CONTRACT AMENDMENT NO. 5

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

1. PARTIES

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

2. EFFECTIVE DATE AND ENFORCEABILITY

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

3. FACTUAL RECITALS

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

4. CONSIDERATION

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

5. LIMITS OF EFFECT

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

6. MODIFICATIONS

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

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

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

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

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

7. START DATE

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

8. ORDER OF PRECEDENCE

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

9. AVAILABLE FUNDS

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

THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

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

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

By: _____
Signature of Authorized Officer

Date: 3-14-17

Michael E. Huotari
Printed Name of Authorized Officer

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

STATE OF COLORADO:
John W. Hickenlooper, Governor

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

Date: 3/17/17

LEGAL REVIEW:
Cynthia H. Coffman, Attorney General

By: NA

Date: _____

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

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

STATE CONTROLLER:
Robert Jaros, CPA, MBA, JD

By: _____
Department of Health Care Policy and Financing

Date: 3/17/17

EXHIBIT A-3
STATEMENT OF WORK

SECTION 1.0 TERMINOLOGY

1.1. ADDITIONAL ACRONYMS, ABBREVIATIONS AND DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.1.1.20. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could responsibly expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

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

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

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

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

1.1.1.25. "Enrollee" means Member.

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

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

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

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

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

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

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

1.1.1.33. "FFP" means Federal Financial Participation

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

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

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

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

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

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

1.1.1.40. "Hospital" means an institution which:

1.1.1.40.1. Is licensed by the State as a Hospital;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.1.1.69. "RCCO" means Regional Care Collaborative Organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 2.0 BACKGROUND

2.1. GENERAL PROGRAM BACKGROUND

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

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

SECTION 3.0 CONTRACTOR AND SERVICE REQUIREMENTS

3.1. GENERAL CONTRACTOR REQUIREMENTS

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

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

3.1.3. Subcontractual Relationships and Delegation

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

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

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

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

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

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

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

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

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

3.2. CONTRACTOR RESPONSIBILITIES AND REGULATORY COMPLIANCE

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

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

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

3.3. PERSONNEL

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

3.3.1.1. Contract Manager

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

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

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

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

3.3.1.2. Financial Manager

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

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

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

3.3.1.3. Medical Director

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

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

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

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

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

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

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

3.3.5. Other Staff Functions

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

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

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

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

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

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

3.3.6.1. DELIVERABLE: Organizational Chart

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

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

3.3.7.1. DELIVERABLE: Updated Organizational Chart

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

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

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

3.3.10. Training of Contractor Employees

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

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

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

3.4. CLIENT ENROLLMENT AND DISENROLLMENT

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

3.4.1.1. Elderly – Age 65+

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

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

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

3.4.1.5. BC Women – Pregnant women age 19+

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

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

3.4.2. Enrollment

3.4.2.1. Enrollment Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

3.4.3. Disenrollment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.4.3.2.3. The Member's diminished mental capacity.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.4.3.4.1.11. The Member is a foster child.

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

3.4.3.4.2. Without cause, under the following circumstances:

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

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

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

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

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

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

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

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

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

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

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

3.4.4.3. PHP Current Enrollment Report (R0315).

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

3.4.4.5. Capitation Summary Report (R0360).

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

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

3.5. COVERED SERVICES

3.5.1. Health Coverage

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

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

3.5.1.3. The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the Member.

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

3.5.2. Coverage Limitations

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

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

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

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

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

3.5.3. Covered Services Through Participating Providers

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

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

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

3.5.4. Coverage of Specific Services and Responsibilities

3.5.4.1. Emergency Services

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

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

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

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

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

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

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

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

3.5.4.2. Emergency Ambulance Transportation

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

3.5.4.3. Verification of Medical Necessity for Emergency Services

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

3.5.4.4. Poststabilization Care Services

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

3.5.4.5. Newborn Services

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

3.5.4.6. Coverage of Prescription Drugs

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

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

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

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

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

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

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

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

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

3.5.4.7. Responsibility Regarding Psychiatric and Medical Diagnoses

3.5.4.7.1. Inpatient Hospital Services

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

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

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

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

3.5.4.7.2. Coverage for Emergency Services

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

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

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

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

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

3.5.4.7.3.1.2. The principal diagnosis is a medical diagnosis.

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

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

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

3.5.4.8. Wrap Around (Fee For Service) Benefits

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

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

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

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

3.6. SERVICE DELIVERY

3.6.1. Access

3.6.1.1. Access to Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.6.1.1.11.1. The physically or developmentally disabled.

3.6.1.1.11.2. Adults and the aged.

3.6.1.1.11.3. Non-English speakers.

3.6.1.1.11.4. Expansion population.

3.6.1.1.11.5. Members with complex behavioral or physical health needs.

3.6.1.1.11.6. Members with Human Immunodeficiency Virus (HI)

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

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

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

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

3.6.1.2. Out of Network Providers

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

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

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

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

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

3.6.1.3. Geographic Access

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

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

3.6.1.4. Service Availability

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

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

3.6.1.4.2.1. DELIVERABLE: Documentation of Service Availability Requirements

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

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

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

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

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

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

3.6.1.4.3.2.3. Practitioner backs up covering all specialties.

3.6.1.5. Scheduling and Wait Times

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

3.6.1.5.1.1. Routine physicals.

3.6.1.5.1.2. Diagnosis and treatment of acute pain or injury.

3.6.1.5.1.3. Follow-up appointments for chronic conditions.

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

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

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

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

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

3.6.1.5.3.1. DELIVERABLE: Documentation of Scheduling Guidelines.

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

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

3.6.2. Service Area Standards

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

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

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

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

3.6.3. Selection and Assignment of Primary Care Medical Providers

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

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

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

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

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

3.7. CARE COORDINATION AND MEDICAL MANAGEMENT

3.7.1. Medical management support

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

3.7.1.1.1. Traditional methods:

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

3.7.1.1.1.2. Catastrophic case management.

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

3.7.1.1.2. Innovative and proven or promising practices:

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

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

3.7.1.1.2.3. Alternate formats for delivering care.

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

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

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

3.7.2. Care Coordination

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

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

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

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

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

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

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

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

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

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

3.7.2.4.1. Comprehensive Care Coordination components include:

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

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

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

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

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

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

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

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

3.7.2.5. Client/Family Centered characteristics include:

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

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

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

3.7.2.5.3.1. The physically or developmentally disabled

3.7.2.5.3.2. Adults and the aged

3.7.2.5.3.3. Non-English speakers

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

3.7.2.5.3.5. Members in need of assistance with medical transitions

3.7.2.5.3.6. Members with complex behavioral or physical health needs

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

3.7.2.6. Integrated Care Coordination characteristics include:

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

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

3.7.2.6.3. Implementing strategies to integrate member care such as:

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

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

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

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

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

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

3.7.2.7.2. DELIVERABLE: Documented Formal System of Care Coordination

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

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

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

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

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

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

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

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

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

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

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

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

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

3.7.2.10.6.1. DELIVERABLE: Systems of Care Report.

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

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

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

3.7.2.11.1.1. Biweekly for any Member classified as Level 4

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

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

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

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

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

3.7.3. Persons with Special Health Care Needs

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

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

3.7.3.2.1. DELIVERABLE: Special Health Care Needs Plan

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

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

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

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

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

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

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

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

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

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

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

3.7.4.2. To promote independent living, the Contractor shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.7.5. Preventative Health Services

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

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

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

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

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

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

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

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

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

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

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

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

3.7.6. Services Delivered Only to Members

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

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

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

3.8. PROVIDER SUPPORT

3.8.1. Administrative Support

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

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

3.8.1.1.1.1. Benefit packages and coverage policies.

3.8.1.1.1.2. Prior authorization Referral requirements.

3.8.1.1.1.3. Claims and billing procedures.

3.8.1.1.1.4. Eligibility and enrollment processes.

3.8.1.1.1.5. Other operational components of service delivery.

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

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

3.8.1.3.1. The Statewide Data Analytics Contractor (SDAC).

3.8.1.3.2. The Department's enrollment broker.

3.8.1.3.3. The Department's Medicaid fiscal agent.

3.8.1.3.4. The Department's utilization management contractor.

3.8.1.3.5. The Department's managed care ombudsman.

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

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

3.8.1.3.8. Healthy Communities.

3.8.1.3.9. The Department's Dental Contractor.

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

3.8.1.4.1. Issues relating to Medicaid provider enrollment.

3.8.1.4.2. Prior authorization and Referral issues.

3.8.1.4.3. Member eligibility and coverage policies.

3.8.1.4.4. PCMP designation problems.

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

3.8.1.5.1. DELIVERABLE: Documentation of Provider Support Activities.

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

3.8.2. Practice Support

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

3.8.2.1.1. Operational practice support.

3.8.2.1.2. Clinical tools.

3.8.2.1.3. Client or Member materials.

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

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

3.8.2.1.5.1. DELIVERABLE: Practice Support Plan

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

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

3.8.2.2.1. Clinical Tools:

3.8.2.2.1.1. Clinical care guidelines and best practices

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

3.8.2.2.1.3. Health and functioning questionnaires.

3.8.2.2.1.4. Chronic care templates.

3.8.2.2.1.5. Registries.

3.8.2.2.2. Client Materials:

3.8.2.2.2.1. Client reminders.

3.8.2.2.2.2. Self-management tools.

3.8.2.2.2.3. Educational materials about specific conditions.

3.8.2.2.2.4. Client action plans.

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

3.8.2.2.3. Operational Practice Support:

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

3.8.2.2.3.2. Training on providing culturally competent care.

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

3.8.2.2.3.4. Guidelines for motivational interviewing.

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

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

3.8.2.2.3.7. Referral and transitions of care checklists.

3.8.2.2.3.8. Visit agendas or templates.

3.8.2.2.3.9. Standing pharmacy order templates.

3.8.2.2.4. Data, Reports and Other Resources:

3.8.2.2.4.1. Expanded provider network directory.

3.8.2.2.4.2. Comprehensive directory of community resources.

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

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

3.8.2.3. Provider Support Accessibility

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

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

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

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

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

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

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

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

3.9. COMPLIANCE AND MONITORING

3.9.1. Utilization Management

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

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

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

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

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

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

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

3.9.1.5. The Contractor shall ensure that any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

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

3.9.2. Compliance Monitoring

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

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

3.9.3. Other Monitoring Activities

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

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

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

3.9.3.1.3. Other reviews determined by the Department.

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

3.9.4. Inspection, Monitoring and Site Reviews

3.9.4.1. Site Reviews

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

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

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

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

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

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

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

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

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

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

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

3.9.6. Encounter Claims Data Provisions

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

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

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

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

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

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

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

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

3.9.6.2.1.3. For Pharmacy Encounter Claims:

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

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

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

3.9.6.2.1.4. For Medical Encounter Claims:

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

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

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

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

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

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

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

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

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

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

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

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

3.9.6.2.3.3. Daily generated PHP Disenrollment Report (R0305)

3.9.6.2.3.4. Monthly generated PHP Disenrollment Report (M0305)

3.9.6.2.3.5. Monthly generated PHP Enrollment Change Report (R0310)

3.9.6.2.3.6. Monthly generated PHP Current Membership Report (R0315)

3.9.6.2.3.7. Daily generated PHP New Membership Report (R0325)

3.9.6.2.3.8. Monthly generated PHP New Membership Report (M0325)

3.9.6.2.3.9. Monthly generated PHP Capitation Summary Report (R0360)

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

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

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

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

3.9.7. Cybersecurity

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

3.9.8. SDAC Access Compliance

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

3.10. SERIOUS REPORTABLE AND NEVER EVENTS

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

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

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

3.11. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

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

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

3.11.2.1. Practice Guidelines.

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

3.11.2.1.1.1. Perinatal, prenatal and postpartum care for women;

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

3.11.2.1.1.3. Well child care.

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

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

3.11.2.1.2.2. The guidelines consider the needs of the Member.

3.11.2.1.2.3. They are adopted in consultation with Participating Providers.

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

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

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

3.11.2.2. Performance Improvement Projects (PIPs)

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

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

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

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

3.11.2.2.4.1. Measurement of performance using objective quality indicators.

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

3.11.2.2.4.3. Evaluation of the effectiveness of the interventions.

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

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

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

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

3.11.2.2.7.1. DELIVERABLE: Performance Improvement Projects.

3.11.2.2.7.2. DUE: To be determined by the Department.

3.11.2.3. Performance Measurement Data

3.11.2.3.1. Healthcare Effectiveness Data and Information Set (HEDIS)

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

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

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

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

3.11.2.3.2. Mandatory Federal Performance Measurements

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

3.11.2.4. Member Satisfaction

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

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

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

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

3.11.2.5. Mechanisms to Detect Over and Under Utilization

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

3.11.2.6. Quality of Care Concerns

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

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

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

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

3.11.2.7. Quality Improvement Committee

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

3.11.2.8. Performance Improvement Advisory Committee (PIAC)

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

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

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

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

3.11.2.8.1.4. Members.

3.11.2.8.1.4.1. Member's families.

3.11.2.8.1.5. Advocacy groups and organizations.

3.11.2.8.1.6. The PCMP network.

3.11.2.8.1.7. Other Medicaid providers.

3.11.2.8.1.8. The Behavioral Health community.

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

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

3.11.2.8.1.11. Open all scheduled meetings to the public.

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

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

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

3.11.2.9. The ACC Program Improvement Advisory Committee

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

3.11.2.10. Program Impact Analysis

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

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

3.11.2.10.2.1. DELIVERABLE: Program Impact Analysis

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

3.11.2.11. Quality Improvement Plan

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

3.11.2.11.1.1. DELIVERABLE: Quality Improvement Plan

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

3.11.2.12. External Review

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

3.11.2.12.1.1. Medical Record review.

3.11.2.12.1.2. Performance improvement projects and studies.

3.11.2.12.1.3. Surveys.

3.11.2.12.1.4. Calculation and audit of quality and utilization indicators.

3.11.2.12.1.5. Administrative data analyses.

3.11.2.12.1.6. Review of individual cases.

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

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

3.11.2.13. Health Information Systems

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

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

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

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

3.11.2.13.4.1. Verifying the accuracy and timeliness of reported data;

3.11.2.13.4.2. Screening the data for completeness; and

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

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

SECTION 4.0 MEMBER AND PROVIDER ISSUES

4.1. MEMBER ISSUES

4.1.1. Member Services, Rights and Responsibilities

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

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

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

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

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

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

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

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

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

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

4.1.1.2. Member Responsibilities

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

4.1.1.3. Written Policies, Procedures and Information Relating to Members

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

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

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

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

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

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

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

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

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

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

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

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

4.1.1.4. Notices of Changes, Information and Actions

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

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

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

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

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

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

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

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