State of Colorado Contract Modification
Contract Amendment #7

State Agency
Department of Health Care Policy and Financing

Contractor
Denver Health Medical Plan, Inc.

Original Contract Number
23-176731

Amendment Contract Number
23-176731A7

Contract Performance Beginning Date
July 1, 2022

Current Contract Expiration Date
June 30, 2026

Current Contract Maximum Amount

Initial Term	
State Fiscal Year 2023	No Maximum
Extension Terms	
State Fiscal Year 2024	No Maximum
State Fiscal Year 2025	No Maximum
State Fiscal Year 2026	No Maximum
State Fiscal Year 2027	No Maximum
Total for all State Fiscal Years	**No Maximum**

THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

Each person signing this Amendment represents and warrants that he or she is duly authorized to execute this Amendment and to bind the Party authorizing his or her signature.

CONTRACTOR
Denver Health Medical Plan, Inc.

DocuSigned by:
Greg McCarthy
D02920A8F4B8478...

Date: 01/14/2026 | 09:58 PST

STATE OF COLORADO
Jared S. Polis, Governor
Department of Health Care Policy and Financing
Kim Bimestefer, Executive Director

DocuSigned by:
0B6A84797EA8493...

Date: 01/15/2026 | 09:58 MST

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD
Department of Health Care Policy and Financing
Jerrod Cotosman, Controller

DocuSigned by:
Jerrod Cotosman
76F69541272B43A...

Amendment Effective Date:
01/15/2026 | 10:26 MST

In accordance with §24-30-202, C.R.S., this Amendment is not valid until signed and dated above by the State Controller or an authorized delegate.

1. **Parties**

   This Amendment (the "Amendment") to the Original Contract shown on the Signature and Cover Page for this Amendment (the "Contract") is entered into by and between the Contractor and the State.

2. **Terminology**

   Except as specifically modified by this Amendment, all terms used in this Amendment that are defined in the Contract shall be construed and interpreted in accordance with the Contract.

3. **Amendment Effective Date and Term**

   A. Amendment Effective Date

      This Amendment shall not be valid or enforceable until the Amendment Effective Date shown on the Signature and Cover Page for this Amendment. The State shall not be bound by any provision of this Amendment before that Amendment Effective Date, and shall have no obligation to pay Contractor for any Work performed or expense incurred under this Amendment either before or after the Amendment term shown in **§3.B** of this Amendment.

   B. Amendment Term

      The Parties' respective performances under this Amendment and the changes to the Contract contained herein shall commence on the Amendment Effective Date shown on the Signature and Cover Page for this Amendment or Month Day, Year, whichever is later and shall terminate on the termination of the Contract or Month Day, Year, whichever is earlier.

4. **Purpose**

   The purpose of this Amendment is to update Exhibit B, SOW and Exhibit J, HB Implementation.

5. **Modifications**

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

   A. The Contract Initial Contract Expiration Date on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Expiration Date shown on the Signature and Cover Page for this Amendment.

B. The Contract Maximum Amount table on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Maximum Amount table shown on the Signature and Cover Page for this Amendment.

C. Contract, Section 16.T.iv shall be deleted in its entirety and replaced with the following:

iv. Accessibility Indemnification. Contractor shall indemnify, save, hold harmless, and assume liability on behalf of the State, its officers, employees, agents and assignees (collectively the "Indemnified Parties") for any and all costs, expenses, claims, damages, liabilities, court awards, attorney fees and related costs, and other amounts incurred by any of the Indemnified Parties in relation to Contractor's noncompliance with §§24-85-101, et seq., C.R.S., or the Accessibility Standards for Individuals with a Disability as established by the Office of Information Technology pursuant to Section §24-85-103, C.R.S. State employees are considered third parties for the purposes of this section.

D. Contract, Section 16.U.i shall be deleted in its entirety and replaced with the following:

i. Contractor shall comply with the Accessibility Standards for Individuals with a Disability, as adopted by the Office of Information Technology pursuant to §24-85-103 C.R.S.

E. Contract, Section 16.U.ii shall be deleted in its entirety and replaced with the following:

ii. The State may require that the Contractor's compliance with the Accessibility Standards for Individuals with a Disability adopted by the Office of Information Technology pursuant to §24-85-103 C.R.S. is determined and tested by a qualified third party selected by the State. The State may ask the Contractor to review the selection of the third party. Contractor shall be responsible for all costs associated with the third-party vendor's assessment. If Contractor is not in compliance as determined by the third-party vendor, at the State's request and at the State's direction, Contractor shall promptly take all necessary actions to come into compliance using a State-approved vendor, at no additional cost to the State.

F. Exhibit B-5, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit B-6, Statement of Work, attached hereto and incorporated by reference into the Contract. All references within this Contract to Exhibit B-1, B-2, B-3, B-4 and B-5 shall now be deemed to reference Exhibit B-6

G. Exhibit J, HB 21-1289 Implementation is updated to HB 22-1289 Implementation.

6. Limits of Effect and Order of Precedence

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments or other modifications to the Contract, if any, remain in full force and effect except as specifically modified in this Amendment. Except for the Special Provisions contained in the Contract, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract or any prior modification to the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The provisions of this Amendment shall only supersede, govern, and control over the Special Provisions contained in the Contract to the extent that this Amendment specifically modifies those Special Provisions.

EXHIBIT B-6, STATEMENT OF WORK

1. CHILD HEALTH PLAN PLUS PROGRAM

1.1. Contractor shall administer Colorado's Children Health Plan Plus (CHP+) program in their approved counties.

1.2. Contractor shall administer the program in accordance with the goals and objectives described in C.R.S. 25.5-8-102, that include, but are not limited to:

1.2.1. Supporting low-income, working parents and families in overcoming barriers in obtaining good quality, affordable health care services for their children.

1.2.2. Providing cost-effective, high-quality health services that promote positive health outcomes for enrolled children.

1.2.3. Operating as a private-public partnership with the efficiency and creativity found in private sector systems and business practices while maintaining the highest level of accountability.

1.2.4. Performing as a community-based program that encourages local participation in enrolling children in and supporting its goals.

1.3. Contractor shall administer the program in alignment with the Department's overall goals of improving health, furthering performance outcomes, and reducing the cost of care for Coloradans. Contractor's activities in these areas shall include, but not be limited to, the following:

1.3.1. Improving the exchange of necessary data and information to more effectively monitor program performance and member health.

1.3.2. Establishing increased alignment between CHP+ and Medicaid.

1.3.3. Identifying and pursuing areas of opportunity to improve operational processes and performance.

1.3.4. Collaborating in the sharing of ideas and best practices.

1.3.5. Ensuring long-term sustainability of CHP+.

2. TERMINOLOGY

2.1. In addition to the terms defined in §5 of this Contract, acronyms and abbreviations are defined at their first occurrence in this Contract, Statement of Work. The following list of terms shall be construed and interpreted as follows:

2.1.1. Adverse Benefit Determination:

2.1.1.1. The denial or limited authorization of a requested service, including determinations based on the type or level or service.

2.1.1.2. Requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.

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

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

2.1.1.5. Failure to provide services in a timely manner.

2.1.1.6. Failure of Contractor to act with the timeframes provided in 42 CFR 438.408(b)(1) – (2) regarding the standard resolution of Grievances and Appeals.

2.1.1.7. Denial of an enrollee's request to dispute a financial liability.

2.1.2. Advance Directive – A written instrument recognized under CRS §15-14-505(2), and defined in 42 CFR §489.100, relating to the provision of medical care when the individual is incapacitated.

2.1.3. Appeal – A review by an MCO, PHIP or PAHP, of an Adverse Benefit Determination.

2.1.4. Applicant – Any person applying for the Program but not yet deemed eligible.

2.1.5. Baseline – The Colorado benchmark, which is the weighted national average of Healthcare Effectiveness Data and Information Set (HEDIS) data.

2.1.6. Behavioral Health –When used in this Contract it is referring to both mental health and substance use.

2.1.7. Business Hours – 8:00 a.m.–5 p.m. Mountain Time each Business Day.

2.1.8. Business Interruption - Any event that disrupts Contractor's ability to complete the Work for a period of time, and may include, but is not limited to a Disaster, power outage, strike, loss of necessary personnel or computer virus.

2.1.9. CAHPS – the Consumer Assessment of Healthcare Providers and Systems Health Plan Surveys.

2.1.10. Capitated Payments –Monthly payments the Department makes on behalf of each Member for the provision of non-Fee-for-Service health services.

2.1.11. Care Coordination – The deliberate organization of Client care activities between two or more participants (including the Client and/or family Members/caregivers) to facilitate the appropriate delivery of physical health, Behavioral Health, oral health, specialty care, and other services.

2.1.12. Centers for Medicare and Medicaid Services (CMS) – The United States federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program.

2.1.13. Child Health Plan Plus (CHP+) – CHP+ is Colorado's Children's Health Insurance Program (CHIP). A title XXI Program, it is a low-cost health insurance Program for uninsured Colorado children under age 19 and prenatal women whose families earn too much to qualify for Medicaid but cannot afford private insurance.

2.1.14. Client – An individual eligible for and enrolled in the Colorado CHP+ Program.

2.1.15. Closeout Period – The period beginning on the earlier of 90 days prior to the end of the last Extension Term or notice by the Department of its decision to not exercise its option for an Extension Term and ending on the day that the Department has accepted the final Deliverable for the Closeout Period, as determined in the Department-approved and updated Closeout Plan, and has determined that the closeout is complete.

2.1.16. Code of Federal Regulations (CFR) – The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the Federal Government.

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

2.1.18. Colorado interChange – The Department's Medicaid Management Information System and supporting services, which includes: Fiscal Agent Operations Services, Provider Web Portal, online Provider enrollment, claims processing and payment, Electronic Data Interchange (EDI), Electronic Document Management System (EDMS), Provider call center, help desk, and general information technology functionality and business operations.

2.1.19. Colorado Revised Statutes (C.R.S.):

2.1.19.1. The legal codes of Colorado.

2.1.19.2. The codified general and permanent statutes of the Colorado General Assembly.

2.1.20. Colorado's 10 Winnable Battles – Public health and environmental priorities that have known, effective solutions focusing on:

2.1.20.1. Healthier air.

2.1.20.2. Clean water.

2.1.20.3. Infectious disease prevention.

2.1.20.4. Injury prevention.

2.1.20.5. Mental health and substance use.

2.1.20.6. Obesity.

2.1.20.7. Oral health.

2.1.20.8. Safe food.

2.1.20.9. Tobacco.

2.1.20.10. Unintended pregnancy.

2.1.20.11. The initiative is overseen by the Colorado Department of Public Health and Environment.

2.1.21. Comprehensive Risk Contract – A risk contract, between the Department and an MCO that covers comprehensive services that includes inpatient Hospital Services and any of the following services, or any three or more of the following services as defined in 42 C.F.R. § 438.2:

2.1.21.1. Outpatient Hospital Services.

2.1.21.2. Rural health clinic services.

2.1.21.3. Federally Qualified Health Center (FQHC) services.

2.1.21.4. Other laboratory and x-ray services.

2.1.21.5. Nursing Facility service.

2.1.21.6. Family planning services.

2.1.21.7. Physician services.

2.1.21.8. Home health services.

2.1.22. Contract Year – Each year starting July 1 and ending June 30 during the performance period of this Contract as amended.

2.1.23. Contractor Pre-Existing Material – Material, code, methodology, concepts, process, systems, technique, trade or service marks, copyrights, or other intellectual property developed, licensed or otherwise acquired by Contractor prior to the Effective Date of this Contract and independent of any services rendered under any other contract with the State.

2.1.24. Covered Drug – Those medications that Contractor pays at least part of the cost for at some time during the year. Contractor maintains a formulary which is a list of the drugs, at minimum, that the CHP+ minimum essential benefit provides.

2.1.25. Covered Services – Those services described in Exhibit H, Covered Services and Copayments, all of which Contractor is required to provide or arrange to be provided to a Member. Covered Services shall also mean those services for which payments are made by Contractor as a result of Appeal and External Review Processes.

2.1.26. CPI-U – The Consumer Price Index for All Urban Consumers published by the US Department of Labor, Bureau of Labor Statistics.

2.1.27. Cultural Competence – The provision of all Covered Services by Participating Providers in a manner respectful of the attitudes and health practices of Members from diverse racial, ethnic, religious, age, gender, sexual orientation, and Disability groups, including but not limited to:

2.1.27.1. Language capability.

2.1.27.2. Participating Provider awareness of cultural difference (e.g., medical beliefs, family involvement in medical decisions).

2.1.27.3. Knowledge of special health issues common to racial and ethnic groups (e.g., illnesses common to immigrants, differences in pharmacological dosages for different ages, gender, and racial groups).

2.1.28. Deliverable – Any tangible or intangible object produced by Contractor as a result of the work that is intended to be delivered to the Department, regardless of whether the object is specifically described or called out as a "Deliverable" or not.

2.1.29. Department – The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado.

2.1.30. Designated Client Representative – any person, including a treating Health Care Professional, authorized in writing by the Member or the Member's legal guardian to represent their 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.

2.1.31. Disability or Disabilities – 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.

2.1.32. Disenrollment or Disenroll – The act of discontinuing a Member's Enrollment in Contractor's MCO.

2.1.33. Disaster – An event that makes it impossible for Contractor to perform the Work out of its regular facility or facilities, and may include, but is not limited to, natural Disasters, fire, or terrorist attacks.

2.1.34. Early intervention services and supports or Early Intervention, (EI) – Services described in CRS 27-10.5 part 7, including education, training, and assistance in child development, parent education, therapies, and other activities for infants and toddlers zero through two (0-2) years of age and their families, which are designed to meet the developmental needs of infants and toddlers, which include, but are not limited to:

2.1.34.1. Cognition.

2.1.34.2. Speech.

2.1.34.3. Communication.

2.1.34.4. Physical.

2.1.34.5. Motor.

2.1.34.6. Vision.

2.1.34.7. Hearing.

2.1.34.8. Social-emotional.

2.1.34.9. Self-help skills.

2.1.35. Early Intervention Trust Fund – The trust fund that has been established in accordance with Section 27-10.5-706(2), C.R.S., which is incorporated by reference as defined in 2 CCR 503-1 section 16.912C for the purpose of accepting deposits from private health insurance carriers for Early Intervention Services to be provided on behalf of infants and toddlers under a participating insurance plan.

2.1.36. Effective Date – The date upon which this Contract will take effect, as defined in the Contract.

2.1.37. Emergency Medical Condition – As defined in 42 C.F.R. § 438.114(a) means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

2.1.37.1. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

2.1.37.2. Serious impairment to bodily functions.

2.1.37.3. Serious dysfunction of any bodily organ or part.

2.1.38. Emergency Services – Covered inpatient and outpatient services that are furnished by a Provider that is qualified to deliver these services under 42 C.F.R. § 438 and needed to evaluate or stabilize an Emergency Medical Condition as defined in 42 C.F.R. § 438.114.

2.1.39. Encounter – An instance of a Member going to a Provider and receiving services.

2.1.40. Encounter Data – The information relating to the receipt of any item(s) or service(s) by an enrollee under a Contract between the State and a Provider as defined in 42 C.F.R. § 438.2.

2.1.41. Enroll or Enrollment – The act of entering a Client as a Member of Contractor's MCO.

2.1.42. EQRO – The Department's External Quality Review Organization

2.1.43. Essential Community Provider (ECP) – Providers that historically serve medically needy or medically indigent individuals and demonstrate a commitment to serve low-income and medically indigent populations who comprise a significant portion of the patient population. To be designated an "ECP," the Provider must demonstrate that it meets the requirements as defined in 25.5-5-404.2, C.R.S.

2.1.44. FDA – The Federal Food and Drug Administration.

2.1.45. Fee-for-Service (FFS) – A payment delivery mechanism based on a unit established for the delivery of that service (e.g., office visit, test, procedure, unit of time).

2.1.46. Federally Qualified Health Center (FQHC) – A Hospital-based or free-standing center that meets the FQHC definition found in Section 1905(1)(2)I of the Social Security Act.

2.1.47. Fiscal Agent – A contractor that processes or pays vendor claims on behalf of the agency that administers Medicaid and CHP+.

2.1.48. Fiscal Year (FY) – 12-month period beginning on July 1 of a year and ending on June 30 of the following year.

2.1.49. Frontier County – A county in Contractor's Service Area with a population density less than or equal to 6 persons per square mile.

2.1.50. Health First Colorado – Colorado's Medicaid Program. It was renamed July 1, 2016.

2.1.51. Health Care Professional – A physician or any of the following:

2.1.51.1. Podiatrist.

2.1.51.2. Optometrist.

2.1.51.3. Chiropractor.

2.1.51.4. Psychologist.

2.1.51.5. Dentist.

2.1.51.6. Physician Assistant.

2.1.51.7. Physical or Occupational Therapist.

2.1.51.8. Therapist Assistant.

2.1.51.9. Speech-language Pathologist.

2.1.51.10. Audiologist.

2.1.51.11. Registered or Practical Nurse (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife).

2.1.51.12. Licensed Clinical Social Worker.

2.1.51.13. Registered Respiratory Therapist.

2.1.51.14. Certified Respiratory Therapy Technician.

2.1.51.15. Pharmacist.

2.1.52. Health Maintenance Organization (HMO) – An entity contracting with the Department that meets the definition of Managed Care Organization as defined in CRS §10-16-102.

2.1.53. HEDIS – The Healthcare Effectiveness Data and Information Set developed by the National Committee for Quality Assurance.

2.1.54. HIPAA – The Health Insurance Portability and Accountability Act of 1996.

2.1.55. HHS-OIG – The U.S. Department of Health and Human Services Office of Inspector General.

2.1.56. Hospital Services – Those Medically Necessary Covered Services 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.

2.1.57. Identification Card – Membership card provided to the Member by Contractor upon Enrollment in Contractor's MCO. The Identification Card shall include, at a minimum, the Member's name, Contractor's name, the Member's effective date of Enrollment, and information which will enable the Member to contact Contractor's MCO for assistance.

2.1.58. Indian Health Care Provider – A health care program operated by Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

2.1.59. Indirect Ownership Interest – An Ownership interest in an entity that has an Ownership interest in another entity. This term includes an Ownership interest in any entity that has an Indirect Ownership Interest in another entity.

2.1.60. I/T/U – Indian Health Service, Tribally operated facility/program, and Urban Indian clinic.

2.1.61. Key Personnel – The position or positions that are specifically designated as such in this Contract.

2.1.62. Managed Care Organization (MCO):

2.1.62.1. An entity that has or is seeking to qualify for, a Comprehensive Risk Contract and that is a federally qualified Health Maintenance Organization that meets the advanced directives requirements.

2.1.62.2. Any public or private entity that meets the Advance Directives requirements and is determined by the Secretary to make the services it provides to its CHP+ enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other CHP+ beneficiaries, within the area served by the entity, and meets the solvency standards of 42 C.F.R. § 438.116 as defined in 42 C.F.R. § 438.2.

2.1.63. Managing Employee – A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control, or who directly or indirectly conducts the day-to-day operation.

2.1.64. Marketing – Any communication from MCO, PIHP, PAHP, PCCM or PCCM Entity to a CHP+ beneficiary who is not enrolled in that entity, which can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular, MCO's, PIHP's, PAHP's, PCCM's or PCCM Entity's, Medicaid product, or either to not enroll in or disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM Entity's and other Medicaid product, as defined in CFR 438.104(a).

2.1.65. Marketing Materials – Materials that are produced in any medium, by or on behalf of Contractor, which can be reasonably interpreted as intended to market Contractor's services to Potential Members.

2.1.66. Medical Home – An approach to providing comprehensive Primary Care that facilitates partnerships between individual Members, their Providers, and, where appropriate, the Member's family.

2.1.67. Medical Loss Ratio (MLR):

2.1.67.1. Percent of a premium used to pay for medical claims and activities that improve the quality of care.

2.1.67.2. A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees.

2.1.68. Medicaid – A program authorized by the Colorado Medical Assistance Act (Section 25.5-4-104, et seq., C.R.S.) and Title XIX of the Social Security Act.

2.1.69. Medicaid Management Information Systems (MMIS) – The Department's automated computer systems that process Medicaid and CHP+ claims and other pertinent information as required under federal regulations.

2.1.70. Medically Necessary – Also called Medical Necessity, shall be defined as described in 10 CCR 2505-10 § 8.076.1.8.

2.1.71. Medical Record – A document, either physical or electronic, that reflects the utilization of health care services and treatment history of the Member.

2.1.72. Member – Any individual enrolled in Contractor's MCO.

2.1.73. Member Handbook – The standard booklet provided to Members that outlines Contractor's policies and procedures, setting forth in detail, the minimum scope and level of Covered Services provided under this Contract, the terms of coverage, and any other pertinent information regarding Contractor's MCO.

2.1.74. Monthly Capitation Payment – A payment the State makes on a monthly basis to a Contractor on behalf of each Member enrolled in its plan under a contract and based on the actuarially sound capitation rate for the provision of services covered under the Contract.

2.1.75. Network Provider – A Provider who is in the employment of, or who has entered into an agreement with, Contractor to provide medical or specialty Behavioral Health services to Contractor's Members.

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

2.1.77. Nursing Facility – A facility that primarily provides skilled nursing care and related services to residents for the rehabilitation of individuals who are injured, disabled, or sick, or on a regular basis above the level of custodial care to other individuals with intellectual or developmental Disabilities.

2.1.78. Operational Start Date – The Effective Date of the Contract, or when the Department authorizes Contractor to begin fulfilling its obligations under the Contract.

2.1.79. Other Personnel - Individuals and Subcontractors, in addition to Key Personnel, assigned to positions to complete tasks associated with the Work.

2.1.80. Overpayment - Any payment made to a Network Provider by an MCO, PIHP, or PAHP to which the Network Provider is not entitled under Title XIX or Title XXI of the Act or any payment to an MCO, PIHP, or PAHP by HHSC to which the MCO, PIHP, or PAHP is not entitled to under Title XIX or Title XXI of the Act. An Overpayment may include but is not limited to, improper payments made as the result of Fraud, Waste, and Program Abuse.

2.1.81. Ownership – The possession of equity in the capital, stock, or profits of an entity.

2.1.82. Ownership or Control Interest – An individual or entity that:

2.1.82.1. Has an ownership interest totaling 5% or more.

2.1.82.2. Has an Indirect Ownership Interest equal to 5% or more.

2.1.82.3. Has a combination of direct and Indirect Ownership Interests equal to 5% or more.

2.1.82.4. Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation to another entity, if that interest equals at least 5% of the value of the property or assets of the other entity.

2.1.82.5. Is an officer or director of an entity that is organized as a corporation.

2.1.83. Is a partner in an entity that is organized as a partnership.

2.1.84. Participating Provider – A Provider who is in the employ of, or who has entered into an agreement with, Contractor to provide medical services to Contractor's Members.

2.1.85. Passive Enrollment – Enrollment of eligible CHP+ Clients within a geographical Service Area into a Contractor's MCO, subject to the Member's election not to accept Enrollment and to choose a different Enrollment.

2.1.86. Persons with Special Health Care Needs – persons defined in 10 C.C.R. 2505-10, §8.205.9, et seq.

2.1.87. PHI - Protected Health Information.

2.1.88. Post-Stabilization Care Services – Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Member's condition.

2.1.89. Prepaid Inpatient Health Plan (PIHP) – An entity that provides health and medical services to enrollees under a non-Comprehensive Risk Contract with the Department, and on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates, and provides, arranges for, or is otherwise responsible for the provisions of any inpatient Hospital or institutional services for its enrollees as defined in 42 C.F.R. § 438.2.

2.1.90. Prevalent Language(s) – A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient, as defined in 42 C.F.R. § 438.10(a).

2.1.91. Primary Care – All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner performs the service.

2.1.92. Primary Care Provider, Primary Care Physician or PCP – A physician, a physician group practice, or an appropriately licensed Health Care Professional, who has entered into a professional service agreement to serve the Members of Contractor's MCO, and has been designated by Contractor, and selected by the Member as the Provider who will attend to the Member's routine medical care, supervise and/or coordinate the delivery or all Medically Necessary Covered Services to the Member.

2.1.93. Program – The Colorado Children's Basic Health Plan ("CBHP"), which is implemented by the Department, pursuant to CRS §25.5- 8, et seq. Colorado Children's Basic Health Plan Program is known to the public as Child Health Plan Plus or CHP+.

2.1.94. Protected Health Information (PHI) – Any Protected Health Information, including, without limitation any information whether oral or recorded in any form or medium:

2.1.94.1. That relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

2.1.94.2. That identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2.1.94.3. PHI includes, but is not limited to, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act.

2.1.95. Provider – Any Health Care Professional or entity that has been accepted as a Provider in the Medicaid program as determined by the Department.

2.1.96. Provider Directory – A list of physicians, Hospitals, dentists, pharmacies, physician assistants, certified nurse practitioners, or other licensed, certified or registered Health Care Professionals or facilities that have entered into a professional service agreement with Contractor to provide Covered Services for Contractor's Members.

2.1.97. Provider Dispute – Any administrative, payment, or other dispute between a Provider and a Contractor that does not involve a Member Appeal and does not include routine Provider inquires that Contractor resolves in a timely fashion through existing informal processes.

2.1.98. Provider Network – The Participating Providers in Contractor's MCO.

2.1.99. Provider Preventable Conditions – 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.

2.1.100. Qualified Interpreter – An interpreter who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary.

2.1.101. Referral or Written Referral – A document from a Provider that recommends or provides permission for a Member to receive additional services.

2.1.102. Rural County – A county in Contractor's Service Area with a total population of less than 100,000 people.

2.1.103. Rural Health Center (RHC) – A Hospital-based or free-standing center that meets the RHC definition found in Section 1905(1)(2)(B) of the Social Security Act.

2.1.104. Service Area – Those counties within the State of Colorado in which:

2.1.104.1. Contractor has been authorized by the Colorado Division of Insurance to conduct business as a Health Maintenance Organization.

2.1.104.2. Contractor has assured access to Covered Services under this Contract.

2.1.104.3. The Department and Contractor have agreed that Contractor shall provide Covered Services to Members.

2.1.105. Significant Business Transaction – Any business transaction or series of transactions that, during any one Fiscal Year, exceed the lesser of $25,000.00 or 5% of Contractor's total operating expenses.

2.1.106. Site Review – The visit of Department staff or its designee to the site or the administrative office(s) of Contractor and/or its Network Providers and/or Subcontractors to assess the physical resources and operational practices in place to deliver contracted services and/or health care.

2.1.107. Stakeholder – any individual, group or organization that is involved in or affected by a course of action related to the CHP+ program. Stakeholders may be Members, family Members, caregivers, clinicians, advocacy groups, professional societies, businesses, policymakers, or others.

2.1.108. Start-Up Period – The period from the Effective Date until the Operational Start Date.

2.1.109. State Review – The process set forth in 42 C.F.R. § 431 subpart E.

2.1.110. Subcontractor – An individual or entity that has a contract with an MCO, PIHP, or PCCM Entity that relates directly or indirectly to the performance of the MCO, PIHP, or PCCM Entity's obligations under its contract with the state. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with the MCO, or PIHP as defined in 42 C.F.R. § 438.2.

2.1.111. Suburban County – A county in Contractor's Service Area with a total population greater than 20,000 people, but less than 100,000 people as determined by the most recent decennial census.

2.1.112. Terminally Ill – As defined in Section 1861 (dd)(3)(A) of the Federal "Social Security Act", an individual is considered to be "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

2.1.113. Termination/Terminated – Occurring when a state Medicaid program, CHP+, or the Medicare program has taken action to revoke a Medicaid or CHP+ Provider's, Medicare Provider's or supplier's billing ID.

2.1.114. Urban County – A county in Contractor's Service Area with a total population equal to or greater than 100,000 people.

2.1.115. Urgent Medical Condition – A medical condition that has the potential to become an Emergency Medical Condition in the absence of treatment.

2.1.116. Urgently Needed Services – The Covered Services that must be delivered to prevent a serious deterioration in the health of a Member. Defined at 42 CFR §422.113(b)(1)(iii).

2.1.117. Utilization Management – The function wherein use, consumption, and outcome services, along with level and intensity of care, are reviewed for their appropriateness using Utilization Review techniques.

2.1.118. Utilization Review – 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.

2.1.119. Wholly Owned Supplier – A supplier whose total Ownership interest is held by Contractor or by a person, persons, or other entity with an Ownership or Control Interest in Contractor.

2.1.120. Work – The tasks and activities Contractor is required to perform to fulfill its obligations under the Contract, including the performance of any services and delivery of any goods.

2.1.121. Work Product – The tangible and intangible results of the Work, whether finished or unfinished, including drafts. Work Product includes, but is not limited to:

2.1.121.1. Documents.

2.1.121.2. Texts.

2.1.121.3. Software (including source code).

2.1.121.4. Research.

2.1.121.5. Reports.

2.1.121.6. Proposals.

2.1.121.7. Specifications.

2.1.121.8. Plans.

2.1.121.9. Notes.

2.1.121.10. Studies.

2.1.121.11. Data.

2.1.121.12. Images.

2.1.121.13. Photographs.

2.1.121.14. Negatives.

2.1.121.15. Pictures.

2.1.121.16. Drawings.

2.1.121.17. Designs.

2.1.121.18. Models.

2.1.121.19. Surveys.

2.1.121.20. Maps.

2.1.121.21. Materials.

2.1.121.22. Ideas.

2.1.121.23. Concepts.

2.1.121.24. Know-how.

2.1.121.25. Any other results of the Work.

2.1.121.26. "Work Product" does not include any Contractor Pre-Existing Material that is used, without modification, in the performance of the Work.

2.2. Any other term used in this Contract that is defined in an Exhibit shall be construed and interpreted as defined in that Exhibit.

3. CONTRACTOR'S GENERAL REQUIREMENTS

3.1. Contractor shall be solely responsible for all tasks and deliverables to be completed, services to be rendered and performance standards to be met under the work outlined in this Contract. (Ref. Exhibit E, Section 1.2.)

3.2. Contractor shall use the Department-developed definition for the following terms, when applicable and when available:

3.2.1. Appeal.

3.2.2. Capitation.

3.2.3. Co-payment.

3.2.4. Durable Medical Equipment.

3.2.5. Emergency Room Care.

3.2.6. Emergency Services.

3.2.7. Excluded Services.

3.2.8. Grievance.

3.2.9. Habilitation Services and Devices.

3.2.10. Health Insurance.

3.2.11. Home Healthcare.

3.2.12. Hospice Services.

3.2.13. Hospitalization.

3.2.14. Hospital Outpatient Care.

3.2.15. Medically Necessary.

3.2.16. Network.

3.2.17. Non-participating Provider.

3.2.18. Physician Services.

3.2.19. Plan.

3.2.20. Preauthorization.

3.2.21. Prescription Drug Coverage.

3.2.22. Primary Care Physician (PCP).

3.2.23. Participating Provider.

3.2.24. Provider.

3.2.25. Rehabilitation Services and Devices.

3.2.26. Skilled Nursing Care.

3.2.27. Specialist.

3.2.28. Urgent Care.

3.3. Deliverables (Ref. Exhibit E, Section 1.6.)

3.4. Communication with the Department (Ref. Exhibit E, Section 1.8.)

3.5. Start-Up and Closeout Periods.

3.5.1. Contractor shall have a Start-Up and a Closeout Period.

3.5.2. Start-Up Period

3.5.2.1. The Start-Up Period shall begin on the Effective Date. The Start-Up Period shall end on the Operational Start Date of the Contract.

3.5.2.2. Contractor shall receive no compensation for the Start-Up Period.

3.5.2.3. Start-Up Plan (Ref. Exhibit E, Section 1.9.4.)

3.5.2.4. Contractor shall submit to the Department Contractor's Colorado Division of Insurance license as a Health Maintenance Organization.

3.5.2.4.1. DELIVERABLE: Contractor's Colorado Division of Insurance license

3.5.2.4.2. DUE: Upon the Effective Date

3.5.2.5. 3.5.2.5. Contractor shall ensure that all requirements of the Start-Up Period are complete by the deadlines contained in the Department-approved Start-Up Plan and that Contractor is ready to perform all Work by the Operational Start Date.

3.5.3. Closeout Period (Ref. Exhibit E, Section 1.10.)

3.5.4. Closeout Plan (Ref. Exhibit E, Section 1.9.5.)

3.6. Business Continuity Plan (Ref. Exhibit E, Section 1.9.3.)

3.7. Contractor shall participate in special workgroups created by the Department or other state agencies as directed by the Department and shall provide requested deliverables to support these workgroups in line accordance with agreed-upon terms and deadlines established by the workgroups.

3.8. Accreditation

3.8.1. In accordance with 42 C.F.R. § 438.332(a) Contractor shall inform the Department of whether it is accredited by a private independent accrediting entity. If so, Contractor shall allow the accrediting entity to provide the Department a copy of the most recent review, including:

3.8.1.1. Accreditation status, survey type, and level.

3.8.1.2. Accreditation results including recommended actions, corrective action plans, or findings.

3.8.1.3. Expiration date of the accreditation.

3.9. Federal Financial Participation Related Intellectual Property Ownership

3.9.1. In addition to the intellectual property Ownership rights specified in the Contract, the following subsections enumerate the intellectual property Ownership requirements Contractor shall meet during the term of the Contract in relation to federal financial participation under 42 CFR §433.112 and 42 CFR §95.617 concerning Mechanized Claim Processing and Information Retrieval Systems ("MCPIRS") to the extent that regulations apply to Contractor's operations under this Contract. CMS Regulations and Guidance, including, but not limited to, the CMS Memorandum RE: Mechanized Claim Processing and Information Retrieval Systems – Enhanced Funding, dated March 31, 2016 (SMD# 16-004) shall be applicable when interpreting requirements of this section and only to the extent they apply to Contractor. Intellectual property Ownership rights specified in the Contract shall not apply to (1) material created or used by Contractor which is unrelated to federal financial participation funding obtained by the State under 42 CFR §433.112 and 45 CFR §95.617 in connection with its MCPIRS, (2) material created using funds other than Contract Funds or (3) material that would

have been developed by Contractor to enhance its own proprietary intellectual property and commercial software used in Contractor's business operations unrelated to the MCPIRS, using funds outside of Contract Funds and regardless of Contractor's performance of work.

3.9.1.1. Contractor shall notify the State before designing, developing, creating or installing any new data, new software or modification of a software using Contract Funds. Contractor shall not proceed with such designing, development, creation or installation of data or software without express written approval from the State.

3.9.1.2. If Contractor uses Contract Funds to develop necessary materials, including, but not limited to, programs, products, procedures, data and software to fulfill its obligations under the Contract, Contractor shall document all Contract Funds used in the development of the Work Product, including, but not limited to the materials, programs, procedures, and any data, software or software modifications.

3.9.1.2.1. The terms of this Contract will encompass sole payment for any and all Work Product and intellectual property produced by Contractor for the State. Contractor shall not receive any additional payments for licenses, subscriptions, or to remove a restriction on any intellectual property Work Product related to or developed under the terms of this Contract.

3.9.1.3. Contractor shall provide the State comprehensive and exclusive access to and disclose all details of the Work Product produced using Contract Funds.

3.9.1.4. Contractor shall hereby assign to the State, without further consideration, all right, interest, title, Ownership and Ownership rights in all Work Product and Deliverables prepared and developed by Contractor for the State, either alone or jointly, under this Contract, including, but not limited to, data, software and software modifications designed, developed, created or installed using Contract Funds, as allowable in the United States under 17 USC §201 and §204 and in any foreign jurisdictions.

3.9.1.4.1. Such assigned rights include, but are not limited to, all rights granted under 17 USC §106, the right to use, sell, license or otherwise transfer or exploit the Work Product and the right to make such changes to the Work Product as determined by the State.

3.9.1.4.2. This assignment shall also encompass any and all rights under 17 USC §106A, also referred to as the Visual Artists Rights Act of 1990 (VARA) and any and all moral rights to the Work Product.

3.9.1.4.3. Contractor shall require its employees and agents to, promptly sign and deliver any documents and take any action the State reasonably requests to establish and perfect the rights assigned to the State or its designees under these provisions.

3.9.1.4.4. Contractor shall execute the assignment referenced in section 3.13.1.4 immediately upon the creation of the Work Product pursuant to the terms of this Contract.

3.9.1.5. The State claims sole Ownership and all Ownership rights in all copyrightable software designed, developed, created or installed under this Contract, including, but not limited to:

3.9.1.5.1. Data and software, or modifications thereof created, designed or developed using Contract Funds.

3.9.1.5.2. Associated documentation and procedures designed and developed to produce any systems, programs, reports, and documentation.

3.9.1.5.3. All other Work Products or documents created, designed, purchased, or developed by Contractor and funded using Contract Funds.

3.9.1.6. All Ownership and Ownership rights pertaining to Work Product created in the performance of this Contract will vest with the State, regardless of whether the Work Product was developed by Contractor or any Subcontractor.

3.9.1.7. Contractor shall fully assist in and allow without dispute, both during the term of this Contract and after its expiration, registration by the State of any and all copyrights and other intellectual property protections and registrations in data, software, software modifications or any other Work Product created, designed or developed using Contract Funds.

3.9.1.8. The State reserves a royalty-free, non-exclusive and irrevocable license to produce, publish or otherwise use such software, modifications, documentation and procedures created using Contract Funds on behalf of itself, the Federal Department of Health and Human Services (HHS) and its Contractors. Such data and software includes, but is not limited to, the following:

3.9.1.8.1. All computer software and programs, which have been designed or developed for the State, or acquired by Contractor on behalf of the State, which are used in performance of the Contract.

3.9.1.8.2. All internal system software and programs developed by Contractor or Subcontractor, including all source codes, which result from the performance of the Contract, excluding commercial software packages purchased under Contractor's own license.

3.9.1.8.3. All necessary data files.

3.9.1.8.4. User and operation manuals and other documentation.

3.9.1.8.5. System and program documentation in the form specified by the State.

3.9.1.8.6. Training materials developed for State staff, agents or designated representatives in the operation and maintenance of this software.

3.10. Performance Reviews (Ref. Exhibit E, Section 1.11.)

3.11. Renewal Options and Extensions (Ref. Exhibit E, Section 1.12.)

3.12. Protection of Systems Data

3.12.1. In addition to the requirements of the main body of this Contract, if Contractor or any Subcontractor is given access to State Records by the State or its agents in connection with Contractor's performance under the Contract, Contractor shall protect all State Records in accordance with this Contract. All provisions of this Contract that refer to Contractor shall apply equally to any Subcontractor performing Work in connection with the Contract.

3.12.2. For the avoidance of doubt, the terms of this Contract shall apply to the extent that any of the following statements is true in regard to Contractor access, use, or disclosure of State Records:

3.12.2.1. Contractor provides physical or logical storage of State Records.

3.12.2.2. Contractor creates, uses, processes, discloses, transmits, or disposes of State Records.

3.12.2.3. Contractor is otherwise given physical or logical access to State Records in order to perform Contractor's obligations under this Contract.

3.12.3. Contractor shall, and shall cause its Subcontractors, to do all of the following:

3.12.3.1. Provide physical and logical protection for all hardware, software, applications, and data that meets or exceeds industry standards and the requirements of this Contract.

3.12.3.2. Maintain network, system, and application security, which includes, but is not limited to, network firewalls, intrusion detection (host and network), annual security testing, and improvements or enhancements consistent with evolving industry standards.

3.12.3.3. Comply with State and Federal rules and regulations related to overall security, privacy, confidentiality, integrity, availability, and auditing.

3.12.3.4. Provide that security is not compromised by unauthorized access to workspaces, computers, networks, software, databases, or other physical or electronic environments.

3.12.3.5. Promptly report to the Department all Incidents, including Incidents that do not result in unauthorized disclosure or loss of data integrity.

3.12.3.6. Colorado Information Security Policy (CISP) Compliance (Ref. Exhibit E, Section 4.1.4.)

3.12.3.7. Health and Human Services HIPAA Security Rule Risk Assessments (Ref. Exhibit E, Section 4.1.5.)

3.12.4. Data Handling (Ref. Exhibit E, Section 4.2.)

4. CONTRACTOR SERVICE AREA AND PERSONNEL

4.1. Contractor shall serve as a CHP+ MCO for Members enrolled with Contractor.

4.2. Contractor's participation in the Program is limited to Enrollment of Members who reside in Contractor's Service Area and are Enrolled in accordance with the terms of this Contract.

4.3. Geographic coverage in the Program may be changed only upon approval by the Department.

4.4. Contractor may request to change their service area at least six months prior to Contractor's expected expansion date, Contractor shall provide the Department with a written request, and a service plan analysis when seeking to expand into a new Service Area. Such written notice and analysis shall include, but not be limited to:

4.4.1. The name of the proposed county or counties in which Contractor is licensed by the Colorado Division of Insurance to conduct business as a Health Maintenance Organization (HMO).

4.4.2. A demonstration that Contractor's Provider Network has the capacity to serve the expected Member Enrollment in the proposed county, provide the full scope of benefits, and comply with the standards for access to care as specified in this Contract.

4.4.2.1. The demonstration shall include an analysis that Contractor maintains a sufficient number, mix, and geographic distribution of Providers.

4.5. Contractor shall be required to participate in an operational readiness review at the direction of the Department, including but not limited to the requirements specified in section 3.10.3.1.3.

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

4.7. Contractor shall notify the Department of plans to discontinue providing Covered Services to Members within a county or counties within Contractor's Service Area, by providing no less than six months prior written notice to the Department of Contractor's intent to discontinue such services. Such written notice shall include, but not be limited to:

4.7.1. The name of the proposed county or counties in which Contractor plans to discontinue providing Covered Services.

4.7.2. Contractor's continuity of care policies and procedures, and plan to minimize disruption to Members' access to care and service delivery.

4.7.3. A notice to Members enrolled with Contractor, consistent with 42 CFR 438.10, that Contractor shall discontinue providing Covered Services in the Member's county.

4.7.4. A notice to Network Providers that Contractor shall discontinue providing Covered Services in the specified county or counties.

4.8. Personnel (Ref. also Exhibit E, Section 2.)

4.8.1. Contractor shall possess the organizational resources and commitment necessary to perform the work and successfully implement and operate the program in Contractor's Region. Specifically, Contractor shall:

4.8.1.1. Have a defined organizational structure with clear lines of responsibility, authority, communication and coordination throughout the organization.

4.8.1.2. Have a physical office located in the state of Colorado, unless otherwise approved by the Department in writing.

4.8.2. Contractor shall hire Key Personnel and other Personnel with experience serving the types of communities and Members the Contractor serves.

4.8.2.1. Contractor shall update this list upon the Department's request to account for changes in the individuals assigned to the Contract.

4.8.2.1.1. DELIVERABLE: Updated Management/Supervisory Staff Contact Information

4.8.2.1.2. DUE: Within five Business Days following the Department's request for an update

4.8.3. Personnel Availability

4.8.4. Contractor shall ensure Key Personnel and Other Personnel assigned to the Contract are available for meetings with the Department during the Department's normal Business Hours, as determined by the Department. Contractor shall also make these personnel available outside of the Department's normal Business Hours and on weekends with prior notice from the Department.

4.8.5. Contractor's Key Personnel and Other Personnel shall be available for all regularly scheduled meetings between Contractor and the Department, unless the Department has granted prior, written approval.

4.8.6. Contractor shall ensure that the Key Personnel and Other Personnel attending all meetings between the Department and Contractor have the authority to represent and commit Contractor regarding work planning, problem resolution and program development.

4.8.7. At the Department's direction, Contractor shall make its Key Personnel and Other Personnel available to attend meetings, as subject matter experts, with Stakeholders both within the state government and with external or private Stakeholders.

4.8.8. All of Contractor's Key Personnel and Other Personnel that attend any meeting with the Department or other Department Stakeholders shall be physically present at the location of the meeting, unless the Department gives prior, written permission to attend by telephone or video conference. If Contractor has any personnel attend by telephone or video conference, Contractor shall provide all additional equipment necessary for attendance, including any virtual meeting space or telephone conference lines.

4.8.9. Contractor shall respond to all telephone calls, voicemails, and emails from the Department within one Business Day of receipt by Contractor.

4.8.10. Key Personnel (Ref. Exhibit E, Section 2.3.)

4.8.11. Subcontractors (Ref. Exhibit E, Section 2.5.)

5. CHILD HEALTH PLAN PLUS CONTRACTOR

5.1. Contractor shall perform all of the functions described in this Contract in compliance with all pertinent state and federal statutes, regulations, and rules.

5.2. Contractor shall be licensed pursuant to C.R.S. §10-16 Part 4, et seq., and the Division of Insurance as a Health Maintenance Organization.

5.2.1. Contractor shall notify the Department, within two business days, of any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, denying renewal, or notifying Contractor of any noncompliance pursuant to C.R.S. §10-16-401, et seq. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, insurance, permits, etc. required for 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.

5.2.2. Contractor shall meet the solvency standards set forth in C.R.S. §10-16-411, et seq., and its implementing regulations and any other applicable regulations. Contractor shall notify the Department, within two 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.

5.3. Contractor shall have a governing body responsible for oversight of Contractor's activities in relation to this Contract.

5.4. Contractor shall publicly list information on Contractor's governing body on Contractor's website, including, but not limited to, the names of the Members of the governing body and their affiliations.

5.5. Contractor shall select members of the governing body in such a way as to minimize any potential or perceived conflicts of interest.

5.6. Contractor shall create a written Organizational Governance Plan that:

5.6.1. Describes how Contractor shall protect against any perceived conflict of interest among its governing body from influencing Contractor's activities under this Contract.

5.6.1.1. Contractor shall include as conflicts of interest any party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor.

5.6.1.2. Contractor shall ensure that conflicts of interest include, but are not limited to, agents, Managing Employees, persons with an Ownership or controlling interest in Contractor and their immediate families, Members of the governing body, Subcontractors, wholly owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

5.6.1.3. Is posted publicly on Contractor's website.

5.6.1.4. Contractor shall submit the Organizational Governance Plan to the Department.

5.6.1.4.1. DELIVERABLE: Organizational Governance Plan

5.6.1.4.2. DUE: Within 30 Business days after Effective Date

5.6.1.5. Contractor shall submit an updated written Governance Plan to the Department and post it when a change is made to the report.

5.6.1.6. Contractor shall update the Organizational Governance Plan and shall submit the Updated Governance Plan to the Department any time a change in governance is discovered by Contractor.

5.6.1.6.1. DELIVERABLE: Updated Organizational Governance Plan

5.6.1.6.2. DUE: Within 30 days after the new change in governance is discovered

6. MEMBER ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

6.1. Contractor shall understand the Member Enrollment processes described in this section.

6.1.1. All CHP+ Clients will be mandatorily enrolled into an MCO.

6.1.2. Individuals in the following categories are eligible for Enrollment in Contractor's MCO:

6.1.2.1. CHP+ Child (N1).

6.1.2.2. CHP+ Prenatal (N2).

6.1.2.3. CHP+ Newborn (N4).

6.1.2.4. CHP+ Prenatal PE (K2).

6.1.2.5. CHP+ Child PE (K7).

6.2. Contractor shall verify CHP+ eligibility and enrollment using the Health Insurance Portability and Accountability Act (HIPAA) 834 Benefit Enrollment and Maintenance transaction generated from the Colorado interChange (MMIS). The Colorado Medical Assistance Program Web Portal may also be used to verify CHP+ eligibility and enrollment. The Department is the final arbiter for all discrepancies between the various systems utilized for verifying eligibility and enrollment.

6.2.1. Contractor shall have systems capable of receiving and processing 834 transactions generated by the Colorado interChange.

6.2.2. Contractor shall ensure that Network Providers supply services only to eligible CHP+ Members.

6.2.2.1. Contractor shall ensure that Network Providers verify that the individuals receiving services covered under this Contract are CHP+ eligible on the date of service, and whether Contractor has authorized a referral or made special arrangements with a provider, when appropriate.

6.3. Enrollment

6.3.1. The Department will Enroll Members into an MCO based on the Department enrollment policies and procedures.

6.3.2. Any Client determined eligible for the program may be Enrolled in Contractor's MCO, provided that the Client resides within in Contractor's Service Area.

6.3.3. Contractor shall accept all eligible Members that are Enrolled with Contractor by the Department in the order in which they are assigned without restriction.

6.3.3.1. Contractor shall not discriminate against Clients eligible to Enroll on the basis of:

6.3.3.1.1. Financial viability.

6.3.3.1.2. Race.

6.3.3.1.3. Color.

6.3.3.1.4. National origin.

6.3.3.1.5. Sex.

6.3.3.1.6. Sexual orientation.

6.3.3.1.7. Gender identity.

6.3.3.1.8. Disability.

6.3.3.2. Contractor shall not use any policy or practice that has the effect of discriminating on the basis of:

6.3.3.2.1. Race.

6.3.3.2.2. Color.

6.3.3.2.3. National origin.

6.3.3.2.4. Sex.

6.3.3.2.5. Sexual orientation.

6.3.3.2.6. Gender identity.

6.3.3.2.7. Disability.

6.3.3.3. Contractor shall also not discriminate against Clients eligible to Enroll on the basis of health status or need for health care services.

6.3.4. The Department will Enroll Members into an MCO on the same day that a Member's CHP+ eligibility notification is received in the Colorado interChange from the Colorado Benefit Management System (CBMS).

6.3.5. The Department may re-determine eligibility status at any time during the term of this Contract, and retroactively adjust the Member's Enrollment status accordingly.

6.3.6. The Department will automatically re-Enroll Members into Contractor's MCO, that was in effect at the time of their loss of CHP+ eligibility, if there is a loss of eligibility of two months or less.

6.3.7. Contractor may limit Enrollment of new Clients, other than newborns, by notifying the Department, in writing, that it will not accept new Clients as long as the Enrollment limitation does not conflict with applicable Federal and State statutes and regulations.

6.3.7.1. In the event that Contractor limits the number of Clients it will accept, Contractor shall notify the Department when the number of Clients is approaching the limit. Contractor shall comply with all timelines and notice requirements, as determined by the Department.

6.3.8. Enrollment of a Newborn

6.3.8.1. Contractor shall furnish Covered Services to newborns who are determined CHP+ eligible. The Department will retroactively enroll the newborn into Contractor's MCO upon receipt of the newborn's state identification number, with a date of enrollment equivalent to the newborn's CHP+ eligibility effective date, which is equivalent to the newborn's date of birth.

6.3.8.1.1. Contractor shall assist in facilitating newborn enrollment and acquiring their own state identification number as soon as possible after their date of birth.

6.3.8.1.1.1. Contractor shall only accept claims for newborn's which are submitted using the newborn's state identification number. All members must have a state identification number prior to the submission of claims.

6.3.8.1.2. Upon receipt of the newborn's state identification number, the Department will automatically enroll newborns into the same MCO as the newborn's mother.

6.3.8.2. Eligible and enrolled newborns shall have 12 months of continuous coverage from their date of birth.

6.3.9. Enrollment of Presumptively Eligible Members

6.3.9.1. Contractor shall furnish Covered Services, as specified in Exhibit H, to Members who are determined presumptively eligible, with a date of enrollment equivalent to the Member's presumptive eligibility effective date.

6.3.9.2. If the Member is determined to not be fully eligible for CHP+, enrollment will end on the last day of the month following the month of approval for presumptive eligibility.

6.3.9.3. Contractor shall receive a Monthly Capitation Payment, as specified in Exhibit C, Rates, for each presumptively eligible Member enrolled to its plan.

6.3.10. Enrollment During Hospitalization

6.3.10.1. If a Potential Member of Contractor's Managed Care Organization is an inpatient of a Hospital at 11:59 p.m. the day before their Enrollment is scheduled to take effect, Enrollment shall be postponed until the first day of the month following discharge.

6.3.10.1.1. Contractor shall, within 14 calendar days of the date Contractor discovers the Member or Potential Member's Hospital admission, notify the Department, and request that the Enrollment be postponed. The new effective date of the Member's Enrollment will then be the first day of the month following the month of discharge. Contractor's request shall include:

6.3.10.1.1.1. The name of the hospital where the Member or Potential Member was an inpatient.

6.3.10.1.1.2. The date of inpatient admission of the Member.

6.3.10.1.2. The Department shall respond to Contractor, in writing, within 5 Business Days of Contractor's request to postpone enrollment or upon confirmation of the hospitalization, whichever is later.

6.4. Annual Open Enrollment Period

6.4.1. Pursuant to 42 C.F.R. §438, Members enrolled in Contractor's MCO will have 90 days in which they may elect to Disenroll from Contractor's MCO and Enroll in another CHP+ plan participating in the Program in their respective geographic region. Those who do not change MCOs shall be enrolled until the Member's next Open Enrollment Period, at which time the Member shall receive an open enrollment notice.

6.4.2. Contractor shall understand that Members may select a different MCO within specified timeframes at the time of eligibility determination and eligibility redetermination through the Department or the Department's designee.

6.4.2.1. Pursuant to section 1932(a)(4)(B) of the Social Security Act and 42 C.F.R. §438.10(f)(1), the Department will notify Members of their Disenrollment rights at least 60 calendar days before each annual Enrollment opportunity.

6.4.3. Assignment into a different MCO will be effective the first day of the month following Disenrollment.

6.4.4. Contractor shall develop procedures to transition services in the event that a Member's assignment is changed from one MCO to a different MCO to ensure that the Member's quality, quantity and timeliness of care is not affected during the transition.

6.4.5. Contractor shall conduct outreach to members to assist them in responding the Department renewal requests for additional information and submitting necessary renewal forms. Contractor shall use multiple modalities when conducting outreach, including telephone, email, and text.

6.4.6. Contractor shall conduct outreach to members who are terminated from CHP+ for procedural reasons and assist individuals in responding to previous renewal requests for additional information and submitting necessary renewal forms.

6.5. Disenrollment

6.5.1. The Department may, at its discretion, unilaterally Disenroll Members from Contractor's MCO at any time.

6.5.2. Contractor may only request Disenrollment of a Member from Contractor's MCO for Cause. The Department will review Contractor's requests for Disenrollment and may grant or reject Contractor's request at its discretion.

6.5.2.1. A Disenrollment for Cause may only occur under the following circumstances:

6.5.2.1.1. Admission of the Member to any federal, state, or county governmental institution for treatment of mental illness, substance use disorder, or a correctional institution.

6.5.2.1.2. Receipt of comprehensive health coverage, other than CHP+, by the Member.

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

6.5.2.1.4. Child welfare eligibility status.

6.5.2.1.5. The Member moves out of Contractor's Service Area.

6.5.2.1.6. Contractor's MCO does not, because of moral or religious reasons, cover the service the Member seeks.

6.5.2.1.7. 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.

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

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

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

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

6.5.2.1.9.3. Behavior of the Member that poses a physical threat to the Provider, to other Providers or Contractor staff or to other Members.

6.5.2.1.9.3.1. Contractor shall provide the following prior to Disenrollment due to abuse or intentional misconduct:

6.5.2.1.9.3.1.1. Oral notification to the Member stating that continuation of the behavior or misconduct will result in a request for Disenrollment

6.5.2.1.9.3.1.2. Written notification to the Member stating that continuation of the behavior or misconduct will result in a request for Disenrollment

6.5.2.1.9.3.1.3. Contractor shall notify the Department of any written warning provided to a Member.

6.5.2.1.9.3.1.3.1. DELIVERABLE: Written warning and written report of abusive behavior or intentional misconduct.

6.5.2.1.9.3.1.3.2. DUE: No less than 30 calendar days prior to Disenrollment unless the Department approves expedited Disenrollment.

6.5.2.1.9.3.1.4. If the Member's behavior or misconduct poses an imminent threat to Providers, Contractor or to Members, Contractor may request an expedited Disenrollment.

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

6.5.2.2. Disenrollment for Cause shall not include Disenrollment because of:

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

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

6.5.2.2.3. The Member's diminished mental capacity.

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

6.5.2.2.5. Member's failure to pay a copayment if that Member is a child.

6.5.3. The Department may Disenroll any Member, who requests Disenrollment, in its sole discretion.

6.5.4. Contractor shall permit an eligible individual who is Enrolled with the entity to terminate or change Enrollment for Cause at any time consistent with the Social Security Act §1903(m) (2) (A) (vi).

6.5.5. The Department may Disenroll a Member from Contractor's MCO upon that Member's request. A Member may request Disenrollment, and the Department may grant the Member's request:

6.5.5.1. For Cause, at any time. A Disenrollment for Cause may occur under the following circumstances:

6.5.5.1.1. The Member moves out of Contractor's Service Area.

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

6.5.5.1.3. 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.

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

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

6.5.5.1.6. Lack of access to Covered Services, as documented by the Department.

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

6.5.5.2. Without Cause, during open Enrollment:

6.5.5.2.1. A Member may request Disenrollment, without Cause once every 12-months during the Members Open Enrollment Period.

6.5.5.2.2. A Member may request Disenrollment upon automatic re-Enrollment under 42 C.F.R. §438.56(g) if the temporary loss of eligibility has caused the Member to miss the annual Disenrollment opportunity.

6.5.5.3. Without Cause, after initial Passive Enrollment

6.5.5.3.1. A Member may request Disenrollment from Contractor's Plan within 90 calendar days of initial Passive Enrollment, as detailed under 42 C.F.R. §438.56(c)(2)(i).

6.5.5.4. Disenrollment due to Medicaid Coverage

6.5.5.4.1. If a Member becomes eligible for the Medicaid program at some point during the 12-month span of eligibility for CHP+, the Member's Medicaid coverage will be effective the first day of the month following the determination of Medicaid eligibility.

6.5.6. Effective Date of Disenrollment

6.5.6.1. In most instances, Disenrollment will be effective the first day of the month following the month in which the request for Disenrollment was made.

6.5.6.1.1. If this does not occur, the Disenrollment will be no later than the first day of the second month following the month in which the request was made.

6.5.6.1.2. If a decision regarding the Member's Disenrollment is not made by the Department, or its designee, by the first day of the second month following the month in which the Member requested the Disenrollment, the Disenrollment shall be considered approved.

6.5.6.2. In the event that a Member is Disenrolled from Contractor's MCO because the Member has become ineligible for CHP+, then the effective date of Disenrollment shall be the date on which the Member became ineligible.

6.5.6.3. If Contractor has been notified of Member Disenrollment status, Contractor agrees to discontinue the provision of Covered Services under this Contract to the Member, at 11:59pm on the last day of the month that notification was received, except as specified at section 6.5.7 of this Contract.

6.5.7. Disenrollment Postponed Due to Inpatient Hospital Stay

6.5.7.1. If a current Member of a Contractor's MCO is an inpatient of a Hospital at 11:59 p.m. the day before that Member's Disenrollment from Contractor's MCO is scheduled to take effect, Disenrollment shall be postponed until the last day of the month in which the Member is discharged from the Hospital.

6.5.7.1.1. Contractor shall, within 10 calendar days of the date Contractor discovers the Member or Potential Member's Hospital admission, request in writing to the Department that the Disenrollment be delayed.

6.5.8. The Department may retroactively adjust Monthly Capitation Payments so as to accurately reflect changes in the date of Member Disenrollment. Such Disenrollment shall be reflected on the electronic Enrollment reports for the following month, depending on the date of the transaction. The Department will not retroactively change a Disenrollment date unless:

6.5.8.1. A Member does not reside in Contractor's Service Area.

6.5.8.2. A Member is identified by either Contractor, the Department or its designee as having other health insurance coverage, including private plans.

6.5.8.3. The Department, in consultation with Contractor, determines that retroactive Disenrollment is necessary and in the best interest of the Member (e.g., in the event that Medicaid eligibility is granted due to catastrophic illness, injury or Disability).

6.6. Continuity of Care

6.6.1. Contractor shall establish policies and procedures to ensure continuity of care for all Members transitioning into or out of Contractor's enrollment list, guaranteeing that a Member's services are not disrupted or delayed.

6.6.1.1. Contractor shall inform any new Member that they may continue to receive Covered Services from the Member's current Provider for 60 calendar days after the date of Enrollment in Contractor's MCO. If a member is enrolled in a new CHP+ MCO because the previous MCO is no longer offering coverage the Member may continue to receive Covered Services from the Member's current Provider for 90 calendar days if the Member is in an ongoing course of the following treatments with that Provider in accordance with C.R.S. 10-16-704, 12-30-112, and 25-3-121:

6.6.1.1.1. Course of treatment for a serious and complex medical condition.

6.6.1.1.2. Course of inpatient care.

6.6.1.1.3. Pregnant and undergoing a course of treatment for the pregnancy.

6.6.1.1.4. Terminally ill as determined under section 1861 (dd)(3)(a) of the federal "Social Security Act", 42 U.S.C. sec. 1395x, as amended.

6.6.1.2. Contactor shall continue to provide treatment at Network Provider rates until the current episode of treatment ends (including completion of postpartum care) or until 90 days after the member is enrolled in Contractor's health plan, whichever occurs first.

6.6.1.3. Contractor may elect to perform its own utilization review in order to reassess and make its own determination regarding the need for continued treatment and authorize any continued procedure, treatment, medication, or service deemed to be medically necessary.

6.6.1.4. In accordance with 42 CFR 438.56(g), individuals who have been previously enrolled with Contractor and who regain eligibility for CHP+ within 60 calendar days of the effective date of exclusion or disenrollment will be reassigned to Contractor. The Department will send members a notice informing them of their enrollment with Contractor.

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

6.6.1.5.1. Contractor shall inform any new Member who is a Person with Special Health Care Needs as defined in 10 CCR 2505-10, §8.205.9, in accordance with 42 C.F.R §438.208, that the Member may continue to receive Covered Services from the Member's current Provider for 60 calendar days after the date of Enrollment in Contractor's MCO. 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 C.R.S. §25.5-5-406(1)(g).

6.6.1.5.2. 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 Contractor's MCO, for a period of 75 calendar days, as specified in C.R.S. §25.5-5-406(1)(g).

7. MEMBER ENGAGEMENT

7.1. Person-and-Family Centered Approach

7.1.1. Contractor shall actively engage Members in their health and well-being by demonstrating the following:

7.1.1.1. Responsiveness to Member and family/caregiver needs by incorporating best practices in communication and cultural responsiveness in service delivery.

7.1.1.2. Utilization of various tools to communicate clearly and concisely.

7.1.1.3. Proactive education promoting the effective utilization of CHP+ benefits and the health care system.

7.1.1.4. Promotion of health and wellness, particularly preventive and healthy behaviors as outlined in initiatives such as Colorado's 10 Winnable Battles and Colorado's State of Health.

7.1.2. Contractor shall align Member engagement activities with the Department's person- and family-centered approach that respects and values individual preferences, strengths, and contributions.

7.1.3. Contractor shall be aware of the work being done and recommendations made by the Department's Member Experience Advisory Council, which consists of Medicaid and CHP+ Clients, family Members and/or caretakers.

7.2. Cultural Responsiveness

7.2.1. Contractor shall provide and facilitate the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, Disabilities, and regardless of gender, sexual orientation or gender identity in compliance with 42 C.F.R. § 438.206(c)(2).

7.2.2. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, Provider directories, enrollee handbooks, Appeal and Grievance notices, and denial and termination notices available in the prevalent non-English languages. 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 438.10.

7.2.3. Contractor shall develop and/or provide cultural and Disability competency training programs, as needed, to Network Providers and Contractor staff regarding:

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

7.2.3.2. The medical risks associated with the Member population's racial, ethnic and socioeconomic conditions.

7.2.4. Contractor shall identify Members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by Contractor of the language proficiency of Members during the Member's orientation or while being served by Network Providers.

7.2.5. Language Assistance Services

7.2.5.1. Contractor shall provide all information for Members in a manner and format that may be easily understood and is readily accessible by Members.

7.2.5.2. Readily accessible is defined as electronic information and services that comply with modern accessibility standards, such as Section 508 of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and Successor versions.Contractor shall provide language assistance services as described in 42 C.F.R. § 438.10, for all Contractor interactions with Members and for all Covered Services. Language

assistance services include bilingual staff and interpreter services, at no cost to any Member. Language assistance shall be provided at all points of contact, in a timely manner and during all hours of operation. Contractor shall implement appropriate technologies for language assistance services in accordance with evolving best practices in communication.

7.2.5.3. Contractor shall make oral interpretation available in all languages and written translation available in each prevalent non-English language at no cost to any Member.

7.2.5.4. Contractor shall ensure the competence of language assistance provided by interpreters and bilingual staff.

7.2.5.5. Contractor shall not use family and friends to provide interpretation services except by request of the Member.

7.2.5.6. Contractor shall provide interpreter services for all interactions with Members when there is no Contractor staff person available who speaks a language understood by a Member.

7.2.5.7. Contractor shall develop policies and procedures on how Contractor shall respond to requests from Participating Providers or Members for interpreter services by a Qualified Interpreter or publications in alternative formats.

7.2.5.8. Contractor shall notify Members verbally and through written notices regarding the Member's right to receive the following language assistance services, as well as how to access the following language assistance services:

7.2.5.8.1. Oral interpretation for any language. Oral interpretation requirements apply to all non-English languages, not just those that the state identifies as prevalent.

7.2.5.8.2. Written translation in Prevalent Languages.

7.2.5.8.3. Auxiliary aids and services for Members with Disabilities.

7.2.5.8.4. Contractor shall ensure that language assistance services shall include, but are not limited to, the use of auxiliary aids such as TTY/TDY and American Sign Language.

7.2.5.8.5. Contractor shall ensure that customer service telephone functions easily access interpreter or bilingual services.

7.2.6. Written Materials for Members

7.2.6.1. Contractor shall ensure that all written materials it creates for distribution to Members meet all noticing requirements of 45 C.F.R. Part 92.

7.2.6.2. Contractor shall ensure that all written materials it creates for distribution to Members are culturally and linguistically appropriate to the recipient.

7.2.6.3. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, Appeal and Grievance notices, and denial and termination notices available in the Prevalent non-English Languages. All materials shall be written in English or Spanish, or any other language, as directed by the Department or as required by 42 CFR 438.10.

7.2.6.3.1. Contractor shall include taglines in the prevalent non-English languages in the State, and in a conspicuously visible font, explaining the availability of written translation or oral interpretation to understand the information provided.

7.2.6.4. Contractor shall notify all Members and Potential Members of the availability of alternate formats for information, as required by 42 C.F.R. § 438.10 and 45 C.F.R. § 92.8, and how to access such information.

7.2.6.5. Contractor shall write all materials in easy-to-understand language and shall comply with all applicable requirements of 42 C.F.R. § 438.10.

7.2.6.5.1. Contractor shall publish all written materials provided to Members using a font size no smaller than 12-point.

7.2.6.6. Contractor shall ensure client correspondence complies with the following requirements:

7.2.6.6.1. Is written using person-first, plain language.

7.2.6.6.2. Is written in a format that includes the date of the correspondence and a client greeting.

7.2.6.6.3. Is consistent, using the same terms throughout to the extent practicable including commonly used program names.

7.2.6.6.4. Is accurately translated into the second most commonly spoken language in the state if a client indicates that this is the client's written language of preference or as required by law.

7.2.6.6.5. Includes a statement translated into the top fifteen languages most commonly spoken by individuals in Colorado with limited English proficiency informing an applicant or client how to seek further assistance in understanding the content of the correspondence.

7.2.6.6.6. Clearly conveys the purpose of the client correspondence, the action or actions being taken by the state department or its designated entity, if any, and the specific action or actions that the client must or may take in response to the correspondence.

7.2.6.6.7. Includes a specific description of any necessary information or documents requested from the applicant or client.

7.2.6.6.8. Includes contact information for client questions.

7.2.6.6.9. Includes a specific and plain language explanation of the basis for the denial, reduction, suspension, or termination of the benefit if applicable.

7.2.6.7. Contractor shall translate all written information into other non-English languages prevalent in Contractor's Service Area.

7.2.6.8. Contractor shall ensure that its written materials for Members are available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the needs of Members with Disabilities, Members who are visually impaired and Members who have limited reading and/or English proficiency, at no cost.

7.2.6.9. Contractor shall ensure that all written materials for any large-scale Member communications or materials have been tested by Member representatives.

7.3. Member Communication

7.3.1. Contractor shall maintain consistent communication, both proactive and responsive, with Members.

7.3.2. Contractor shall ensure that Contractor's Member communications adhere to Colorado CHP+ brand standards.

7.3.3. Contractor shall maintain a Member contact center which includes a toll-free line for all CHP+ Members Enrolled to Contractor's MCO and all Member inquiries.

7.3.4. The Member contact center shall have the capability to receive calls, make outbound calls, and send emails.

7.3.4.1. Contractor shall ensure that each Member contact is recorded, and shall include, at minimum, all of the following:

7.3.4.1.1. Member's name.

7.3.4.1.2. State ID.

7.3.4.1.3. Purpose of the contact.

7.3.4.1.4. Date, time, and method of contact.

7.3.4.1.5. The outcome of the contact.

7.3.4.2. Contractor's Member contact center shall be open, at a minimum, from 8:00 a.m. to 5:00 p.m. Mountain Time (MT) every Business Day. Voice Message will be available 24hours a day, seven days a week for after hour's coverage.

7.3.4.3. Contractor's Member Contact center shall be adequately staffed by personnel sufficiently knowledgeable about Program policy and requirements to be able to respond immediately to all inquiries from Members.

7.3.4.4. Contractor shall maintain sufficient toll-free and toll-bearing soft lines, internet bandwidth, an email account and staff capable of managing all contacts, including during fluctuations in call volumes.

7.3.4.5. Contractor shall ensure that Language Assistance Services are provided to all Members, as appropriate. Contractor shall provide these services using its own staff or make this interpretive service available by contracting with a third-party interpretive service. This service shall be provided without additional cost to either the Department or any individual calling the customer contact center.

7.3.4.6. Contractor shall remind members to update their contact information with the Department in member communications, including but not limited to notices, manuals, and websites.

7.3.5. General Member Information Requirement

7.3.5.1. Contractor shall develop electronic and written materials for distribution to newly Enrolled and existing Members, with input from the Department, in accordance with 42 C.F.R. § 438.10 that must include, at a minimum, all of the following:

7.3.5.1.1. Contractor's single toll-free, customer service phone number.

7.3.5.1.2. Contractor's Email address.

7.3.5.1.3. Contractor's website address.

7.3.5.1.4. State relay information.

7.3.5.1.5. The basic features of an MCO.

7.3.5.1.6. The Service Area covered by Contractor.

7.3.5.1.7. CHP+ benefits.

7.3.5.1.8. Any restrictions on the Member's freedom of choice among Network Providers.

7.3.5.1.9. A Provider Directory.

7.3.5.1.9.1. DELIVERABLE: Provider Directory

7.3.5.1.9.2. DUE: Five days prior to the Operational Start Date

7.3.5.1.10. The requirement for Contractor to provide adequate access to services covered under the CHP+ benefit, including the network adequacy standards.

7.3.5.1.11. Contractor's responsibilities for the coordination of Member care.

7.3.5.1.12. Information about where and how to obtain counseling and Referral services that Contractor does not cover because of moral or religious objections.

7.3.5.1.13. Upon request, any physician incentive plans in place, as set forth in 42 C.F.R. § 438.3.

7.3.5.1.14. Contractor shall notify Members when it adopts a policy to discontinue coverage of a counseling or Referral service based on moral or religious objections at least 30 days prior to the Effective Date of the policy for any particular service.

7.3.5.1.15. To the extent possible, quality and performance indicators for Contractor, including Member satisfaction.

7.3.6. Member Rights and Responsibilities

7.3.6.1. 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 Member Handbook Requirements.

7.3.6.2. Contractor shall have written policies guaranteeing each Member's right to be treated with respect and due consideration for their dignity and privacy.

7.3.6.3. Contractor shall provide information to Members regarding their Member Rights as stated in 42 C.F.R. § 438.100 that include, but are not limited to:

7.3.6.3.1. The right to be treated with respect and due consideration for their dignity and privacy.

7.3.6.3.2. 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.

7.3.6.3.3. The right to participate in decisions regarding their health care, including the right to refuse treatment.

7.3.6.3.4. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

7.3.6.3.5. The right to request and receive a copy of their Medical Records and request that they be amended or corrected.

7.3.6.3.6. The right to obtain available and accessible services under the Contract.

7.3.6.3.7. Freely exercise their rights with Contractor or its Providers treating the Member adversely.

7.3.6.4. Contractor shall post and distribute Member rights to individuals, including but not limited to:

7.3.6.4.1. Members.

7.3.6.4.2. Member's families.

7.3.6.4.3. Providers.

7.3.6.4.4. Case workers.

7.3.6.4.5. Stakeholders.

7.3.6.5. Contractor shall have written policies guaranteeing each Member's right to receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand.

7.3.7. Identification Cards, Provider Directory, Formulary and Member Handbook

7.3.7.1. Upon notification by the Department of a Member's Enrollment in Contractor's MCO, annually, and upon Member's request, Contractor shall furnish each Member the information specified in 42 C.F.R. §438.10 in both electronic and paper format, upon request, and:

7.3.7.1.1. Issue an Identification Card, and Member Handbook setting forth a statement of the services and benefits to which the Member is entitled.

7.3.7.1.2. Formulary information, including which medications are covered (both generic and name brand) and the tier for each medication.

7.3.7.1.3. Information not specified in 42 C.F.R. §438.10 but required as part of this contract may be accessible to Members online. If a Member requests a hard copy, Contractor shall issue to the Member. Contractor must notify Members annually of the online location and the Members right to request and receive a hard copy.

7.3.7.1.4. In the event that the new Member has not designated a PCP at the time of Enrollment in Contractor's MCO, Contractor shall issue an Identification Card, or another appropriate written notification, to the Member after an assignment is made, in accordance with the process and timeframe specified in Section 10.3 of this contract.

7.3.7.2. Member Handbook

7.3.7.2.1. The Member Handbook shall include information for all CHP+ eligible Members Enrolled to Contractor's MCO, at a minimum, all of the following:

7.3.7.2.1.1. Information that enables the Member to understand how to effectively use the CHP+ Program.

7.3.7.2.1.2. Information about how to access language assistance services as specified in 7.2.6.

7.3.7.2.1.3. How to obtain information regarding Contractor's Participating Providers who serve Members.

7.3.7.2.1.4. Information that enables the Member to understand how to select and change their PCP.

7.3.7.2.1.5. The amount, duration, and scope of benefits available under the contracts in sufficient detail to ensure that Members understand the benefits to which they are entitled.

7.3.7.2.1.6. Procedures for obtaining benefits, including any requirements for service authorizations, Referrals for specialty care, and for other benefits not furnished by the enrollee's PCP.

7.3.7.2.1.7. Extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network Providers.

7.3.7.2.1.8. Extent to which, and how, after hours and emergency coverage are provided. Contractor shall ensure that this information includes at least the following:

7.3.7.2.1.8.1. An explanation that an Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual (or with respect to a pregnant woman, the health of the woman or her

unborn child) in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

7.3.7.2.1.8.2. An explanation that emergency services means covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish these services under Colorado CHP+ and needed to evaluate or stabilize an Emergency Medical Condition.

7.3.7.2.1.8.3. An explanation that Post-Stabilization Care 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 to improve or resolve the Member's condition when Contractor does not respond to a request for pre-approval within one hour, Contractor cannot be contacted, or Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a Managed Care Entity physician is not available for consultation.

7.3.7.2.1.8.4. A statement that prior authorization is not required for emergency services.

7.3.7.2.1.8.5. The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent.

7.3.7.2.1.8.6. The locations of any emergency settings and other locations at which Providers and Hospitals furnish emergency services and post-stabilization services covered under the contracts.

7.3.7.2.1.8.7. A statement that the Member has the right to use any Hospital or other setting for emergency care.

7.3.7.2.1.9. Any restrictions on the Member's freedom of choice among Network Providers.

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

7.3.7.2.1.11. A statement that prior authorization is not required to receive services from family planning Providers.

7.3.7.2.1.12. Procedures for obtaining the names, qualifications, and titles of professionals providing and/or responsible for Members' care.

7.3.7.2.1.13. How Members will be notified of any change in benefits, services, or service delivery offices/sites.

7.3.7.2.1.14. Circumstances under which Members may have to pay for care.

7.3.7.2.1.15. Information regarding Contractor's rights and the Member's obligations regarding third party liability, as outlined in section 12 of the Contract.

7.3.7.2.1.16. Member rights and responsibilities, as defined in Section 7.3.6.

7.3.7.2.1.17. A statement about presumptive eligibility, how long medical coverage lasts, and notification that Members are excluded from dental benefits.

7.3.7.2.1.18. Information for pregnant individuals regarding how to enroll their newborn.

7.3.7.2.1.19. Information about Member cost-sharing requirements, including:

7.3.7.2.1.19.1. Cost-sharing amounts that a Member may be liable for when obtaining services.

7.3.7.2.1.19.2. A statement that the Member is responsible for tracking copayments and notifying the Department if copayments exceed the maximum allowed in Title XXI of the Social Security Act (5% of the Member's family's gross annual income).

7.3.7.2.1.19.3. If the Member reaches the maximum allowable copayment and notifies the Department, the Department will provide the Member with an adhesive sticker to be attached to their Identification Card to be used to notify any Provider that the copayment is no longer required for that Member.

7.3.7.2.1.19.4. Contractor shall not charge any copayment for any Member who has reached the maximum allowable copayment amount, as indicated by a special adhesive sticker attached to the Member's Identification Card.

7.3.7.2.1.19.5. Contractor shall apply all copayment maximums as described in Title XXI of the Social Security Act annually and shall be renewed on the first day of the Member's new Enrollment year.

7.3.7.2.1.20. The transition of care policies for Members and potential Members.

7.3.7.2.1.21. Information on how to report suspected fraud or abuse.

7.3.7.2.1.22. A section with information specific to Contractor's Service Area.

7.3.7.2.1.23. Procedures and timeframes to voice a complaint, file a Grievance or Appeal, or obtain a State Review related to coverage, benefits, or any aspect of the Member's relationships to Contractor through both Contractor's internal Grievance and Appeal process and the Department's or the State's external process(es) as detailed in section 8.

7.3.7.2.2. If a Member requests a hard copy of the Member Handbook, Contractor shall issue to the Member, within 5 business days of request.

7.3.7.2.3. The Department may review the Member Handbook upon request. Contractor shall make any changes to the Member Handbook as directed by the Department within 30 days of the Department's request. Contractor shall submit the updates to the Department for review and approval. If the Member Handbook is disapproved by the Department, the Department will specify the reason(s) for disapproval in the written notice to Contractor.

7.3.7.2.3.1. DELIVERABLE: Updated Member Handbook

7.3.7.2.3.2. DUE: Within 30 days of request by the Department

7.3.7.2.4. Contractor shall issue to each Member, at least 30 days before the intended effective date of the change, written updates reflecting any substantive changes made by the Department to the scope and/or descriptions of Covered Services set forth in the Member Handbook during the Contract Year.

7.3.8. Contractor Website

7.3.8.1. Contractor shall develop and maintain a customized and comprehensive website that follows modern principles of optimizing user experience on mobile and personal computer platforms and is navigable by individuals who have low literacy, disabilities, or require language assistance. Contractor shall ensure that the website provides online access to general customer service information that includes, but is not limited to:

7.3.8.1.1. Contractor's contact information.

7.3.8.1.2. Member rights and responsibilities.

7.3.8.1.3. Member handbook.

7.3.8.1.4. Grievance and Appeal procedures and rights.

7.3.8.1.5. General functions of Contractor.

7.3.8.1.6. Contractor's formulary.

7.3.8.1.7. Contractor shall make the following information on Contractor's Network Providers available to Members as a Provider directory in electronic form and in paper form upon request:

7.3.8.1.7.1. Names, as well as any group affiliations.

7.3.8.1.7.2. Street addresses.

7.3.8.1.7.3. Telephone numbers.

7.3.8.1.7.4. Website URLs, as appropriate.

7.3.8.1.7.5. Specialties, as appropriate.

7.3.8.1.7.6. Whether Network Providers will accept new Members.

7.3.8.1.7.7. The cultural and linguistic capabilities of Network Providers, including languages (including ASL) offered by the Provider or a skilled medical interpreter at the Provider's office, and whether the Provider has completed Cultural Competence training.

7.3.8.1.7.8. Whether Network Providers' offices/facilities have accommodations for people with physical Disabilities, including offices, exam room(s) and equipment.

7.3.8.1.8. Contractor shall ensure that the electronic Provider Directory is updated no later than 30 calendar days after Contractor receives updated Provider information.

7.3.8.1.9. Contractor shall make the Provider Directory available on its website in a machine-readable file and format, as specified by the Secretary of the Department of Health and Human Services.

7.3.8.1.10. Contractor shall update the paper Provider Directory at least quarterly as required by 42 CFR 438.10(h)(3).

7.3.8.1.11. Access to Care Standards.

7.3.8.1.12. Colorado Crisis Services information.

7.3.8.2. Contractor shall provide a link to the Department's website on Contractor's website for standardized information about the CHP+ benefit, as well as a statement that all information is available to Members in paper form upon request.

7.3.8.3. Contractor's website shall include information on Contractor's Member engagement process.

7.3.8.4. Contractor shall organize the website to allow for easy access of information by Members, family members, providers, stakeholders and the general public in compliance with the Americans with Disabilities Act (ADA).

7.3.8.5. Contractor shall ensure that web materials are able to produce printer-friendly copies of information.

7.3.9. Termination of Provider Agreement

7.3.9.1. Upon termination of a Network Provider's agreement, for any reason, Contractor shall make a good faith effort to give written notice of termination of a Network Provider to each Member who received their primary care from, or was seen on a regular basis by, the terminated Network Provider. As required in 42 C.F.R. § 438.10(f)(1), notice to the enrollee must be provided by the

later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.

7.3.9.1.1. DELIVERABLE: Notice to Members of Network Provider Termination

7.3.9.1.2. DUE: The later of 30 calendar days prior to the effective date of the termination or 15 calendar days after the notice of a termination

7.3.9.2. In cases where a PCP or other Provider has been terminated from Contractor's MCO, Contractor shall allow Members to select another PCP or make a re-assignment within 15 business days of the termination effective date of their PCP.

7.3.10. Information on Grievance and Appeals Process

7.3.10.1. Contractor shall provide information to Members on Grievance, Appeals and State Review procedures and timelines (as relevant and described in Section 8.0). The description shall include at least the following:

7.3.10.1.1. A Member's right to file Grievances and Appeals.

7.3.10.1.2. The toll-free number the Member can use to file a Grievance or Appeal by phone.

7.3.10.1.3. Requirements and timeframes for filing a Grievance or Appeal.

7.3.10.1.4. Availability of assistance for filing a Grievance, Appeal, or State Review.

7.3.10.1.5. A Member's right to a State Review.

7.3.10.1.6. The method for obtaining a State Review.

7.3.10.1.7. The rules that govern representation at the State Review

7.3.10.1.8. Any Appeal rights the state makes available to Providers to challenge the failure of Contractor to cover a service.

7.3.11. Member Material Review Process

7.3.11.1. Contractor shall notify the Department at least 30 Business Days prior to Contractor's printing or disseminating any large-scale Member communication initiatives.

7.3.11.1.1. Contractor shall describe the purpose, frequency, and format of the planned Member communication.

7.3.11.1.1.1. DELIVERABLE: Notification of large-scale Member communication initiative

7.3.11.1.1.2. DUE: At least 30 Business Days prior to Contractor printing or disseminating any large-scale Member communication initiatives

7.3.11.1.2. Contractor shall work with the Department to make any suggested changes to the Member communication initiative in order to align Contractor's communication with the Department's communication standards and strategies.

7.3.11.2. The Department may review any Member materials used by Contractor and request changes or redrafting of Member materials as the Department determines necessary to ensure that the language is easy to understand and that the document aligns with the Department standards. Contractor shall make any changes to the Member materials requested by the Department. This requirement shall not apply to individualized correspondence that is directed toward a specific Member.

7.3.11.3. Contractor shall ensure that all large-scale Member communications and materials have been Member-tested.

7.3.11.3.1. Contractor shall develop and implement policies and procedures for obtaining Member feedback for Member materials.

7.3.12. Electronic Distribution of Federally Required Information

7.3.12.1. In order to electronically distribute information required by 42 C.F.R. § 438.10 to Members, Contractor shall meet all of the following conditions:

7.3.12.1.1. The format is readily accessible and complies with modern accessibility standards such as Section 508 of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and W3C's Web content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

7.3.12.1.2. The information is placed in a location on the state or Contractor's website that is prominent and readily accessible.

7.3.12.1.3. The information is provided in an electronic form, which can be electronically retained and printed.

7.3.12.1.4. The information is consistent with the content and language requirements of 42 C.F.R. § 438.10.

7.3.12.1.5. The Member is informed that the information is available in paper form without charge upon request and Contractor provides the information upon request within five Business Days.

7.3.13. Accessibility Indemnification

7.3.13.1. Contractor shall indemnify, save, and hold harmless the Indemnified Parties, against any and all costs, expenses, claims, damages, liabilities, court awards and other amounts (including attorneys' fees and related costs) incurred by any of the Indemnified Parties in relation to Contractor's failure to comply with §§24-85-101, et seq., C.R.S., or the Accessibility Standards for Individuals with a Disability as established by OIT pursuant to Section §24-85-103 (2.5), C.R.S.

7.3.14. Accessibility

7.3.14.1. Contractor shall ensure the Work Product provided under this Contract shall be in compliance with all applicable provisions of §§24-85-101, et seq., C.R.S., and the Accessibility Standards for Individuals with a Disability, as established by OIT pursuant to Section §24-85-103 (2.5), C.R.S. Contractor shall also comply with all State of Colorado technology standards related to technology accessibility and with Level AA of the most current version of the Web Content Accessibility Guidelines (WCAG), incorporated in the State of Colorado technology standards.

7.3.14.2. The Department may require Contractor's compliance to the State's Accessibility Standards to be determined by a third party selected by the Department to attest to Contractor's Work Product and software is in compliance with §§24-85-101, et seq., C.R.S., and the Accessibility Standards for Individuals with a Disability as established by OIT pursuant to Section §24-85-103 (2.5), C.R.S.

7.4. Marketing

7.4.1. Contractor shall not engage in any Marketing Activities, as defined in 42 C.F.R. § 438.104, during the Start-Up Period.

7.4.2. During the Contract phase, Contractor may engage in Marketing Activities at its discretion. Contractor shall not distribute any Marketing Materials without the Department's approval.

7.4.3. Marketing Materials, including those at Provider sites, will present Contractor's MCO only as one Plan among other options available under the Program.

7.4.3.1. This requirement does not prohibit representatives of Contractor's MCO from communicating with prospective Members, only that what is presented to them must not differ from the Marketing Materials.

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

7.4.5. Contractor shall distribute the Marketing Materials to its entire Service Area as defined by the Contract.

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

7.4.7. Contractor and any Subcontractors shall not, directly or indirectly, engage in door-to-door, telephone or other Cold-Call Marketing activities.

7.4.8. Contractor shall not create Marketing Materials that contain any assertion or statement, whether written or oral, that the Potential Member must Enroll with Contractor to obtain benefits or not to lose benefits.

7.4.9. Contractor shall ensure that Marketing Materials do not contain any assertion or statement, whether written or oral, that Contractor is endorsed by the Centers for Medicare and Medicaid Services, the federal or state government or similar entity.

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

8. GRIEVANCE AND APPEALS

8.1. In accordance with 42 C.F.R. § 438 Subpart F and 10 CCR 2505-10, Section 8.209 of the Medicaid state rules for Managed Care Grievances and Appeals Processes, Contractor shall have a Grievance and Appeal system to handle Grievances about any matter related to this Contract other than an adverse benefit determination and Appeals of an adverse benefit determination, as well as processes to collect and track information about them.

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

8.3. Contractor shall inform Network Providers and Subcontractors, at the time they enter into a contract about the following, in compliance with 42 CFR 438.414 and 42 CFR 438.10(g)(2)(xi)(A) - (B):

8.3.1. The Member’s right to file an Appeal, including:

8.3.1.1. The requirements and timeframes for filing.

8.3.1.2. The availability of assistance with filing.

8.3.1.3. The toll-free number to file orally.

8.3.2. The Member’s right to a State Review, how Members obtain a review, and the representation rules at a State Review.

8.3.3. The Member's right to file Grievances related to Contractor or services provided through Contractor.

8.3.4. Any rights the Provider has to Appeal or otherwise challenge the failure of Contractor to cover a service.

8.3.5. Any timeliness considerations in filing a Grievance, filing for an Appeal, or filing for a State Review.

8.4. Grievances

8.4.1. Contractor shall establish and maintain a Grievance process through which Members may express dissatisfaction about any matter related to this Contract, other than an Adverse Benefit Determination.

8.4.2. Contractor shall ensure that information about the Grievance process, including how to file a Grievance, is available to all Members and is given to all Network Providers and Subcontractors.

8.4.3. In accordance with 42 C.F.R. §438.402(b)(2) and 10 CCR 2505-10 §8.209.5.A, Contractor shall allow a Member to file a Grievance either orally or in writing at any time and shall acknowledge receiving the Grievance.

8.4.4. Contractor shall ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were a subordinate of anyone who was. The decision maker shall be a Health Care Professional with clinical expertise in treating the Member's condition or disease if any of the following apply:

8.4.4.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

8.4.4.2. The Member is Appealing a denial that is based on lack of Medical Necessity.

8.4.4.3. The Grievance or Appeal involves clinical issues.

8.4.5. Contractor shall send the Member written acknowledgement of each Grievance within two business days of receipt.

8.4.6. Contractor shall make a decision regarding the Grievance and provide notice to the Member of its decision within 15 Business Days of when the Member files the Grievance.

8.4.7. Contractor may extend the timeframe for processing a Grievance by up to 14 calendar days if a Member requests or Contractor shows (to the satisfaction of the Department, upon its request) that there is a need for additional information and that the delay is in the Member's best interest.

8.4.7.1. If Contractor extends the timeline for a Grievance not at the request of a Member, Contractor shall:

8.4.7.1.1. Make reasonable efforts to give the Member prompt oral notice of the delay.

8.4.7.1.2. Give the Member written notice, within two calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if they disagree with that decision.

8.4.8. Contractor shall notify a Member of the resolution of a Grievance and ensure such methods meet, at a minimum, the standards described at 42 C.F.R § 438.10.

8.4.9. Contractor shall only provide a Member sufficient time to Disenroll, based on the timeframe specified in 42 C.F.R. 438.56(e)(1) if Contractor approves a Disenrollment in response to a Grievance.

8.4.10. Contractor shall document problems a Network Provider submits to Contractor, and the solutions Contractor has offered to the Network Provider. The Department may review any of the documented solutions. If the Department determines the solution to be insufficient or otherwise unacceptable, it may direct Contractor to find a different solution or follow a specific course of action.

8.4.10.1. If the Department is contacted by a Member, family members or caregivers of a Member, advocates, or other individuals/entities with a Grievance regarding concerns about the care or lack

of care a Member is receiving, Contractor shall address all issues as soon as possible after the Department has informed Contractor of the concerns. Contractor shall keep the Department informed about progress on resolving concerns in real time and shall advise the Department of final resolution.

8.5. Notice of Adverse Benefit Determination

8.5.1. If Contractor denies, partially denies, suspends, reduces, or terminates coverage of or payment for a Covered Service, Contractor shall send to the Member a notice of Adverse Benefit Determination that meets the following requirements:

8.5.1.1. Is in writing.

8.5.1.2. Is available in the state-established prevalent languages in its region.

8.5.1.3. Is available in alternative formats for Persons with Special Needs.

8.5.1.4. Is in an easily understood language and format.

8.5.1.5. Explains the Adverse Benefit Determination Contractor or its Subcontractor has taken or intends to take.

8.5.1.6. Explains the reasons for the Adverse Benefit Determination.

8.5.1.7. Provides information about the Member's right to file an Appeal, or the Provider's right to file an Appeal when the Provider is acting on behalf of the Member as the Member's designated representative.

8.5.1.8. Explains the Member's right to request a State Review.

8.5.1.9. Describes how a Member can Appeal or file a Grievance.

8.5.1.10. Explains a Member's right to the Appeals process available under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable.

8.5.1.11. Gives the circumstances under which expedited resolution of an Appeal is available and how to request it.

8.5.1.12. Explains the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination.

8.5.1.13. A Notice of Adverse Benefit Determination for denial of behavioral, mental health, or SUD benefits includes, in plain language:

8.5.1.13.1. A statement explaining that Members are protected under the Federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to medical and surgical benefits.

8.5.1.13.2. A statement providing information about contacting the Office of the Ombudsman for Behavioral Healthcare if the Member believes their rights under the MHPAEA have been violated.

8.5.1.13.3. A statement specifying that Members are entitled, upon request to Contractor and free of charge, to a copy of the Medical Necessity criteria for any behavioral, mental, and SUD benefit.

8.5.2. Contractor shall ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

8.5.3. Contractor shall give notice according to the following schedule:

8.5.3.1. At least 10 days before the date of action, if the Adverse Benefit Determination is a termination, suspension or reduction of previously authorized CHP+ Covered Services.

8.5.3.2. At least five days prior to the date of Adverse Benefit Determination if Contractor has verified information indicating probable beneficiary fraud.

8.5.3.3. By the date of Adverse Benefit Determination when any of the following occur:

8.5.3.3.1. The Member has died.

8.5.3.3.2. The Member submits a signed written statement requesting service termination.

8.5.3.3.3. The Member submits a signed written statement including information that requires termination or reduction and indicates that the Member understands that service termination or reduction will occur.

8.5.3.3.4. The Member has been admitted to an institution in which the Member is ineligible for under the plan for further services.

8.5.3.3.5. The Member's address is determined unknown based on returned mail with no forwarding address.

8.5.3.3.6. The Member is accepted for Medical Assistance Services by another local jurisdiction, state, territory or commonwealth.

8.5.3.3.7. A change in the level of medical care is prescribed by the Member's physician.

8.5.3.3.8. The notice involves an Adverse Benefit Determination with regard to preadmission screening requirements.

8.5.3.3.9. The transfer or discharge from a facility will occur in an expedited fashion.

8.5.3.4. On the date of Adverse Benefit Determination when the Adverse Benefit Determination is a denial of payment.

8.5.3.5. As expeditiously as the Member's health condition requires, but no longer than seven (7) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

8.5.3.5.1. Contractor shall take no longer than 14 calendar days for standard authorizations that deny or limit residential services for members under the age of 21 and that require an Independent Assessment.

8.5.3.5.2. Contractor may extend the seven (7) calendar day service authorization notice timeframe of up to 14 additional days if the Member or the Provider requests extension; or if Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

8.5.3.5.2.1. Contractor may extend the 14 calendar day service authorization notice timeframe for up to 14 additional days for residential services for members under the age of 21 that require an Independent Assessment if the Member or the Provider requests extension; or if Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

8.5.3.5.3. If Contractor extends the 7- or 14-day service authorization notice timeframe, it must give the Member written notice of the reason for the extension and inform the Member of the right to file a Grievance if they disagree with the decision.

8.5.3.6. On the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

8.5.3.7. For cases in which a Provider, or Contractor, determine that following the standard authorization timeframe could seriously jeopardize the Member's life or health or their ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than72 hours after receipt of the request for service.

8.5.3.7.1. Contractor may extend the 72 hours expedited service authorization decision time period by up to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

8.6. Appeal Process

8.6.1. Contractor shall handle Appeals of Adverse Benefit Determination, in compliance with 42 C.F.R. § 438.400 and 42 C.F.R. § 457.1260.

8.6.2. The Contract shall acknowledge receipt of each Appeal, in accordance with 42 C.F.R. § 438.406(b)(1).

8.6.2.1. Contractor shall, within two business days of Contractor receipt of the Member's or Provider's request for Appeal, send the Member a letter notifying the Member how they may receive a copy of the case file related to the Appeal and how they can submit additional information whether in writing or in person to Contractor.

8.6.3. Contractor shall ensure that decision makers on Appeals were not involved in previous levels of review or decision-making nor a subordinate of any such individual.

8.6.4. Contractor shall ensure the decision maker is a Health Care Professional with clinical expertise in treating the Member's condition or disease if any of the following apply:

8.6.4.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

8.6.4.2. The Member is Appealing a denial that is based on lack of Medical Necessity.

8.6.4.3. The Grievance or Appeal involves clinical issues.

8.6.5. Contractor shall allow Members, and Providers acting on behalf of a Member and with the Member's written consent, to file Appeals:

8.6.5.1. Within 60 calendar days after the date of Contractor's notice of Adverse Benefit Determination.

8.6.5.2. Either orally or in writing.

8.6.6. Contractor shall ensure that oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals.

8.6.7. If the Member, or Provider acting on behalf of the Member, orally requests an expedited Appeal, Contractor shall not require a written, signed Appeal following the oral request.

8.6.8. Contractor shall provide a reasonable opportunity for the Member to present evidence and allegations of fact or law, in person as well as in writing.

8.6.9. Contractor shall inform the Member of the limited time available to present evidence and allegations of fact or law, if the Member requests an expedited Appeal resolution.

8.6.10. Contractor shall give the Member and the Member's representative an opportunity, sufficiently in advance before and during the Appeals process, to examine the Member's case file, including Medical

Records and any other documents and records free of charge and sufficiently in advance of the resolution timeframe.

8.6.11. Contractor shall consider the Member, the Member's representative, or the legal representative of a deceased Member's estate as parties to an Appeal.

8.6.12. Contractor shall take no punitive action against a Provider who either requests an expedited resolution or supports a Member's Appeal, in accordance with 42 C.F.R. § 438.410.

8.6.13. Resolution and Notification of Appeals

8.6.13.1. Contractor shall resolve each Appeal and provide notice as expeditiously as the Member's health condition requires and no later than the date the extension expires, and not to exceed the following:

8.6.13.1.1. For standard resolution of an Appeal and notice to the affected parties, 10 working days after the day the MCO receives the Appeal.

8.6.13.2. Contractor may extend the timeframe for processing an Appeal by up to 14 calendar days if the Member requests or Contractor shows (to the satisfaction of the Department, upon its request) that there is a need for additional information and that the delay is in the Member's best interest.

8.6.13.2.1. Contractor shall provide the Member with written notice within two calendar days after the extension of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member. Contractor shall establish and maintain an expedited review process for Appeals when Contractor determines from a request from the Member or when the Network Provider indicates, in making the request on the Member's behalf or supporting the Member's request, which taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

8.6.13.2.2. If Contractor denies a request for expedited resolution of an Appeal, Contractor shall transfer the Appeal to the standard timeframe for Appeal resolution and give the Member prompt oral notice of the denial and a written notice within two calendar days after receiving the request for expedited resolution.

8.6.13.2.3. Contractor shall resolve each expedited Appeal and provide notice as expeditiously as the Member's health condition requires, within state-established timeframes not to exceed 72 hours after Contractor receives the expedited Appeal request.

8.6.13.2.4. Contractor may extend the timeframe for processing an expedited Appeal by up to 14 calendar days if the Member requests the extension or Contractor shows that there is need for additional information and that the delay is in the Member's best interest.

8.6.13.2.5. Contractor shall provide the Member with written notice within two calendar days and make a reasonable effort to give the Member prompt oral notice of the reason for any extension to the timeframe for processing an expedited Appeal that is not requested by the Member and inform the Member of the right to file a Grievance if they disagree with that decision.

8.6.13.2.6. Contractor shall provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited Appeal.

8.6.13.3. Contractor shall provide written notice of the disposition of the Appeals process, which shall include the results and data of the Appeal resolution.

8.6.13.4. Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than 72 hours from the date of reversal if the

services were not furnished while the Appeal was pending and if Contractor or State Review Officer reverses a decision to deny, limit, or delay services.

8.6.13.5. Contractor shall notify the requesting Provider and give the Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

8.6.13.6. For Appeal decisions not wholly in the Member's favor, Contractor shall include the following:

8.6.13.6.1. The Member's right to request a State Review.

8.6.13.6.2. How the Member can request a State Review.

8.6.14. State Review

8.6.14.1. Contractor shall allow a Member to request a State Review after the Member has exhausted Contractor's Appeal process.

8.6.14.1.1. The Member has 120 calendar days after the date of a notice of an adverse Appeal resolution to request a State Review.

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

8.6.14.3. Contractor shall be a party to the State Review as well as the Member and their representative or the representative of a deceased Member's estate.

8.6.14.4. The state's standard timeframe for reaching its decision on a State Review request is within 90 days after the date the Member filed the Appeal with Contractor, excluding the days the Member took to subsequently file for a State Review, or the date the Member filed for direct access to a State Review.

8.6.14.5. Contractor shall participate in all State Reviews regarding Appeals and other matters arising under this contract.

8.6.15. Expedited State Review

8.6.15.1. When the Appeal is heard first through Contractor's Appeal process, the Department's Office of Appeals will issue a final agency decision for an expedited State Review decision as expeditiously as the Member's health condition requires, but no later than 72 hours from the Department's receipt of a hearing request for a denial of service that:

8.6.15.1.1. Meets the criteria for an expedited Appeal process but was not resolved with Contractor's expedited Appeal timeframes, or,

8.6.15.1.2. Was resolved wholly or partially adversely to the Member using Contractor's expedited Appeal timeframes.

8.7. Grievance and Appeals Report

8.7.1. Contractor must maintain records of Grievances and Appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department's quality strategy.

8.7.2. Contractor shall submit a quarterly Grievance and Appeals Report that includes the following information about Member Grievances and Appeals:

8.7.2.1. A general description of the reason for the Grievance or Appeal.

8.7.2.2. The date received.

8.7.2.3. The date of each review or, if applicable review meeting.

8.7.2.4. Resolution at each level of the Appeal or Grievance, if applicable.

8.7.2.5. Date of resolution at each level, if applicable.

8.7.2.6. Name of the covered Member for whom the Appeal or Grievance was filed.

8.7.2.6.1. DELIVERABLE: Grievance and Appeals Report

8.7.2.6.2. DUE: 45 days after the end of the reporting quarter.

8.7.3. Contractor shall collaborate with the Department to revise and develop a Grievance and Appeals Report Template.

9. NETWORK DEVELOPMENT AND ACCESS STANDARDS

9.1. Establishing a Network

9.1.1. Contractor shall create, administer, and maintain a Network of Providers to serve the needs of its Members.

9.1.2. Contractor shall maintain a service delivery system that includes mechanisms for ensuring access to high-quality, general and specialized care, from a comprehensive and integrated Provider Network.

9.1.2.1. Contractor may create networks based on quality indicators, credentials, and price.

9.1.3. Contractor shall ensure that its contracted networks are capable of serving all Members, including contracting with Providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

9.1.4. Contractor's network shall include, but not be limited to, the following:

9.1.4.1. Public and Private providers, including independent practitioners.

9.1.4.2. Federally Qualified Health Centers (FQHC).

9.1.4.3. Rural Health Clinics (RHC).

9.1.4.4. Community Mental Health Centers (CMHC).

9.1.4.5. Substance Use Disorder Clinics.

9.1.4.6. School Based Health Centers (SBHC).

9.1.4.7. Indian Health Care Providers.

9.1.4.8. Essential Community Providers (ECP).

9.1.4.9. Providers capable of billing both Medicare and Medicaid.

9.1.5. If a provider type specified in 9.1.4 is not within Contractor's network, Contractor shall make a good faith effort to enter into a contract, letter of agreement, single-case agreement or other form of relationship to ensure adequate access to care for Members.

9.1.6. Contractor shall take the following into consideration, as required by 42 C.F.R. § 438.206, when establishing and maintaining its networks:

9.1.6.1. The anticipated number of Members.

9.1.6.2. The expected utilization of Covered Services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in Contractor's Service Area.

9.1.6.3. The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the covered CHP+ services.

9.1.6.4. The numbers of Participating Providers who are accepting new Members.

9.1.6.5. The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, Members' access to transportation and whether the location provides physical access and accessible equipment for CHP+ Members with Disabilities.

9.1.6.6. The ability of Providers to communicate with limited English proficient Members in their preferred language.

9.1.6.7. The ability of Network Providers to ensure physical access, reasonable accommodations, culturally competent communications and accessible equipment for Members with physical or mental Disabilities.

9.1.6.8. The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions.

9.1.7. Contractor shall develop and implement a strategy to recruit and retain qualified Providers including but not limited to those with experience serving racial and ethnic communities, the deaf and hard of hearing community, the Disability community, and other culturally diverse communities who may be served.

9.1.7.1. Contractor may use mechanisms such as telemedicine to address geographic barriers to accessing clinical Providers with experience serving these communities.

9.1.8. Contractor shall ensure that its Provider selection policies and procedures, consistent with 42 C.F.R. § 438.12, do not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

9.1.9. Contractor shall not discriminate against any Provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification.

9.1.10. Contractor shall comply with any additional Provider selection requirements established by the Department.

9.1.11. If Contractor declines to include an individual Provider or group of Providers in its network, it shall give the affected Providers' written notice of the reasons for its decision, in accordance with 42 C.F.R. § 438.12. In no event shall this provision be construed to:

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

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

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

9.1.12. Contractor shall document decisions on the admission or rejection of Providers in accordance with Contractor's publicly posted policies and procedures and provide documented decisions to the Department upon request.

9.1.13. Contractor shall ensure that its network includes Providers who meet The Americans with Disabilities Act of 1990 (ADA) access standards and communication standards or Contractor shall offer alternative locations that meet these standards.

9.1.14. Contractor shall ensure that its networks provide Contractor's Members with a reasonable choice of Providers.

9.1.15. Contractor shall allow each Member to choose a PCP to the extent possible and appropriate.

9.1.16. Contractor shall continually work to expand and enhance the CHP+ networks, including activities such as recruiting new Providers and encouraging Network Providers to expand their capacity to serve more Members.

9.1.17. Contractor shall have policies and procedures describing the mechanisms used to ensure Provider compliance with the terms of this Contract.

9.1.18. Contractor shall document its relationship with and requirements for each Provider in Contractor's network in a written contract.

9.1.19. Contractor shall offer contracts to all willing and qualified FQHCs, CMHCs, RHCs, and Indian Health Care Providers located in the Contract Region.

9.1.20. Contractor may not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

9.1.21. Contractor shall terminate any providers of services or persons terminated (as described in section 1902(kk)(8) of the Social Security Act) from participation under title XIX, title XVIII, or title XXI from participating as a provider in Contractor's network.

9.1.22. To the extent Contractor has a Provider Network, Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian enrollee to a Network Provider in accordance with 42 C.F.R. § 438.14(b)(6).

9.2. Provider Credentialing and Re-credentialing

9.2.1. Contractor shall ensure that all contracted Network Providers are credentialed and ensure that re-credentialing of all individual practitioners occurs at least every three years.

9.2.2. Contractor shall ensure that all Providers in its network meet the following criteria:

9.2.2.1. Enrolled in the Colorado interChange as a Participating Provider.

9.2.2.2. Licensed and/or credentialed, per established State and Federal requirements, and able to practice in the State of Colorado.

9.2.3. Contractor shall have documented procedures for credentialing and re-credentialing Network Providers that are publicly available to Providers upon request. The documented procedures shall include Contractor's timeframes for the credentialing and re-credentialing processes.

9.2.3.1. Contractor shall use NCQA credentialing and re-credentialing standards and guidelines as the uniform and required standards for all contracts.

9.2.3.2. Contractor may accept accreditation of Primary Care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to satisfy individual credentialing elements required by this Contract, or NCQA credentialing standards, if the Department deems the elements to be substantially equivalent to the NCQA elements and/or standards.

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

9.2.4. Contractor shall terminate its health care Provider contracts for provision of services to Members with contracted Providers if such Provider fails to revalidate Enrollment, as required by 42 C.F.R. §

455.414, regardless of Provider type, when the Provider is no longer identified as a Participating Provider in the Colorado interChange.

9.3. Access to Care Standards

9.3.1. Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care, as determined by the State in accordance with 42 C.F.R. § 438.68, and shall meet and/or exceed Provider Network time and distance standards specified in 9.3.10.

9.3.2. Contractor shall ensure that its network allows for adequate Member freedom of choice amongst Providers.

9.3.3. Contractor shall provide the same standard of care to all Members, regardless of eligibility category.

9.3.4. Contractor shall require that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Members or that are comparable to other CHP+ Providers.

9.3.5. Contractor shall ensure the Provider Network is sufficient to support minimum hours of Provider operation to include service coverage from 8:00 a.m.–5:00 p.m. Mountain Time, Monday through Friday.

9.3.6. Contractor's network shall provide for extended hours, outside the hours from 8:00 a.m.–5:00 p.m. Mountain Time, on evenings and weekends and alternatives for emergency room visits for after-hours urgent care.

9.3.6.1. Contractor shall ensure that evening and weekend support services for Members and families shall include access to clinical staff, not just an answering service or Referral service staff.

9.3.7. Contractor shall implement a network management process and maintain an up-to-date database or directory of contracted Providers approved to deliver services, which includes all the information listed in Section 7.3.8.1.6 of this contract. Contractor shall ensure that the directory is updated at least monthly and shall be made available to the Department upon request.

9.3.8. Contractor shall ensure that its network provides for 24 hour a day availability of information, Referral and treatment of Emergency Medical Conditions in compliance with 42 C.F.R. § 438.114.

9.3.9. Contractor shall provide 24/7 phone coverage with access to a clinician that can triage the Member's health need.

9.3.10. Contractor shall ensure that its Provider Network complies with the time and distance standards in the following Provider Network Time and Distance Standards table:

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Provider Network Time and Distance Standards Table

Provider Type	**Large Metro County** Time (minutes)	**Large Metro County** Distance (miles)	**Metro County** Time (minutes)	**Metro County** Distance (miles)	**Micro County** Time (minutes)	**Micro County** Distance (miles)	**Rural County** Time (minutes)	**Rural County** Distance (miles)	**Counties with Extreme Access Considerations** Time (minutes)	**Counties with Extreme Access Considerations** Distance (miles)
Acute Inpatient Hospital (Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Primary Care – Adult	20	10	30	15	40	20	60	30	90	60
Primary Care – Pediatric	20	10	30	15	40	20	60	30	90	60
Gynecology, OB/GYN*	20	10	30	15	40	20	60	30	90	60
PT / OT / ST** Providers	20	10	45	30	80	60	90	75	120	110
Pediatric Specialty Care	30	15	45	30	80	60	90	75	120	110
Adult Specialty Care Providers	30	15	45	30	80	60	90	75	120	110
Pharmacy	10	5	15	10	30	20	40	30	70	60
Outpatient Clinical Mental Health (Licensed, accredited, or certified professionals) – Adult	20	10	30	15	40	20	60	30	90	60

Provider Type	**Large Metro County** Time (minutes)	**Large Metro County** Distance (miles)	**Metro County** Time (minutes)	**Metro County** Distance (miles)	**Micro County** Time (minutes)	**Micro County** Distance (miles)	**Rural County** Time (minutes)	**Rural County** Distance (miles)	**Counties with Extreme Access Considerations** Time (minutes)	**Counties with Extreme Access Considerations** Distance (miles)
Outpatient Clinical Mental Health (Licensed, accredited, or certified professionals) – Pediatric	20	10	30	15	40	20	60	30	90	60
General Pediatric Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	110	100
General Adult Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	110	100
SUD Treatment Practitioner – Adult	20	10	30	15	40	20	60	30	90	60
SUD Treatment Practitioner – Pediatric	20	10	30	15	40	20	60	30	90	60

*obstetrician-gynecologist

**physical therapy, occupational therapy, speech therapy

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9.3.11. Contractor shall ensure that its Provider Network has a sufficient number of Providers so that each Member has their choice of at least two Providers within the maximum distance for their county classification. For Rural and Frontier areas, the Department may adjust this requirement based on the number and location of available Providers.

9.3.11.1. In the event that there are less than two practitioners that meet the Provider standards within the defined area for a specific Member, then Contractor shall not be bound by the requirements of the prior paragraph for that Member.

9.3.11.2. In the event that there are no Behavioral Health Providers who meet the Behavioral Health Provider standards within the defined area for a specific Member, then Contractor shall not be bound by the time and distance requirements of the prior table for that Member.

9.3.11.3. Contractor shall use GeoAccess or a comparable service to measure the distance between the Members and the Providers in Contractor's Region.

9.3.12. Contractor shall ensure that its Provider Networks meets the following practitioner to Client ratios and distance standards:

9.3.12.1. Adult Primary Care Providers: One practitioner per 1,800 adult Members.

9.3.12.2. Mid-level adult Primary Care Providers: One practitioner per 1,200 adult Members.

9.3.12.3. Pediatric Primary Care Providers: One practitioner per 1,800 child Members.

9.3.12.4. Physician specialist: One physician specialist per 1,800 Members.

9.3.12.4.1. Physician Specialist includes physicians designated to practice:

9.3.12.4.1.1. Cardiology.

9.3.12.4.1.2. Otolaryngology/ENT.

9.3.12.4.1.3. Endocrinology.

9.3.12.4.1.4. Gastroenterology.

9.3.12.4.1.5. Neurology.

9.3.12.4.1.6. Orthopedics.

9.3.12.4.1.7. Pulmonary Medicine.

9.3.12.4.1.8. General Surgery.

9.3.12.4.1.9. Ophthalmology.

9.3.12.4.1.10. Urology.

9.3.12.4.2. Physician specialists designated to practice Gerontology, Internal Medicine, Infectious Disease, OB/GYN and Pediatrics shall be counted as either a PCP or physician specialist, but not both.

9.3.12.5. Pediatric physician specialist to Members ratio: One practitioner per 1,800 child Members.

9.3.12.5.1. Pediatric physician specialist includes Pediatric physicians designated to practice:

9.3.12.5.1.1. Cardiology.

9.3.12.5.1.2. Otolaryngology/ENT.

9.3.12.5.1.3. Endocrinology.

9.3.12.5.1.4. Gastroenterology.

9.3.12.5.1.5. Neurology.

9.3.12.5.1.6. Orthopedics.

9.3.12.5.1.7. Pulmonary Medicine.

9.3.12.5.1.8. General Surgery.

9.3.12.5.1.9. Ophthalmology.

9.3.12.5.1.10. Urology.

9.3.12.5.2. Pediatric physician specialists designated to practice Internal Medicine, Infectious Disease, OB/GYN and Pediatrics shall be counted as either a PCP or physician specialist, but not both.

9.3.12.6. Adult mental health Providers: One practitioner per 1,800 adult Members.

9.3.12.7. Pediatric mental health Providers: One practitioner per 1,800 child Members.

9.3.12.8. Substance use disorder Providers: One practitioner per 1,800

9.3.13. 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 PCP if that source is not a women's health specialist.

9.3.14. Contractor shall not restrict the Member's free choice of family planning services and supplies.

9.3.15. Contractor shall maintain and monitor a network of Provider that are able to provide services to Members with special health care needs as specified in 10 CCR 2505-10, §8.205.9, et seq. and 42 CFR 438.208(c).

9.3.16. Contractor shall maintain sufficient Indian or Tribal Providers in the Network to ensure timely access to services available under the Contract for Indian or Tribal Members who are eligible to receive services from such Providers, in accordance with the American Recovery and Reinvestment Act of 2009.

9.3.16.1. Indian or Tribal Members eligible to receive services from an Indian or Tribal Provider in the PCP Network are permitted to choose that Indian or Tribal Provider as their PCP, as long as that Provider has the capacity to provide services.

9.3.16.2. Contractor shall permit Indian or Tribal Members to obtain Covered Services from out-of-network Indian or Tribal Providers from whom the Member is otherwise eligible to receive such services.

9.3.16.3. Contractor shall permit Indian Members to access out-of-state Indian or Tribal Providers, in accordance with 42 CFR 438.14(b)(5), in a state where timely access to Covered Services cannot be ensured due to few or no Indian or Tribal Providers.

9.3.16.4. Contractor shall exempt from all cost sharing any Indian or Tribal who is currently receiving or has ever received an item or service furnished by an Indian or Tribal Provider through Referral under contract health services.

9.3.17. Contractor may use the Department's template to request an exception from the maximum time and distance standards when a service area has an insufficient number of Providers/facilities to meet the standard network adequacy requirements for a specific Provider type.

9.3.17.1. The Department's approval of an exception on this basis does not relieve Contractor from demonstrating access to the specific service provided by the Provider/facility type that is insufficient in the service area.

9.3.17.1.1. DELIVERABLE: Service Area Exception

9.3.17.1.2. DUE: Annually, by May 15

9.3.18. Contractor shall ensure its Provider Network is sufficient so that services are provided to Members on a timely basis, as follows:

9.3.18.1. Urgent Care – within 24 hours after the initial identification of need.

9.3.18.2. Outpatient Follow-up Appointments – within seven days after discharge from a Hospitalization.

9.3.18.3. Non-urgent, Symptomatic Care Visit – within seven days after the request.

9.3.18.4. Well Care Visit – within one month after the request, unless an appointment is required sooner to ensure the provision of screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule.

9.3.18.5. Emergency Behavioral Health Care:

9.3.18.5.1. By phone – within 15 minutes after the initial contact, including TTY accessibility; in person within one hour of contact in Urban and suburban areas, in person within two hours after contact in Rural and Frontier areas.

9.3.18.6. Non-urgent, Symptomatic Behavioral Health Services – within seven days after a Member's request.

9.3.18.6.1. Contractor shall not consider administrative intake appointments or group intake processes as a treatment appointment for non-urgent, symptomatic care.

9.3.18.6.2. Contractor shall not place Members on waiting lists for initial routine service requests

9.3.18.7. Contractor shall address Member complaints on appointment wait times immediately on a Member-specific basis and researched to determine solutions to any causal systemic issues.

9.3.19. Contractor shall take actions necessary to ensure that all Primary Care, Behavioral Health care, and specialty care covered under this Contract are provided to Members with reasonable promptness, including but not limited to the following:

9.3.19.1. Utilizing out-of-network Providers.

9.3.20. In compliance with 42 C.F.R. §438.206(c), Contractor shall:

9.3.20.1. Establish mechanisms to ensure compliance to access to care standards by Network Providers.

9.3.20.2. Monitor Network Providers regularly to determine compliance with access to care standards.

9.3.20.3. Take corrective action and notify the Department of the action taken if Network Providers do not comply with access to care standards.

9.3.21. Contractor shall establish policies and procedures to ensure continuity of care for all Members transitioning into or out of Contractor's Enrollment, guaranteeing that a Member's services are not disrupted or delayed.

9.3.22. Contractor shall have a system in place for monitoring patient load in their Provider Network and recruit Providers as necessary to assure adequate access to all Covered Services.

9.3.23. Contractor shall provide for a second opinion from a Network Provider or arrange for the Member to obtain a second opinion outside the network, at no cost to the Member.

9.3.24. Out of Network Providers

9.3.24.1. In the event that Contractor is unable to provide any Covered Service to a Member from a Provider within its network, then 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.

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

9.3.24.3. Contractor shall work with any Provider that is not within its network with respect to any payment that Contractor must make to the Provider to meet the requirements of 13.1.5.3. All payments from Contractor to a Provider that is not within Contractor's MCO shall be made in accordance with C.R.S. §25.5-4, unless otherwise negotiated between Contractor and that Provider.

9.4. Network Changes and Deficiencies

9.4.1. Contractor shall notify the Department, in writing, of Contractor's knowledge of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the Provider Network. The notice shall include:

9.4.1.1. Information describing how the change will affect service delivery.

9.4.1.2. Availability, or capacity of Covered Services.

9.4.1.3. A plan to minimize disruption to the Members' care and service delivery.

9.4.1.4. A plan to correct any network deficiency.

9.4.1.4.1. DELIVERABLE: Network Changes and Deficiencies

9.4.1.4.2. DUE: Within five days after Contractor's knowledge of the change or deficiency.

9.5. Network Adequacy Plan and Report

9.5.1. Contractor shall create a Network Adequacy Plan that contains, at a minimum, the following information for its Provider Network:

9.5.1.1. How Contractor shall maintain and monitor a network of appropriate Providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the Contract for all Members, including those with limited English proficiency and Members with physical or mental disabilities.

9.5.1.2. How Contractor shall ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for CHP+ enrollees with physical or mental Disabilities.

9.5.1.3. Number of Network Providers by Provider type and areas of expertise as identified in the Department's Network Adequacy Report Templates.

9.5.1.4. Number of Network Providers accepting new CHP+ Members by Provider type.

9.5.1.5. Geographic location of Providers in relationship to where CHP+ Members live.

9.5.1.6. Cultural and language expertise of Providers.

9.5.1.7. Number of Providers offering after-hours and weekend appointment availability to CHP+ Members.

9.5.1.8. Standards that will be used to determine the appropriate case load for Providers and how this will be continually monitored and reported to the Department to ensure standards are being met and maintained across Contractor's Provider Network.

9.5.1.9. A description of how Contractor's network of Providers of the Member population in Contractor's area, specifically including a description of how Members in special populations are able to access care.

9.5.2. Contractor shall submit the Network Adequacy Plan to the Department.

9.5.2.1. DELIVERABLE: Network Adequacy Plan

9.5.2.2. DUE: Annually, on July 31.

9.5.3. Contractor shall submit a Network Report to the Department on a quarterly basis. The Network Report shall contain all components identified in the Department's Network Adequacy Report Template(s) and supporting data of high quality.

9.5.3.1. Contractor shall submit any additional information, as requested by the Department.

9.5.3.2. Contractor shall submit the Network Report to the Department, or Department designee.

9.5.3.2.1. DELIVERABLE: Network Report

9.5.3.2.2. DUE: Quarterly, on the last Business Day of July, October, January, and April.

10. CONTRACTOR'S HEALTH PLAN ADMINISTRATION REQUIREMENTS

10.1. Contractor shall be responsible for managing the health of all its Members.

10.1.1. Contractor shall design and implement a population management strategy to inform, assess, track, and manage the health needs and outcomes of all its Members in order to improve health, control costs, and improve the experience of care.

10.1.2. Contractor's population management activities shall include, but not be limited to, the following:

10.1.2.1. Member identification and risk stratification.

10.1.2.2. Member engagement and outreach.

10.1.2.3. Wellness promotion.

10.1.2.4. Utilization of evidence-based and promising practices.

10.1.2.5. Programs for managing Department identified health conditions.

10.1.2.6. Care Coordination for Members utilizing CHP+ services.

10.1.3. Contractor shall develop programs and materials to assist Members in effectively utilizing CHP+ benefits and to support Members in becoming proactive participants in their health and well-being.

10.1.4. Contractor shall have a comprehensive approach to population health management and shall develop programs to manage and support Members' health and well-being. Contractor's population management strategy shall focus on the following areas:

10.1.4.1. Routine preventative care, including well-child visits and immunizations.

10.1.4.2. Perinatal, prenatal, and postpartum care for women.

10.1.4.3. Conditions related to Persons with Special Health Care Needs.

10.1.4.4. Early interventions and supports.

10.1.5. Contractor shall provide access to all required components of periodic health screens, as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule.

10.1.5.1. Contractor shall proactively provide education and outreach to inform Members of the importance of routine preventative care.

10.1.6. Contractor shall proactively outreach to pregnant mothers to improve prenatal education and outcomes around maternity support and prenatal care benefits and advantages.

10.1.6.1. Contractor shall complete an evidence-based risk assessment for all pregnant members, (unless member declines or is unable to be reached) within 7 business days of identifying a pregnant member.

10.1.6.1.1. This can be delegated to a provider or medical home.

10.1.6.1.2. Contractor may conduct the initial risk assessment in lieu of or in combination with the initial health needs screening.

10.1.6.2. Contractor must conduct outreach to initiate service coordination activities within 7 business days of designating a high-risk pregnancy.

10.1.6.3. Contractor shall ensure that quality perinatal services are provided for pregnant and postpartum members through promoting guidelines used to evaluate perinatal services shall be most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG). Contractor will make the ACOG guidelines available to providers and members.

10.1.6.4. Contractor shall provide access to ACIP-recommended vaccines for those age 19 and older without cost sharing.

10.1.7. Contractor shall develop a systematic communication process with Network Providers to educate Providers on tools available to assist physicians on best practices for population management and Care Coordination.

10.1.7.1. Contractor shall utilize existing programs among its Network Providers to manage and support Members with specific health conditions.

10.1.8. Contractor shall implement mechanisms to ensure Members with complex needs are identified and their needs are supported and addressed in a timely manner.

10.1.9. Contractor shall collaborate with the Department to identify health conditions needing wellness interventions and implementing and evaluating evidence-based programs designed to improve the health of identified health conditions and prevent disease progression of Department identified health conditions.

10.2. Community and Social Determinants of Health

10.2.1. Contractor shall recognize that the conditions in which Members live also impact their health and well-being and establish relationships and communication channels with community organizations that provide resources such as economic assistance, food, housing, energy assistance, childcare, education and job training in the region.

10.2.2. Contractor shall actively work to establish and strengthen relationships with effective community organizations, state agencies, and programs in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts.

10.2.2.1. Contractor shall establish and strengthen relationship with, but not limited to, the following organizations, programs, agencies, and statewide efforts:

10.2.2.1.1. Colorado Crisis Services.

10.2.2.1.2. Colorado Managed Service Organizations.

10.2.2.1.3. Early Intervention Colorado.

10.2.2.1.4. Temporary Assistance for Needy Families (TANF).

10.2.2.1.5. Early Head Start and Head Start Programs.

10.2.2.1.6. Healthy Steps.

10.2.2.1.7. Nurse-Family Partnership.

10.2.2.1.8. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

10.2.2.1.9. Supplemental Nutrition Assistance Program (SNAP).

10.2.2.1.10. Local School Districts.

10.2.2.1.11. Any other organizations, programs, and agencies, as identified by the Department

10.2.3. Healthy Colorado for All

10.2.3.1. Contractor shall provide a Healthy Colorado for All Plan to address health disparities that impact Members within their service area. The plan shall include an inventory of current and future efforts around removing obstacles to health care access and focusing on positive health outcomes for all members.

10.2.3.2. Contractor shall modify the Healthy Colorado for All Plan as directed by the Department to account for any changes in the work, in the Department's processes and procedures, in Contractor's processes and procedures, or to address any health access related deficiencies determined by the Department.

10.2.3.3. Contractor shall review and update the Healthy Colorado for All Plan annually and submit it to the Department for review.

10.2.3.3.1. DELIVERABLE: Healthy Colorado for All Plan

10.2.3.3.2. DUE: Annually by December 31.

10.3. PCP Selection and Assignment

10.3.1. Contractor shall have written policies and procedures for allowing Members to select or be assigned to a PCP at any time.

10.3.2. Contractor shall provide Members with a meaningful choice in selecting a PCP. Contractor shall allow, to the extent possible and appropriate, each Member to choose a PCP.

10.3.3. Contractor shall have written policies and procedures for assigning each of its Members, who have not selected a PCP at the time of Enrollment, to a PCP or clinic.

10.4. Health Needs Assessment

10.4.1. Contractor shall ensure that a Member-appropriate, individual health needs assessment is completed by the Member within 90 days after the effective date of Enrollment, and at any other time necessary, as part of the onboarding process to capture basic information about a Member's individual health needs. Contractor shall:

10.4.1.1. Make subsequent attempts to conduct an initial screening of each Member's needs if the initial attempt to contact the Member is unsuccessful.

10.4.1.2. Use the results of the assessment to inform Member outreach and Care Coordination activities.

10.4.1.3. Work with Network Providers to develop an individual treatment plan as necessary based on the needs assessment and to avoid duplication of treatment.

10.4.1.4. Ensure individual needs assessment allows for the screening of Special Health Care Needs.

10.5. Care Coordination

10.5.1. Contractor shall ensure Care Coordination is part of Contractor's population health strategy and in compliance with the requirements specified in 42 CFR § 438.208.

10.5.2. Contractor shall use a person- and family-centered approach to Care Coordination, which takes into consideration the preferences and goals of Members and their families and connects them to the resources required to carry out needed care and follow up.

10.5.3. Contractor shall create policies and procedures to ensure:

10.5.3.1. Each Member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Member, and Members are provided information on how to contact their designated person or entity.

10.5.3.2. Care is coordinated for the Member within a practice, as well as between the practice and other Network Providers and community organizations and shall ensure that Care Coordination is provided to Members who are transitioning between health care settings.

10.5.3.2.1. Contractor shall ensure the coordination of services provided to the Member:

10.5.3.2.1.1. Between settings of care, including appropriate discharge planning for short term and long-term Hospital and institutional stays.

10.5.3.2.1.2. With the services the enrollee receives from any other MCO.

10.5.3.2.1.3. With the services the enrollee receives in CHP+FFS.

10.5.3.2.1.4. With the services the enrollee receives from community and social support Providers.

10.5.3.2.1.5. Including knowledge regarding out-of-state medical care as described in 10 CCR 2505-10 8.013.

10.5.3.3. Timely coordination of services and supports between Primary Care Providers, Behavioral Health Providers, specialists, and community organizations to ensure information is communicated appropriately, and interventions are provided appropriately to meet the needs of the Member.

10.5.4. Contractor's Care Coordination programs and/or procedures shall comprise:

10.5.4.1. A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being.

10.5.4.2. Deliberate interventions for specific Members who require more intense and extended assistance.

10.5.4.3. Mechanisms to increase access for Members to appropriate care and reduce unnecessary utilization of costly emergency services and limited specialty care resources.

10.5.5. Contractor shall ensure that Care Coordination:

10.5.5.1. Is available to all Members.

10.5.5.2. Is provided at the point of care whenever possible.

10.5.5.3. Addresses both short and long-term health needs.

10.5.5.4. Is culturally responsive.

10.5.5.5. Respects Member preferences.

10.5.5.6. Supports regular communication between care coordinators and the practitioners delivering services to Members.

10.5.5.7. Is documented, for both medical and non-medical activities.

10.5.5.8. Addresses potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs in order to achieve optimal health, wellness or end-of-life outcomes, according to Member preferences.

10.5.5.9. Protects Member privacy.

10.5.6. Contractor shall ensure that each Provider furnishing services to Members maintains and shares, as appropriate, a health record in accordance with professional standards.

10.5.7. Contractor shall ensure that Care Coordination tools, processes, and methods are available to Network Providers.

10.5.8. Contractor shall develop and disseminate practice guidelines to Network Providers and, upon request, to Members and potential Members.

10.5.8.1. Contractor shall develop practice guidelines for the following:

10.5.8.1.1. Perinatal, prenatal and postpartum care for women.

10.5.8.1.2. Conditions related to Persons with Special Health Care Needs.

10.5.8.1.3. Well child care.

10.5.8.2. Contractor shall adopt practice guidelines that consider the needs of Members.

10.5.8.3. Contractor shall adopt practice guidelines in consultation with Network Providers.

10.5.8.4. Contractor shall review and update practice guidelines periodically as appropriate.

10.5.8.5. Contractor shall ensure guidelines are consistent with decisions regarding Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply.

10.5.9. Members with Special Health Care Needs

10.5.9.1. Contractor shall ensure Care Coordination activities for Members with Special Health Care Needs consist of the following:

10.5.9.1.1. Mechanisms to assess Members identified as a Person with Special Health Care Needs within 30 calendar days in order to identify any ongoing special conditions of the Member that requires a course of treatment or regular care monitoring.

10.5.9.1.2. Mechanisms to review and revise Member's treatment or service plan upon reassessment of functional need for Members with Special Health Care Needs, at least every 12 months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

10.5.9.1.3. Mechanisms to assess the quality and appropriateness of care furnished to Members with Special Health Care Needs, and in accordance with any applicable state quality assurance and Utilization Review standards.

10.5.9.1.4. Mechanisms to allow Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

10.5.9.1.5. Mechanisms to coordinate health care services for Members with Special Health Care Needs with other agencies or entities.

10.5.9.2. Early Intervention (EI) Services and Supports

10.5.9.2.1. Contractor shall provide EI Services and Support by participating in the EI trust, in accordance with C.R.S. 27-10.5-709.

10.5.9.2.2. Contractor shall develop a process in coordination with Colorado Department of Human Services (CDHS) to ensure EI Services and Support are provided which shall include, but not be limited to the following steps:

10.5.9.2.2.1. CDHS will notify Contractor of a CHP+ Member's eligibility for EI Services and Supports.

10.5.9.2.2.2. Within 30 calendar days of notification from CDHS, Contractor shall submit funds in the amount established by the EI Program in the eligible CHP+ Member's name.

10.5.9.2.2.3. Within 90 days after CDHS determines that the CHP+ Member is no longer eligible for the EI Program, for the purposes of C.R.S 10-16-104(1.3), CDHS shall notify Contractor. All unused monies deposited in the EI trust on behalf of the CHP+ Member that are not expended before the Member became ineligible for the EI Program shall be returned to Contractor.

10.5.9.2.2.4. No later than April 1 of each Contract year, CDHS shall provide Contractor with a report specifying the amount of benefits paid to certified Early Intervention Service Brokers for services provided to an eligible Member during the prior calendar year, including the amount paid to each certified Early Intervention Service Broker and the services provided to an eligible Member.

10.5.9.2.3. Contractor shall not be responsible for services funded by the trust and shall ensure that any qualified Early Intervention Provider that receives reimbursement for services funded by the trust fund shall accept such reimbursement as payment in full for services under C.R.S. Section 10-16-104(1.3) and shall not seek additional reimbursement from either the eligible Member's family or the carriers.

10.6. Provider Support

10.6.1. Contractor shall serve as a point of contact for Network Providers regarding services and programs, regional resources, clinical tools, and general administrative information.

10.6.2. Contractor shall support Network Providers that are interested in:

10.6.2.1. Integrating Primary Care and Behavioral Health services.

10.6.2.2. Enhancing the delivery of team-based care by leveraging all staff.

10.6.2.3. Advancing business practices and use of health technologies.

10.6.2.4. Participating in value-based payment structures.

10.6.2.5. Other activities designed to improve Member health and experience of care.

10.6.3. Contractor shall provide practice support to Network Providers to support them with implementing Contractor's population management and Care Coordination activities.

10.6.4. Contractor shall support Network Providers in implementing and utilizing telehealth solutions.

10.6.5. Contractor shall ensure adequate informational support for Network Providers, while being mindful of not duplicating existing materials.

10.6.6. Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for the following topics:

10.6.6.1. General information about CHP+ and Contractor's role and purpose.

10.6.6.2. Contractor's process for handling Appeals and Grievances.

10.6.6.3. Available Member resources, including the Member Provider Directory.

10.6.6.4. Clinical resources, such as screening tools, clinical guidelines, practice improvement activities, templates, trainings and any other resources Contractor has compiled.

10.6.6.5. Community-based resources, such as childcare, food assistance, housing assistance, utility assistance and other non-medical supports.

10.6.7. Contractor shall act as a liaison between the Department and its other contractors, partners and Providers.

10.6.8. Contractor shall ensure that Contractor's Provider communications adhere to Colorado CHP+ brand standards.

10.6.9. Contractor shall support the delivery of evidence-based medicine by Network Providers.

10.6.10. Contractor shall assist Providers in resolving barriers and problems, including, but not limited to, the following:

10.6.10.1. Provider Enrollment in the Colorado interChange system.

10.6.10.2. Member eligibility and coverage policies.

10.6.10.3. Service authorization and Referral.

10.6.10.4. Member and PCP assignment.

10.6.11. Contractor shall establish a timely process for responding to and resolving barriers and problems reported by Providers related to Contractor's payment and benefits systems, including, but not limited to, the following:

10.6.11.1. Billing and claims payment.

10.6.11.2. Provider credentialing.

10.6.11.3. Provider contracting.

10.6.11.4. Service authorization.

10.6.12. Contractor shall develop trainings and host forums for ongoing Provider Training regarding the Program, the services Contractor offers, and promote participation in state and local training programs.

10.6.12.1. Contractor shall ensure that trainings and updates on the following topics are made available to Contractor's Network Providers:

10.6.12.1.1. Colorado CHP+ and Medicaid eligibility and application processes.

10.6.12.1.2. CHP+ benefits.

10.6.12.1.3. Access to Care standards.

10.6.12.1.4. Contractor's Population Management Programs.

10.6.12.1.5. Cultural responsiveness.

10.6.12.1.6. Member rights, Grievances, and Appeals.

10.6.12.1.7. Quality improvement initiatives.

10.6.12.1.8. Other trainings identified in consultation with the Department.

10.6.13. Contractor shall educate and inform Network Providers about the tools and systems available to the Providers, including, but not limited to, the following:

10.6.13.1. Care Coordination Tools, Data, or Reports.

10.6.13.2. Risk Stratification Tools, Data, or Reports.

10.6.13.3. Colorado interChange (MMIS).

10.6.13.4. PEAK website and PEAKHealth mobile app.

10.6.13.5. Regional health information exchange.

10.6.14. Contractor shall provide practice-level data and reports to Network Providers and assist Providers with data analysis and reporting. Training shall include utilizing data to improve care for complex Members, improve care for Members with Department identified health conditions, implement wellness and prevention strategies, and identify Members who require additional services.

10.6.15. Contractor shall train and support Providers in implementing and utilizing health information technology (Health IT) systems and data. Contractor shall keep up to date with changes in Health IT in order to best support Providers.

10.6.16. Contractor shall facilitate clinical information sharing by supporting Network Providers in connecting electronic health records (EHRs) with the regional health information exchange (HIE).

10.6.16.1. Contractor shall promote the use of Office of the National Coordinator for Health Information Technology (ONC) Interoperability Standards for PCP EHR systems, to improve data exchange. These standards can be found at https://www.healthit.gov/policy-researchers-implementers/interoperability.

11. COVERED SERVICES

11.1. Contractor shall administer and manage the delivery of all services covered under the CHP+ benefit for Members, which means Contractor shall:

11.1.1. Provide Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under the established minimum essential benefit for the CHP+ program.

11.1.2. Determine the Medical Necessity of Covered Services and shall make benefit and coverage determinations in a manner that is fully consistent with the terms of this Contract.

11.1.3. Assume comprehensive risk for all CHP+ Covered Services.

11.1.4. Take full responsibility for providing and arranging for the provision of all Medically Necessary Covered Services.

11.2. Contractor shall ensure access to care for all Members for only those Covered Services described in Exhibit H, Covered Services and Copayments, and Exhibit I, Fluoride Varnish Program Details, under the terms of this Contract.

11.3. Contractor shall provide a guarantee that Contractor shall not avoid costs for services covered in this Contract by referring Members to publicly supported health care resources.

11.4. As the administrator of the CHP+ benefit, Contractor shall employ strategic health care management practices described throughout the Contract in administering the benefit, create financial incentives to drive quality care and have strong Member experience protections.

11.5. Contractor shall administer the CHP+ Benefit in a manner that is fully integrated with the entirety of the Work outlined in the Contract thereby creating a seamless experience for Members and Providers.

11.6. Contractor shall demonstrate a commitment to the following principles in administering the CHP+ Benefit:

11.6.1. Recovery and Resilience: Treatment that supports Members in making positive changes in their behaviors so they can improve their health and life outcomes. Positive changes are achieved by sharing information, building skills, and empowering Members to make changes by leveraging individual strengths and protective factors. The benefits of recovery and resilience principles extend across ages and settings and can be particularly helpful for low-income children.

11.6.2. Trauma-informed: Treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences on Members' health.

11.6.3. Least Restrictive Environment: The provision of community-based supports and services that enable individuals with serious mental illness and other disabilities to live in the community to the greatest extent possible and as appropriate.

11.6.4. Culturally Responsive: Providers and provider staff deliver effective, understandable, and respectful care in a manner compatible with Members' cultural health beliefs, practices and preferred language.

11.6.4.1. Contractor shall develop policies and procedures, as needed, on how Contractor shall respond to requests from participating Providers for interpreter services.

11.6.5. Prevention and Early Intervention: Broad community-wide efforts to reduce the impact of mental health and substance use disorders on individuals and communities that include, but are not limited to, the following:

11.6.5.1. Improving the public's understanding of mental health and substance use disorders.

11.6.5.2. Normalizing mental health and substance use disorders as legitimate and treatable health issues.

11.6.5.3. Actively promoting emotional health.

11.6.5.4. Promoting education and public awareness of mental health and substance use disorder symptoms.

11.6.5.5. Increasing access to effective treatment and supporting individual recovery.

11.6.6. Evidence-based: Treatment is provided in accordance with the best available research and clinical expertise.

11.6.7. Member and Family Centered Care: Services and supports are provided in the best interest of the individual to ensure that the needs of the individual and family are being addressed. Systems, services, and supports are based on the strengths and needs of the entire family or community.

11.7. Contractor shall furnish information about the services that Contractor does not cover because of moral or religious objections to the Department whenever it adopts such a policy during the term of the contract.

11.8. Contractor would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if Contractor objects to the service on moral or religious grounds.

11.9. Specific Services and Responsibilities

11.9.1. Mental Health, Behavioral Health, and Substance Use Disorder Services

11.9.1.1. Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

11.9.1.1.1. To meet the requirements of 42 CFR 440.395, Contractor shall cover, in addition to services covered under the state plan, any behavioral health services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K.

11.9.1.2. In accordance with CRS 10-16-139(5), Contractor shall include coverage and reimbursement for Behavioral Health screenings using a validated screening tool for Behavioral Health; coverage and reimbursement may be no less extensive than the coverage and reimbursement for the annual physical examination.

11.9.1.3. Contractor must ensure that the diagnosis of an intellectual or developmental Disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving medically necessary covered Behavioral Health services.

11.9.1.4. In accordance with CRS 25.5.5-422.2, Contractor shall not:

11.9.1.4.1. Impose any prior authorization requirements on any prescription medication approved by the Food and Drug Administration (FDA) for the treatment of substance use disorders.

11.9.1.4.2. Impose any step therapy requirements as a prerequisite to authorizing coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

11.9.1.4.3. Exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medication and services were court ordered

11.9.2. Prescription Drugs

11.9.2.1. Contractor shall establish a drug formulary for all Covered Drugs with its own prior authorization criteria. The formulary must include at minimum, the same drugs furnished under the established minimum essential benefit for the CHP+ program.

11.9.2.2. Contractor shall develop and maintain a process to authorize and provide coverage of any Medically Necessary Drugs unmet by Contractor's formulary. Contractor shall ensure that the program includes the following criteria:

11.9.2.2.1. Provision of a telephonic or telecommunication response within 24 hours of a request for prior authorizations.

11.9.2.2.1.1. If additional information is needed for making an authorization decision regarding covered outpatient drugs, Contractor must:

11.9.2.2.1.1.1. Provide telephonic or telecommunications notice of the authorization decision within 24 hours of receiving complete information from the prescriber/requestor.

11.9.2.2.1.1.2. Work with the prescriber/requestor to ensure all additional documentation is provided in a timely manner to ensure access to the drug is not delayed.

11.9.2.2.2. Prescription of at least a 72-hour supply of outpatient Covered Drugs in an Emergency situation, with the exception of drugs referred to in section 42 USC 1396r-8(d)(2) of the Act. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well-being.

11.9.2.3. Effective January 1, 2024, Contractor shall not allow the use of spread pricing, as defined by CMS, by Contractor's Pharmacy Benefit Management System.

11.9.3. Specialty Drugs

11.9.3.1. Contractor shall administer and manage the delivery of Specialty Drugs covered under the CHP+ benefit, as identified by the Department, and in accordance with the coverage requirements, medical necessity standards, and prior authorization requirements specified herein Section 11.

11.9.3.1.1. Contractor shall have a specific process to ensure that Specialty Drugs are managed away from outpatient hospitals into home infusion, where appropriate.

11.9.3.1.2. Contractor shall prior authorize Specialty Drugs, in advance, and in accordance with their clinical coverage criteria and medical necessity standards.

11.9.3.1.3. Contractor shall report to the Department, at least quarterly, costs incurred by Contractor for Specialty Drugs with supporting invoice(s), authorization data, and encounter data.

11.9.3.1.4. Contractor shall use the Department-developed template for the Specialty Drugs Cost Report.

11.9.3.1.4.1. DELIVERABLE: Specialty Drugs Quarterly Cost Report

11.9.3.1.4.2. DUE: No later than 60 days following the quarter in which a claim was paid

11.9.4. Emergency and Post-Stabilization Services

11.9.4.1. Contractor shall cover and pay for Emergency Services and Post-Stabilization Care Services as specified in 42 C.F.R. § 438.114 and 42 C.F.R. § 422.113(c).

11.9.4.2. Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor.

11.9.4.3. Contractor shall cover and pay non-contracted Providers for Emergency Services no more than the amount that would have been paid if the service had been provided by a Network Provider.

11.9.4.4. Contractor shall not refuse to cover treatment obtained under either of the following circumstances:

11.9.4.4.1. A Member had an Emergency Medical Condition in which the absence of immediate medical attention would not necessarily have had the outcomes specified in the definition of Emergency Medical Condition.

11.9.4.4.2. A representative of Contractor instructs the Member to seek Emergency Services.

11.9.4.5. Contractor shall not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or Fiscal Agent not notifying Contractor of the Member's screening and treatment within 10 calendar days of presentation for Emergency Services.

11.9.4.6. Contractor shall not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

11.9.4.7. Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a 24 hour per day, seven day per week basis.

11.9.4.7.1. Members temporarily out of the Service Area may receive out-of-area Emergency Services and Urgently Needed Services.

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

11.9.4.9. Contractor acknowledges that the attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge; that determination is binding on Contractor for coverage and payment.

11.9.4.10. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Provider Network that are pre-approved by Contractor.

11.9.4.11. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's network that are not pre-approved by Contractor, but administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

11.9.4.11.1. Contractor does not respond to a request for pre-approval within one hour.

11.9.4.11.2. Contractor cannot be contacted.

11.9.4.11.3. Contractor and the treating Provider cannot reach an agreement concerning the Member's care and a plan Provider is not available for consultation. In this situation, Contractor shall give the treating Provider the opportunity to consult with a plan Provider and the treating Provider may continue with care of the Member until a plan Provider is reached or one of the criteria in 42 C.F.R. § 422.113(c)(3) is met.

11.9.4.12. Contractor shall limit charges to Members for Post-Stabilization Care Services to an amount no greater than what Contractor would charge the Member if they had obtained the services through Contractor.

11.9.4.13. Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved shall end when:

11.9.4.13.1. A plan Provider with privileges at the treating Hospital assumes responsibility for the Member's care.

11.9.4.13.2. A plan Provider assumes responsibility for the Member's care through transfer.

11.9.4.13.3. Contractor and the treating Provider reach an agreement concerning the Member's care.

11.9.4.13.4. The Member is discharged.

11.9.4.14. Nothing in this section shall preclude Contractor from conducting a retrospective review consistent with these rules regarding emergency and Post-Stabilization Care Services.

11.9.4.15. Verification of Medical Necessity for Emergency Services

11.9.4.15.1. Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services.

11.9.4.15.2. Contractor shall not deny benefits for conditions which a reasonable person outside of the medical community would perceive as Emergency Medical Conditions.

11.9.4.15.3. Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

11.9.5. Alternative Services

11.9.5.1. Contractor shall cover services or settings for enrollees that are in lieu of those covered under the state plan if:

11.9.5.1.1. The state determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the state plan.

11.9.5.1.2. The state determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the state plan.

11.9.5.2. The Member shall not be required by Contractor to use the alternative service or setting.

11.10. Copayments

11.10.1. Contractor shall be authorized to impose copayments for Members, not to exceed the amounts specified in Exhibit H, Covered Services and Copayments.

11.10.2. All cost sharing and co-payments, if greater than zero, shall be implemented and imposed in accordance with 42 C.F.R. §447.50 through 42 C.F.R. §447.57.

11.10.3. Contractor shall not charge cost sharing for the following eligibility categories:

11.10.3.1. Pregnant women.

11.10.3.2. American Indians.

11.10.3.3. Native Alaskans.

11.10.4. Contractor may invoice Members for unpaid co-payments if payment is not made at the time of service.

11.10.5. For fees or premiums charged by Contractor to Members in excess of amounts specified in Exhibit H, Covered Services and Copayments, Contractor may be liable for penalties of up to $25,000.00 or double the amount of the charges, whichever is greater. The Department will deduct from the penalty the amount of overcharge and return it to the affected Members.

11.11. Service Limits

11.11.1. Contractor shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

11.11.2. Contractor shall ensure that services supporting beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

11.11.3. 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.

11.11.4. Contractor may place appropriate limits on a service as follows:

11.11.4.1. On the basis of criteria applied under the CHP+ State Plan, such as Medical Necessity.

11.11.4.2. For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose.

11.11.4.2.1. Contractor shall ensure that mental health and substance use disorder benefits are in compliance with parity requirements, as specified in 42 C.F.R. § 457.496.

11.11.4.2.1.1. Contractor shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees, whether or not the benefits are furnished by the same managed care plan.

11.11.4.2.1.2. Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

11.11.4.2.1.3. Contractor may only apply a non-qualitative treatment limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors

applied to the same NQTL in the same benefit classification of the enrollee's medical/surgical benefits.

11.11.4.2.2. For Utilization Management, provided family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning to be used.

11.11.5. 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, must be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's condition or disease.

11.11.6. Contractor shall inform Members, or their families/designated representative, by email, phone, or mail of the approved timeframe for select authorized services, so that Members, or their representatives, are aware of how long the services have been authorized for and therefore may request a continuation of and/or additional services if needed. Contractor shall record and document its notification of Members and families.

11.11.7. Contractor shall establish clear and specific criteria for discharging Members from treatment.

11.11.7.1. Contractor shall include these criteria in Member materials and information.

11.11.7.2. Contractor shall note individualized criteria for discharge agreed upon by Member and Provider in the Member's health care record and modified, by agreement, as necessary.

11.11.8. Contractor shall not be liable for any Covered Services provided prior to the date a Member is enrolled under this Contract or after the date of disenrollment.

11.11.9. Contractor shall not hold a Member liable for Covered Services:

11.11.9.1. Provided to the Member, for which the Department does not pay Contractor.

11.11.9.2. Provided to the Member, for which the Department or Contractor does not pay the Provider that furnishes the service under a contract, Referral, or other arrangement.

11.11.9.3. Furnished under a contract, Referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor provided the services directly.

11.11.10. Contractor shall not prohibit or restrict a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient regarding:

11.11.10.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

11.11.10.2. Any information the Member needs to decide among all relevant treatment options.

11.11.10.3. The risks, benefits, and consequences of treatment or non-treatment.

11.11.10.4. The enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

11.12. Utilization Management

11.12.1. Contractor shall ensure access to and appropriate utilization of covered services.

11.12.2. Contractor shall provide care coordination, utilization management, disease management, and pharmacy medical management for members to promote the appropriate and cost-effective utilization of covered services.

11.12.3. Utilization Management involves:

11.12.3.1. Prospective, concurrent, and retrospective review.

11.12.3.2. Preauthorization system.

11.12.3.3. Medical Management Team oversight.

11.12.3.4. Transplant coordination.

11.12.3.5. Onsite reviews.

11.12.3.6. Discharge planning.

11.12.3.7. Case Management.

11.12.3.8. Appeals and Grievances.

11.12.4. Disease Management Programs designed to improve the health status of the entire identified disease/condition population. These programs include Diabetes, Asthma, High Risk OB, and Depression.

11.12.4.1. Accomplished by identification and stratification.

11.12.4.2. Stratification by population management.

11.12.4.3. Measured and reported by utilization, process improvement, and clinical outcomes.

11.12.5. Contractor shall establish and maintain a documented Utilization Management Program and Procedures, in compliance with 42 CFR 457.496 and 42 CFR 438.210, that includes, at a minimum, the following:

11.12.5.1. Description of its Utilization Management program structure and assignment of responsibility for Utilization Management activities to appropriate individuals.

11.12.5.2. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

11.12.5.3. Identification of the type of personnel responsible for each level of Utilization Management decision-making.

11.12.5.4. Standards for the individual denying a service to either be a health care professional with clinical expertise in treating the Member's condition or disease or to document a consultation with a health care professional with clinical expertise in treating the Member's condition or disease.

11.12.5.5. Policies and procedures for the use and periodic review of written clinical decision-making criteria based on clinical evidence.

11.12.5.6. Provider Dispute resolution.

11.12.5.7. Description of a Provider Dispute Resolution process which follows Division of Insurance Provider Dispute Resolution requirements and timelines.

11.12.5.7.1. DELIVERABLE: Utilization Management Program and Procedures

11.12.5.7.2. DUE: September 30, 2021 and 30 days after any significant change is made.

11.12.6. Contractor shall implement Contractor's documented Utilization Management Program and Procedures.

11.12.7. Contractor's Utilization Management process shall in no way impede timely access to services.

11.12.8. Contractor shall have mechanisms for Providers and Members on how they can obtain the Utilization Management decision-making criteria upon request.

11.12.9. Contractor shall not provide incentives, through conditional or contingent payments or by any other means, for those making the determination to deny, limit, or discontinue Medically Necessary services.

11.12.10. Contractor shall provide education and ongoing guidance to Members and Providers about its Utilization Management program and protocols.

11.13. FQHC And RHC Encounter Reimbursement

11.13.1. Contractor shall reimburse the FQHC or RHC by at least the Encounter Rate in accordance with 10 CCR 2505-10 § 8.700.6 and the CHP+ State Plan for each FQHC or RHC visit, for services identified in 10 CCR 2505-10 § 8.700.3 for allowable costs identified in 10 CCR 2505-10 § 8.700.5. The Department reserves the right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

11.13.1.1. Each FQHC and RHC has an Encounter Rate calculated in accordance with 10 CCR 2505-10 § 8.700.6C.

11.13.1.2. The Department will notify Contractor of changes to the FQHC and RHC rates and rules.

11.13.1.3. The Department conducts quarterly accuracy audits with FQHCs and RHCs. Should the Department recognize any discrepancy in FQHC or RHC payments (less than the full Encounter Rate), Contractor is responsible for reimbursing the FQHC or RHC the difference of the Encounter payment and the initial reimbursement amount. FQHC and RHC visits are defined in 10 CCR 2505-10 § 8.700.1.

11.13.2. If multiple services are provided by an FQHC or RHC within one visit, Contractor shall require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. Contractor shall pay the FQHC or RHC at least the Encounter Rate.

11.13.3. Contractor shall submit the Encounter Data for FQHC and RHC visits to the Department per the specifications provided in Section 13.1.6.

11.13.3.1. DELIVERABLE: FQHC and RHC Encounter Data

11.13.3.2. DUE: Within 30 days before the end of each calendar year quarter

11.13.4. Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs, as directed by Department staff.

11.14. Indian Health Services Providers Reimbursement

11.14.1. Contractor shall reimburse any Indian Health Care Provider (IHCP) enrolled in CHP+ as an FQHC but not a Network Provider at least the Encounter Rate.

11.14.1.1. Contractor shall reimburse IHCPs not enrolled in CHP+ as an FQHC, regardless of whether they are Network Providers, the applicable Encounter Rate published annually in the Federal Register by the Indian Health Service (IHS), or in the absence of a published Encounter Rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.

11.14.2. Contractor shall pay 90% of all clean claims from I/T/U Network Providers (whether in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt and pay 99% of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt.

11.15. Physician Incentive Plans

11.15.1. Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

11.15.1.1. Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any Member.

11.15.2. Contractor shall only operate physician incentive plans if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

11.15.3. If Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, Contractor shall ensure that the physician or physician group has adequate stop-loss protection.

11.15.3.1. DELIVERABLE: Physician Incentive Plan

11.15.3.2. DUE: On the Effective Date or upon implementation of a physician incentive plan

12. THIRD PARTY PAYER LIABILITY AND COORDINATION OF BENEFITS

12.1. Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing Covered Services under this Contract as required pursuant to 42 U.S.C. § 1397gg(e)(1)(B). All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the CHP+ program.

12.1.1. Potential liable third parties shall include carriers offering health or casualty insurance to any individual, and an entity or program that is or may be liable to pay all or part of the expenditures on behalf of a Member. Contractor shall provide information to the Department regarding commercial third-party resources that it identifies.

12.2. Contractor shall submit to the Department's Fiscal Agent, electronically via the Provider portal, any third-party payers identified by Contractor. Contractor shall submit to the Department's Fiscal Agent the following information:

12.2.1.1. Member's state identification number.

12.2.1.2. Member's full name.

12.2.1.3. Identification of the health carrier or health plan.

12.2.1.4. Member's health plan identification and group numbers.

12.2.1.5. Policy holder's full name.

12.2.1.6. Member's relationship to policyholder.

12.2.1.6.1. DELIVERABLE: Third Party Resource Identification

12.2.1.6.2. DUE: Within five Business Days electronically to the Fiscal Agent's Provider portal from the time when the third-party resource is identified by Contractor.

12.3. Contractor shall inform Members, in its written communications and publications, that when a third party is primarily liable for the payment of the costs of a Member's medical benefits, the Member shall comply with the protocols of the third party, including using Providers within the third party's network, prior to receiving non-emergency medical care.

12.4. Contractor shall also inform its Members that failure to follow Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that Contractor would have been

liable to pay. If Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to Contractor or the Network Provider for payment or cost of the care or services.

12.5. Contractor shall not restrict access to Covered Services due to the existence of possible or actual third-party liability.

12.6. Contractor shall identify and pursue third party payers in the case of an accident or incident where coverage should be paid by the property and casualty coverage or other accident liability policy.

12.7. In the case of accident or casualty coverage, Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by Contractor.

12.8. Contractor has the right to be subrogated to the Member's rights to the extent of the Covered Services received under this Contract. This includes Contractor's right to bring suit against the third party in the Members name. Contractor's right of reimbursement shall have first priority over any claim of a Member to be fully compensated for claims paid by it in connection with such injury or illness.

12.9. In addition to compensation paid to Contractor under the terms of this Contract, Contractor may retain as income all amounts recovered from third party resources, up to Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

12.10. Coordination of Benefits

12.10.1. Contractor shall identify and coordinate with all third parties against whom a Member may have a claim for payment or reimbursement for Covered Services so that no more than 100% of Covered Services incurred will be paid on behalf of the Member.

12.10.2. None of the above rules as to coordination of benefits shall serve as a barrier to the Member first receiving Covered Services from Contractor, but neither shall Contractor be prohibited from exercising its full rights to coordinate benefits with other health care payers who may cover the Member.

13. DATA, ANALYTICS, CLAIMS PROCESSING, AND DEPARTMENT REQUESTS FOR INFORMATION

13.1. Central Role of Data and Analytics

13.1.1. Contractor shall use data and analytics to successfully operate the CHP+ Program. Data and information are used for a range of management, coordination and care activities, such as process improvement, population health management, federal compliance, claims processing, outcomes tracking and cost control.

13.1.1.1. Contractor shall understand the key cost drivers within its Service Area and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

13.1.1.1.1. Contractor shall be responsible for monitoring utilization of low value services and analyzing cost categories that are growing faster than would normally be expected.

13.1.1.1.2. Contractor shall incorporate risk adjusted utilization expectations into its analytic procedures as Members with more complex conditions and needs are expected to use more resources.

13.1.1.2. Contractor shall possess the resources and capabilities to leverage existing data systems and analytics tools or create new ones as necessary to perform the Work, conscious to avoid the creation of duplicative systems.

13.1.2. Contractor shall ensure that it meets all federal regulations regarding standards for privacy, security, electronic health care transaction and individually identifiable health information, the privacy regulations found at 42 C.F.R. Part 2, 45 C.F.R. § 160, 162 and 164, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the American Recovery and Reinvestment Act of 2009 (ARRA)/HITECH Act (P.L. 111-005), and State of Colorado Cyber Security Policies. See Colorado Cyber Security Policies at http://oit.state.co.us/ois/policies.

13.1.3. Contractor shall control the use or disclosure of Protected Health Information (PHI) as required by the HIPAA Business Associate agreement or as required by law. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the HIPAA privacy requirements.

13.1.4. Contractor shall notify the Department at least 90 days in advance of any system migrations or new system implementation.

13.1.5. Contractor shall create a data governance policy that describes the circumstances when Contractor shall allow other entities, including Providers and community organizations, full access to Member level data will be shared.

13.1.5.1. Contractor shall submit its Data Governance Policy to the Department.

13.1.5.1.1. DELIVERABLE: Data Governance Policy

13.1.5.1.2. DUE: Operational Start Date

13.1.5.2. Contractor shall update the data governance policy annually by July 31.

13.1.5.2.1. DELIVERABLE: Annual Data Governance Policy Update

13.1.5.2.2. DUE: Annually, July 31

13.1.6. Claims Processing System

13.1.6.1. Contractor shall maintain a claims processing system to reimburse Providers Covered Services under the terms of this Contract and produce Encounter claims.

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

13.1.6.3. Contractor shall meet the requirements of FFS timely payment, per 42 CFR 447.46, including the paying of 90% of all clean claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within 30 days of the date of receipt; and paying 99% of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within 90 days of the date of receipt.

13.1.6.4. Contractor shall ensure that the date of receipt is the date that Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

13.1.6.4.1. A clean claim means one that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in the Department's claims system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

13.1.6.5. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 C.F.R. §§ 95.1 and 95.7, the Department will file all claims for reimbursement of payments to Contractor with CMS within two years after the calendar quarter in which the Department made the expenditure. Contractor and the Department will work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file Contractor's

claims or capitation payments within two years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 C.F.R. § 95.19, no claims or capitations will be paid to Contractor for any period of time disallowed by CMS. Furthermore, the Department will recover from Contractor all claims and capitations paid to Contractor for any period of time disallowed by CMS.

13.1.6.6. Timely Clean Claims Payment Report

13.1.6.6.1. Contractor shall electronically submit, on a quarterly basis, a Timely Clean Claims Payment Report in accordance with 42 C.F.R. 438.400(b) in a format determined by the Department.

13.1.6.6.1.1. DELIVERABLE: Timely Clean Claims Payment Report

13.1.6.6.1.2. DUE: Quarterly, within 45 days following the end of the quarter for which the report covers

13.1.6.6.2. If the Department determines that there are errors or omissions in any reported information, Contractor shall produce an updated deliverable that corrects all errors and includes all omitted data or information. Contractor shall submit the updated deliverable to the Department within 10 days after the Department's request for the updated deliverable.

13.1.6.6.2.1. DELIVERABLE: Updated Timely Clean Claims Payment Deliverable

13.1.6.6.2.2. DUE: 10 days after the Department's request for the updated deliverable.

13.1.7. Encounter Data Reporting

13.1.7.1. Contractor shall electronically submit all Encounter Data for Covered Services, 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). Contractor shall ensure that the quality and timeliness of its Encounter Data meets the state's standards.

13.1.7.2. Contractor shall collaborate with the Department or the Department's Pharmacy Benefit Management System (PBM) vendor to ensure compliance as set forth in the Colorado Pharmacy Benefit Management System (PBMS) Batch Pharmacy Encounters Companion Guide.

13.1.7.3. Contractor shall submit Medical Encounter Data in the ANSI ASC X12N 837 format directly to the Department's Fiscal Agent using the Department's data transfer protocol. Contractor shall submit any 837 format Encounter claims, reflecting paid, adjusted or denied by Contractor, via a regular monthly batch process. Contractor shall submit all Encounter claims in accordance with the following:

13.1.7.3.1. Applicable HIPAA transaction guides posted available at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/AdoptedStandardsandOperatingRules.

13.1.7.3.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

13.1.7.3.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

13.1.7.4. Contractor shall submit all Pharmacy Encounter Data to the Department's Rx Contractor electronically. Contractor shall submit the following type of electronic transactions for pharmacy Encounters.

13.1.7.4.1. National Council for Prescription Drug Programs (NCPDP) (pharmacy claim)

13.1.7.5. Contractor shall submit 95% of all clean encounter claims within 30 calendar days after the claim payment or denial date, and 100% of all clean encounter claims within 120 calendar days after the claim payment or denial date, following an agreed upon methodology developed by the Department and Contractor. Contractor shall submit paid and denied clean Encounter Data into the MMIS each month. The Department will measure performance on a monthly basis.

13.1.7.6. Claims submitted in accordance with Department policy and rejected due to system configuration error will not be used in the Department's calculation. At the discretion of the Department, or at the request of Contractor, the accuracy rate may be adjusted to account for Department system changes. Contractor shall develop and implement a plan to meet this standard.

13.1.7.7. Contractor shall make an adjustment to Encounter claims when Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If the Department discovers errors or a conflict with a previously adjudicated Encounter claim, Contractor shall adjust or void the Encounter claim within 14 calendar days of notification by the Department. Claims submitted in accordance with Department policy and rejected due to system configuration error will not be used in the Department's calculation.

13.1.7.8. Contractor shall meet or exceed 98% reported clean encounter claims acceptance rate for the measurement quarter following the month in which Contractor adjudicated a provider claim, following the methodology developed by the Department. The Department will measure performance on a quarterly basis. Claims submitted in accordance with Department policy and rejected due to system configuration error will not be used in the Department's calculation. At the discretion of the Department, or at the request of Contractor, the accuracy rate may be adjusted to account for Department system changes. Contractor shall develop and implement a plan to meet this standard.

13.1.7.9. Contractor shall submit monthly data certifications for all Encounter Data used for rate setting, in compliance with 42 C.F.R. § 438.604 and 438.606 and 457.950. Contractor shall ensure that the data certification includes certification that data submitted is accurate, complete and truthful, and that all paid Encounters are for Covered Services provided to or for enrolled Members. This certification shall be provided by either the Chief Executive Officer or 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.

13.1.7.9.1. DELIVERABLE: Certified Monthly Encounter Data submission

13.1.7.9.2. DUE: Monthly, on the last business days of the month

13.1.7.10. Contractor shall submit its raw Encounter Data, excluding data protected by 42 C.F.R. Part 2, to the Colorado All-Payer Claims Database (APCD) in accordance with the guidelines found in the most current version of the Center for Improving Value in Health Care: Colorado All-Payer Claims Database Data Submission Guide found at http://www.colorado.gov/hcpf.

13.1.7.11. Contractor shall comply with changes in Department data format requirements as necessary. The Department reserves the right to change format requirements following consultation with Contractor and retains the right to make the final decision regarding format submission requirements.

13.1.7.12. Contractor shall use the eligibility and 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:

13.1.7.12.1. HIPAA compliant X12N 270/271 Eligibility Verification transaction

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

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

13.1.7.12.4. HIPAA X12N 834 Daily Roster.

13.1.7.12.5. HIPAA X12N 834 Monthly Roster: Generated on the first Business Day of the month.

13.1.7.12.6. Colorado interChange Encounter Reconciliation Report

13.1.7.13. Contractor shall submit all necessary Encounter Data, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR 438.242.

13.1.8. Flat File Submission

13.1.8.1. Contractor shall on a quarterly basis electronically submit a flat file table to the Department that contains all Encounters for that State Fiscal Year, with one record per Encounter, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer or 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.

13.1.8.1.1. The Department will provide Contractor with the specifications for the Flat File Submission using a Flat File Specifications document. The Department will collaborate on proposed changes to the Flat File Specifications document with Contractor at least 90 days in advance of implementation. In the event that collaborative agreement cannot be achieved, the Department retains the right to make the final decision regarding format submission requirements.

13.1.8.1.2. The Department will conduct a quality review of the submission to determine if flat file meets the required specifications.

13.1.8.1.2.1. Contractor shall be responsible for the accuracy of flat file submissions.

13.1.8.1.2.2. Contractor shall submit a flat file that contains 90% of paid claim lines within 30 days of the claim paid month.

13.1.8.1.2.3. Contractor shall submit a flat file that contains 99% of paid claim lines within 90 days of the claim paid month.

13.1.8.1.2.4. Flat file accuracy is determined quarterly for completeness of data fields, and annually for completeness of inclusion of all claims.

13.1.8.1.2.5. The Department will notify Contractor within forty-five (45) Business Days if it discovers errors or incomplete data on a submitted flat file encounter claim upon validation. Contractor shall correct and resubmit the encounter claim within 14 calendar days following notification by the Department.

13.1.8.1.2.5.1. DELIVERABLE: Certified Quarterly Flat File Submission

13.1.8.1.2.5.2. DUE: Quarterly, 15 days after the State Fiscal Year quarter ends.

13.1.8.2. Annual Flat File Submission

13.1.8.2.1. Contractor shall on an annual basis, electronically submit a flat file and data certification certifying the flat file is as accurate, complete, and truthful based on Contractor's best

knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer or 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.

13.1.8.2.1.1. The Department will provide Contractor with the specifications for the annual flat file submission.

13.1.8.2.1.2. The Department will conduct a quality review of the annual submission to determine if the flat file meets the required specifications.

13.1.8.2.2. DELIVERABLE: Certified Annual Flat File

13.1.8.2.3. DUE: Annually, by October 31

13.1.9. Colorado Immunization Information System (CIIS)

13.1.9.1. Contractor shall work with the Colorado Department of Public Health and Environment to submit immunization information for all covered Members to the Colorado Immunization Information System (CIIS) on at least a monthly basis per CIIS's Health Level 7 or Flat file specifications.

13.1.10. MMIS Processing

13.1.10.1. All encounter claims from Contractor are edited and reviewed prior to submission for payment by the Department of Health Care Policy and Financing (the State or HCPF). Pre-submission edits and reviews are applied in five key domains of accuracy to ensure that payments in excess of allowed Medical Assistance reimbursement do not occur. These are:

13.1.10.1.1. Eligibility.

13.1.10.1.2. Benefits.

13.1.10.1.3. Pricing.

13.1.10.1.4. Continuation of Benefits (COB) & Third-Party Liability (TPL) Adjustments.

13.1.10.1.5. Duplicates.

13.1.10.2. Set forth below is a high-level summary of how the edits and reviews are applied in current payment and reporting processes.

13.1.10.3. The MMIS produces daily and monthly eligibility/enrollment records electronically for Contractor. These records are stored on the Department's MMIS and are available for Contractor through the provider web portal. The records are produced for the Department and Contractor concurrently so that MMIS and Contractor have the same eligibility information. Encounters for ineligible clients will be denied and priced at zero, which is why the Department supplies Contractor daily eligibility records. Also, client's eligibility span must correspond with the date of service from the transaction.

13.1.10.4. Eligibility edits that deny encounters are listed on the Department webpage, on the Provider site under Billing Manuals.

13.1.10.5. The MMIS applies the same benefit coverage logic for encounters as the fee-for-service program. Encounters including a procedure or revenue code that is not covered by CHP+ fee-for-service program will be denied, and the service will be priced at zero. Procedure and revenue code coverage information is retained in the MMIS reference subsystem.

13.1.10.6. MMIS does not price an encounter differently than a fee-for-service claim.

13.1.10.7. The MMIS edits and adds TPL adjustments for all encounters similarly to fee-for-service claims. MMIS relies on the Colorado Benefit Management System (CBMS) and other sources to supply valid TPL information for appropriate encounter processing. TPL information is retained in the MMIS. The TPL information is used to edit encounters and will adjust the encounter price based on the information submitted on the transaction. MMIS will deny encounters if Contractor does not supply TPL information for clients who have other insurance coverage. For encounters that contain TPL information, the price of the encounter will be adjusted. The amount paid by another carrier will be deducted from the final price of the encounter.

13.1.10.8. Contractor submits pharmacy encounters into the Magellan Rx. Magellan Rx adjudicates the encounters on the basis of the CHP+ fee-for-service payment schedule and pushes the adjudicated encounter to MMIS.

13.1.10.9. The MMIS denies all duplicate encounters. Any duplicate encounters submitted will deny and price at zero.

13.1.10.10. The interChange Error Codes will be included on Health Care Policy and Financing webpage, on the Provider site, under Billing Manuals.

14. OUTCOMES, QUALITY ASSESSMENT, AND PERFORMANCE IMPROVEMENT PROGRAM

14.1. Continuous Quality Improvement

14.1.1. Contractor shall implement and maintain an ongoing comprehensive quality assessment and performance improvement program (Quality Improvement Program) that complies with 42 C.F.R. § 438.310-370.

14.1.2. Contractor shall take into consideration the federal definition of quality when designing its program. The Centers for Medicare and Medicaid Services (CMS) defines quality as the degree to which Contractor increases the likelihood of desired outcomes of its Members through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge and interventions for performance improvement.

14.1.3. Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for the MCO.

14.2. Quality Improvement Program

14.2.1. Contractor's Quality Improvement Program shall align with the Department's Quality Strategy and include population health objectives as well as clinical measures of quality care. Quality Improvement Program activities shall, at a minimum, consist of the following:

14.2.1.1. Performance improvement projects.

14.2.1.2. Collection and submission of performance measurement data, including Member experience of care.

14.2.1.3. Mechanisms to detect both underutilization and overutilization of services.

14.2.1.4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by the Department, and in accordance with any applicable state quality assurance and utilization review standards.

14.2.1.4.1. Mechanisms to review and revise reassessment of functional need for Members with special health care needs, at least every 12 months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

14.2.1.4.2. Mechanisms to allow Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

14.2.1.5. Quality of Care Concerns.

14.2.1.6. External Quality Review.

14.2.1.7. Advisory committees and learning collaboratives.

14.2.2. Contractor shall develop and submit a Quality Improvement Plan to the Department and/or its designee outlining how Contractor plans to implement its Quality Improvement Program. Contractor shall make reasonable changes to the Quality Improvement Plan at the Department's direction.

14.2.2.1.1. DELIVERABLE: Quality Improvement Plan

14.2.2.1.2. DUE: Due within 30 business days after the Effective Date

14.2.3. Upon Department approval, Contractor shall implement the Quality Improvement Plan.

14.2.4. Contractor shall review and update the Quality Improvement Plan at least one time annually.

14.2.4.1. DELIVERABLE: Quality Improvement Plan Update

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

14.2.5. Contractor shall create an Annual Quality Report to the Department and/or designee, detailing the progress and effectiveness of each component of its Quality Improvement Program. Contractor shall include the following, at a minimum, in the report:

14.2.5.1. A description of the techniques Contractor used to improve its performance.

14.2.5.2. A description of the qualitative and quantitative impact the techniques had on quality.

14.2.5.3. The status and results of each Performance Improvement Project conducted during the year.

14.2.5.4. Any opportunities identified for improvement.

14.2.6. Contractor shall submit the Annual Quality Report to the Department for review and approval.

14.2.6.1. DELIVERABLE: Annual Quality Report

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

14.3. Performance Improvement Projects

14.3.1.1. Contractor shall conduct Performance Improvement Projects designed to achieve 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.

14.3.1.2. Contractor shall complete Performance Improvement Projects 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.

14.3.1.3. Contractor shall conduct two (2) Performance Improvement Projects chosen in collaboration with the Department 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.

14.3.1.4. Contractor shall conduct Performance Improvement Projects on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a particular topic.

14.3.2. Contractor shall have the capacity to conduct up to two additional Performance Improvement Projects upon request from CMS after Year 1 of the Contract.

14.3.3. Contractor shall ensure that Performance Improvement Projects include the following:

14.3.3.1. Measurement of performance using objective quality indicators.

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

14.3.3.3. Evaluation of the effectiveness of the interventions.

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

14.3.4. Contractor shall participate in a Performance Improvement Project Learning Collaborative at the end of each Performance Improvement Project cycle, hosted by the Department, which includes sharing of data, outcomes, and interventions.

14.3.5. Contractor shall submit Performance Improvement Projects for validation by the Department's External Quality Review Organization (EQRO) to determine compliance with requirements set forth in 42 C.F.R. § 438.350, and as outlined in External Quality Review Organization Protocol for Validating Performance Improvement Projects. These requirements include:

14.3.5.1. Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction.

14.3.5.2. Mechanisms to detect both under-utilization and over-utilization of services.

14.3.5.3. Mechanisms designed to assess the quality and appropriateness of care furnished to Members with special health care needs.

14.3.5.4. Measurement of performance using objective valid and reliable quality indicators.

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

14.3.5.6. Empirical evaluation of the effectiveness of the interventions.

14.3.6. Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report described in 14.2.5.

14.4. Performance and Operation Measurement

14.4.1. Contractor shall participate in the measurement and reporting of performance measures required by the Department, with the expectation that this information will be placed in the public domain.

14.4.2. Contractor shall consult with the Department to develop measurement criteria, reporting frequency and other performance measurement components. The Department will determine the final measurement criteria.

14.4.3. Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

14.4.4. Contractor shall provide data, as requested, to enable the Department or its designee to calculate the performance measures, unless the data is already in the Department's possession.

14.4.5. Contractor shall work to improve performance for measures established by the Department.

14.4.6. Contractor shall collaborate with the Department in identifying additional performance and outcomes-based measures to improve ongoing program monitoring, accountability, and overall administration of the CHP+ program.

14.4.7. Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

14.4.8. Contractor shall electronically submit, on a monthly basis, a Health Plan Operation Measures Deliverable, which contains all measures identified by the Department.

14.4.8.1. Contractor shall ensure that the Health Plan Operation Measures Deliverable is complete, contains all required elements, and is submitted in a template provided by the Department.

14.4.8.1.1. The Deliverable shall include, at a minimum, all of the following:

14.4.8.1.1.1. Customer Service Reporting.

14.4.8.1.1.2. Provider Service Reporting.

14.4.8.1.2. Contractor shall submit the Monthly Health Plan Operation Measures Deliverable in a template provided by the Department for review and approval.

14.4.8.1.2.1. DELIVERABLE: Monthly Health Plan Operation Measures Deliverable

14.4.8.1.2.2. DUE: 14 days after the end of the reporting month

14.4.8.1.3. If the Department determines that there are errors or omissions in any reported information, Contractor shall produce an updated Deliverable that corrects all errors and includes all omitted data or information. Contractor shall submit the updated Deliverable to the Department within 10 business days after the Department's request for the updated Deliverable.

14.4.8.1.3.1. DELIVERABLE: Updated Monthly Health Plan Operation Measures Deliverable

14.4.8.1.3.2. DUE: 10 business days after the Department's request for the updated Deliverable

14.4.9. Healthcare Effectiveness Data and Information Set (HEDIS) Report

14.4.9.1. Contractor shall calculate and submit specified HEDIS measures, core set measures, and other measures, as required by the Department. Contractor shall track the CMS core measure set development, and the HCPF defined measure set, to ensure reporting on all required and requested measures. The Department will collaborate with Contractor's quality improvement committee to designate the required measures.

14.4.9.2. Contractor shall use the results and data from the HEDIS Report and to inform Contractor's Quality Improvement Plan.

14.4.9.3. Contractor shall contract with an external entity to perform an external audit of the HEDIS measures according to HEDIS and EQRO protocols.

14.4.9.3.1. Contractor shall work to resolve any issues identified by the external auditor and make all necessary changes to ensure issues are corrected in a timely fashion.

14.4.9.4. Contractor shall provide an annual HEDIS Report to the Department. This report shall meet the following requirements:

14.4.9.4.1. The HEDIS Report shall contain all HEDIS measures determined by the Department for that year.

14.4.9.4.2. The HEDIS Report shall follow the format approved by the Department and be delivered for review and approval

14.4.9.4.2.1. DELIVERABLE: HEDIS Report

14.4.9.4.2.2. DUE: Annually, by August 1

14.4.10. Occurrence Rates

14.4.10.1. Contractor shall provide occurrence rates for the identified measures per the specifications provided by the Department no later than December 16th each year for the previous calendar year.

14.4.10.1.1. Measure DEV: Developmental Screening in the First Three Years of Life. CHP+ plan shall provide rates using CPT code 96110.

14.4.10.1.1.1. DELIVERABLE: Occurrence Rates

14.4.10.1.1.2. DUE: No later than December 16th for the previous calendar year

14.4.10.1.1.3. If specifications for this measure change, the Department will notify Contractor as soon as possible to ensure the changes may be implemented by Contractor for the reporting period for which the changes are implemented.

14.5. Member Experience of Care

14.5.1. Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by Contractor and Network Providers.

14.5.2. Contractor shall use tools to measure Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, call center data, and Grievance and Appeals data.

14.5.3. Contractor shall assist the Department or it's designated vendor with the annual administration of the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for children.

14.5.3.1. Contractor shall work with the Department to provide sample frames for the CHP+ population for the CAHPS survey in accordance with NCQA deadlines.

14.5.3.2. Contractor shall develop strategies with the Department to increase Member participation in the CAHPS survey.

14.5.4. Contractor shall inform the Department if they conduct any additional surveys of Members and share findings with the Department.

14.5.5. Contractor shall use the results and data from CAHPS and all other surveys conducted by Contractor to inform Contractor's Quality Improvement Plan.

14.5.6. Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

14.5.6.1. Contractor shall develop a corrective action plan for a Network Provider when a pattern of complaint is detected, when trends in decreasing Member satisfaction are detected, or when a serious complaint is reported.

14.6. Mechanisms to Detect Overutilization and Underutilization of Services

14.6.1. Contractor shall implement and maintain mechanisms 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. Contractor may incorporate mechanisms developed for Contractor's Utilization Management program.

14.6.2. Contractor shall develop policies that more effectively support Member accountability for utilization of health services over an extended period of time, such as a Provider lock-in policy.

14.7. Quality of Care Concerns

14.7.1. Contractor shall investigate any alleged Quality of Care (QOC) concerns, which are defined as concerns raised by the Department or Providers, or concerns discovered by Contractor. Contractor

shall not consider Member complaints about care to be QOC concerns and should process these complaints as Grievances, unless the Department instructs otherwise.

14.7.1.1. Contractor shall have a system for identifying and addressing all alleged QOC concerns.

14.7.2. When a QOC concern is raised, Contractor shall investigate, analyze, track, trend and resolve QOC concerns by doing the following, but not limited to:

14.7.2.1. Investigate the QOC issue(s).

14.7.2.2. Follow-up with the Member to determine if the Member's immediate health care needs are being met.

14.7.2.3. Refer QOC issues to Contractor's peer review committee, when appropriate.

14.7.2.4. Refer or report the QOC issue to the appropriate regulatory agency and Child or Adult Protective Services for further research, review or action, when appropriate.

14.7.2.5. Notify the appropriate regulatory or licensing board or agency when the affiliation of a Network Provider is suspended or Terminated due to QOC concerns.

14.7.2.6. Notify the Department that Contractor has received a QOC.

14.7.2.7. Document the incident in a QOC summary to be sent to the Department. This file shall include, at a minimum:

14.7.2.7.1. The name and contact information of the originator of the QOC concern.

14.7.2.7.2. A description of the QOC concern including issues, dates and involved parties.

14.7.2.7.3. All steps taken during the QOC investigation and resolution process.

14.7.2.7.4. Corrective action(s) implemented and their effectiveness.

14.7.2.7.5. Evidence of the QOC resolution.

14.7.2.7.6. A copy of the acknowledgement and resolution letter.

14.7.2.7.7. Any Referral made by Contractor to peer review, a regulatory agency or a licensing board or agency.

14.7.2.7.8. Any notification made by Contractor to a regulatory or licensing agency or board.

14.7.2.7.9. Any outcome of the review as determined by Contractor.

14.7.2.8. For QOC concerns involving Network Providers, Contractor may use the process of its professional review committee, as set forth in Sections 12-36.5-104 and 12-36.5-104.4, C.R.S.

14.7.2.9. Contractor shall submit a letter to the Department, upon request, which includes a brief description of the QOC concern, the efforts that Contractor took to investigate the concern and the outcome of the review as determined by Contractor.

14.7.2.9.1. Contractor shall include a description of whether the issue was found to be a QOC issue and what action Contractor intends to take with the Provider(s) involved.

14.7.2.9.2. Contractor shall not include in its letter the names of the persons conducting the investigation or participating in a peer review process.

14.7.2.9.3. Contractor shall inform the Department if it refers the matter to a peer review process.

14.7.2.9.4. Contractor shall send the complete letter within 10 Business Days of the Department's request. Upon request from Contractor, the Department may allow additional time to investigate and report.

14.7.2.9.4.1. DELIVERABLE: QOC Letter

14.7.2.9.4.2. DUE: Within 10 Business Days of the Department's request

14.8. External Quality Review

14.8.1. Annually, Contractor shall participate in an external independent Site Review and performance measure validation in order to review compliance with Department standards and Contract requirements. External quality review activities shall be conducted in accordance with federal regulations 42 C.F.R. § 438 and the CMS mandatory activity protocols.

14.8.2. Contractor shall participate in an external quality review that includes a review of the:

14.8.2.1. Contractor’s administration of the Contract as a CHP+ MCO.

14.8.3. Contractor shall participate in an annual external review that may include, but is not limited to, the following:

14.8.3.1. Medical Record review. For external review activities involving Medical Record abstraction, Contractor shall obtain copies of the Medical Records from the sites in which the services reflected in the Encounter occurred at no cost to the Department or its vendors.

14.8.3.2. Performance improvement projects and studies.

14.8.3.3. Surveys.

14.8.3.4. Network adequacy during the preceding 12 months.

14.8.3.5. Calculation and audit of quality and utilization indicators.

14.8.3.6. Administrative data analyses.

14.8.3.7. Review of individual cases.

14.8.3.8. Care Coordination record review.

14.8.3.9. Provider site visits.

14.8.3.10. Encounter Data validation.

14.8.4. 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.

14.9. Advisory Committees and Learning Collaboratives

14.9.1. To ensure the CHP+ Program is effectively serving Members and Providers, Contractor shall collaborate with the Department to identify opportunities to engage Stakeholders and assist in the development of multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the Program overall and guiding the improvement of program performance.

14.9.2. Contractor shall participate in ad hoc advisory committees and learning collaboratives to monitor specific program activities and share lessons learned, as identified by the Department and as appropriate.

14.9.3. Quality Improvement Committee

14.9.3.1. Contractor shall have its Quality Improvement Director participate in the Department's Quality Improvement Committee (IQuIC) to provide input and feedback regarding:

14.9.3.1.1. Quality improvement priorities.

14.9.3.1.2. Performance improvement topics.

14.9.3.1.3. Measurements and specifics of reporting formats and timeframes.

14.9.3.1.4. Other collaborative projects.

14.10. CHP+ MCO Biannual Leadership Meeting

14.10.1. Contractor shall host a biannual meeting with Department leadership (to include the Executive Director) to present and review the following:

14.10.1.1. Performance reports that summarize Contractor performance on key Contractor responsibilities and member outcomes.

14.10.1.2. Areas of opportunity and challenge to be addressed for Contractor to improve performance, including barriers to properly address those opportunities and challenges.

14.10.1.3. Provider areas of opportunity and where the Department can be of assistance.

14.11. Ad Hoc Quality Reports

14.11.1. Contractor shall provide to the Department or its agents any information or data relative to the Contract. In such instances, and at the direction of the Department, Contractor shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested.

14.11.1.1. Contractor shall have at least 30 calendar days, or a timeframe mutually agreed upon between the Department and Contractor, to fulfill such requests.

14.11.1.2. Contractor shall certify that data and information it submits to the Department is accurate.

15. COMPLIANCE AND PROGRAM INTEGRITY

15.1. Program Integrity Compliance Program Requirements

15.1.1. Contractor shall have a program in place for ensuring compliance with the CHP+ and Managed Care Program rules, Contract requirements, state and federal regulations and confidentiality regulations, and a program to detect Fraud, Waste and Program Abuse. Contractor shall ensure that all aspects of the system are focused on providing high-quality services that are of Medical Necessity in accordance with Contract requirements.

15.1.2. Contractor shall comply with all applicable CMS regulations in 42 C.F.R. § 438 and 42 C.F.R. § 457.

15.1.3. Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by Contractor for coverage of services and payment of claims under the Contract shall have a compliance program to implement and maintain arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Program Abuse.

15.1.4. The compliance program shall be approved by Contractor's Program Manager and Compliance Officer.

15.1.5. Contractor shall ensure that the compliance program, at a minimum includes:

15.1.5.1. Written policies and procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements and standards under the Contract and all applicable federal and state requirements.

15.1.5.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

15.1.5.3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing Contractor's compliance program and its compliance with the requirements under the Contract.

15.1.5.4. A system for training and education for the Compliance Officer, Contractor's Key Personnel, and Contractor's employees for the federal and state standards and requirements under the Contract.

15.1.5.4.1. Contractor shall ensure that this training is conducted in a manner that allows the Department to verify that the training has occurred.

15.1.5.5. Effective lines of communication between the Compliance Officer and Contractor's employees.

15.1.5.6. Enforcement of standards through well publicized disciplinary guidelines.

15.1.5.7. Establishment and implementation of procedures and a program integrity infrastructure that includes adequate systems and staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract. Contractor shall ensure that the system includes:

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

15.1.5.7.2. Processes to screen all Provider claims processed or paid by Contractor collectively and individually, for Suspected Fraud, Waste or Program Abuse.

15.1.5.7.3. Processes to identify Overpayments to Providers, including but not limited to, instances of up-coding, unbundling of services, services that were billed for but never rendered, inflated bills for services and goods provided or any other improper payment.

15.1.5.7.4. Processes to recover Overpayments to Providers.

15.1.5.7.5. Processes to identify and promptly report to the Department instances of Suspected Fraud, Waste and Program Abuse.

15.1.5.7.6. Processes for Member verification of services. Specifically, to provide individual notices to all or a statistically significant sample of Members who received services to verify and report whether services billed by Providers were actually received by Members.

15.1.5.8. Requirements for Network Providers to report to Contractor when they have received an Overpayment, to return the Overpayment to Contractor, and to notify Contractor in writing of the reason for the Overpayment within 60 calendar days after the date on which the Overpayment was identified.

15.1.5.9. Contractor, if it makes or receives annual payments under the Contract –of at least $5,000,000.00, shall have written policies for all employees of the entity, and of any contractor or agent, who provides detailed information about the False Claims Act and other federal and state laws

described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

15.1.5.10. Contractor shall comply with the Department policies related to recoveries of Overpayments.

15.1.5.11. Contractor shall not retroactively deny reimbursement after 12 months have passed since the claim's paid date. For claims in which Medicare is the primary payer, the time limit extended to 48 months. The time limitations do not apply if the retroactive denial is because the claim was fraudulent, the provider improperly coded the claim, or the claim submitted was a duplicate.

15.1.6. Contractor shall have a process for the prompt Referral to the Department of all cases where the agency or entity has actual and reasonable cause to believe that there is Suspected Fraud and Waste, Program Abuse and Patient Abuse, neglect, and exploitation, and false representation. The process shall be aligned with applicable requirements set forth in Statement of Work Section.

15.1.6.1. Neglect is the willful failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, including any neglect that constitutes a criminal violation under state law.

15.1.6.2. Exploitation includes any wrongful taking or use of funds or property of a patient residing in a health care facility or board and care facility that constitutes a criminal violation under state law.

15.1.6.3. False representation is any inaccurate statement that is relevant to a claim for reimbursement and is made by a Provider or Client who has actual knowledge of the truth or false nature of the statement, or by a Provider or Client acting in deliberate ignorance of or with reckless disregard for the truth of the statement.

15.2. Compliance Plan Requirements

15.2.1. Contractor shall have a documented Compliance Plan that implements all elements of the Compliance Program.

15.2.2. Contractor shall ensure adequate and dedicated staffing and resources needed in order to successfully implement the Compliance Plan and routinely monitor Providers and Clients to detect and prevent aberrant billing practices, potential Fraud, Waste, Program Abuse and promptly address potential compliance issues and problems.

15.2.3. Contractor shall ensure the Compliance Plan, at minimum, includes:

15.2.3.1. A risk assessment of Contractor's various Fraud, Waste, and Program Abuse and program integrity processes.

15.2.3.2. An outline of activities proposed for the next reporting year regarding compliance and audit activities, including, but not limited to:

15.2.3.2.1. Conducting prospective, concurrent, and/or post-payment reviews of claims, including, but not limited to Medical Records reviews, data mining, and desk audits.

15.2.3.2.2. Verifying Provider adherence to professional licensing and certification requirements.

15.2.3.2.3. Verifying Provider records and other documentation to ensure services billed by Providers were actually rendered.

15.2.3.2.4. Reviewing goods provided and services rendered for Fraud, Waste and Program Abuse.

15.2.3.2.5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology

(CPT), Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).

15.2.3.2.5.1. Contractor shall not include activities related to administrative billing issues, such as financial statement audits.

15.2.3.2.6. An outline of activities proposed for the next reporting year regarding education of federal and state laws and regulations related to CHP+ Program Integrity against Fraud, Waste, and Program Abuse to ensure that all of its officers, directors, managers, and employees know and understand the provisions of Contractor's Compliance Program.

15.2.3.2.7. An outline of activities proposed for the next reporting year regarding Provider education of federal and state laws and regulations related to CHP+ Program Integrity against Fraud, Waste, and Program Abuse and on identifying and educating targeted Providers with patterns of incorrect billing practices and/or Overpayments.

15.2.3.2.8. Descriptions of specific controls in place for prevention and detection of Overpayments and potential or Suspected Fraud, Waste, and Program Abuse, including but not limited to:

15.2.3.2.9. automated pre-payment claims edits.

15.2.3.2.10. automated post-payment claims edits.

15.2.3.2.11. desk audits on post-payment review of claims.

15.2.3.3. Work plans for the next year regarding conducting both announced and unannounced site visits and field audits to providers defined as high-risk (e.g., providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

15.2.4. Contractor shall submit its Compliance Plan to the Department for review and approval. Contractor shall only submit finalized Compliance Plans; the Department will not accept draft versions.

15.2.4.1. DELIVERABLE: Compliance Plan

15.2.4.2. DUE: Annually, by July 31

15.2.5. Contractor shall modify the Compliance Plan as requested by the Department within 10 Business Days following the receipt of the Department's requested changes.

15.2.5.1. DELIVERABLE: Compliance Plan revisions and changes

15.2.5.2. DUE: Within 10 Business Days following the Department's request

15.3. Reports and Disclosures

15.3.1. Contractor shall follow all requirements in this Statement of Work Section 15.3 to notify the Department of all work, activities, and events occurring under the requirements of Statement of Work Section 15.1.

15.3.1.1. Reports Requiring Monthly Notification

15.3.1.1.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a one month period.

15.3.1.1.2. Contractor shall report, at minimum:

15.3.1.1.2.1. All recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including whether the Overpayment was related to an audit or Fraud case, and dates when Overpayments were recovered.

15.3.1.1.2.2. All suspended claim reimbursements and payments to a Provider, including information whether the suspension is related to an audit or a credible allegation of fraud case and dates of when reimbursements and payments were suspended.

15.3.1.1.2.3. All Provider circumstance changes where a Provider is no longer in Contractor's network, but was not removed for cause, including providing information on why the Provider was withdrawn.

15.3.1.1.2.4. Any Provider terminations not based on quality or performance or for cause, including but not limited to:

15.3.1.1.2.4.1. A change in Ownership or control of a Provider.

15.3.1.1.2.4.2. A Provider voluntarily withdrawing from the MCE's network.

15.3.1.1.2.4.3. The death of a Provider.

15.3.1.1.2.4.4. Contractor shall provide the following:

15.3.1.1.2.4.4.1. Date of removal.

15.3.1.1.2.4.4.2. Reason for the termination.

15.3.1.1.2.4.4.3. Numbers of Members served by the Provider.

15.3.1.1.2.4.4.4. Plan to ensure that Members receive continuous services.

15.3.1.1.2.4.5. Any other information as specified by the Department

15.3.1.1.3. Contractor shall use the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

15.3.1.1.3.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report

15.3.1.1.3.2. DUE: Within 10 (ten) Business Days after the end of each month.

15.3.1.1.4. Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within 10 Business Days following the receipt of the Department's requested changes.

15.3.1.1.4.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report Revisions and Changes

15.3.1.1.4.2. DUE: Within 10 Business Days following the Department's request

15.3.1.2. Reports Requiring Semi-Annual Notification

15.3.1.2.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a six-month period.

15.3.1.2.2. The six-month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

15.3.1.2.3. Contractor shall use the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

15.3.1.2.4. Contractor shall report, at minimum:

15.3.1.2.4.1. All audits or reviews which have been started, are on-going or completed as part of the Compliance Program and Compliance Plan, including issue(s) being reviewed or audited,

the status of the review or audit, the start and end dates of services covered by the review or audit, and the start and end dates of the review or audit.

15.3.1.2.4.2. All instances of Suspected Fraud, Waste and Program Abuse, discovered and reported to the Department, including the suspected issue, the start and end dates of the services suspected to involve Fraud, the approximate amount of the claims affected and the date of report to the Department.

15.3.1.2.4.3. All verification conducted of Member services, including the number of notices sent to Members to verify and report whether services billed by Providers were received by Members, the number of responses received, number of responses warranting further action.

15.3.1.2.4.4. All identified and recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including whether the Overpayment was related to an audit or Fraud case, dates of when Overpayments were identified, and dates when Overpayments were recovered.

15.3.1.2.4.5. Any other information as specified by the Department.

15.3.1.2.5. Contractor shall not include activities related to administrative billing issues, such as reviews of financial statements or credit balances.

15.3.1.2.5.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Report

15.3.1.2.5.2. DUE: Within 45 days of the end of the six month reporting period

15.3.1.2.6. Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within 10 Business Days following the receipt of the Department's requested changes.

15.3.1.2.6.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report Revisions and Changes

15.3.1.2.6.2. DUE: Within 10 Business Days following the Department's request

15.3.1.3. Disclosures Requiring Prompt Notification

15.3.1.3.1. Provider Terminations

15.3.1.3.1.1. Contractor shall notify the Department of its decision to terminate any existing Network Provider on the basis of quality or performance issues or for cause per 10 CCR 2505-10, Section 8.076.1.7

15.3.1.3.1.2. Contractor shall provide the following:

15.3.1.3.1.2.1. Provider's name and identification number.

15.3.1.3.1.2.2. Date of removal.

15.3.1.3.1.2.3. Number of Members served by the Provider.

15.3.1.3.1.2.4. Reason for the termination.

15.3.1.3.1.2.5. Narrative describing how Contractor intends to provide or services for affected Members after the termination.

15.3.1.3.1.2.6. Any information as required by the Department.

15.3.1.3.1.2.6.1. DELIVERABLE: Notice of Network Provider Termination for Quality of Performance or For Cause

15.3.1.3.1.2.6.2. DUE: Within two Business Days of the decision to terminate for quality or performance issue terminations or terminations for cause

15.3.1.3.2. Changes in Member Circumstances Affecting Eligibility

15.3.1.3.2.1. In accordance with 42 C.F.R. 438.608 (a)(3), Contractor shall promptly notify the Department when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including, but not limited to, all of the following:

15.3.1.3.2.1.1. Changes in the Member's residence.

15.3.1.3.2.1.2. The death of a Member.

15.3.1.3.2.2. Contractor shall use the Provider/Member Change in Circumstance Disclosure template.

15.3.1.3.2.3. Contractor shall provide the following:

15.3.1.3.2.3.1. The Member's name.

15.3.1.3.2.3.2. Medicaid ID number.

15.3.1.3.2.3.3. Date of change.

15.3.1.3.2.3.4. Description of the change.

15.3.1.3.2.3.5. Any information as required by the Department.

15.3.1.3.2.3.5.1. DELIVERABLE: Monthly Member Change in Circumstance Disclosure Report

15.3.1.3.2.3.5.2. DUE: Within 10 Business Days after the end of each month.

15.3.1.3.3. Reporting of Identified Overpayments

15.3.1.3.3.1. In accordance with 42 C.F.R. 438.608(a)(2) Contractor shall promptly notify the Department when it identifies an overpayment, specifying if the overpayment is due to potential fraud.

15.3.1.3.3.2. Contractor shall provide the following:

15.3.1.3.3.2.1. The Provider's name.

15.3.1.3.3.2.2. The Providers Medicaid ID number.

15.3.1.3.3.2.3. The date of identification.

15.3.1.3.3.2.4. The amount identified.

15.3.1.3.3.2.5. A description of the nature of the overpayment.

15.3.1.3.3.2.6. Any information as required by the Department.

15.3.1.3.3.2.6.1. DELIVERABLE: Overpayment Identification Disclosure

15.3.1.3.3.2.6.2. DUE: Within five business days of identifying the overpayment.

15.3.1.4. Disclosures Requiring Notification within 30 Days

15.3.1.4.1. Provider Licensure and Professional Review Actions

15.3.1.4.1.1. Contractor shall report all adverse licensure and professional review actions it has taken against any Provider, in accordance with 45 C.F.R. Subtitle A, Part 60, Subpart B, to the

National Practitioner Data Bank and to the appropriate state regulatory board. Following list of reportable actions:

15.3.1.4.1.1.1. Malpractice payments.

15.3.1.4.1.1.2. Licensure and certification actions.

15.3.1.4.1.1.3. Negative actions or findings.

15.3.1.4.1.1.4. Adverse actions.

15.3.1.4.1.1.5. Health Care-related Criminal Convictions.

15.3.1.4.1.1.6. Health Care-related Civil Judgments.

15.3.1.4.1.1.7. Exclusions from Federal or state health care programs.

15.3.1.4.1.1.8. Other adjudicated actions of decisions.

15.3.1.4.1.1.8.1. DELIVERABLE: Notification of Adverse Licensure of Professional Review

15.3.1.4.1.1.8.2. DUE: Must be submitted to the Department and National Practitioner Data Bank within 30 days following the action being reported.

15.3.1.5. Disclosures Requiring Notification within 60 Days

15.3.1.5.1. Overpayments and Excess Capitation Payments

15.3.1.5.1.1. Within 60 calendar days of identifying any Overpayments, per 42 C.F.R 438.608(d)(2), and any excess capitation payments, Contractor shall report and return an Overpayment to the Department.

15.3.1.5.1.2. Contractor shall provide the following:

15.3.1.5.1.2.1. Client information.

15.3.1.5.1.2.2. Claims information.

15.3.1.5.1.2.3. Encounter Data information.

15.3.1.5.1.2.4. Paid amounts.

15.3.1.5.1.2.5. Provider information.

15.3.1.5.1.2.6. Dates of when Overpayment was identified and recovered.

15.3.1.5.1.2.7. Recovery amounts.

15.3.1.5.1.2.8. Capitation information.

15.3.1.5.1.2.9. Any information as required by the Department.

15.3.1.5.1.3. Contractor shall use the Overpayment and Recovery Disclosure template.

15.3.1.5.1.3.1. DELIVERABLE: Overpayment and Recovery Notification Disclosure

15.3.1.5.1.3.2. DUE: Within 60 calendar days of identifying capitation or other payments.

15.4. Fraud, Waste, and Program Abuse

15.4.1. Contractor shall temporarily suspend all review activities or actions related to any Provider upon request of the Department.

15.4.2. Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

15.4.3. Contractor shall provide expert assistance to the Department, and its Recovery Audit Contractor, as requested by the Department, related to review of overpayments, abuse, suspension of payments, or termination of a Network Provider, or the investigation of Suspected Fraud by a Network Provider.

15.4.4. Contractor shall provide expert assistance that includes, but is not limited to, the following topics:

15.4.4.1. Any reports made pursuant to this section.

15.4.4.2. Any Medical Records review or Medical Necessity findings or determinations made pursuant to this Contract.

15.4.4.3. Provider treatment and business practices.

15.4.4.4. Provider billing practices and patterns.

15.4.4.5. Contractor shall meet with the Department, or its contractors to explain any reports or findings made pursuant to the section. It shall cooperate with and provide assistance with any review, recovery effort, informal reconsideration, Appeal or investigation conducted by the federal or state government, law enforcement, the Program Integrity Section, the Department's contractors, federal or state auditors, or any other entity engaged in program integrity functions.

15.4.5. Contractor shall not take any kind of recovery action or initiate any kind of activity against a Network Provider when possible Fraud is suspected without the approval of the Department.

15.4.6. Contractor shall not take any action that might interfere with an investigation of possible Fraud by the Department or any other law enforcement entity. Contractor shall assist the Department, or any other law enforcement entity as requested with any preliminary or full investigation.

15.4.7. Contractor shall temporarily suspend all review activities or actions related to any Provider which Contractor suspects is involved in fraudulent activity. Contractor shall continue its investigation as requested by the Department.

15.5. Provider Fraud (Ref. Exhibit E, Section 1.14.)

15.6. Member Fraud (Ref. Exhibit E, Section 1.15.)

15.7. Suspension of Payments Due to a Credible Allegation of Fraud

15.7.1. Contractor shall suspend payments due to a Credible Allegation of Fraud in full or in part only at the direction of the Department, in accordance with 42 C.F.R. § 455.23.

15.7.2. Contractor shall release suspended payment amounts to the Provider within one payment cycle when directed to do so by the Department.

15.7.3. Contractor shall not suspend payment when law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

15.7.4. The Department may suspend payments to Contractor if Contractor is under investigation for a Credible Allegation of Fraud.

15.8. Quality Improvement Inspection, Monitoring and Site Reviews

15.8.1. Contractor shall enable and support the Department or its designee to conduct Site Reviews of Contractor's, Subcontractors' or Providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in its sole discretion to determine compliance with applicable Department regulations and the requirements of this Contract.

15.8.2. Site Reviews may include but are not limited to determining compliance with state and federal requirements, contracts and Provider agreements, service provision and billing procedures, and Provider Manuals. Contractor shall cooperate with Department Site Review activities to monitor Contractor performance.

15.8.3. Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

15.8.4. Contractor shall allow the Department or its designee to conduct an emergency or unannounced review for instances including, but not limited to, Member safety, quality of care, and Suspected Fraud or financial viability. The Department may determine when an emergency review is required in its sole discretion.

15.8.5. Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

15.8.6. For routine Site Reviews, Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted by the Department or its designee 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 Contractor at least three weeks prior to the visit. Contractor shall submit copies of policies, procedures, manuals, handbooks, reports and other requested materials to facilitate the Department and/or designee's desk audit prior to the Site Review. Contractor has a minimum of 30 days to submit the required materials for non-emergency reviews.

15.8.7. 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, or immediately on an emergency basis. Delays in the availability of such documents and records may subject Contractor to remedial actions. 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.

15.8.8. The Department will transmit a written report of the Site Review to Contractor within 45 days of the Site Review. Contractor is allowed 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.

15.8.9. Contractor shall respond to any required actions identified by the Department or its designee, if necessary, with a corrective action plan within 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 Contractor is found to be in complete compliance. The Department will notify Contractor in writing when the corrective actions have been completed, accepted and Contractor is considered to be in compliance with Department regulations and the Contract.

15.8.9.1. 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 Members, as determined by the Department.

15.8.9.2. For corrective action plans affecting the provision of Covered Services to Members, Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.

15.8.9.3. The Department will not accept any data submitted by Contractor to the Department or its agents after the last site visit day towards compliance with the visit in the written report. The Department will only apply this data toward the corrective action plan.

15.8.10. Contractor shall understand that the Site Review may include reviews of a sample of Network Providers to ensure that Network Providers have been educated and monitored by Contractor about the requirements under this Contract.

15.8.11. In the event that the Site Reviewers wish to inspect a Network Provider location, Contractor shall ensure that:

15.8.11.1. Network Providers make staff available to assist in the audit or inspection effort.

15.8.11.2. Network Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

15.9. Prohibitions

15.9.1. Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. Contractor shall not pay a Network Provider for provider-preventable conditions, as identified in 42 C.F.R. § 438(g). Contractor shall ensure that Network Providers identify provider-preventable conditions that are associated with claims for CHP+ payment or with courses of treatment furnished to CHP+ patients for which CHP+ payment would otherwise be available.

15.9.1.1. Contractor shall create a Provider Preventable Conditions Report that includes all provider-preventable conditions. Contractor shall submit this report to the Department on an annual basis.

15.9.1.1.1. DELIVERABLE: Provider Preventable Conditions Report

15.9.1.1.2. DUE: Annually, no later than July 31 of each year.

15.9.2. Contractor shall ensure all Network Providers are enrolled in the Colorado interChange system consistent with Provider disclosure, screening, and Enrollment requirements, and no payment is made to a Network Provider pursuant to this Contract if a Network Provider is not enrolled with the state in the Colorado interChange system.

15.9.3. The Department will not make payment to Contractor, if Contractor is:

15.9.3.1. An entity that could be excluded from under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

15.9.3.2. An entity that has a contract for the administration, management or provision of medical services, the establishment of policies, or the provision of operation support, for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act or an individual described in in the section on prohibited affiliations or that has been excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.

15.9.3.3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

15.9.3.3.1. Any individual or entity excluded from participation in federal health care programs.

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

15.9.3.4. Contractor shall not pay a Provider or Subcontractor, directly or indirectly, for the furnishing of any good or service if:

15.9.3.4.1. The Provider or Subcontractor is excluded from participation in federal health care programs.

15.9.3.4.2. The Provider of Subcontractor has a relationship described in the section on prohibited affiliations.

15.9.4. Prohibited Affiliations

15.9.4.1. Contractor is prohibited from having a relationship with an individual or entity that is excluded from participation in any federal health care program as described in Sections 1128 and 1128A of the Social Security Act.

15.9.4.2. Contractor shall not knowingly have a relationship with:

15.9.4.2.1. A director, officer, or partner who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.2. A Subcontractor which is, or is affiliated with, a person/entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the, Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.3. A person with Ownership or more than 5% of Contractor's equity who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.4. An employment, consulting, or other arrangement with an individual or entity for the provision of the contracted items or services who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.5. A Provider which is, or is affiliated with, a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.3. Contractor shall provide written disclosure to the Department of any prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, as defined in 438.608(c)(1).

15.9.4.4. If the Department learns that Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, the Department:

15.9.4.4.1. Must notify the Secretary of the Department of Health and Human Services (Secretary) of the noncompliance.

15.9.4.4.2. May continue an existing agreement with Contractor unless the Secretary directs otherwise.

15.9.4.4.3. May not renew or extend the existing agreement with Contractor unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

15.9.5. Prohibited Payments

15.9.5.1. Contractor shall not make payments:

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

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

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

15.9.5.1.1.3. By an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a Credible Allegation of Fraud against the individual or entity, unless the Department determines there is a good cause not to suspend such payments.

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

15.9.5.1.3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the CHP+ State Plan.

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

15.10. General Compliance and Program Integrity Requirements

15.10.1. Mental Health Parity

15.10.1.1. Contractor shall comply with all regulations within 42 C.F.R. Part 438, subpart K regarding parity in mental health and substance use disorder benefits, and submit all necessary documentation and reporting required to the Department to establish and demonstrate compliance with 42 C.F.R. Part 438, subpart K.

15.10.2. Health Information Systems

15.10.2.1. Contractor shall comply with the following, aligning with the Department's implementation timeline:

15.10.2.1.1. Contractor shall implement and maintain a secure, standards-based application program interface (API) which provides current members, or their personal representatives, with access to specified claims and encounter data, certain clinical information, and information about covered outpatient drugs.

15.10.2.1.1.1. The API shall comply with the requirements of 42 CFR § 438.242 and 45 CFR § 170.215.

15.10.2.1.2. Contractor shall implement and maintain an API that makes complete and accurate provider directory information available through a public-facing digital endpoint on Contractor's website.

15.10.2.1.2.1. The API shall meet the requirements of 42 CFR § 438.242 as well as the provider directory information specified in § 438.10.

15.10.2.1.3. Contractor shall comply with the requirements of 42 CFR § 438.62 through the development and maintenance of a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213.

15.10.2.1.3.1. The USCDI data classes and elements received from other plans must be incorporated into Contractors' records about the member.

15.10.2.1.3.2. At the request of a member, Contractor must incorporate into its records such member data with a date of service on or after January 1, 2016, from any other payer that has provided coverage to the member within the preceding 5 years.

15.10.2.1.3.3. Any time during a member's enrollment with Contractor and up to 5 years after disenrollment, Contractor must send, upon a member's request, all such data to any other payer that currently covers the member, or a payer that the member specifically requests to receive the data classes and elements included in the USCDI content standards.

15.10.3. Business Transaction Disclosures

15.10.3.1. Contractor shall submit, full and complete information about:

15.10.3.1.1. The Ownership of any Subcontractor with whom Contractor has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the 12-month period ending on the date of the request.

15.10.3.1.2. Any Significant Business Transactions between Contractor and any Wholly Owned Supplier, or between Contractor and any Subcontractor, during the 5-year period ending on the date of the request.

15.10.3.1.2.1. DELIVERABLE: Disclosure of Business Transactions

15.10.3.1.2.2. DUE: Within 35 calendar days following a request by the Department or by the Secretary of the Department of Health and Human Services.

15.10.4. Ownership or Control Disclosures

15.10.4.1. Contractor shall disclose to the Department information regarding Ownership or Control Interests in Contractor at the time of submitting a Provider application, at the time of executing the Contract with the State, at Contract renewal or extension, and within 35 calendar days of either a change of Ownership or a written request by the Department.

15.10.4.2. Contractor shall include the following Ownership and control disclosure information in a form to be provided by the Department:

15.10.4.2.1. The name, title and address of any individual or entity with an Ownership or Control Interest in Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

15.10.4.2.2. Date of birth and Social Security Number of any individual with an Ownership or Control Interest in Contractor.

15.10.4.2.3. Tax identification number of any corporation or partnership with an Ownership or Control Interest in Contractor, or in any Subcontractor in which Contractor has a 5% or more interest.

15.10.4.2.4. Whether an individual with an Ownership or Control Interest in Contractor is related to another person with an Ownership or Control Interest in Contractor as a spouse, parent, child, or sibling; or whether an individual with an Ownership or Control Interest in any Subcontractor in which Contractor has a 5% or more interest is related to another person with Ownership or Control Interest in Contractor as a spouse, parent, child, or sibling.

15.10.4.2.5. The name of any other Provider (other than an individual Provider or Group of Providers), Fiscal Agent, or managed care entity in which an owner of Contractor has an Ownership or Control Interest.

15.10.4.2.6. The name, title, address, date of birth, and Social Security Number of any Managing Employee of Contractor.

15.10.4.2.6.1. DELIVERABLE: Ownership or Control Disclosures

15.10.4.2.6.2. DUE: Annually on July 31 and within 35 calendar days of either a change of Ownership or a written request by the Department.

15.10.5. Conflict of Interest

15.10.5.1. Contractor shall comply with the conflict-of-interest safeguards described in 42 C.F.R. §438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

15.10.5.2. The term "conflict of interest" means that:

15.10.5.2.1. Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

15.10.5.2.2. The relationship between the third party and the Department is such that one party's interests could only be advanced at the expense of the other's interests.

15.10.5.2.3. A conflict of interest exists even if Contractor does not use information obtained from one party in its dealings with the other.

15.10.5.3. Contractor shall submit a full disclosure statement to the Department, setting forth the details that create the appearance of a conflict of interest.

15.10.5.3.1. DELIVERABLE: Conflict of Interest Disclosure Statement

15.10.5.3.2. DUE: Within 10 Business Days of learning of an existing appearance of a conflict-of-interest situation.

15.10.6. Subcontracts and Contracts

15.10.6.1. Contractor shall disclose to the Department copies of any existing subcontracts and contracts with Providers upon request.

15.10.6.2. Contractor shall ensure that no Member is billed by a Subcontractor or Provider for any amount greater than would be owed if Contractor provided the services directly or in violation of 25.5-4-301(1)(a)(I), (II) and (II.5), C.R.S.

15.10.6.2.1. DELIVERABLE: Subcontracts and Provider Contracts

15.10.6.2.2. DUE: Within five Business Days of the Department's Request.

15.10.7. Screening of Employees and Contractors

15.10.7.1. Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the HHS-OIG.

15.10.7.2. Contractor shall screen all of its employees and Subcontractors against the HHS-OIG's List of Excluded Individuals (LEIE) prior to hire or contracting and at least monthly thereafter to determine whether they have been excluded from participation in Medicaid.

15.10.7.3. If Contractor determines that one of its employees or Subcontractors has been excluded, Contractor shall take appropriate action in accordance with federal and state statutes and regulations and shall report the discovery to the Department.

15.10.7.3.1. DELIVERABLE: Notification of Discovery of Excluded Employee or Subcontractor

15.10.7.3.2. DUE: Within five Business Days of discovery

15.10.8. Disclosure of Information on Persons Convicted of Crimes

15.10.8.1. Upon submitting a Provider application, upon execution of the Contract, upon renewal or extension of the Contract, and within 35 calendar days of the date of a written request by the Department, Contractor shall disclose the identity of any person who:

15.10.8.1.1. Has an Ownership or Control Interest in Contractor, or who is a Managing Employee of Contractor.

15.10.8.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX services program, or Title XXI of the Social Security Act.

15.10.8.1.2.1. DELIVERABLE: Disclosure of Information on Persons Convicted of Crimes

15.10.8.1.2.2. DUE: January 1, 2020 and annually thereafter within 35 calendar days of either a change of Ownership or a written request by the Department.

15.10.9. Security Breaches and HIPAA Violations

15.10.9.1. In the event of a breach of the security of sensitive data Contractor shall immediately notify the Department and the Office of Information Technology (OIT) of all suspected loss or compromise of sensitive data within five Business Days of the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

15.10.9.2. Contractor shall comply with the requirements of C.R.S. § 6-1-716 and any other applicable state and federal laws and regulations.

15.10.9.3. Contractor shall report all HIPAA violations as described in the HIPAA Business Associates Addendum.

15.10.9.3.1. DELIVERABLE: Security and HIPAA Violation Breach Notification

15.10.9.3.2. DUE: Within five Business Days of becoming aware of the breach

15.10.10. Maintenance of Records

15.10.10.1. Contractor shall ensure that all Subcontractors and Providers comply with all record maintenance requirements of the Contract.

15.10.10.2. Notwithstanding any other requirement of the Contract, Contractor shall retain and require Subcontractors to retain, as applicable, enrollee Grievance and Appeal records in accordance with 42 C.F.R. § 438.416, base data in accordance with 42 C.F.R. § 438.5(c), MLR reports in accordance with 42 C.F.R. § 438.8(k), and the data, information, and documentation specified is 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610 for a period of no less than 10 years.

15.10.11. Inspection and Audits

15.10.11.1. Contractor shall allow the Department, CMS, HHS-OIG, the Comptroller General and their designees to inspect and audit any records or documents of Contractor or its Subcontractors and shall allow them to, at any time, inspect the premises, physical facilities and equipment where CHP+-related activities or Work is conducted.

15.10.11.2. Notwithstanding any other provision in the Contract, Contractor shall allow the Department, CMS, the HHS-OIG, the Comptroller General and their designees this authority for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

15.10.11.3. Contractor shall allow CMS or its agent or designated contractor and the Department or its agent to conduct unannounced, on-site inspections for any reason.

15.10.11.4. In the event that right of access is requested, Contractor and/or its Subcontractors or Providers shall:

15.10.11.4.1. Make staff available to assist in any audit or inspection under the Contract.

15.10.11.4.2. Provide adequate space on the premises to reasonably accommodate Department, state or federal or their designees' personnel conducting all audits, Site Reviews or inspections.

15.10.11.4.3. The Secretary of Health and Human services, the Department of Health and Human Services, and the Department have the right to audit and inspect any books or records of Contractor or its Subcontractors pertaining to the ability of Contractor or its Subcontractor's ability to bear the risk of financial losses.

15.10.11.4.4. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of Contractor's, Subcontractor's or Providers' provision of care.

15.10.11.4.5. Contractor shall allow access to Contractor's claims system and claims data by Department staff for program integrity activities.

15.10.11.4.6. In consultation with the Department, Contractor shall participate in compliance monitoring activities and respond to any Department or designee request for information related to compliance monitoring, including Encounter Data analysis and Encounter Data validation (the comparison of Encounter Data with Medical Records). The Department may request other information or analyses needed for compliance monitoring.

15.10.11.5. Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five Business Days.

15.10.11.6. Must have staff available to assist in any audit or inspection under the Contract.

15.11. Financial Reporting

15.11.1. Audited Annual Financial Statement

15.11.1.1. Contractor shall compile an Audited Annual Financial Statement that includes, at a minimum, the following:

15.11.1.1.1. Annual internal financial statements, including balance sheet and income statement.

15.11.1.1.2. Audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP). The audited annual financial statements must be certified by an independent public accountant and Contractor's Chief Financial Officer or their designee.

15.11.1.1.3. Contractor shall submit their Audited Annual Financial Statement that covers the entirety of the previous State Fiscal Year to the Department in a format approved by the Department for review and approval. If format changes are required by the Department, the Department will provide 60 days advance notice to Contractor prior to requiring the implementation of the requested changes.

15.11.1.1.3.1. DELIVERABLE: Audited Annual Financial Statement

15.11.1.1.3.2. DUE: No later than six months from the end of Contractor's Fiscal Year that the statement covers. Any changes to Contractor's Fiscal Year shall be reported to the Department at least 60 days prior to implementation.

15.11.2. Contractor shall submit other financial reports and information as requested by the Department or its designee.

15.11.3. Contractor shall assist the Department in verifying any reported information upon the Department's request. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:

15.11.3.1. Fact-checking.

15.11.3.2. Auditing reported data.

15.11.3.3. Performing site visits.

15.11.3.4. Requesting additional information.

15.11.4. If the Department determines that there are errors or omissions in any reported information, Contractor shall produce an updated report that corrects all errors and includes all omitted data or information. Contractor shall submit the updated report to the Department within 14 days after the Department's request for the updated report.

15.11.4.1. DELIVERABLE: Updated Financial Reports or Statements

15.11.4.2. DUE: 14 days after the Department's request for the updated report or statement.

15.12. Solvency

15.12.1. Contractor shall notify the Department, upon becoming aware of or having reason to believe that it does not, or may not, meet the solvency standards, established by the State for Health Maintenance Organizations.

15.12.2. Contractor shall not hold liable any Member for Contractor's debts, in the event Contractor becomes insolvent.

15.12.3. Contractor shall not hold liable any Member for covered services provided to the Member, for which the Department does not pay Contractor, or for which the Department or Contractor does not pay the provider that furnished the service under a contractual, referral, or other arrangement.

15.12.4. Contractor shall not hold liable any Member for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor covered the services directly.

15.12.5. Contractor shall provide assurances satisfactory to the Department that its provision against the risk of insolvency is adequate to ensure that Members will not be liable for Contractor's debt, in the event Contractor becomes insolvent.

15.12.5.1. DELIVERABLE: Solvency Notification

15.12.5.2. DUE: Within two Business Days of becoming aware of a possible solvency issue.

15.13. Warranties and Certifications

15.13.1. Contractor shall disclose to the Department if it is no longer able to provide the same warranties and certifications as required at the Effective Date of the Contract.

15.14. Actions Involving Licenses, Certifications, Approvals and Permits

15.14.1. Provider Insurance

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

15.14.1.1.1. Physicians participating in Contractor's MCO shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and one million five-hundred thousand dollars ($1,500,000.00) in aggregate per year.

15.14.1.1.2. Facilities participating in Contractor's MCO shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and three million dollars ($3,000,000.00) in aggregate per year.

15.14.1.1.3. Sections 15.14.1.1.1 and 15.14.1.1.2 shall not apply to physicians and facilities in Contractor's network which meet any of the following requirements:

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

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

15.14.1.1.4. Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such coverage, Contractor shall notify the Department of such cancellation within two Business Days of when the coverage is cancelled.

15.14.2. Contractor shall notify the Department of:

15.14.2.1. Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of Section 10, 16, -401, et seq., C.R.S. as a Health Maintenance Organization.

15.14.2.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

15.14.2.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

15.14.2.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

15.14.2.3.2. DUE: Within two Business Days of Contractor's notification.

15.15. Federal Intermediate Sanctions

15.15.1. The Department may implement any intermediate sanctions, as described in 42 CFR 438.702, if Contractor:

15.15.1.1. Fails substantially to provide Medically Necessary services that Contractor is required to provide, under law or under its Contract –with the Department, to a Member covered under the Contract.

15.15.1.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the CHP+ program.

15.15.1.3. Acts to discriminate among Members on the basis of their health status or need for health care services.

15.15.1.4. Misrepresents or falsifies information that it furnishes to CMS or to the Department.

15.15.1.5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider.

15.15.1.6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.

15.15.1.7. Has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information.

15.15.1.8. Has violated any of the other applicable requirements of sections 1903(m), 1932, or 1905(t) of the Act and any implementing regulations.

15.15.2. Notice of Sanction and Pre-Termination Hearing

15.15.2.1. Before imposing any of the intermediate sanctions specified in this section, the State must give the affected entity timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

15.15.2.2. Before terminating any contracts with Contractor, the State must provide Contractor a pre-termination hearing.

15.15.2.3. Prior to a pre-termination hearing, the State must provide Contractor with the following:

15.15.2.4. Written notice of its intent to terminate, the reason for termination, and the time and place of the hearing.

15.15.2.5. After the hearing, the State must provide Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination.

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

15.15.3. Payments provided for under the Contract shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

15.16. Termination Under Federal Regulations

15.16.1. The Department may terminate this Contract for cause and Enroll any Member enrolled with Contractor in another Plan, or provide their CHP+ benefits through other options included in the State plan, if the Department determines that Contractor has failed to:

15.16.1.1. Carry out the substantive terms of its contracts.

15.16.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

15.16.2. Before terminating Contractor's Contract as described in this section, the Department will:

15.16.2.1. Provide Contractor a cure notice that includes, at a minimum, all of the following:

15.16.2.1.1. The Department's intent to terminate.

15.16.2.1.2. The reason for the termination.

15.16.2.1.3. The time and place for the pre-termination hearing.

15.16.2.2. Conduct a pre-termination hearing.

15.16.2.3. Give Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

15.16.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department will send a written termination notice to Contractor that contains the Effective Date of the termination.

15.16.2.4.1. Upon receipt of the termination notice, Contractor shall give Members enrolled with Contractor notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHP+ services following the effective date of termination.

15.16.3. Once the Department has notified Contractor of its intent to terminate under this section, the Department may give Members enrolled with Contractor written notice of the Department's intent to terminate the Contract.

15.16.4. The Department may choose to impose any of the following intermediate sanctions if Contractor violates any applicable requirements of sections 1903(m) or 1932 of the Social Security Act and its implementing regulations:

15.16.4.1. Allow Members enrolled with Contractor to Disenroll immediately, without cause.

15.16.4.2. Suspend all new Enrollments to Contractor's managed care capitation initiative, after the date the Secretary or the Department notifies Contractor of a determination of violation of any requirement under sections 1903(m) or 1932 of the Act.

15.16.4.3. Suspend payments for all new Enrollments to Contractor's managed care capitation initiative until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

15.16.5. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the Work ends, Contractor shall not be paid for that Work. If the state paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the Work

was to be performed after the date the legal authority ended, the payment for that Work should be returned to the state. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that Work in its payments to Contractor, Contractor may keep the payment for that Work even if the payment was made after the date the program or activity lost legal authority.

15.17. Interoperability Rule

15.17.1. Contractor shall implement and maintain a secure, standards-based, application program interface (API) aligning with the Department's implementation timeline. The API shall:

15.17.1.1. Be available through a public-facing digital endpoint on Contractor's website.

15.17.1.2. Include complete and accurate provider directory information.

15.17.1.2.1. The provider directory must meet the same technical standards as the patient access API, excluding the security protocols related to user authentication and authorization.

15.17.1.2.2. The provider directory information shall be updated no later than 30 calendar days after the Department or Contractor receives the provider directory information or updates to provider directory information.

15.17.1.2.3. Comply with the requirements of 42 CFR § 438.242, 45 CFR § 170.215, as well as the provider directory information specified in § 438.10.

15.17.1.2.4. Provide current members, or their personal representatives, with access to claims and Encounter Data within one business day of receipt, including:

15.17.1.2.4.1. Adjudicated claims, including data for payment decisions that may be appealed, were appealed, or in the process of appeal.

15.17.1.2.4.2. Provider remittances and beneficiary cost-sharing pertaining to adjudicated claims.

15.17.1.2.4.3. Services and Items Provided in Treatment.

15.17.1.2.4.4. Clinical information within one business day of receipt, if collected and maintained by Contractor, including:

15.17.1.2.4.4.1. Diagnoses and Related Codes.

15.17.1.2.4.4.2. Medical Records and Reports.

15.17.1.2.4.4.3. Statements of Medical Necessity.

15.17.1.2.4.4.4. Laboratory Test Results.

15.17.1.2.4.5. Information about covered outpatient drugs within one business day after the effective date of any update, including:

15.17.1.2.4.5.1. Formulary of prescription drugs and costs to the member.

15.17.1.2.4.5.2. Preferred drug list information.

15.17.2. Contractor shall comply with the requirements of 42 CFR § 438.62 by developing and maintaining a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213.

15.17.3. Contractor shall incorporate the USCDI data classes and elements received from other plans about the member.

15.17.4. Contractor shall, at a minimum, upon request by a member:

15.17.4.1. Incorporate into its records member data with a date of service on or after January 1, 2016, from any other payer that has provided coverage to the member within the preceding five years.

15.17.4.2. Send all such data to any other payer that currently covers the member, or a payer that the member specifically requests to receive the data classes and elements included in the USCDI content standards, any time during a member's enrollment with Contractor and up to five years after disenrollment.

16. COMPENSATION AND INVOICING

16.1. Summary of Compensation to Contractor

16.1.1. Compensation to Contractor shall consist of the following:

16.1.1.1. One actuarially certified monthly Capitated Payment, as specified in Exhibit C, Rates, for each active Member assigned to Contractor on the first day of the month and for Members whose Enrollment starts from the 2nd through the 17th of the month. The Department will set the monthly Capitated Payment rates at the actuarially certified point estimate in accordance with 42 C.F.R. § 438.3.

16.2. Process for Capitated Payments

16.2.1. The Department will calculate the number of active Members enrolled in Contractor's Managed Care Organization based on the Enrollment information in the Colorado interChange.

16.2.2. The Department will remit all Capitated Payments through the Colorado interChange via electronic funds transfer to a bank account designated by Contractor. The Department will provide Contractor with a monthly payment report through the Colorado interChange.

16.2.2.1. Contractor shall ensure the accuracy of direct deposit information provided to the Department and update such information as needed.

16.2.3. The Department will remit all Capitated Payments to Contractor within the month for which the payment applies.

16.2.3.1. In the event that Contractor is not compensated for a Member in a month for which Contractor should have been compensated, per Department records, the Department will compensate Contractor for that Member retroactively.

16.2.4. The Department will remove Third Party Recovery amounts from the calculation of the Monthly Capitation Rates. The Department will not seek recovery of reimbursement from Contractor.

16.2.5. The monthly Capitated Payment shall be considered payment in full for all Covered Services set forth in this Contract.

16.3. Deliveries

16.3.1. Contractor shall receive payment for delivery services provided to Members through a case rate payment. The payment, which is set forth in this Contract, includes facility and professional service costs related to the delivery and post-partum care. One payment shall be made for each delivery regardless of the number of births associated with that delivery.

16.3.2. In order to receive payment for deliveries, Contractor shall submit to the Department, documentation in accordance with the Department's CHP+ Quarterly Reconciliation Process Specifications. Documentation of the delivery, e.g., a claim record of delivery, must accompany the request for payment. The request for payment shall be submitted to the Department no later than 60 days following the quarter in which a claim was paid.

16.3.3. Contractor shall certify all data submitted is accurate, complete and truthful based on 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.

16.3.4. Each quarter, the Department will adjudicate Contractor's request for payment within 90 days of receipt of all documentation from all CHP+ Contractors for delivery services.

16.4. Newborn Services

16.4.1. The Department will share the cost of newborn services with Contractor through a reinsurance model, at a per claim basis, if the cost exceeds a specific dollar threshold, and according to the terms in this section.

16.4.2. The reinsurance model shall comprise the following components:

16.4.2.1. Attachment point – the dollar threshold amount that a claim must exceed in order to initiate reimbursement through the Department's reinsurance model.

16.4.2.1.1. At least two years of historical claims data will be used to determine claims paid amount distribution to inform the decision around the attachment point level.

16.4.2.2. Risk sharing percentage – the share of cost percentage between the Department and Contractor on a claim's paid amount above the attachment point.

16.4.3. Reimbursement for newborn services whose cost exceeds the attachment point will only be made for eligible services. In order to qualify for the reinsurance model, claims must meet the following criteria:

16.4.3.1. Member must be eligible for CHP+ at the time of service.

16.4.3.2. Member must be enrolled into Contractor's plan at the time of service.

16.4.3.3. Total claim paid amount must be above the attachment point of the reinsurance model.

16.4.3.4. Member's age must be less than two-years-old.

16.4.3.4.1. Age will be based on capitation paid for the month of service.

16.4.3.5. Revenue codes must be 0100, 0101, 0110-0160, 0164, 0167, 0169, 0170-0174, 0179, 0200-0219 or bill type 11X, 12X, 89X.

16.4.3.6. Professional fees must be excluded.

16.4.3.7. Start date of service for the claim must be within the timely filing deadline.

16.4.4. Cost Sharing Calculations

16.4.4.1. Contractor shall be held solely responsible for final incurred costs to Contractor for eligible services up to $50,000.00 per claim. The Department will reimburse Contractor for eligible services in excess of $50,000.00, utilizing the following risk sharing percentage:

Attachment Point	MCO Share	State Share
$50,000.00	25%	75%

16.4.4.2. The payment amount will be calculated as the difference between total claim paid amount and the attachment point multiplied by the State share as indicated in the table above. A single payment shall be made to Contractor for all reimbursement requests submitted within a quarter.

16.4.4.3. Reimbursement amount for eligible services will be based on the attachment point and risk sharing percentage effective during the State Fiscal Year in which a service was rendered.

16.4.4.4. To be considered for reimbursement, the request submitted to the Department must reflect net paid claims amount by Contractor.

16.4.4.4.1. Contractor shall ensure that all available third-party liability benefits are exhausted before reimbursement through the Department's reinsurance model is initiated.

16.4.5. Reimbursement Process

16.4.5.1. In order to receive reimbursement, Contractor shall submit to the Department documentation in accordance with the Department's CHP+ Quarterly Reconciliation Process Specifications . The request for payment shall be submitted to the Department no later than 60 days following the quarter in which a claim was paid.

16.4.5.1.1. Contractor shall certify all data submitted are accurate, complete and truthful based on Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer, the Chief Financial Officer or another individual who has delegated signatory authority and who reports directly to the Chief Executive Officer or Chief Financial Officer.

16.4.5.2. Each quarter, the Department will adjudicate Contractor's request for payment within 90 days of receipt of all documentation from all CHP+ contractors for newborn insurance.

16.4.5.3. The Department reserves the right to review all relevant documentation for the submitted claims. Contractor shall document and provide supporting information for the submitted claims. The Department reserves the right to exclude claims from reimbursement that do not have any supporting information or documentation.

16.4.5.4. The Department reserves the right to review claims paid amount for reasonableness and to request supporting documentation as necessary.

16.4.5.5. The Department will have the final decision on all cost sharing calculations.

16.4.6. Medical Loss Ratio (MLR) Reporting

16.4.6.1. Contractor shall exclude the reimbursed amount from the reinsurance model as revenue in the MLR report.

16.4.6.2. Contractor shall exclude the State's share of claims paid amount above the attachment point of the reinsurance model from the claims incurred line in the MLR report.

16.4.7. Future Rate Setting

16.4.7.1. All claims reimbursed by the reinsurance model will have their claim paid amount readjusted to be net of the State Share reimbursement when included as base data for rate-setting.

16.4.7.2. The Department will review and update the parameters and criteria of the reinsurance model annually. All changes of the reinsurance model will be presented to Contractor before the capitation rates model is finalized.

16.5. Specialty Drug Reimbursement

16.5.1. The Department will reimburse Contractor in accordance with the deductions stated below after the drug cost of the Specialty Drugs exceeds $100,000.00 per treated Member per year.

16.5.2. The Department will reimburse Contractor for eligible Specialty Drugs according to instructions in the Specialty Drug Quarterly Cost Report.

16.5.3. Specialty Drugs which are eligible for reimbursement following the cost sharing calculation specified in section 16.6. will be excluded from eligibility for reimbursement following the newborn reinsurance cost sharing calculation specified in section 16.4.

16.5.4. Reimbursement for Specialty Drugs will only be made for claims which meet the following criteria:

16.5.4.1. Member must be eligible for CHP+ at the time of service.

16.5.4.2. Member must be enrolled into Contractor's plan at the time of service.

16.5.4.3. Cost of Specialty Drug must exceed $100,000.00.

16.5.4.4. Professional fees must be excluded.

16.5.4.5. Claim must be within the timely filing deadline.

16.5.5. The Department will reimburse Contractor for the invoice cost of the drugs, after all the following have been deducted:

16.5.5.1. Any drug rebates available to the requesting provider.

16.5.5.2. Any amounts received by Contractor, or Contractor's parent company for Contractor's CHP+ business, pursuant to reinsurance settlements for any private catastrophic cost policies maintained by Contractor, or Contractor's parent company for Contractor's CHP+ business, for the current Performance Period. If reinsurance is an umbrella policy, the Department will calculate the pharmacy settlement amount by pharmacy/Medical service ratio.

16.5.5.3. Any Contractor offsets attributable to substitution effects that will occur during the State fiscal year due to Member treatment with the requested Specialty Drug, as calculated on an actuarially sound basis.

16.5.6. For the purpose of executing the substitution effect requirement stated above, the Department, with assistance from its contracted actuary and with review and comment from Contractor's actuary, will apply appropriate methods to review the cost associated with the Specialty Drugs treatment, including but not limited to; diagnosis code-based review, other identification code-based review, Member-specific case-by-case review, and episode cost to determine the following:

16.5.6.1. The calculated trended historical cost embedded in capitation rate, associated with the treated Member, or the diagnoses, and other codes related treatment.

16.5.6.2. The cost in the current State Fiscal Year associated with the treated Member, or the diagnoses and other codes related treatment, excluding Specialty Drugs.

16.5.6.3. The value of appropriate cost adjustments to covered services, delivered under this Contract, is calculated as the difference between the calculations in Sections 16.6.7.1. and 16.6.7.2. whether they are lower or higher, on an actuarially sound basis.

16.5.7. In order to receive reimbursement, Contractor shall submit to the Department, documentation in accordance with the Department's CHP+ Quarterly Reconciliation Process Specifications . Documentation of the eligible Specialty Drug(s) shall accompany the request for payment. The request for payment shall be submitted to the Department no later than 60 days following the quarter in which a claim was paid.

16.5.7.1. Contractor shall certify all data submitted are accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer, the Chief Financial Officer or another individual who has delegated signatory authority, and who reports directly to the Chief Executive Officer or Chief Financial Officer.

16.5.7.2. The Department reserves the right to review all relevant documentation for the submitted claims. Contractor shall document and provide supporting information for the submitted claims. The Department reserves the right to exclude claims from reimbursement that do not have any supporting information or documentation.

16.5.7.3. The Department reserves the right to review claims paid amount for reasonableness and to request supporting documentation as necessary.

16.5.7.4. Each Quarter, the Department will adjudicate Contractor's request for payment within 90 days of receipt of all documentation from all CHP+ contractors for specialty drug reimbursement.

16.5.8. The Department determines drug selection, substitution effect calculation, and payment reconciliation.

16.5.9. Medical Loss Ratio (MLR) Reporting.

16.5.9.1. Contractor shall exclude the reimbursed amount for Specialty Drug(s) as revenue in the MLR report.

16.5.9.2. Contractor shall exclude the State's share of claims paid amount for Specialty Drug(s) from the claims incurred line in the MLR report.

16.6. Abortion Services Reimbursement

16.6.1. The Department will reimburse Contractor for certain Abortion Services using state-only funds.

16.6.2. Abortion Services, which are eligible for reimbursement are defined in the Department's CHP+ Quarterly Reconciliation Process Specifications.

16.6.3. Reimbursement for Abortion Services will only be made for claims which meet the following criteria:

16.6.3.1. Member must be eligible for CHP+ at the time of service.

16.6.3.2. Member must be enrolled into Contractor's plan at the time of service.

16.6.3.3. Start date of service for the claim must be within the timely filing deadline.

16.6.4. The Department will reimburse Contractor for the cost of eligible abortion services. To be considered for reimbursement, the request submitted to the Department must reflect net paid claims amount by Contractor.

16.6.5. Contractor shall ensure that all available third-party liability benefits are exhausted before reimbursement through the Department's reconciliation process is initiated.

16.6.6. In order to receive reimbursement, Contractor shall submit to the Department documentation in accordance with the Department's CHP+ Quarterly Reconciliation Process Specifications. Documentation of the eligible Abortion Services shall accompany the request for payment. The request for payment shall be submitted to the Department no later than 60 days following the quarter in which a claim was paid.

16.6.7. Contractor shall certify all data submitted are accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer, the Chief Financial Officer or another individual who has delegated signatory authority, and who reports directly to the Chief Executive Officer or Chief Financial Officer.

16.6.8. The Department reserves the right to review all relevant documentation for the submitted claims. Contractor shall document and provide supporting information for the submitted claims. The Department reserves the right to exclude claims from reimbursement that do not have any supporting information or documentation.

16.6.9. The Department reserves the right to review claims paid amount for reasonableness and to request supporting documentation as necessary.

16.6.9.1. Each quarter, the Department will adjudicate Contractor's request for payment within 90 days of receipt of all documentation from all CHP+ contractors for Abortion Services reimbursement.

16.7. Actions impacting existing rates

16.7.1. Contractor shall inform the Department prior to making changes to rate payment methodologies, Provider recoupments, or other financial adjustments that may impact the underlying assumptions the rate is built on. Contractor shall notify the Department at least 30 days in advance prior to making any such changes.

16.8. Payment Calculation Disputes

16.8.1. In the event that Contractor believes that the calculation or determination of any payment is incorrect, Contractor shall notify the Department of its dispute within 30 days of the receipt of the payment. The Department will review calculation or determination and may make changes based on this review. The determination or calculation that results from the Department's review shall be final. No disputed payment shall be due until after the Department has concluded its review.

16.9. Recoupments

16.9.1. Contractor shall refund to the Department any overpayments due the Department within 30 days after discovering the overpayments or being notified by the Department that overpayments are due. If Contractor fails to refund the overpayments within 30 days, the Department shall deduct the overpayments from the next payment to Contractor

16.9.2. Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within 90 days of termination.

16.9.3. Payments made by the Department to Contractor due to Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

16.9.4. Where Membership is disputed between two Contractors, the Department will be final arbitrator of Membership and shall recoup any Capitated Payments. Contractor's obligation to refund all calculated remittance owed continues subsequent to termination of the Contract.

16.10. Closeout Payments

16.10.1. Notwithstanding anything to the contrary in this Contract, all payments for the final month of this Contract shall be paid to Contractor no sooner than 10 days after the Department has determined that Contractor has completed all of the requirements of the Closeout.

16.11. Medical Loss Ratio (MLR)

16.11.1. Contractor shall calculate and report the MLR according to the instructions provided on the MLR template and the guidance provided in 42 C.F.R. § 438.8(a).

16.11.2. Annual measurement periods will align with the state Fiscal Year, beginning on July 1 and ending on June 30 of the subsequent calendar year.

16.11.3. Contractor shall submit an MLR report to the Department, for each MLR reporting year, which includes:

16.11.3.1. Total incurred claims.

16.11.3.2. Expenditures on quality improvement activities.

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

16.11.3.4. Non-claims costs.

16.11.3.5. Premium revenue.

16.11.3.6. Taxes.

16.11.3.7. Licensing fees

16.11.3.8. Regulatory fees.

16.11.3.9. Methodology(ies) for allocation of expenditures.

16.11.3.10. Any credibility adjustment applied if the MLR reporting year experience is partially credible.

16.11.3.10.1. Any credibility adjustment shall be added to the reported MLR calculation before calculating any remittances.

16.11.3.10.2. Contractor shall not add a credibility adjustment to the calculated MLR if the MLR reporting year experience is fully credible.

16.11.3.11. The calculated MLR.

16.11.3.12. Any remittance owed to the state, if applicable.

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

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

16.11.3.15. The number of Member months.

16.11.4. All data provided by Contractor for the purpose of MLR calculation shall use actual costs.

16.11.4.1. Contractor shall allow for three months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five months.

16.11.4.2. Contractor shall submit the completed MLR calculation on the Department approved template and provide supporting data and documentation per 42 CFR 438.8(k), including, but not limited to, all Encounters, certified financial statements and reporting, and flat files, in compliance with the Department guidelines, for the measurement period by January 15. Contractor shall submit Encounter claims in compliance with requirements in Section 13.1.6.

16.11.4.2.1. DELIVERABLE: MLR calculation template and supporting data and documentation

16.11.4.2.2. DUE: Annually, by January 15th of each year

16.11.4.3. Contractor's Medical Spend will be calculated using audited supplemental data provided in Contractor's annual financial reporting and verified using Encounter Data submitted through flat file submission on a secure server, until such time that the Department deems it appropriate for such Encounter Data submissions to be sent through the Colorado interChange.

16.11.4.4. MLR Target: Contractor shall have an MLR of at least 85%. Contractor shall calculate an age-cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department.

16.11.4.5. The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

16.11.4.5.1. Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of

expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

16.11.4.5.2. Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

16.11.4.5.3. Contractor shall ensure that shared expenses, including expenses under the terms of a management contract, are apportioned pro rata to the contract incurring the expense.

16.11.4.5.4. Contractor shall ensure that expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, are borne solely by the reporting entity and are not apportioned to the other entities.

16.11.4.5.5. The numerator is the sum of Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's Fraud reduction activities. The numerator does not include the MLR remittance per 42 C.F.R. § 438.8(f)(2)(vi).

16.11.4.6. Contractor shall round the MLR to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.

16.11.4.6.1. Contractor shall aggregate data for all CHP+ eligibility groups covered under this Contract.

16.11.4.7. If Contractor's MLR does not meet or exceed the MLR Target, then Contractor shall reimburse the Department the difference using the following formula:

16.11.4.7.1. Reimbursement amount shall equal the difference between the adjusted earned revenue and the net qualified medical expenses divided by the MLR target.

16.11.4.7.2. Contractor shall reimburse the Department within 30 days of the Department finalizing the MLR validation. The Department will designate the MLR rebate and initiate the recovery of funds process by providing notice to Contractor of the amount due, pursuant to 10 CCR 2505-10 § 8.050.3 A-C Provider Appeals, as well as § 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

16.11.4.7.2.1. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

16.11.4.7.2.2. Contractor shall submit all encounters, audited financial statements and reporting, and flat files for the measurement period, before the Department can validate the MLR.

16.11.5. Subcontracted Claims Adjudication Activities

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

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

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

16.11.6.2. Submit a new MLR report meeting the applicable requirements.

16.11.6.2.1. DELIVERABLE: MLR Calculation Template

16.11.6.2.2. DUE: Annually on January 15

16.11.7. Adjusted MLR Target

16.11.7.1. Contractor shall collaborate with the Department to develop MLR Quality Targets, thresholds, processes, and identifying quality metrics for the purpose of measuring Contractor performance and overall Program improvement.

16.12. Rate Setting Financial Template

16.12.1. Contractor shall submit an Annual Certified Rate Setting Financial Template that provides a summary of Contractor's financial data for the rate setting cycle, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. The Department will provide the template to Contractor no less than 60 days in advance of the due date.

16.12.2. Contractor shall not modify the Annual Certified Rate Setting Financial Template and shall submit supporting data and documentation to provide clarity and detail. The Department may modify the template and will notify Contractor within five business days of the modification.

16.12.3. Contractor shall submit any requested supporting data and documentation to the Department and the designated outside vendor within 7 business days of the Department's request.

16.12.3.1. DELIVERABLE: Annual Certified Rate Setting Financial Template with supporting data and documentation

16.12.3.2. DUE: Annually, by November 15

16.13. Financial Stability

16.13.1. Contractor shall attest to financial soundness of Contactor's CHP+ program and delivery of services to members covered in the contract.

16.13.2. Contractor shall submit a Financial Stability Letter to the Department in a format agreed upon by Contractor and the Department. The letter shall ensure capitation payments set forth for the next fiscal year comply with all applicable federal and state requirements that govern the capitation payments.

16.13.2.1. DELIVERABLE: Financial Stability Letter

16.13.2.2. DUE: Annually, within 30 days of rates agreement

EXHIBIT J, HB 22-1289 IMPLEMENTATION

STATE FISCAL YEAR 2025-26

1. PROJECT REQUIREMENTS

1.1. Starting January 1, 2025, the Contractor shall expand Work to the following populations as covered Members, in compliance with C.R.S. 25.5-8-109(6)(a) and C.R.S. 25.5-8-109(7)(a):

1.1.1. Pregnant or postpartum individuals up to 12 months after the pregnancy ends who otherwise would not have been eligible for Medicaid due solely to the individual's immigration or citizenship status.

1.1.2. Children who are less than nineteen years of age who otherwise would not have been eligible for Medicaid due solely to the child's immigration or citizenship status.

1.2. Contractors shall align Work provided to these populations with Work provided to all other Members.

1.3. Contractor shall not discriminate against any Member based on immigration or citizenship status for the implementation of Work.

2. FUNDING REQUIREMENTS

2.1. Contractor shall ensure that project funds are tracked distinctly from other funds and are not mixed with any federal funding.

2.2. Contractor shall submit financial reporting specific to these populations to the Department in a format and frequency determined by the Department.

3. PRIVACY

3.1. Contractor shall use the minimum data necessary to protect the personal health information and enrollment status in the program for Members covered and engaged by Contractor with the Work under these categories.

4. DELIVERABLES

4.1. Contractor shall report on Members covered under these categories in an existing deliverable in a format and frequency determined by the Department.

5. PAYMENT

5.1. Due to uncertainty associated with coverage for the Cover All Coloradans (CAC) population, all applicable CAC cohorts for this time period shall be subject to a risk corridor calculation.

5.1.1. The risk corridor will be calculated prior to the Medical Loss Ratio, and any reconciliations under the risk corridor will be incorporated as an adjustment to revenue within the Medical Loss Ratio calculation.

5.2. Population Covered

5.2.1. The following population cohorts will be included in the CAC risk corridor.

Program	Cohort
CHP+	Prenatal/Delivery
CHP+	Postpartum
CHP+	Children 0-1

Program	Cohort
CHP+	Children 2-18

5.3. Calculation Process

5.3.1. The Department will calculate a CAC target PMPM as the medical portion of the actuarial sound PMPM for the contract period on a cohort basis.

5.3.2. CAC Adjusted Actual PMPM.

5.3.2.1. The Department, or its designee, will calculate an adjusted actual PMPM for the contract period to be used in the risk corridor for the CAC population on a cohort level basis.

5.3.2.2. The numerator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, using the submitted encounter data with three months runout and submitted financial information on a cohort level.

5.3.2.3. The denominator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, as the incurred member months for the contract period with three months runout as represented in the Department's system of record on a cohort level.

5.3.3. The Department, or its designee, will calculate the difference between the CAC Adjusted Actual PMPM and the CAC Target PMPM to determine any cost sharing reconciliation based on the calculation table listed below.

5.3.4. The actuarially determined CAC Target PMPM is equivalent to one hundred percent (100%) in the risk corridor structure.

5.3.5. Risk corridor calculations will be made according to the following:

Corridor #	Risk Corridor Minimum	Risk Corridor Maximum	MCE Share	State Share
A	0.00%	94.99%	0%	100%
B	95.00%	98.99%	50%	50%
C	99.00%	100.99%	100%	0%
D	101.00%	104.99%	50%	50%
E	105.00%	+	0%	100%

5.4. Recoupment or Additional Reimbursement

5.4.1. From the above table, a ratio of greater than 100% indicates a payment due from the Department to the Contractor. A ratio of less than 100% indicates a payment due from the Contractor to the Department.

5.4.2. After finalizing the risk corridor calculation, the Department will present the calculations to the Contractor and allow 7 business days for feedback.

5.4.3. The Department will issue a demand/notification letter for any amount due as recoupment from or payment to the Contractor.

5.4.4. Contractor shall reimburse the Department, where applicable, within sixty (60) days of the Department issuing the demand letter.

5.4.5. The Department shall reimburse the Contractor, where applicable, for risk corridor calculations within 60 days of the Department issuing the notification letter.

5.5. Rates for all providers

5.5.1. Effective 07/01/2025 – 06/30/2026.

Rate Cell	Rate Cell Description	SFY26 Payment Rate
CHP17	Pregnant/Prenatal	$734.64
CHP18	Postpartum	$256.41
CHP19	Children 00-01	$404.70
CHP20	Children 02-18	$209.05
Deliveries	Pregnant/Prenatal	$6,749.12