AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Services Agreement - ELAP Services, LLC

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Gunnison County, Colorado and ELAP Services, LLC

Term Begins: 01/01/2020 **Term Ends:** **Grant Contract #:**

Summary:

This agreement is an ELAP Amendment to the Core Services Agreement and the Cost-Containment and Guide Services Agreement dated 01/01/2019.

Fiscal Impact:

Submitted by: Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:
No concerns. However, will increase fees paid to ELAP per top of page 6. ln

Reviewed by: GUNCOUNTY1\lNienhueser Discharge Date: 2/7/2020

County Attorney Review: (●) Required ( ) Not Required

Comments:
ok db 2/10/20

Reveiwed by: GUNCOUNTY1\dBaumgarten Discharge Date: 2/10/2020 Certificate of Insurance Required Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/13/2020

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 2/18/2020

Revised April 2015

CORE SERVICES AGREEMENT AMENDMENT No. 2 and COST-CONTAINMENT and GUIDE SERVICES AGREEMENT No. 2

The Core Services Agreement and the Cost-Containment and Guide Services Agreement (the "Agreements") by and between **Gunnison County, Colorado** and its health plan having its principal office at 200 E. Virginia Ave., Gunnison, CO 81230 (the "Employer") and ELAP Services, LLC ("ELAP") (each a "Party" and, together, the "Parties") are hereby amended as set forth below effective as of January 1, 2020.

WHEREAS, the Parties entered into certain Agreements dated January 1, 2019 pursuant to which the Parties agreed that ELAP would provide certain services to Employer related to Employer's sponsorship and administration of the Gunnison County, Colorado Employee Medical Benefit Plan (the "Plan"). Employer and ELAP now desire to amend the terms and conditions as follows:

The Parties executed Core Services Agreement Amendment No. 1 and Cost-Containment and Guide Services Amendment No. 1 which is NULL and VOID.

I. Amendment No. 2 to Core Services Agreement

1) Article 1, Definitions, (s) Plan Participant, is hereby deleted in its entirely and replaced as follows:

(s) "Plan Participant" shall mean, with regard to any Referred Appeal, Disputed Audit or Clean Claim submitted to ELAP (and at the time such Referred Appeal or Clean Claim is submitted to ELAP), a person whom the Plan Administrator (and/or their designee with regard to such functions) determines is eligible for benefits under the Plan.

2) Article I, Definitions, is hereby amended to add definitions as follows:

"Referred Appeal" shall mean the referral by the Plan Administrator to ELAP of a final appeal, made in accordance with the terms of the Plan by a Plan Participant or a Medical Provider, to review the benefits denied by the Plan Administrator (for services provided (or to be provided) by a Medical Provider) on the basis that (1) such services are not Covered Benefits under the Plan, or (2) that if such services are Covered Benefits, the Plan is not financially responsible for some or all of the payment amount. "Referred Appeal" shall not mean any appeal for any "claim involving urgent care" which is also a "pre-service claim" (both terms as defined in subsection (m) of 29 C.F.R. § 2560.503-1 (the "DOL Claims Regulations")), the

adjudication of which shall be the sole responsibility of the Plan Administrator and any other person or entity to whom it may delegate such responsibility. "Referred Appeal" shall include appeals for an external review as defined in the Public Health Service Act (PHS Act) section 2719(b).

"Referred Appeal Services" shall mean the services of the ELAP described in Article 5.6 of this agreement.

3) Article 2, Term and Termination, Section 2.3 Effect of Termination, is hereby deleted in its entirety and replaced as follows:

2.3 Effect of Termination. Upon termination, except as otherwise stated in this Agreement, the rights and obligations of the parties under this Agreement shall terminate and the authorities granted to ELAP shall be rescinded. For each Disputed Audit and/or Referred Appeal, the services that ELAP provides to the Employer and the Plan under Article 5 of this Agreement shall survive termination of this Agreement for a period extending from the date ELAP audited the Claim through a period of one (1) year post termination, including any agreed upon run-out period, and the Covered Expenses provided under Article 6 of this Agreement shall survive termination of this Agreement for a period of time not exceeding the statute of limitation for breach of contract applicable to collection of medical debt in the state in which the Plan is incorporated, provided that:

(a) The Plan and/or the Plan Sponsor paid the fees of ELAP in full;
(b) The Disputed Audit and/or the Referred Appeal was submitted to ELAP one (1) year after termination of this Agreement and the Claim date of service was incurred when the Agreement was in effect.; and
(c) The services apply to Disputed Audits of Claims where:
    1. ELAP audited the Disputed Audit and determined the Allowable Claim Limit prior to termination of this Agreement; and
    2. The Plan reimbursed the Claim that was the subject of the Disputed Audit at the Allowable Claim Limit determined by ELAP.

4) Article 3, Representations of Parties, Section 3.1(e), is hereby deleted in its entirety and replaced as follows:

(e) The Plan Sponsor, as settlor, has amended the Plan to adopt certain provisions as designated in Exhibits A and D.

5) Article 4, Delegation of Powers and Authorities, is hereby amended to add new Section (f) as follows:

(f) Review and, subject to the ultimate approval of the Plan Administrator (and/or the designee of the Plan Administrator), decide and negotiate the settlement of any and all Referred Appeals regarding issues which relate to Claims (including determining what services, supplies, care and treatments are Covered Benefits) and/or which relate to rights of Plan Participants;

6) Article 5, Core Services, is hereby amended to add new Section 5.6 Referred Appeals as follows:

5.6 Referred Appeal Services. ELAP will review Referred Appeals in accordance with the terms of the Service Level Agreement ("SLA") appearing in Exhibit D (Referred Appeal Services SLA). In doing so, ELAP will review such Referred Appeals in accordance with the Plan's claims and appeals rules, to the extent such rules are not inconsistent with the requirements of the DOL Claims Regulations. ELAP will provide the Plan an external and independent assessment of the denial of benefits by the Plan Administrator for services provided or to be provided by a Medical Provider and determine whether such services are Covered Benefits under the Plan and/or are the financial responsibility of the Plan.

7) Article 5, Core Services, Section 5.2, is hereby deleted and replaced as follows:

5.2 Referred Appeals, Disputed Audits and Claims. ELAP shall review all Disputed Audits and Referred Appeals and audit and determine Allowable Claim Limit for all Claims submitted by the Plan Administrator provided that:

(a) The Plan Administrator submitted the Disputed Audit, Referred Appeals and/or the Claims in the manner and within the timeline described in Articles 8.3 (c) and (d) of this agreement;
(b) The Plan Documents applicable to the determination of Disputed Audits, Referred Appeals and/or Claims materially comply with, and have at all times materially complied with, ERISA or any other applicable law, and the Plan Administrator materially complies with, and has at all times materially complied with, any applicable reporting or disclosure obligations (under ERISA or any other applicable law);
(c) Sufficient information is made available to ELAP, in a timely fashion, to review Disputed Audits, Referred Appeals and/or determine Allowable Claim Limits for Claims; and

(d) ELAP is satisfied that the Plan Administrator and/or Plan Sponsor has properly described in Plan Documents ELAP's role with respect to Disputed Audits, Referred Appeals and audit and determination of the Allowable Claim Limit for Claims.

8) Article 5, Core Services, Section 5.5, shall be deleted in its entirely and replaced as follows:

5.5 Payments to Third-Party Experts. ELAP shall pay the fees and costs of third party experts it hires for the purpose of adjudicating Referred Appeals and/or auditing and determining Allowable Claim Limit for Claims submitted by the Plan Administrator; and

9) Article 6, ELAP – Covered Expenses, Section 6.1, shall be deleted in its entirety and replaced as follows:

6.1 ELAP Responsibility for ELAP Covered Expenses. ELAP shall be responsible for payment of all ELAP Covered Expenses (including ELAP Covered Expenses incurred by Plan Participants, provided that the Plan Participants have not pursued legal actions against the Plan and/or the Plan Sponsor with respect to an ELAP audited Claim). Covered Expenses shall be paid by ELAP with ELAP solely approving the choice of legal counsel providing such legal services; provided that any ELAP liability for such legal services will end, and ELAP will have no further liability for any ELAP Covered Expenses, if the Plan refuses to cooperate with legal counsel, including refusing to assent to compromise of Claims and Referred Appeals where the proposed compromise would absolve the Plan of any liability for the disputed amount or benefit.

10) Article 6, ELAP – Covered Expenses, Sections 6.2(a) and 6.2(b)1, are hereby deleted in their entirety and replaced as follows:

(a) ELAP shall not be liable for any amount payable to a Medical Provider for medical services including any Disputed Audits, Referred Appeals or any judgment or verdict arising from or compensating a Medical Provider for any lawsuit regarding an ELAP audited Claim.

(b) 1. The result of disagreement between the Plan Administrator and ELAP that resulted in the Plan Administrator, in accordance with Article 4 of this Agreement, overriding the determinations made by ELAP with respect to a Disputed Audit, Referred Appeal or reimbursing a Claim at an amount other than the Allowable Claim Limit determined by ELAP;

11) Article 8, Responsibilities of the Plan Administrator, Section 8.3, is hereby deleted in its entirety and replaced as follows:

8.3 Claims and Appeal Processing, Submission of Referred Appeals, Disputed Audits and Claims to ELAP.

(a) Complying with all requirements, including notices and disclosures to Plan Participants and Medical Providers, of the DOL Claims Regulations and the ACA, in the processing of Claims and appeals under the Plan. Further, the Plan Administrator shall review Claims and appeals of denied benefits in accordance with the terms of the Plan Documents and applicable laws;

(b) Complying with all provisions of Direct Agreements, including providing required notices, in the processing of Claims submitted under the Plan by Directly Contracted Providers;

(c) Forwarding Disputed Audits and/or Referred Appeals, including the entire file related to the Referred Appeal, to ELAP within three (3) business days of receipt, even if the Plan Participant or the Medical Provider also submits a copy to ELAP. A Disputed Audit or Referred Appeal is considered duly submitted to ELAP when the Plan Administrator provides both the Disputed Audit or Referred Appeal and the entire file relating to the Disputed Audit or Referred Appeal within the timeframe set forth in this paragraph; and

(d) Submitting, within three (3) business days of receipt, Clean Claims to ELAP for audit and determination of Allowable Claim Limit prior to payment being made to Medical Providers.

12) Exhibit B, Allowable Claim Limit Guidelines, Sections 2. Additional Guidelines, section a is hereby removed in its entirety and replaced as follows:

a. **Facility Guidelines.** The Allowable Claim Limit for Claims by a facility, including but not limited to, hospitals, emergency, rehabilitation and skilled nursing centers, and any other health care facility shall be the greater of (I) 112% of the hospital's most recent departmental cost ratio, reported to CMS and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify either one of the hospital's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein, to the extent that it can be identified. In the event that insufficient information is available to identify both the hospital's most recent department cost ratio and the Medicare allowed amount, ELAP shall determine the Allowable Claim Limit, in its sole discretion and in accordance with Section 2.d. or 2.e., below.

13) Exhibit C, Fee Schedule, is amended to add a new first paragraph as follows:

Referred Appeal Services. For Referred Appeal Services provided under this Agreement, one dollar ($1.00) per employee enrolled in the Plan per month. Such amount shall be due on the first of each month during the term of this Agreement.

14) Exhibit D, Referred Appeal Services SLA, is hereby added to the Core Services Agreement as follows:

EXHIBIT D

REFERRED APPEAL SERVICES SLA

ELAP shall use its best efforts to perform its duties under this Referred Appeal Services Service Level Agreement ("SLA") within a period of time that provides the Plan Administrator a reasonable amount of time to meet the compliance time limits set forth in the DOL Claims Regulations (provided that the determination of whether or not a period of time as described above is a "reasonable amount of time" will be determined by ELAP in its sole discretion). The terms of this Exhibit D shall not apply to any appeal for any "claim involving urgent care" which is also a "pre-service claim" (both terms as defined in subsection (m) of 29 C.F.R. § 2560.503-1), which shall be the sole responsibility of the Plan Administrator and any other person or entity to whom it may delegate such responsibilities. ELAP will review Referred Appeals in accordance with the following provisions:

1. ELAP will provide the Plan an external and independent assessment of the denial of benefits by the Plan Administrator for services provided or to be provided by a Medical Provider.
2. ELAP will engage at its own cost the services of an independent review organization (IRO) accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review in accordance with the Plan's appeal review procedures.
3. The IRO review procured by ELAP will review Referred Appeals and determine the applicability of Plan terms (including, but not limited to, Covered Benefits and Excluded Benefits) in accordance with the terms contained in the Plan Documents.
4. In the event that medical services provided or to be provided by a Medical Provider are not explicitly listed as Covered Benefits under the Plan, the IRO should evaluate Medical Eligibility as set forth herein (to the extent such terms are incorporated into Plan Documents). In determining Medical Eligibility for services not explicitly listed as Covered Benefits, the IRO should consider

whether all three of the following criteria (which such criteria are or shall be incorporated into Plan Documents) have been met:

a. The treatment is recommended or performed by an eligible provider for the diagnosis or treatment of an illness or injury;
b. The prevailing opinion within the appropriate specialty of the United States medical profession is that the treatment is safe and effective for its intended use; and
c. The treatment is the most appropriate level of service or supply considering the potential benefits and possible harm to the patient.

5. ELAP shall ensure that its review of Referred Appeals is completed within the time period for notifying Plan Participants of appeal determination, as stated in the provisions of the Plan governing final appeals.
6. For the avoidance of doubt, unless otherwise agreed to by the Third Party Administrator, ELAP is considered to have the exclusive authority under the terms of the Plan to review and make recommendations with regard to Referred Appeals. Unless explicitly indicated to the contrary by the Plan Administrator, this Exhibit D is deemed to be incorporated into the Plan document.

II. Amendment No.2 to the Cost-Containment and Guides Services Agreement

1) Exhibit A, Article I. Definitions, is hereby amended to add the following definition:

"Referred Appeal" shall mean the referral by the Plan Administrator to ELAP of a final appeal, made in accordance with the terms of the Plan by a Plan Participant or a Medical Provider, to review the benefits denied by the Plan Administrator (for services provided by a Medical Provider) on the basis that (1) such services are not Covered Plan Benefits under the Plan, or (2) that if such services are Covered Plan Benefits, the Plan is not financially responsible for some or all of the payment amount. "Referred Appeal" shall not mean any appeal for any "claim involving urgent care" which is also a "pre-service claim" (both terms as defined in subsection (m) of 29 C.F.R. § 2560.503-1 (the "DOL Claims Regulations")), the adjudication of which shall be the sole responsibility of the Plan Administrator and any other person or entity to whom it may delegate such responsibility. "Referred Appeal" shall include appeals for an External Review as defined in the Public Health Service Act (PHS Act) section 2719(b).

2) Exhibit B, Article I. Definitions, (q) Plan Participant, shall be deleted in its entirety and replaced as follows:

(q) "Plan Participant" shall mean, with regard to any Referred Appeal or Clean Claim submitted to ELAP (and at the time such Referred Appeal or Clean Claim is submitted to ELAP), a person whom the Plan Administrator (and/or their designee with regard to such functions) determines is eligible for benefits under the Plan.

3) Exhibit B, Article II. Delegation of Power and Authorities, the last paragraph, is hereby deleted in its entirety and replaced as follows:

In carrying out its co-fiduciary responsibilities to the Plan, ELAP shall act prudently and adhere to the applicable ERISA fiduciary standards of conduct as set forth in Sections 404(a)(1)(A), (a)(1)(B) and (a)(1)(D) (29 U.S.C. § 1104(a) (1) (A), (B) and (D)). The Plan Administrator shall have the authority to override any and all Claims decisions and/or Balance Bill Administration and Defense determinations made by ELAP (including Disputed Audits and Referred Appeals), provided, however, that to the extent that the Plan Administrator overrides any decision and/or determination made by ELAP, ELAP shall not be considered to be a fiduciary with regard to such decision and the Plan Administrator will fully indemnify and make whole ELAP with regard to any claims or disputes (and any expenses related to such claims and disputes) arising out of, or in any way related to, such decisions and/or determinations. Except as provided above, ELAP shall have no fiduciary authority over the Plan, shall not act as a fiduciary with respect to the Plan, and shall not be considered to be the "appropriate named fiduciary" of the Plan for purposes of Section 503 of ERISA and any and all regulations thereunder.

4) Addendum, Metric-Based Negotiation Services Authorization, is hereby added to the Cost-Containment and Guide Services Agreement as follows:

ADDENDUM

METRIC-BASED NEGOTIATION SERVICES AUTHORIZATION

Employer and the Plan expressly authorize ELAP to negotiate on behalf of the Plan with out of network Professional Medical Providers, or their designees/representatives, to reach an agreed upon reimbursement rate up to the Maximum Acceptable Reimbursement during the specified timeframe as detailed below. Any reimbursement amount above the Maximum Acceptable Reimbursement shall require prior written approval from the Plan. The Plan hereby acknowledges and agrees that if ELAP is unable to secure reimbursement rates up to the Maximum Acceptable Reimbursement, and prior approval for an

exception is not granted by the Plan and/or Plan Administrator, ELAP shall provide Claim Audit Review and Repricing and/or Balance Bill Administration and Defense Services (in accordance with the terms of a Core Services Agreement and Cost-Containment and Guide Services Agreement between ELAP and Employer).

The Plan further acknowledges and fully accepts that reimbursement under the terms of this authorization may be higher than the reimbursement amount paid to a Medical Provider under ELAP's Claim Review and Audit Program with the understanding that the purpose of allowing for higher reimbursement amounts is to manage Plan expenses as well as minimize and/or avoid disruption and Plan Participant confusion and dissatisfaction, which may result from payment disputes and balance billing for the benefit of the Plan and Plan Participants. The Plan also understands that Plan Participant cost-sharing, which includes coinsurance, deductibles, and co-pays, may be adjusted as a result of additional reimbursement to the Medical Provider.

Maximum Acceptable Reimbursement

The Employer hereby authorizes ELAP to use the following Maximum Acceptable Reimbursement when providing Metric-based Negotiation Services:

> For post-service negotiations, the Maximum Acceptable Reimbursement for out of network Professional Claims shall be 50% above the original Allowable Claim Limit as determined by ELAP in accordance with its Claim Review and Repricing Services and shall not exceed 90% of billed charges.
>
> For pre-service negotiations, the Maximum Acceptable Reimbursement for out of network Professional Claims shall be 50% above the estimated Allowable Claim Limit as determined by ELAP and shall not exceed 90% of billed charges.

Timeframe for Initiation of Customized ELAP Negotiation for Plan

The Employer authorizes ELAP to provide Metric-Based Negotiation Services in accordance with the above Maximum Acceptable Reimbursement during the following timeframe(s):

Pre-service or post-service where the Medical Provider is disputing reimbursement under the Plan and/or the Plan Participant receives communications regarding a Balance Bill. In the event that ELAP is unable to secure agreement up to the Maximum Acceptable Reimbursement, or receive approval from the Plan for an exception, or in the event a credit impairment or notice of a legal action is received, ELAP will provide its Claim Audit Review and Repricing and Balance Bill Administration and Defense Services.

In pursuing negotiation for settlement of any pre-service negotiations, Balance Bill or payment dispute on behalf of the Plan or Plan Sponsor, ELAP will keep the Plan and Plan Sponsor informed of the following:

a. when ELAP will pursue an agreement or settlement that falls above the Maximum Acceptable Reimbursement and/or ELAP is seeking authority to agree or settle above the Maximum Acceptable Reimbursement;
b. for post-service, when ELAP successfully settles a Balance Bill or payment dispute as part of the Metric-Based Negotiation Services and the Claim will need to be re-processed for additional payment;
c. on a periodic, mutually-agreeable timeframe, a listing of the Claims where negotiations under the Metric-Based Negotiation Services were attempted, but were unsuccessful
d. any stipulations outside of the standard negotiation settlement template that a Medical Provider may require prior to signing a settlement agreement, for which approval from the Plan or Plan Sponsor is needed.

All other provisions of the Agreements and Authorization not expressly amended by this Amendment shall remain in full force and effect.

By signing on behalf of **Gunnison County, Colorado**, the person signing represents and warrants that he/she has the full and complete authority necessary to bind the terms of this Amendment and Authorization as set forth herein.

On behalf of:

Gunnison County, Colorado	**ELAP Services, LLC**
By: _____	By: _____
Name: _____	Name: Trisha Leh
Title: _____	Title: SVP, Operations