - Instruction for a designated client representative, when the client is unable to receive or understand such services due to a disability;
  - Information about services, including recommendations on generally accepted medical standards for use and frequency of such service.

### **Prosthetics and Orthotics**

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:

- Ankle-foot/knee-ankle-foot Orthotics
- Artificial limbs
- Augmentative communication devices and communication boards

- 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
- Facial prosthetics
- Lumbar-sacral orthoses (LSO)
- Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements when an integral part of a leg or ankle brace
- Recumbent ankle positioning splints
- Rigid and semi-rigid braces
- Specialized eating utensils and other Medically Necessary activities of daily living aids; and
- Therapeutic shoes
- Thoracic-lumbar-sacral orthoses (TLSO)

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.

#### **Radiology – see Imaging**

#### **Radiation Therapy**

#### **Rural Health Clinics (RHC)**

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.

- A. Services furnished by a physician.
- B. Services furnished by a physician assistant, nurse practitioner, or nurse midwife, under the medical supervision of a physician.
- C. Services and supplies that are furnished as an incident to professional services under (A) and (B) above.
- D. Part-time or intermittent visiting nurse care and related medical supplies (other than pharmaceuticals).
- E. 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.
- F. 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.

#### **Speech Pathology (see Audiology and Speech Pathology)**

**Substance Abuse:** Includes the medical treatment for withdrawal from the physiological effects of acute alcohol or drug abuse.

## **Surgical Services**

For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File shall be considered the prevailing guide.

- Reconstructive surgery
  - 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
  - Reconstructive services following mastectomy, subject to prior approval.
  
- Male genital system
  
- Female genital system
  
- Oral Surgical Services (limited to treat certain conditions, as follows):
  - Accidental injury to jawbones or surrounding tissues;
  - Correction of non-dental pathophysiological condition which has resulted in a severe functional impairment, including temporomandibular disorder; or
  - Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, floor of mouth.
  
- Sterilization

Stipulations: In order to receive sterilization services, the following criteria must be met:

  - The client must be at least 21 years of age;
  - The client may not be currently institutionalized for the care and treatment of mental illness;
  - He or she must be mentally competent;
  - 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.

## **Tobacco Cessation**

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. Tobacco Cessation benefit does not include any group or individual counseling services. Group or individual counseling services and all FDA approved prescription medications and over the counter tobacco cessation products related to Tobacco Cessation are available for all Medicaid members as a wrap-around benefit.

## **Telemedicine**

- 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.



- Any health benefits provided through Telemedicine shall meet the same standard of care as in-person care.

### **Transplant Services**

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:

- 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.
- 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.
- Immunosuppressive drugs as supportive therapy for the transplant.

### **Vision Services**

Under age 21, see EPSDT.

Age 21 and over: 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.

- Eye exams
  - One refraction once during any 24 month period for adults age 21 to 47;
  - One refraction each 12 months for adults age 48 or older;
- Vision correction: one pair of corrective lenses and no less than the Medicaid allowable contribution for frames ordered as a result of the covered examinations.

NOTE: The Contractor may require completion of six (6) continuous months of enrollment before providing vision benefits for adults age 21 years and older.

**EXCLUSIONS:** The following services are excluded from coverage:

#### **Acupuncture**

**Air ambulance services** when a Client could be safely transported by ground ambulance or by means other than ambulance.

**Ambulatory surgical procedures** not listed on the state approved list.

**Ambulance services** when a Client could be safely transported by means other than ambulance.

**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.

#### **Autopsy charges**

**Biofeedback**, stress management, behavioral testing and training, and counseling for sexual dysfunction.

**Behavioral Health** inpatient or outpatient psychiatric or psychological care that is a benefit of the Mental Health Capitation Program (MHCP). Exhibit I lists all of the contractor covered behavioral health procedure codes.

**Chiropractic services** unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.

**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.

**Counseling** for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders or chronic situational reactions.

**Dental services:**

- Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.
- 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.

**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.

**EPSDT services** not provided under this contract are:

- Hearing aids and auditory training.
- 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.
- Services that are experimental, not safe or cost effective, or services provided for the convenience of the caregiver need not be covered.
- Expanded EPSDT services.

**Experimental** or investigational services or pharmaceuticals.

**Government-sponsored care**

- Items and services provided by federal programs, such as a Veteran's Hospital.
- Services provided in facilities that serve a specific population, such as prisoners.
- Care for conditions that federal, state, or local laws require to be treated in a public facility.
- 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.

**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.

**FQHC Services:** Inpatient hospital stays are not covered under FQHC Services but may be a benefit under Inpatient Hospital Care.

**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.

**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

**High colonics**

**Holistic or homeopathic care** including drugs and ecological or environmental medicine.

**Home delivery:** Services associated with non-emergent home delivery, unless prior authorized by the Contractor are excluded.

**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.

Long Term Home as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.

Home Health Services provided by a person who ordinarily resides in the Client's home or is an immediate family member are not covered.

**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.

**Hospital back up level of care.** Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470 is excluded.

**Hypnosis**

**Immunizations** related to foreign travel.

**Imaging (Radiology or X-ray) Services** performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

**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.

**Inpatient hospital excluded services include:**

- Psychiatric/psychological care included and covered through the Mental Health Capitation Program.
- Discharge medications and experimental drugs.
- Inpatient hospital services defined as experimental by the Medicare program.
- 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.

**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.

**Isometric exercise**

**Expenses for medical reports**, including presentation and preparation.

**Laboratory services** performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

**Long Term Home Health** as defined at 10 CCR 2505-10, Sections 8.520 is excluded.

**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.

**Portable and liquid oxygen is now carved out of the rates. Procedure codes and descriptions are listed below:**

<b>PROC_CD</b>	<b>Description</b>
A4617	Mouth piece
E1340	Use K0739 or K0740 after 7/31/09
S8121	O2 contents liquid lb
A4619	Face tent
E0425	Gas system stationary compre
E0441	Oxygen contents, gaseous
E0550	Humidif extens suppl w ippb
E1353	Oxygen supplies regulator
E0444	Portable O2 contents, liquid
E1392	Portable oxygen concentrator, rental
K0738	Portable gas oxygen system
E0434	Portable liquid O2
E0439	Stationary liquid O2
E1405	O2/water vapor enrich w/heat
E1406	O2/water vapor enrich w/o he
S8120	O2 contents gas cubic ft
A7046	Repl water chamber, PAP dev
E0430	Oxygen system gas portable
E0435	Oxygen system liquid portabl
E0443	Portable O2 contents, gas
E1355	Oxygen supplies stand/rack

A4615	Cannula nasal
A4616	Tubing (oxygen) per foot
E0455	Oxygen tent excl croup/ped t
E1390	Oxygen concentrator
A4483	Moisture exchanger
A4620	Variable concentration mask
E0424	Stationary compressed gas O2
E0431	Portable gaseous O2
E0440	Oxygen system liquid station
E0442	Oxygen contents, liquid
E1391	Oxygen concentrator, dual
E1354	Wheeled oxygen cart

**Paternity Testing.** Such services shall be reimbursed by the Medicaid Program and recouped through the court system.

**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.

**Physical examinations** of the following nature are excluded:

- 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.
- 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.

**Private Duty Nursing (PDN).** Private duty nursing services are a Wrap Around Benefit.

**Psychiatric/psychological care** as follows:

- Milieu therapy
- Play therapy
- Day care
- Electroshock treatment rehabilitation
- Night care
- Family therapy
- Biofeedback

**Reversal of surgically performed sterilization or subsequent re-sterilization.**

Procedures, services and supplies relating to **sex change** or transformation.

**Skilled Nursing Facility Services** are a Wrap Around Benefit.

**Surrogate Mother Services** or supplies received in connection with a Client acting as or utilizing the services of a surrogate mother.

**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 through the Medicaid broker at CONEMT.

**Travel**, whether or not recommended or prescribed by a Physician or other medical practitioner.

**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.

**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:

- **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.
- **Pediatric Behavioral Therapies** – procedure codes for the assessment and treatment are H0031, H0036, H2015, H0031/TS.
- **Cavity Free at Three** dental services
- **Comprehensive dental assessment, care and treatment for children.**
- **Dental services for adults** are limited to emergency services and minimal Medically Necessary dental services for adults with concurrent medical conditions.
- **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.
- **HCBS Services** including case management (for Model 200 children); home modification, electronic monitoring, and non-medical transportation.
- **Hospice services**, however client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested.
- **Hospital back up level of care** as set forth in 10 CCR 2505-10, Section 8.470.
- **Inpatient substance abuse rehabilitation treatment** for individuals aged 20 and under, DRG 772 (Valley View), as set forth in 10 CCR 2505-10, Section 8.300.4.5.
- **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.
- **Non-emergency transportation** to medical appointments for Covered Services only, through the client's county of residence.

**Private Duty Nursing (PDN)**, nursing services only. **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.

## **EXHIBIT F, MEMBER HANDBOOK REQUIREMENTS**

To inform Members of their rights and responsibilities, the Department shall distribute a Member Handbook to all of Contractor's Members. . If the Contractor wishes to send out their own proprietary Member Handbook, such material shall include, but is not limited to the following information:

1. A complete statement of Member rights and responsibilities as specified in 10 CCR 2505-10.8.205.3;
2. Covered Services and any additional benefits and services offered by the Contractor;
3. Excluded or non-covered services;
4. Information about the Contractor's standards for the availability and accessibility of services including points of access for primary care, specialty, Hospital, and other services and how to request accommodations for Special Needs, including materials in alternative formats;
5. Hours of service;
6. Location of Contractor's facilities/offices;
7. Appropriate use of and procedures for obtaining after hours care and Emergency Care within the service area;
8. Appropriate use of and procedures for obtaining after hours care and Emergency Care when out of the service area;
9. Instructions about accessing urgently needed services;
10. Enrollment procedures of the Contractor, including how to change Primary Care Providers, and disenrollment information as required in Section 4.0. of the Contract to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so and members are informed about how to access the Department concerning disenrollment;
11. Maximum number of days between appointment request and actual visit with appropriate Provider, as follows:
  - a. Non-urgent health care and adult, non-symptomatic well care physical examinations scheduled within thirty (30) days.
  - b. Urgently Needed Services provided within forty-eight (48) hours of notification of the Primary Care Provider or Contractor.
12. Policies on referrals for specialty care;
13. Informal and formal procedures and timeframes to voice a complaint, file a grievance or obtain a fair hearing related to coverage, benefits, or any aspect of the Member's relationships to the

Contractor through both the Contractor's internal grievance process and the Department's or the State's external process(es) to include:

- a. The requirements and timeframes for filing a grievance or appeal.
    - 1) The availability of assistance in the filing process.
    - 2) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
    - 3) The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and the fact that the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
    - 4) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
  
  - b. For State fair hearing:
    - 1) The right to hearing;
    - 2) The method for obtaining a hearing;
    - 3) The timeframes for reaching a decision regarding state fair hearings;
    - 4) The right to an expedited hearing;
    - 5) The timeframes for reaching an expedited resolution; and
    - 6) The rules that govern representation at the hearing.
  
  - c. Information regarding State fair hearing timeframes.
  
  - d. Additional information that is available upon request, including the following:
    - 1) Information on the structure and operation of the MCO.
    - 2) Physician incentive plans as set forth in §II.G.3.A.
14. Information about the Contractor's Utilization Management program and how it is used to determine Medical Necessity of services. Information shall include: appropriate points of contact with the Utilization Management program; contact persons or phone numbers for information or questions, the member services number; and information about how to initiate appeals related to utilization management decisions;
15. EPSDT services;
16. Family planning policies;
17. Procedures for obtaining the names, qualifications, and titles of professionals providing and/or responsible for members' care;
18. Circumstances under which Members may have to pay for care;
19. Procedures for arranging transportation;
20. That Members will be notified of any change in benefits, services, or service delivery offices/sites;



21. Information regarding the Member's right to formulate Advanced Directives, according to applicable statutes and regulations and the Contractor's policies respecting the implementation of such rights;
22. How to request information about the Contractor's Quality Management and Improvement program;
23. How to obtain information regarding the Contractor's Participating Providers who serve members. The information shall include the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals;
24. Information regarding Member participation on the Contractor's consumer advisory committee, and notification of right to attend meetings of the committee. Such information shall include telephone contact number;
25. Information concerning a Member's responsibility for providing the Contractor with written notice to the Contractor after filing a claim or action against a third party responsible for illness or injury to the Member;
26. Information concerning a member's responsibility for following any protocols of a liable third party payor prior to receiving non-emergency services;
27. Information regarding the entity's responsibilities for coordination of enrollee care;
28. How to access auxiliary aids and services, including information in alternative formats or languages;
29. The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees;
30. Information on how to report suspected fraud or abuse;
31. Information on restrictions, if any, on the enrollee's freedom of choice among network providers;
32. Specifications on Members that are exempt from cost sharing or co-payment charges; and
33. Any other content required by the State, or 42 CFR 438.10

**EXHIBIT I, COVERED BEHAVIORAL HEALTH PROCEDURE CODES**

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

<b>BHO MH Diagnoses Ranges</b>	
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

<b>SUD Diagnoses Ranges</b>	
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

<b>BHO Specialty Provider Types</b>		
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

<b>FQHC &amp; RHC Provider Types</b>		
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

<b>Proc Code</b>	<b>Full description of the procedure codes</b>
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.

<b>Evaluation and Management</b>	
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

<b>Laboratory</b>
80047 - 89398

<b>Emergency (CMS-1500)</b>	
31500	
31603	
99058	
99140	
99285	
S5160	
D7990	
D9110 or Emergency Indicator	

<b>Screening &amp; Assessment</b>	
*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.

**EXHIBIT J, Not Used**

**THIS EXHIBIT IS INTENTIONALLY LEFT BLANK**