CONTRACT AMENDMENT #2

SIGNATURE COVER PAGE

State Agency Department of Health Care Policy & Financing	**Original Contract Number** C22-169631
Contractor Health Management Systems, Inc.	**Amendment Contract Number** C22-169631A2
Contract Maximum Amount Initial Term State Fiscal Year 2022 Contingency Based Extension Terms: State Fiscal Year 2023 Contingency Based State Fiscal Year 2024 Contingency Based State Fiscal Year 2025 Contingency Based State Fiscal Year 2026 Contingency Based Total for All State Fiscal Years Contingency Based	**Initial Contract Expiration Date** June 30, 2022 **Current Contract Expiration Date** June 30, 2026

Principal Representatives

For the State:

Stephanie Denning
Colorado Department of Health Care Policy & Financing
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Denver, CO 80203

Email: Stephanie.Denning@state.co.

For Contractor:

Cristhian Bermudez
Health Management Systems, Inc.
225 E. John Carpenter Fwy., Ste 500
Irving, TX 75062

Email: cristhian.bermudez@gainwelltechnologies.com

With a copy to the same address attention to:
ATTN: Office of the General Counsel

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
Health Management Systems, Inc.

Signed by:
By: Mark Knickrehm
4EE6BBD6856646D...
Date: 08/27/2025 | 08:30 MDT

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

DocuSigned by:
By: KBim
0B6A84797EA8493...
Date: 08/27/2025 | 08:51 MDT

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

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD

DocuSigned by:
By: Jerrod Cotosman
76F69541272B43A...
Amendment Effective Date: 08/27/2025 | 09:17 MDT

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 the 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 and shall terminate on the termination of the Contract.

4) PURPOSE

The Department entered into a contract for recovery audit services (C22-169631) effective July 1, 2021. Since the initial effective date, the State statute was amended by the Colorado General Assembly in H.B. 23-1295 and most recently § 25.5-4-301, C.R.S. was amended by S.B. 25-314. This Amendment brings the Statement of Work into compliance with these changes to State law governing recovery audit services.

5) MODIFICATIONS

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

a) Exhibit E, "Contractor's Administrative Requirements," is modified by adding new subsections 2.4.3.7.1, 2.4.3.7.2, 2.4.3.7.10, and 2.4.3.7.11 and renumbering accordingly. Amended Section 2.4.3.7 is replaced with the following:

2.4.3.7. Review Personnel

2.4.3.7.1. Contractor shall ensure that its personnel rendering clinical audit findings are appropriately licensed pursuant to industry standards and applicable law. Contractor shall also ensure that personnel rendering audit determinations regarding a provider's billing are trained in billing and coding guidelines and rules adopted by the Department.

2.4.3.7.2. To ensure Contractor's staff have the qualifications and experience to make audit findings, the Contractor shall maintain accreditation with the Utilization Review Accreditation Commission (URAC) in the appropriate accreditation or certification program. Contractor must immediately notify the Department of any changes to its URAC accreditation and must

provide evidence of its ongoing URAC accreditation upon request by the Department.

2.4.3.7.5. Contractor shall peer-match case reviewers to the kind of Provider being reviewed (i.e. doctors will review doctors; dentists will review dentists, etc.). At a minimum, Contractor shall have case reviewers of the following Provider types:

2.4.3.7.5.1. Nurses.

2.4.3.7.5.2. Dentists.

2.4.3.7.5.3. Dental hygienists.

2.4.3.7.5.4. Pharmacists.

2.4.3.7.5.5. Physicians.

2.4.3.7.5.6. Physical therapists.

2.4.3.7.6. Contractor shall peer-match case reviewers to the same or similar specialty or subspecialties as the case type being reviewed (i.e. urologists will review urologists; cardiologists will review cardiologists, etc.).

2.4.3.7.7. Case reviewers shall be familiar with Colorado laws and variations of community practice standards specific to city, rural, mountain and remote geographical regions of Colorado.

2.4.3.7.8. Contractor shall only use experienced and appropriately certified professional claims coding specialists to review Provider coding.

2.4.3.7.9. Contractor's physicians and case reviewers shall not review cases in any of the following circumstances:

2.4.3.7.9.1. Where the recipient is one for whom the reviewer has provided case or consultation services.

2.4.3.7.9.2. Where the facility or entity under review is one in which the reviewer has admitting privileges, current employment or any financial interest.

2.4.3.7.9.3 Where the Provider involved in the care under review has a relationship with the reviewer or any conflict of interest with the reviewer.

2.4.3.7.10. DELIVERABLE: Upon the Department's request, provide a report of Contractor's Personnel's qualifications in positions rendering clinically-related audit findings within ten (10) business days of the request.

2.4.3.7.11. DELIVERABLE: Upon the Department's request, evidence of current accreditation or certification with URAC within five (5) business days of the request.

b) Exhibit B, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit B-1, Statement of Work, attached hereto and incorporated by reference into the Contract. All references to Exhibit B in the Contract shall now be deemed to reference Exhibit B-1.

EXHIBIT B-1, STATEMENT OF WORK

1. PROJECT SPECIFIC STATEMENT OF WORK

1.1. SCOPE OF RECOVERY FOR MEDICAID CLAIMS AND CHP+ CLAIMS

1.1.1. The Contractor shall be prepared to suspend, in whole or in part, any Work as outlined in the Project Specific Statement of Work upon direction and notice of the Department. Requested changes shall require a process change management request, suspensions of work shall be communicated immediately in an email communication to the Contractor's Principal Representative and Contractor's contract manager and will be formally documented in a transmittal that shall contain, at the minimum, the following:

1.1.1.1. Contract citations relevant to the suspension.

1.1.1.2. A description of the rationale for the suspension.

1.1.1.3. Deliverables, remedies, conditions, and a timeline, if relevant, for the Department to lift the suspension.

1.1.1.4. Documentation of changes to the Work that may require the Contractor and the Department to update any deliverables. .

1.1.1.5 The Department's contract manager, Principal Representative, or designee, which designee will be communicated to Contractor in advance and in writing, shall sign and date transmittals following approval of the content of the transmittal and send them to the Contractor's Representative.

1.1.2. Contractor shall analyze and review Medicaid claims and CHP+ claims from all Provider types.

1.1.3. Contractor shall only review paid and adjudicated claims.

1.1.4. Contractor shall identify and recover overpayments , as directed by the Department, due to the following:

1.1.5.1. Incorrect billing.

1.1.5.2. Processing errors.

1.1.5.3. High risk areas related to fraud, waste, and abuse.

1.1.5.4. Self-disclosures.

1.1.5.5. Pre-payment reviews.

1.1.5.6. Targeted reviews.

1.1.5.7. Other program integrity analytics and functions, as approved by CMS as part of and compensable under the Recovery Audit contractor program.

1.1.6. The Contractor shall suggest the best methods of obtaining and using managed care data and

collaborate with the Department to determine the best methods. Contractor shall incorporate best methods of obtaining and using managed care data in Contractor's Audit Project Plan.

1.1.7. When managed care data (encounter or claims) becomes available, Contractor shall analyze and review claims for Medicaid and CHP+ managed care enrolled Members, from all Provider types, to identify improper payments.

1.1.8. Contractor shall identify, review and recover, if applicable, all of the following:

1.1.8.1. Erroneous Medicaid fee-for-service billings paid on behalf of newborns whose mothers were enrolled in a physical health managed care plan on the date of birth.

1.1.8.2. Any managed care covered benefit submitted to, and paid by, Medicaid on a fee-for-service basis notwithstanding the Member's enrollment in a managed care plan.

1.1.9. Contractor shall provide all suggestions and analysis in a form determined by the Department.

1.1.9.1. Formatting and expected outcomes shall be communicated in a transmittal. The transmittal shall include, at a minimum, the following:

1.1.9.1.1. Contract citations relevant to the project or ongoing Work

1.1.9.1.2. A timeline of the request, i.e. hours, days, weeks, or ongoing Work.

1.1.9.1.3. A description of the request.

1.1.9.1.4. Deliverables and expectations related to the work.

1.1.9.1.5. Documentation of changes that may require the Contractor and the Department to update any deliverables.

1.1.10. The Department's contract manager, Principal Representative, or designee, shall sign and date transmittals following approval of the content of the transmittal.

1.1.11. Contractor shall begin auditing services after they obtain the needed requirements and approval of the deliverables outlined in the start-up phase of the contract and have an approved audit review project plan, which is the multiple year project plan and timeline for all approved audit topics under section 1.13.

1.1.12. The approval process for new audit review projects and scenarios following the startup phase and during the pendency of the contract is described below in Section 1.13

1.2. SCOPE OF RECOVERY FOR HOSPITAL CLAIMS

1.2.1. Contractor shall analyze and review hospital claims utilizing DRG methodology and report the result of this analysis and review to the Department in a form acceptable to the Department and as defined in the deliverables contained within the audit project plan and the preparatory phase, under Section 1.13.

1.2.2. Contractor's analysis of paid inpatient and hospital medical claims shall include the specific requirements as outlined under section 1.13 for development and vetting of audit project scenarios for each specific audit topic.

1.2.2. Inpatient audits shall follow all state and federal requirements for hospital audits including:

1.2.2.1. Department's regulations governing hospitals under 10 CCR-2505-10, section 8.300 entitled "Hospital Services, Long Term Care Single Entry Point System."

1.2.2.2. Other Department rules contained in 10 CCR 2505-10, Volume 8.

1.2.2.3. Regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) and other informal guidance issued by CMS.

1.2.3. Contractor shall identify overpayments and improper payments due to any of the following:

1.2.3.1 Inappropriate setting.

1.2.3.2 Medically and non-medically necessary services.

1.2.3.3 Incorrect billing.

1.2.3.4 Processing errors.

1.2.3.5 High risk areas related to fraud, waste, or abuse.

1.2.3.6 Self-disclosures.

1.2.3.7 Pre-payment reviews.

1.2.3.8 Other program integrity analytics and functions, as approved by CMS as part of and compensable under the Recovery Audit contractor program.

1.3. IMPROPER PAYMENTS

1.3.1. Contractor shall identify improper payments, or areas of risk for improper payments for Medicaid claims from all Provider types, using the post payment claims review process. The parties may mutually agree to include audit projects identifying improper payments in connection with managed care and CHP+ claims.

1.3.2. Improper Payments may result from any of the following:

1.3.2.1. Fraud, waste, and abuse.

1.3.2.2. Erroneous payment amounts for any Covered Service as prescribed by 42 C.F.R. § 455.506.

1.3.2.3. Paid and denied claims.

1.3.2.4. Payments for any medically and non-medically necessary service.

1.3.2.5. Payment for an inappropriate setting (e.g., inpatient vs. observation/outpatient).

1.3.2.6. Payment for unnecessary outlier days.

1.3.2.7. Payments for any non-covered service.

1.3.2.8. Payments for any non-covered Member (e.g., illegal aliens).

1.3.2.9. Payments where the Member is dead.

1.3.2.10. Payments where the Provider is dead.

1.3.2.11. Payments where the Provider was not licensed (at the time) to provide the service.

1.3.2.12. Payments where the Provider and/or managing employees and/or Provider Subcontractors were excluded at the time of service.

1.3.2.13. Payments made for an otherwise covered Member, but temporarily ineligible (e.g., in jail, or in prison).

1.3.2.14. Incorrectly coded services.

1.3.2.15. Unbundled services.

1.3.2.16. Upcoded services.

1.3.2.17. Duplicate claims.

1.3.2.18. Improperly paid prescription drugs.

1.3.2.19. Documentation errors and missing physician orders that do not substantiate the services reflected on the claim.

1.3.2.20. Payments associated with claims made outside the timely filing period.

1.3.2.21. Managed Care payments that should not have been paid.

1.3.2.22. Managed care "birth bump payments" that should not have been paid.

1.3.2.23. Payments made on a fee-for-service basis that should have been covered by another State, County or State department, facility, entity, or different reimbursement structure.

1.3.2.24. Anything identified by the Department as a hospital DRG-related overpayment.

1.3.2.25. Anything identified by the Department as an overpayment.

1.3.2.26. Excluded improper payments.

1.3.3. Excluded Claims

1.3.3.1. Contractor shall use only the post payment claims review process to identify Improper Payments.

1.3.3.2. All of the following kinds of claims are excluded from this Contract:

1.3.3.2.1. Claims that have previously been audited, unless the scope of work is surrounding self-disclosures, pre-payment, fraud, or other applicable projects agreed upon by the parties in writing.

1.3.3.2.2. Claims under investigation for criminal or civil recovery actions unless the scope of work is surrounding self-disclosures, pre-payment, fraud, or other applicable projects agreed upon by the parties in writing.

1.3.3.2.3. For Complex Audits for Place of Service, claims that are contained on the inpatient only list published by CMS on the date of service regarding a level-of-care determination. As CPT codes are not required for inpatient claims, Contractor shall use its internal CPT to ICD-10 crosswalk to exclude inpatient claims from the place of service reviews.

1.3.3.2.4. Claims predicated on the Contractor's review to determine whether a provider's prior authorization received from the Department is valid

1.3.3.2.5. Claims currently subject to reviews or audits by other contractors or entities performing audits of Providers unless the scope of work is surrounding self-disclosures, pre-payment, fraud, or other applicable projects agreed upon by the parties.

1.3.3.2.6. Medicaid-paid claims where Medicaid should have been a secondary payer, and the other payer(s) were neither identified nor billed by the Provider.

1.3.3.2.7. Medicaid-paid claims for Members dually eligible for Medicaid and Medicare where Medicaid should have been the secondary payer.

1.3.3.2.8. Capitation payments and quality of care reviews unless the scope of work is surrounding self-disclosures, pre-payment, fraud, or other applicable projects agreed upon by the parties in writing.

1.4. LIMITATIONS ON THE SCOPE OF RECOVERY

1.4.1. The Department reserves the right to limit, control or exclude certain categories of recovery, certain Providers, recipients and/or medical services from Contractor's Work under this Contract to prevent duplication of recovery efforts, to protect fraud investigations or recoveries, or to honor federal requests to delay or cease recovery actions. Contractor shall pause, cease pursuit, or make changes, to a case or project when directed by the Department.

1.4.2. Contractor shall pause or cease pursuit of a case or project immediately upon the Department's direction. Contractor shall not receive any payment for any cases or projects terminated at the Department's direction. Notwithstanding the foregoing, any claims for which notice of adverse action letters were sent to Providers outlining overpayments are subject to recovery and shall be paid in accordance with the Contract to Contractor based on the actual amounts recovered, unless the Department determines that Contractor's findings are not correct and the overpayment amounts should not have been or be recovered from the respective Providers.

1.4.3. The Department reserves the right to prohibit the use of certain Contractor algorithms or criteria or to modify and limit the use of them as outlined in this Contract.

1.4.4. The Department shall immediately communicate any determination to pause or cease Work and will provide a properly signed transmittal to the Contractor. Any determinations by the Department regarding any suspension of audit activities shall apprise the Contractor of:

1.4.4.1. A description of the event or cause leading to the suspension

1.4.4.2. Deliverables, remedies and a timeline, if possible or relevant, to end the suspension

1.4.4.3. Documentation of changes that may require the Contractor and the Department to update any monthly, or annual deliverables

1.4.4.4. If the limitation is applicable to certain regions, claim types, Provider types or any other reason, the Department will notify the Contractor of the region affected, by claim type, by Provider type, or by other reason.

1.4.4.5. The Department will communicate any such determination to pause or cease Work through an executed transmittal.

1.4.5. The Contractor shall not review claims that are older than three (3) years from the date of the expiration of the timely filing period in accordance with Section 25.5-4-301(3.3)(h), C.R.S. The timely filing period is described in the Department's General Provider Information Manual.

1.4.6. Contractor shall not review claims that have already been audited or that are currently being audited by another entity in accordance with 42 C.F.R. § 455.508(g). Excluded claims may include, but are not limited to, reviews conducted by the following entities:

1.4.6.1. The Department's Fraud, Waste, & Abuse Division

1.4.6.2. Other Department staff.

1.4.6.3. Other Department contractors.

1.4.6.4. Other State departments.

1.4.6.5. CMS.

1.4.6.6. The Federal Medicaid Integrity Contractors (MIC).

1.4.6.7. The Office of the State Auditor (OSA).

1.4.6.8. The Federal Medicare-Medicaid data matching project (Medi-Medi).

1.4.6.9. Medicaid Fraud, Abuse and Neglect Unit (MFANU).

1.4.6.10. The Federal Payment Error Rate Measurement (PERM) project.

1.4.6.11. Unified Program Integrity Contractor (UPIC).

1.4.6.12. Other audits that have already been audited or that are currently being audited by another entity, as determined by the Department.

1.4.6.13. The United States Department of Health and Human Services, Office of the Inspector General (HHS-OIG).

1.4.7. The process for identifying claims subject to an exclusion from an audit review project or audit scenario shall be documented in the Contractor's policies and procedures manual.

1.5 PATTERN LETTERS, MANUAL LETTERS AND DEPARTMENT APPROVALS

1.5.1 Pattern Letters

1.5.1.1. Contractor shall draft Pattern Letters or templated letters, using Department provided content and submit the draft Pattern Letters to the Department for approval. Contractor shall use the Department-approved Pattern Letters only upon receiving the Department's formal, written approval via Transmittal signed by the Department's contract manager or Principal Representative. Contractor shall draft Pattern Letters including, but not limited to the following:

1.5.1.1.1. Audit Notification Letters.

1.5.1.1.2. Notice of Adverse Action Letters and Accompanying Case Summary.

1.5.1.1.3. No Audit Findings Letters.

1.5.1.1.4. Medical Records Request (MRR) Letters and Accompanying Attachment(s).

1.5.1.1.5. Additional Documentation Request Letter

1.5.1.1.6. Preliminary Finding Letter

1.5.1.1.7. Notice of Informal Reconsideration Letter

1.5.1.1.8. Informal Reconsideration Response Letters and Accompanying Case Summary.

1.5.1.1.9. Audit Reversal Letters and Accompanying Case Summary.

1.5.1.1.10. Unable to Render a Timely Decision Letter.

1.5.1.1.11. Audit Cancellation Letters and Accompanying Case Summary.

1.5.1.1.12. Other letters deemed necessary by the Department.

1.5.1.2. Contractor shall ensure that all Pattern Letters and accompanying attachments that it sends to Providers:

1.5.1.2.1. Are on the Department's letterhead.

1.5.1.2.2. Are signed by the Department.

1.5.1.2.3. Comply with all state and federal laws, rules and regulations as approved by the Department through the review and approval process.

1.5.1.2.4. Have received written, formal approval from the Department.

1.5.1.2.5. Are in a Department-approved format. At the Department's request, this format shall include information being available in electronic form that is text-searchable or in specified file types.

1.5.1.3. Contractor shall have a merge/macro letter generation system that generates the Pattern Letters.

1.5.1.4. Contractor's automated merge/macro letter generation system shall be nimble and flexible to accommodate Department requested edits, changes and deletions to existing Pattern Letters. Contractor shall use this system to generate Department-approved Pattern Letters within thirty (30) days of Department requested edits, changes and deletions to existing Pattern Letters for review.

1.5.1.5. Contractor shall include trackable unique identification numbers for all finalized letters.

1.5.1.6. Contractor shall maintain all Pattern Letters.

1.5.2. Manual Letters

1.5.2.1. Should a Pattern Letter not sufficiently cover a specific Provider scenario as determined by the Department, Contractor shall draft Manual Letters and submit the draft Manual Letters to the Department for approval by the contract manager or Principal Representative. Contractor shall use the Department-approved Manual Letters only upon receiving the Department's formal, written approval.

1.5.2.2. Manual letters shall include, but not be limited to:

1.5.2.2.1. Ad hoc letters.

1.5.2.2.2. General Correspondence.

1.5.2.2.3. Any other letters as determined by the Department.

1.5.2.2.4. Contractor shall include individual trackable unique identification numbers for all finalized letters.

1.5.3. Letter Revision Process

1.5.3.1. Contractor shall provide draft Pattern Letters and Manual Letters to the Department for review and approval within thirty (30) days of the Department's request for that letter.

1.5.3.1.1. DELIVERABLE: Pattern Letters and Manual Letters

1.5.3.1.2. DUE: Within thirty (30) days of the Department's request for that Letter.

1.5.3.2. Unless otherwise specified in writing by the Department, Contractor shall make all changes requested by the Department, modify and edit the Letters and submit a complete revised version of the Letters within thirty (30) days following receipt of the Department's directed changes.

1.5.3.3. The Department may request material changes to Letters at any time. Changes to previously approved pattern letters will be made on a go-forward basis and letters previously generated may be sent in the original approved format unless the change is necessary to remedy a statutory or regulatory error and sending out letters with that error would provide information that conflicts with law.

1.5.3.3.1. DELIVERABLE: Changes to Pattern Letters and Manual Letters

1.5.3.3.2. DUE: Unless otherwise specified in writing by the Department, within thirty (30) days following receipt of the Department's requested changes.

1.6 CORRESPONDENCE, REPORTS AND DATA

1.6.1. Contractor shall ensure that its Pattern Letters, Manual Letters, case summaries, attachments and other enclosures meet Department-approved format and content requirements. At the Department's direction, Contractor shall provide such documents in electronic form that is text searchable.

1.6.2. At the Department's request, Contractor shall deliver all correspondence, reports, data and any other information generated as a result of this Work. Contractor shall provide tracking numbers and proof that Provider correspondence was delivered for such correspondence that is delivered within two business days of the Department's request for such proof.

1.7 DATABASE OF PROVIDER CONTACTS, PROGRESS OF AUDIT AND STATUS OF CASE

1.7.1. Contractor shall create and maintain a database of Provider contact information to properly address all Provider correspondence to the individual(s) that the Providers themselves identify. The database of Provider contact information shall be provided to the Department within one business day of the Department's request.

1.7.2. Contractor shall develop and maintain a secure Provider web portal, allowing multiple-user access, to let Providers:

1.7.2.1. Obtain Contractor contact information.

1.7.2.2. View and download general RAC project related letters.

1.7.2.3. Customize their addresses.

1.7.2.4. Update their contact information at any time.

1.7.2.5. View the progress of their medical records audits, which shall include, but not be limited to:

1.7.2.5.1. Date of introductory letter mailed.

1.7.2.5.2. Date of MRR or documentation request letter mailed.

1.7.2.5.3. Date of receipt of medical records by Contractor (at the patient/Member detail level).

1.7.2.5.4. Date of notice of preliminary findings was mailed out.

1.7.2.5.5. Date of receipt of request for an exit conference or request for an Informal Reconsideration (at the claim detail level).

1.7.2.5.6. Date of notice of Informal Reconsideration was mailed out following an exit conference.

1.7.2.5.7. Date of Informal Consideration meeting.

1.7.2.5.8. Date of notice of adverse action following the Informal Consideration meeting.

1.7.2.5.9. Any other data elements as mutually agreed upon by the Contractor and the Department.

1.7.2.6. Access information about the status of a Medical Record Review Project. Contractor shall use Contractor existing status terminology.

1.7.2.7. View results of audits conducted by Contractor, including Provider-specific results and overall audit results.

1.7.2.8. Access training presentations and Provider outreach materials.

1.7.2.9. View any documentation, data or information as agreed upon by the Contractor and the Department.

1.7.3. Any Contractor-generated Provider web portal access agreements or confidentiality agreements will be subject to Department review and approval prior to implementation.

1.7.4. DELIVERABLE: Provider web portal

1.7.5. DUE: Within thirty (30) days of the Effective Date of the Contract.

1.8 MAINTAIN REVIEW PROJECT CASE FILES

1.8.1. Contractor shall maintain a case file for each Review Project. Case files include any and all documents and information created by Contractor whether the information is in draft or final form. Documents include any document created in performing an audit and include, but are not limited to, reports, hand-written notes, auditor’s notes, and electronic media.

1.8.2. Each case file shall contain, at a minimum:

1.8.2.1. A copy of all correspondence sent to the Provider, Provider representatives, Provider groups and associations, and any other entities in regard to the claims under review.

1.8.2.2. A description, including dates, times and Contractor personnel involved, of all contacts with

Providers, Provider representatives, Provider groups and associations, and any other entities communicating with Contractor about the claims under review.

1.8.2.3. A copy of all medical records, documents and correspondence received from the Provider, Provider representatives, Provider groups and associations, and any other entities related to the claims under review.

1.8.2.4. Notes, write-ups, opinions and all other materials generated by Contractor in each case.

1.8.3. Contractor shall provide a case file to the Department within five (5) Business Days of the Department's request.

1.8.4. At the Department's request or no later than fifteen (15) days after Contract termination, Contractor shall provide the Department scanned or PDF versions of all case files. Contractor shall in all instances have fifteen (15) days to provide the case files.

1.9. SPREADSHEET BASED ON RECOVERY PAYMENT DATA

1.9.1. Contractor shall maintain a balance tracking report in Microsoft Excel with individual tabs for each Scenario to track all recovery payments received from a Provider against each single Notice of Adverse Action letter. The report shall be grouped by Review Project.

1.9.2. The tracking report shall be in a format acceptable by the Department, shall contain information at the case and Internal Control Number (ICN) line or detail level and shall include:

1.9.2.1. Name of the Provider.

1.9.2.2. Provider ID number.

1.9.2.3. Recipient name.

1.9.2.4. Recipient ID.

1.9.2.5. Case ID.

1.9.2.6. Project name.

1.9.2.7. Total of the amounts owed by the Provider by claim number (ICN).

1.9.2.8. Original amount paid.

1.9.2.9. Demand amount on the ICN line level.

1.9.2.10. Date of demand.

1.9.2.11. Aggregate demand amount for all ICNs with that Provider for that audit.

1.9.2.12. Payments, offsets, or rebilling applied to the total owed.

1.9.2.13. Outstanding balances owed by the Provider.

1.9.2.14. Total contingency fee.

1.9.2.15. Member/ICN sub-detail which shall contain:

1.9.2.15.1. Name(s) of the Medicaid Member(s)

1.9.2.15.2. Procedure code(s) and modifier(s), or DRG and descriptions (if applicable).

1.9.2.15.3. Header (HDR) adjustment ICN.

1.9.2.19.4. Line item number.

1.9.2.19.7. Unique identification numbers associated with the recovery (adjusted and/or voided ICN numbers, etc.).

1.9.2.19.8. Specification if the amount is a partial, or full satisfaction of the total amount owed.

1.9.3. Contractor shall submit a copy of the applicable Provider balance tracking report discussed in Section 1.9.1 when a Contractor's invoice is submitted to the Department. If adjustments are made to the Provider's overpayment amount, including but not limited to changes in determination through an Exit Conference, Informal Reconsideration, Formal Appeal, or litigation, Contractor shall revise the Provider balance tracking report and provide a copy to the Department. Contractor shall maintain a summary report reconciling the total contingency fees invoiced by Contractor against the Contract .

1.9.4. The Department may change the format and content of the tracking report at any time. Within thirty (30) days, Contractor shall make changes to the format and content of the spreadsheet as directed by the Department.

1.10 DOCUMENT EXCHANGE AND STORAGE

1.10.1. Contractor shall store and share imaged medical records and all documents that Contractor creates or receives within the scope of Work performed under this Contract. Documents include any document created in performing an audit and include, but are not limited to, reports, hand-written notes, auditor's notes, and electronic media. Contractor shall provide an image document management system to track electronic documents and electronic images of scanned paper approved by the Department.

1.10.2. Contractor shall provide the Department, at Contractor's own expense, a method to securely transmit Protected Health Information (PHI) between Contractor and the Department.

1.10.3. Contractor shall provide for the secure transfer of documents from Providers to Contractor, from Contractor to the Department and from Department to Contractor via a File Transfer Protocol (FTP) site, a web-based file storage site or an equivalent form of electronic data transfer. Contractor shall organize the stored medical records and documents by Review Project and Provider. Contractor shall store each Provider's information as a group/collection for ease of retrieval.

1.10.4. Contractor shall ensure that all electronic mail communications that contain PHI are either sent securely, encrypted or both. PHI on removable media shall be encrypted.

1.10.5. Contractor's electronic file sizes shall not exceed five (5) megabytes to facilitate email redistribution by the Department. Partitioning of records, information and data into multiple files is permissible under a format approved by the Department.

1.10.6. Contractor's electronic files shall be appropriately named so that persons unfamiliar with the projects can identify the file's content without needing to open them.

1.10.7. Contractor shall deliver, or make available for download, word-searchable electronic portable document format (PDF) files of Contractor's correspondence to Providers (MRR letters, notice of

adverse action letters, informal reconsideration letters, etc.) within five (5) Business Days of mailing. The Department, at its sole discretion, may allow other formats.

1.10.8. Contractor shall deliver, or make available for download, a copy of all Provider correspondence to Contractor, in word-searchable PDF files to the Department within two (2) Business Days of receipt. The Department, at its sole discretion, may allow other formats.

1.10.9. Contractor shall deliver to the Department, or make available for download by the Department, all case files, medical records and other correspondence within five (5) Business Days of the Department's request.

1.10.10. Contractor shall maintain a log of all requests for medical records and rationale documents indicating at least the requester, a description of the record being requested, the date the request was received and the date the request was fulfilled.

1.11 OBTAINING CLAIMS DATA

1.11.1. Contractor shall have and maintain all hardware, software and interfaces necessary to access the interChange claims data without requiring any modification to the Department's systems. Contractor shall follow all Department policies, processes and procedures necessary to gain access to the Department's systems.

1.11.2. The Department shall assist Contractor with obtaining Virtual Private Network (VPN) and/or FTP access to the interChange claims data. Contractor shall be responsible for any costs for the initial set up.

1.11.3. Any costs associated with data extraction, with expansion or alteration of the data files or their contents and with data transmission shall be the sole responsibility of the Contractor.

1.12 CUSTOMER SERVICE STANDARDS

1.12.1. Contractor shall establish and maintain a Provider call center, a toll-free telephone number, email address and fax line for communication with Providers. Contractor shall be available to Providers to discuss the claim audit review processes, results, and practice modifications via the toll-free number.

1.12.2. Contractor shall respond to Provider questions and requests submitted through the Contractor Provider Services call center for information expeditiously, within two business days maximum, with a high degree of professional courtesy. Contractor shall perform periodic informal conferences via telephone or in person with Providers to discuss the RAC program, process, and findings as required. The Department reserves the right to approve and attend such conferences.

1.12.3. Contractor shall keep a log of all Provider comments and feedback regarding the entire review process. At the Department's request and with Department approval, Contractor shall amend its review process to address Provider concerns while maintaining regulatory compliance.

1.12.4. Contractor shall document and log all calls and emails with Providers regarding Review Projects. The documentation shall include, but is not limited to, all of the following:

1.12.4.1. The Provider's topics.

1.12.4.2. Questions and issues.

1.12.4.3. Requests for information and requests for documentation.

1.12.4.4. What the Contractor told the Provider.

1.12.4.5. The date and time the Provider's call or email was received.

1.12.4.6. The date and time the call or email was returned by the Contractor. Contractor shall document a call and e-mail as returned only when either:

1.12.4.6.1. Contractor has made direct contact with the Provider representative who made the initial contact. Direct contact occurs when the Provider speaks to Contractor on the telephone or when the Provider responds via e-mail, e-mail delivery receipt, e-mail read receipt or via another method.

1.12.4.6.2. Contractor has made three (3) documented attempts to contact the Provider with no response from the Provider. Contractor shall make these attempts at no greater than four (4) hour intervals. These documented attempts include voicemails and e-mails.

1.12.4.7. The date and time a Provider's request for information or documentation was returned by the Contractor. Contractor shall document a request for information and a request for documentation as returned only when Contractor has sent the Provider the requested information and/or documentation via e-mail or mail. The time stamp on the e-mail and the post mark on the mail shall be considered the date and time of Contractor's return of the requested information and/or documentation.

1.12.4.8. The Provider's Medicaid ID.

1.12.4.9. The name of the person communicated with.

1.12.4.10. The email address or phone number of the Provider.

1.12.4.11. The name of Contractor's staff person who took the call or answered the email.

1.12.4.12. Other documentation deemed necessary by the Department.

1.12.5. Contractor shall provide the document and log of the communications to the Department within 10 calendar days of the Department's request or within the timeframe as outlined in Section 1.19.7 if there is a formal appeal.

1.13. PREPARATORY PHASE — IDENTIFY AND DEVELOP AUDIT SCENARIOS

1.13.1. Identifying Audit Scenarios or Review Projects

1.13.1.1. Contractor shall perform an analysis of Department's claims data to identify the Provider(s) or Provider types, services or claims types that should be subject to analysis. The Department will provide claims data and Provider data to Contractor.

1.13.1.2. Contractor shall deliver to the Department a list of potential or proposed Review Projects, based upon Contractor's data mining, analysis and expertise. The Department may identify recovery strategies and Secondary Audit/Review Projects, with or without input from the Contractor. Contractor shall include Department-identified recovery strategies and Department-Directed Secondary Audit/Review Projects on the list of potential or proposed Review Projects.

1.13.1.3. Potential audit scenarios shall be submitted to the Department for an initial review to determine whether the Department desires the Contractor to develop the audit scenario.

1.13.1.4. If the Department approves of the potential audit scenario upon the initial review, Contractor shall develop the audit scenario in greater depth by pre-validating the audit scenario by testing all criteria and algorithms' effectiveness against real data.

1.13.1.5. For each Review Project on the list, Contractor shall describe at a minimum, all of the following during this in-depth :

1.13.1.5.1. Applicable State or federal law whether statutory or regulatory in nature, the citations and text of the applicable authority.

1.13.1.5.2. Applicable Department billing guidance: rules, standards, provider-specific billing rules, billing manuals, provider bulletins, and program guidance.

1.13.1.5.3. Coding references and guidelines with citation and full text.

1.13.1.5.4. Codes and/or DRG weights to be audited.

1.13.1.5.5. Provider type to be audited.

1.13.1.5.6. Vulnerability issues to be investigated (e.g., office visit upcoding, unbundling, etc.).

1.13.1.5.7. Type of review (Automated Review or Complex Review).

1.13.1.5.8. Rationale or case for doing the Review Project.

1.13.1.5.9. Confirmation that Contractor tested its criteria and algorithm effectiveness against real data to pre-validate the recovery strategy and Review Project.

1.13.1.5.10. Provider communication and education dates and methods

1.13.1.5.11. Estimated potential recovery, if available.

1.13.1.5.12. Estimated time, including date ranges, to conduct and complete the review.

1.13.1.6. Review projects and audit scenarios during this in-depth validation shall be presented to the Department to approve and determine whether the review project or audit scenario should be subject to a pilot with selected providers. The Department and the Contractor shall work collaboratively to identify selected providers for the purpose of testing the newly created audit scenario, but the Department shall ultimately make the final determination.

1.13.1.7. The Contractor shall present the provider feedback derived from the pilot with selected providers. Based upon the pilot, the Contractor will recommend any changes to the review project or audit scenario

1.13.1.8. Contractor and the Department will mutually agree on which projects to finalize and the priority of such Review Projects. The Department must approve of a review project before Contractor implements and conducts a review project. The final approval will occur following incorporation of any feedback from the provider pilot.

1.13.2. Audit Project Plan

1.13.2.1. Contractor shall prepare a master Audit Project Plan, using Microsoft Project or other similar software, which outlines the resources and time frames for completing the agreed upon Work during the term of the Contract. The Audit Project Plan shall be a flexible document that shall be modified, upon receiving Department approval, when new overpayment opportunities are

identified.

1.13.2.2. Contractor shall include all of the following in the Audit Project Plan:

1.13.2.2.1. An inventory of all audit scenarios or review projects including reference to the stage of the Department's approval.

1.13.2.2.2. Each Provider and the audit look-back period for each Review Project.

1.13.2.2.3. The associations, Provider groups, and managed care contractors who shall receive presentations on the nature of the Review Projects before they begin, and the date and method to deliver the presentations.

1.13.2.2.4. A minimum level of Work which Contractor shall perform during the Full Performance Period of the Contract. A method by which Contractor shall maintain and ensure the minimum level of Work is completed.

1.13.2.2.5. Milestone dates in the audit process including:

1.13.2.2.6. The target dates to send medical record request letters.

1.13.2.2.7. The expected date to complete evaluation of the medical records following receipt from the Provider.

1.13.2.2.8. The expected date to issue notice of adverse action letters.

1.13.2.2.9. For newly approved audit scenarios the Audit Project Plan shall document whether the Department's review has occurred of the scenario within eighteen months of the audit scenarios rollout. This review shall assess the validity of the audit project in coordination with providers and the provider advisory group established pursuant to Section 25.5-4-301(3.5), C.R.S.

1.13.2.3. The Audit Project Plan shall ensure that no Provider is subject to more than four (4) automated audit scenarios per calendar year and no more than three (3) complex audits scenarios per year. Exceptions to these limitations will be communicated to the Contractor in writing by the Department if appropriate.

1.13.2.4. The Audit Project Plan shall note the maximum size of complex audits, which are based on the size of the hospital and the limits on the number of medical record requests per month that may be made to a particular hospital. A hospital's size is defined by total Medicaid reimbursement in the previous fiscal year for that hospital NPI number. Hospitals are grouped in eight tiers and the number of medical records for each tier are defined in Section 25.5-4-301(3.3)(i)(II)(A) to (H), C.R.S.

1.13.2.5. The Audit Project Plan shall reflect the limits for automated scenarios on the maximum number of provider claims across all of a provider's locations in a calendar year. The percentage of a provider's claims that may be subject to an automated scenario is divided into four tiers which are defined in Section 25.5-4-301(3.3)(j)(II)(A) to (D), C.R.S.

1.13.2.6. In the Audit Project Plan, Contractor shall group review activities into the following seven (7) phases:

1.13.2.6.1. Audit Scenario Development.

1.13.2.6.2. Provider Outreach and Education.

1.13.2.6.3. Claims Investigation, Review, and Preliminary Findings.

1.13.2.6.4. Exit Conference.

1.13.2.6.5. Informal Reconsideration.

1.13.2.6.6. Formal Appeal.

1.13.2.6.7 Litigation.

1.13.2.7. Contractor shall adhere to the limits for the amounts of claims and medical records that can be audited for each review as directed by Colorado statute and by the Department.

1.13.2.8. The Audit Project Plan shall be a flexible document. Contractor shall contact the Department to suggest updates to the Audit Project Plan when new overpayment opportunities are identified, as adjudication issues arise, new regulations are implemented, new algorithms are developed and refined, and Provider billing practices change.

1.13.2.8.1. The Department may identify Secondary Reviews and Audits and direct Contractor to conduct the Secondary Reviews and Audits. Contractor shall modify its Audit Project Plan to include reviews and audits identified by the Department. The Department-directed Secondary Reviews and Audits may include, but are not limited to the following:

1.13.2.8.2. Utilization management reviews and audits.

1.13.2.8.3. Focused review of specific Providers, Departments, services, rules or periods of time.

1.13.2.8.4. Dental claims reviews and audits.

1.13.2.8.5. Other reviews as directed by the Department.

1.13.2.9. Contractor shall modify the Audit Project Plan when the audit project or scenario changes, or upon the Department's request. Contractor shall submit all modifications to the Department for approval prior to implementing the modified Audit Project Plan.

1.13.2.10. Once the Department has notified Contractor of its acceptance of the Audit Project Plan or of an updated Audit Project Plan, Contractor shall implement all requirements of that plan and perform all audits according to the Audit Project Plan. Contractor shall not implement the final Audit Project Plan and shall not perform Work on any projects until the Department accepts Contractor's Audit Project Plan or modification of the Audit Project Plan.

1.13.2.10.1. All requirements, due dates, and milestones contained in the most recently approved Audit Project Plan or updated Audit Project Plan shall be considered to be requirements, due dates, and milestones of this Contract.

1.13.2.10.2. Contractor shall follow all plans, standards, processes and procedures of the most recently approved Audit Project Plan.

1.13.2.10.3. DELIVERABLE: Audit Project Plan.

1.13.2.10.4. DUE: Within two (2) weeks of finalizing and prioritizing the Audit Scenarios and Review Projects.

1.13.2.10.5. DELIVERABLE: Updates and Changes to Audit Project Plan.

1.13.2.10.6. DUE: Within two (2) weeks of the Department requesting the changes or when the Review Project or Audit Scenario changes.

1.13.3. In collaboration with each other, Contractor and the Department shall prioritize the Review Projects into a multi-year work plan. The work plan shall be modified and updated periodically, as required by the Department.

1.13.4. Contractor shall identify an audit date range for each Review Project. All targeted claims within the date range shall be audited at once. Contractor shall not re-audit the same date range for the same kind of overpayment issue, absent fraud or deliberate interference with the audit by the Provider.

1.14 PROVIDER OUTREACH PHASE

For approved audit review projects or audit scenarios, Contractor shall perform Provider outreach in order to inform specific Providers, either collectively or through a Provider organization or association, about the review process and the rights and responsibilities of all parties in advance of initiating medical record request or document request letters. Contractor shall work collaboratively with the Department to identify Providers requiring outreach prior to upcoming reviews.

1.14.1. Contractor shall perform provider outreach prior to selected audits, as determined by the Department. Contractor shall perform additional outreach as determined by Provider request and interest, and as requested by the Department.

1.14.2. In Complex Review cases, Contractor shall complete Provider-type specific outreach, to the Department's satisfaction, at least thirty (30) calendar days prior to issuing any medical record request letter to the Provider. For Automated Review, the Department will advise Contractor whether outreach is needed and if so, the preferred method and timing of that outreach. Contractor shall perform outreach as directed by the Department for Automated Review cases.

1.14.3. After an initial presentation to a Provider community, at the Department's request, Contractor shall do supplemental Provider outreach in order to describe changes to the review program or, after a long period of time with no activity, in order to refresh Provider recollections of the RAC program.

1.14.4. Contractor shall conduct Provider outreach in person, by webinar and by phone. Contractor's Project Manager, at a minimum, shall attend the outreach meeting. The Department will determine which party—the Department or Contractor— presents the information and the manner in which it is presented. At the Department's request and direction, Contractor shall present the information and shall do so in the manner (person, webinar, or phone) directed by the Department.

1.14.5. Contractor shall prepare all written materials and presentation materials, which will be subject to Department review and prior approval. The Department reserves the right to specify what will and will not be shared at the outreach presentations.

1.14.6. Contractor shall arrange the times, places and means of presentation, in consultation with the Department and the affected Providers, Provider groups or associations.

1.14.7. Contractor shall not speak for, nor represent that it speaks for, the Department, or Department policy.

1.14.8. Provider Outreach Plan

1.14.8.1. Contractor shall develop a Provider Outreach Plan.

1.14.8.1.1. The Provider Outreach Plan, shall contain, at a minimum, all of the following:

1.14.8.1.1.1. The method(s) for notification to Providers regarding:

1.14.8.1.1.1.1. Audit policies and procedures.

1.14.8.1.1.1.2. Right to request extensions.

1.14.8.1.1.1.3. Exit interviews and informal reconsiderations.

1.14.8.1.1.2. Formal appeals process, and the requirement to seek the informal reconsideration to resolve disputes prior to seeking a formal appeal.

1.14.8.1.1.3. Audit processes and correct billing methods, protocols, and policies.

1.14.8.1.1.4. Changes in billing and/or coding.

1.14.8.1.1.5. Who to call for an extension of time.

1.14.8.1.1.6. How to access the Provider Web portal.

1.14.8.1.1.7. How to customize addresses and contact information for all correspondence, including medical record request letters, notice of adverse action letters and informal reconsiderations.

1.14.8.1.1.8. How to obtain information on:

1.14.8.1.1.9. The progress of an audit.

1.14.8.1.1.10. The status of a case.

1.14.8.1.1.11. Submitting records electronically.

1.14.8.1.1.12. Any other information as requested by the Department.

1.14.8.1.1.13. The method(s) Contractor will utilize to communicate relevant information to Providers. These methods may include:

1.14.8.1.1.14. Direct mailings.

1.14.8.1.1.15. Pamphlets/brochures.

1.14.8.1.1.16. Website.

1.14.8.1.1.17. Webinars.

1.14.8.1.1.18. In-person presentations.

1.14.8.1.1.19. Telephone conferences.

1.14.8.1.1.20. Contractor shall deliver the Provider Outreach Plan to the Department for review and approval.

1.14.8.1.2 Contractor shall not initiate Provider outreach without Department approval as to content, form and forum.

1.14.8.1.3 Contractor shall prepare all written education materials and presentation materials and provide the materials to the Department for approval. Contractor shall not engage in education program activities, nor distribute written education materials, without the express prior approval of the Department.

1.15 INVESTIGATORY PHASE

1.15.1. Claim Identification

1.15.1.1. In identifying cases for medical review, Contractor shall use generally accepted auditing, accounting, analytical, statistical or peer-review methods, or combinations thereof. Contractor shall give preference to targeted review methods that identify claims most likely to contain overpayments, rather than random review methods or focusing upon high dollar claims. Contractor shall provide all methods that Contractor uses for identifying cases to the Department within one business day of the Department's request. If Contractor's methods are proprietary, Contractor shall provide an explanation of why it cannot provide the detailed-methods and a general synopsis of Contractor's methods.

1.15.1.1.1. Contractor shall identify the most recent ICN for each claim including adjustments made.

1.15.1.1.2. Contractor shall implement its own process in determining the most recent ICN to examine.

1.15.1.2. Contractor's claim identification shall be based upon the professional coding manuals, Department's benefit plans, rules, regulations, reimbursement policies, contracts, billing instructions, and claims processing edits in effect on the dates of service. Contractor shall provide all documentation and methods used for claim identification to the Department within one (1) Business Day of the Department's request.

1.15.1.3. Contractor shall identify all claims for the entire period under review or audit at the same time.

1.15.1.4. Contractor shall temporarily suspend any review activities and actions, and seek direction from the Department, if the claim identification results seem to indicate that fraud, waste or abuse is involved, or when requested to suspend review activities by the Department.

1.15.2. Evidence

1.15.2.1. Contractor shall only identify claim overpayments where there is demonstrable evidence of the overpayment. Contractor shall use the following means of overpayment identification:

1.15.2.2. Through "Automated Review" of claims data without human review of medical and other records.

1.15.2.3. Through "Complex Review" which entails human review of a medical record or other documentation and an evaluation of Medical Necessity, as defined in 10 CCR 2505-10, section 8.076.1.8; and medical or other records.

1.15.2.4. Whenever feasible and practical, Contractor shall base a determination of an overpayment on a Complex Review.

1.15.2.5. A physician's record or other order for health care services, drugs, or medicinal supplies in a form transmitted electronically shall be sufficient to validate the Provider's records regarding

the ordering of the health care services, drugs, or medicinal supplies.

1.15.2.6. Contractor shall follow all relevant Department procedures and policies, state and federal regulations, and coding conventions and guidelines.

1.15.3. Automated Review

1.15.3.1. Contractor may use Automated Review when *all* of the following conditions apply:

1.15.3.2. There is reasonable certainty that the service is not covered or is incorrectly coded.

1.15.3.2.1 A written Colorado Medicaid policy, Colorado Medicaid article or Colorado Medicaid-sanctioned coding guideline exists.

1.15.3.2.2 Contractor may use Automated Review when making other determinations (e.g., duplicate claims, pricing mistakes) when there is reasonable certainty that an improper payment exists. Written policies/articles/guidelines often do not exist for these situations.

1.15.3.2.2 With Department approval, Contractor may use Automated Review when Contractor identifies a "clinically unbelievable" situation (i.e., the total of all timed Current Procedural Terminology (CPT) codes in a day exceeds the number of hours in a day).

1.15.3.3. Upon request of the Department, Contractor will recalculate or reprice claims when Contractor determines that it is feasible.

1.15.4. Complex Review

1.15.5. Contractor shall use a Complex Review in the following situations:

1.15.5.1 Where the requirements for Automated Review are not met.

1.15.5.2 Where Contractor is unsure whether the requirements for Automated Review are met.

1.15.5.3 When directed to do so by the Department. If this occurs, Contractor and the Department will validate the viability of performing a Complex Review.

1.15.5.4 Where there is a probability (but not certainty) that the service is not covered.

1.15.5.5 Where no Colorado Medicaid policy, Colorado Medicaid article, or Colorado Medicaid-sanctioned coding guideline exists.

1.15.5.6 When Medical Necessity has been determined in audit criteria by Contractor or the Department

1.15.5.7 When possible and feasible, Contractor will recalculate or reprice claims when directed by the Department.

1.15.6. ICN vetting for Excluded Claims

1.15.6.1. In order to minimize the impact on the Provider Community, Contractor shall avoid situations where Contractor and another entity are working on the same claim or where fraud investigations or law enforcement actions are being contemplated or are underway.

1.15.6.2. Before making any request for medical records on a claim, Contractor shall determine if an exclusion exists for that claim. If an exclusion exists for that claim, Contractor shall not review that claim.

1.15.6.3. The Department maintains a ICN Data Warehouse, which includes a master table of excluded Providers and claims. This table is updated on an as needed basis.

1.15.6.4. To determine exclusion, Contractor shall supply to the Department, in MS Excel, a list of all TCNs that Contractor intends to use to support MRR letters in a Complex Review case or to support notice of adverse action letters in Automated Review cases. The Department will inform Contractor if any ICN is an excluded claim as determined in accordance with Section 1.4 herein ("Excluded Claim"). The Department will add these ICNs to the ICN Data Warehouse.

1.15.6.5. Contractor shall not issue MRR or notice of adverse action letter for any claim that has not first been evaluated for exclusion.

1.15.6.6. If another entity enters one of Contractor's proposed ICNs after Contractor begins review, but before the claim is locked in the MMIS by Contractor, the Department will determine, in cooperation with the other entity and Contractor, which entity may review the claim.

1.15.6.7. Contractor shall not review Excluded Claims.

1.15.7. Medical Record Requests ("MRRs")

1.15.7.1. In Complex Review cases, Contractor, in accordance with Section 25.5-4-301(3)(a)(IV), C.R.S. shall request a Provider's records by delivering to the Provider, either directly or through a trade group, a written request for records, not less than ten (10) Business Days prior to the commencement of the review. At the Provider's request, Contractor shall also deliver a copy of the request to a second specifically identified individual.

1.15.7.2. Prior to any notice being sent to a Provider, or prior to the start of an audit, Contractor shall confirm Provider contact information by reaching out to the Provider.

1.15.7.3. If no contact can be found, Contractor shall determine whether the Provider is still in business or has ceased doing business; if a Provider has ceased doing business, Contractor shall cease pursuit of the medical record and no audit will occur.

1.15.7.4. Contractor shall address MRRs to a specific, named individual at a confirmed address.

1.15.7.5. Contractor shall deliver MRRs by methods which return to Contractor signed evidence of actual receipt, or documentary equivalent, by the Provider.

1.15.7.6. Contractor shall request the Provider records through the MMR-approved Pattern Letter with the Department's signature.

1.15.7.7. Contractor shall not issue an MRR letter that deviates from the approved Pattern Letter without the Department's prior approval.

1.15.7.8. Contractor's MRR content shall comply with requirements set forth in 10 CCR 2505-10, Section 8.076.2. In each request, Contractor shall describe the requested medical records and/or medical documentation in detail and offer the Provider the option of delivering, via secure transmission, a reproduction of the medical records and/or medical documentation or the option of inspection/duplication by Contractor's reviewer at the Provider's site.

1.15.7.9. If the Provider chooses to provide a reproduction of the medical records and/or medical documentation requested by Contractor instead of on-site inspection, Contractor shall give the Provider a reasonable period of time, that will be not less than forty-five (45) calendar days, to

provide such records taking into account the scope of the request, the time frame covered, and the reproduction arrangements available to the Provider.

1.15.7.9.1. Contractor shall ensure that MRR letters contain:

1.15.7.9.2. The timeframe that sets forth the due dates for medical records and or/medical documentation submission by the Provider.

1.15.7.9.3. Permissible extensions of dates.

1.15.7.9.4. Timelines to request an exit conference and informal reconsideration.

1.15.7.9.5. Deadlines for the Provider to request a formal appeal following participation in an informal reconsideration.

1.15.7.9.6. Contact information the Provider may use for questions.

1.15.7.9.7. Information about the mechanism the Provider can use to update the Provider's contact information.

1.15.7.9.8. Any other information as agreed upon by Contractor and the Department.

1.15.7.10. Contractor shall limit the medical records subject to the request to such records directly related to claims under review by Contractor for Improper Payment determination and reimbursement by the Provider. Requests shall not duplicate information already submitted by the provider.

1.15.7.11. Contractor shall accept imaged or electronic medical records from Providers, claim clearinghouses and medical record clearinghouses. Contractor shall ensure that Providers and clearinghouses first successfully complete a connectivity and readability test with Contractor before being invited to submit imaged or electronic records to Contractor.

1.15.7.12. Contractor may allow extensions of time for the Provider to deliver the documents in phases. Contractor shall confirm any such extensions in writing.

1.15.7.13. Contractor may (but is not required to) pay for medical records requested. Contractor shall submit any pricing formula to the Department for review. Contractor shall not agree to pay the Provider without prior Department approval.

1.15.7.14. In the event the records are available from a County Department of Social Services or another agency, subdivision, or contractor of the State, Contractor shall request such records from such other agencies as may be appropriate, with the approval and guidance of the Department, prior to making a request to the Provider.

1.15.7.15. When requesting medical records, Contractor shall ensure the number of medical records in the request shall not negatively impact the Provider's ability to provide care.

1.15.7.16. Contractor shall provide signed copies of each MRR letter to the Department via the HMS Portal within one business day of the letters being sent to the Provider.

1.15.8. On-site Inspection of Medical Records

1.15.8.1. Contractor shall not conduct unannounced, on-site inspections of any Provider locations. Prior to an on-site inspection, Contractor shall contact the Provider to set up an on-site inspection at a reasonable time during the Provider's regular business hours.

1.15.8.2. If the Provider chooses on-site inspection for the delivery of records rather than to provide a reproduction of the records, Contractor shall conduct on-site inspections at reasonable times during the Provider's regular business hours.

1.15.8.3. Contractor shall make arrangements necessary for the reproduction of such records on site.

1.15.8.4. Contractor shall obtain Department approval prior to arranging an on-site Provider review.

1.15.8.5. Contractor may copy all medical records on-site and evaluate them for overpayment later off-site.

1.15.8.6. Contractor may, but is not required to, assess the likelihood of an overpayment at the time of the on-site inspection. If Contractor elects to inspect the medical records on-site, and if the on-site inspection appears likely to result in an Improper Payment finding, Contractor shall copy the relevant portions of the medical record and retain them for future use. If the on-site inspection of a medical record results in no finding of Improper Payment, Contractor shall retain a copy of the medical record.

1.16. REVIEW PHASE

1.16.1. Timeliness of Medical Record Review

1.16.1.1. Contractor shall complete its review of medical records within the agreed-upon timeline. This timeline is subject to Department approved extensions for good cause. Any such extensions must be approved prior to the end of the timeline indicated in the Review Project Request.

1.16.1.2. The Review Project Request shall establish the timeframe for Contractor to review the provider's medical records to ensure that preliminary audit findings are provided in a reasonable timeframe.

1.16.1.3. The timeframe outlined in the previous section shall factor in the provider's duty to provide all relevant medical records to the Contractor and Contractor shall specify such timeframe to the provider in the request for records.

1.16.1.4. The Department shall define what a reasonable period of time to conduct the review following submission by the provider of all relevant records. This determination shall be made in collaboration with the provider advisory group created in subsection C.R.S. § 25.5-4-301(3.5)(c)(I).

1.16.2. Insufficient Records

Contractor may deem claims without supporting documentation to be overpayments. Providers are required to maintain documentation to substantiate their claims for six (6) years.

1.16.3. Medical Necessity Determinations

Contractor shall use a Complex Review in the situations listed in Section 1.15.4 titled "Complex Review" when an element of the audit involves a determination of medical necessity.

1.16.4. Denials

1.16.4.1 Technical Overpayment or Denial

1.16.4.1.1 Contractor may find an entire claim to be an overpayment if medical records are requested and not received within forty-five (45) calendar days after the date of the medical record request

letter or any extension thereof. Additional attempts to contact the Provider to obtain documents after the deadline are at the discretion of the Contractor.

1.16.4.1.2 If a Provider has not responded to an MRR letter and not submitted any medical records within the allowed time limits of the MRR letter, Contractor shall issue a notice of preliminary findings to the Provider within 60 calendar days of when the medical records were due. The Department will support this Contractor deliverable by approving the notice of adverse action letter within 10 Business Days of submission by Contractor to the Department for approval. If the Department is unable to approve the letter within such period, Contractor and the Department shall agree on a new Letter Review Plan.

1.16.4.1.3 The Contractor shall provide clear and convincing written and oral opinions to support overpayment findings and to defend them in litigation.

1.16.4.2 Full Overpayment or Denial

1.16.4.2.1 Contractor may find an entire claim to be an overpayment if:

1.16.4.2.2 The claim was not reasonable and necessary and no other service (for that type of Provider) would have been reasonable and necessary.

1.16.4.2.3 No service was provided.

1.16.4.2.4 The claim is a duplicate.

1.16.4.2.5. The claim should have been bundled into another claim that was paid.

1.16.4.2.6. No documentation exists to support the claim.

1.16.4.2.7. Any other reason, approved by the Department, which precludes payment of the claim in its entirety.

1.16.4.3 Partial Overpayment or Denial

1.16.4.3.1 Contractor may find part of a claim to be an overpayment if:

1.16.4.3.2 The claim was not reasonable and necessary, but a lower level service would have been reasonable and necessary.

1.16.4.3.3 The claim was upcoded (and a lower level service was actually performed) or an incorrect code (such as a discharge status code) was submitted that caused a higher payment to be made.

1.16.4.2.4 Documentation supports some, but not all, line items on a claim.

1.16.4.2.5 The Provider failed to apply a payment rule that caused an improperly high payment (e.g., failure to reduce payment on multiple surgery cases).

1.16.4.3.6 Any other reason as approved by the Department.

1.16.4.3.7 In partial denial cases, Contractor shall determine the proper payment amount for the service described in the claim and in the medical record. The overpayment amount is the difference between the amount paid and the amount that should have been paid.

1.16.4.3.8 Where Contractor is unable to determine the proper payment amount, Contractor may find

the entire claim to be an overpayment depending on the specific circumstances.

1.16.5 Determinations

1.16.5.1. Coverage Determinations

Contractor may find a full or partial overpayment exists if the service is not covered. See e.g., 10 CCR 2505-10, Section 8.011.1.

1.16.5.2. Coding Determinations

Contractor may find that an overpayment exists if the services were not correctly coded resulting in a payment in excess of the allowable amount.

1.16.5.3. Provider Disqualification Determinations

Contractor may find a full or partial overpayment exists if the service was delivered to a Member while the Provider lacked the licensure or credentials to perform the service or the Provider was excluded from participation at the time of service, or if the Provider was deceased.

1.16.5.4. County or State Department Primary Payer Determinations

Contractor may find a full or partial overpayment exists if the service was one included in the scope of services covered by a County, but it was paid by Medicaid on a Fee for Service basis. Before making an overpayment determination, Contractor shall validate with the Department whether or not there might be a coverage exception that was applied.

1.16.5.5. Clinical guidelines.

Contractor shall utilize Milliman Care Guidelines ("MCG") for complex audits of hospital claims. In the event the audited provider urges Contractor to employ another vendor's clinical guidelines rather than MCG, Contractor shall notify the Department. Any decision to apply clinical guidelines other than MCG's guidelines will be based upon mutual agreement of the Contractor and the Department.

1.16.5.6. Medicaid Policies, Coding Guidelines and Procedures

1.16.5.6.1. Contractor may determine that an overpayment exists if the claim was the result of an error in payment and should not have been paid pursuant to Department's policy. Contractor shall not apply a billing requirement, policy, billing or coding guideline or statute or rule retroactively to claims processed prior to the effective date.

1.16.5.6.2. The Department reserves the right to prospectively control and limit application of a policy, coding guidelines and procedures that may be used by Contractor in a review project or audit scenario. Contractor shall comply with any Department instruction regarding the Department's interpretation of any policy, coding guideline or procedure.

1.16.5.7. Minor Omissions

Contractor shall not base denials on minor omissions. Contractor shall follow all Departmental instructions regarding what constitutes minor omissions.

1.16.5.8. Managed Care Enrollment Determinations.

Contractor may find a full or partial overpayment exists if the service should have been paid by the managed care plan on behalf of the managed care enrollee, but it was paid by Medicaid on a Fee for Service basis of reimbursement. Before making an overpayment determination based on managed care enrollment, Contractor shall validate with the Department whether or not there might be a coverage exception in effect.

1.16.5.9. Waiver Program Determinations

Contractor may find a full or partial overpayment exists if the service was paid by Medicaid on a Fee for Service basis, but the payment was duplicative or inconsistent with a waiver service payment to or on behalf of the same Member. Before making an overpayment determination, Contractor shall validate any finding with the Department whether or not there might be a coverage exception in effect.

1.16.5.10. Skilled Nursing Facility Determinations

Contractor may find a full or partial overpayment exists if the service was included in the skilled nursing facility's daily rate payment, was delivered to a Member living in a skilled nursing facility, but it was paid by Medicaid on a Fee for Service basis. Before making an overpayment determination, Contractor shall validate the finding with the Department whether or not there might be an applicable coverage exception.

1.16.5.11. Hospice Determinations

Contractor may find a full or partial overpayment exists if the service was one included in the scope of hospice services, was delivered to a Member in hospice, but it was paid by Medicaid in Fee for Service. Before making an overpayment determination, Contractor shall validate with the Department whether or not a coverage exception was applied.

1.16.6 PRELIMINARY AUDIT FINDINGS

1.16.6.1 If Contractor identifies overpayments, determinations, or other audit findings during the review phase described above, Contractor shall send the provider a notice of the preliminary audit findings. Such notice shall apprise the provider of:

1.16.6.1.2 The details of the audit findings.

1.16.6.1.3 The rationale behind the audit findings.

1.16.6.1.4 The amount of the overpayment and the methodology utilized to calculate the amount of the overpayment.

1.16.6.1.5 The notice shall inform the provider of the right to seek review of the preliminary audit findings by requesting an informal reconsideration and the necessary measures to seek such a review. In cases of complex audits, the Contractor shall also notify the provider of the right to request an exit conference prior to participating in an informal reconsideration of the preliminary audit findings.

1.16.7 EXIT CONFERENCES

1.16.7.1 The provider may request an exit conference to discuss preliminary audit findings of complex audits by requesting the exit conference no later than thirty (30) days after receipt of the notice of preliminary audit findings.

1.16.7.2. The Contractor shall schedule the exit conference within sixty (60) days of receiving the request from the provider. The exit conference shall occur at a mutually agreed time and date.

1.16.7.3. The Contractor shall coordinate the exit conference with the Department to ensure that the Department's medical director or designee is present at the exit conference.

1.16.7.4. The provider shall have the right to furnish additional information at the exit conference in support of their claims.

1.16.7.5. Within thirty (30) days following the exit conference, the Contractor shall provide notice to the provider whether any of the preliminary audit findings have been overturned or modified based upon the information presented at the exit conference. The notice and the findings from the exit conference must be approved by the Department prior to issuing the notice.

1.16.7.6. The notice of informal reconsideration shall include details of the findings, the rationale for the findings, and the methodology utilized to calculate the amounts of the overpayments.

1.16.7.7. The notice of informal reconsideration shall provide the steps necessary to request an informal reconsideration with respect to any of the findings of the notice. The notice shall disclose to the provider that to seek review, the provider must furnish within sixty (60) days all relevant medical records and reasoning as to why the findings should be overturned.

1.16.8 INFORMAL RECONSIDERATION

1.16.8.1. Contractor shall participate in an informal reconsideration along with the Department if the provider requests review of the notice of informal reconsideration following the exit conference or in absence of an exit conference, the provider requests review of the preliminary audit findings.

1.16.8.2. The provider has sixty (60) days to request an informal reconsideration and submit medical records, and rationale for the provider's disagreement with the preliminary audit findings.

1.16.8.3. The Contractor shall review the provider's medical records and any additional information submitted in support of the request prior to the informal reconsideration meeting.

1.16.8.4. The Contractor shall schedule the informal reconsideration meeting on a date and time mutually agreed upon by the Contractor, provider, and the Department within ninety (90) days of issuing the notice of informal reconsideration.

1.16.8.5. The parties may request an extension of time not to exceed sixty (60) days.

1.16.8.6. The parties at the informal reconsideration meeting shall exercise a good faith effort to resolve the dispute over the preliminary audit findings.

1.16.8.7. The Contractor shall confer with the Department following the informal reconsideration meeting to determine which preliminary audit findings remain in dispute following the informal reconsideration. The Contractor shall be bound by the Department's determination as to the findings following the informal reconsideration meeting.

1.16.8.8. The Contractor will issue the notice of adverse action within sixty (60) days of the informal reconsideration meeting.

1.16.8.9. Contractor shall only send notice of adverse action letters in the approved pattern letter format with the Department's signature.

1.16.8.10. The notice of adverse action shall contain the following content:

1.16.8.10.1. Inform the provider of its right to request a formal appeal within thirty (30) days of receipt of the Department's notice of adverse action,

1.16.8.10.2. Describe the basis and rationale for the overpayment,

1.16.8.10.3. Set forth the methodology used to calculate the overpayment,

1.16.8.10.4. Disclose why the Department did not agree with the provider's evidence to overturn the preliminary audit findings; and,

1.16.8.10.5. Adequately inform the provider of the disposition of all the claims subject to the original notice of preliminary audit findings, so that the provider understands which claims to appeal. Categories of the disposition of the original claims could include: (i) undisputed overpayments, (ii) overpayments disputed by the provider, (iii) overpayments overturned by the Contractor, (iv) claims which did not undergo the informal reconsideration step and therefore are deemed overpayments not subject to appeal.

1.16.8.16. Contractor shall also make the notice of adverse action letter available to the Provider electronically via the Provider web portal, in accordance with Section 1.7.2.

1.16.8.17. In the event that the claims subject to an overpayment determination have not been locked to prevent adjustments or voiding of the claim, Contractor shall review claims data prior to Contractor's issuance of a notice of adverse action letter to ensure that adjustments or rebilling have not occurred and recalculate the overpayment if needed.

1.16.8.18. Contractor shall address the notice of adverse action letter to a specific, named individual at a confirmed address. At the Provider's request, Contractor shall deliver a copy of the notice of adverse action letter to a second specifically identified individual.

1.16.8.19. Contractor shall send the notice of adverse action to the provider by certified or registered mail, return receipt requested, or by recognized overnight courier with proof of delivery.

1.16.8.20. The Contractor shall issue the notice of adverse action within sixty (60) days of the informal reconsideration meeting. If the Contractor has not issued the notice of adverse action in one hundred twenty days following the informal reconsideration meeting, the Contractor shall forego any contingency fee on the claim unless the delay was not caused by the Contractor.

1.16.8.21. Neither the Department nor the Contractor shall recover an overpayment until the informal reconsideration process and formal appeal have been completed, if the provider has requested such review.

1.16.8.22. The Department and the Contractor shall not recover the state share of an overpayment if the Department has not issued a notice of adverse action within one hundred twenty (120) days following the informal reconsideration meeting.

1.16.8.23. Contractor shall provide copies of each finalized notice of adverse action letter to the Department through via the HMS Portal within twenty-four (24) hours of the letters being sent to the Provider.

1.17 UNDERPAYMENT CASE REVIEW

1.17.1. Contractor is under no obligation to accept requests from Providers to conduct an underpayment case review. If medical records are received from Providers that were not requested by Contractor, Contractor may destroy the records. If Contractor destroys records sent by a Provider, Contractor shall notify the Department and create and log the documents destroyed and why.

1.17.2. In the event that Contractor reviews a claim and determines there is an underpayment, Contractor shall identify the underpayment and inform the Department of the discovery.

1.17.2.1. Services that a Provider failed to include on a claim are not considered underpayments for the purposes of this Contract. For example, the medical record indicates that the Provider performed additional services such as an EKG, but the Provider did not bill for the service, or the medical record indicates that the Provider implanted a particular device for which a separate reimbursement could have been made, but the Provider did not bill for the device.

1.17.2.2. Contractor shall use only the post payment claims review process to identify underpayments.

1.17.2.3. Contractor may determine that an underpayment exists if the claim was the result of an error in payment policy.

1.17.2.4. Contractor may find that an underpayment exists if the services were not correctly coded.

1.17.3. Contractor may request medical records for the purpose of identifying an underpayment.

1.17.4. If during a claims review (either Automated or Complex) Contractor discovers a Provider has been underpaid, Contractor shall send a separate underpayment notification letter to the Provider.

1.17.5. Underpayment notification letters shall be prior approved by the Department and shall include all of the following:

1.17.5.1. The claim(s) and Medicaid Member detail.

1.17.5.2. The approved pattern letter for underpayments.

1.17.6. Upon a request from the Provider to explain an underpayment notification letter, Contractor shall contact the Provider and offer explanation or clarification. Underpayment determinations are not subject to informal reconsideration or appeal.

1.17.7. Contractor shall not include identified underpayments in any notice of adverse action letter.

1.17.8. Contractor shall create and provide to the Department underpayment notification letters.

1.17.9. Contractor may use Automated Review when making other determinations (e.g. duplicate claims, pricing mistakes) when there is certainty that an overpayment or underpayment exists. Written policies/articles/guidelines often do not exist for these situations.

1.17.10. Contractor shall provide the Department with a monthly report for any underpayments discovered during audits. This report shall include:

1.17.10.1. Means by which underpayments were identified, or the project’s particular methodology or purpose.

1.17.10.2. Sum total of all initial underpayments identified in the prior month.

1.17.10.3. Sum total of all underpayments still in queue for all open Review Projects (including those on appeal) as of the last day of the month.

1.18 FORMAL APPEAL PHASE

1.18.1 Contractor shall provide formal appeals assistance consistent with Sections 25.5-4-301(3)(a)(VIII), 24-4-105, C.R.S. and 10 CCR 2505-10, §8.050.

1.18.2 Contractor's assistance with formal appeals shall include, but not be limited to, all of the following:

1.18.3 Providing all information and supporting documentation as requested by the Department for the appeal including the administrative record from the informal reconsideration meeting.

1.18.3.1 Answering all questions regarding the appeal from the Department or the Attorney General's Office.

1.18.3.2 Any support for Contractor's technical and professional findings.

1.18.3.3 Providing witnesses to testify at the hearing.

1.18.3.4 Support for any mediation or settlement conferences including repricing claims, if feasible, prior to the settlement conferences to assist with evaluation of the overpayments of each claim.

1.18.3.5 Providing its professional opinion regarding any of the bases for the appeal, and recommending any course of action for, or defense of, Contractor's position to the Department.

1.18.4 Contractor's responsibility to assist the Department with any appeals relating to any of the Work completed by Contractor shall survive the termination of this Contract.

1.18.4.1 DELIVERABLE: Support and assistance with defending or pursuing an appeal as requested by the Department

1.18.4.2 DUE: Within a reasonable amount of time as prescribed by the formal appeal process.

1.18.5 When a Provider formally appeals, the Department will notify the Contractor of the appeal.

1.18.6 If Contractor receives a verbal request to appeal from a Provider, Contractor shall direct the Provider to their notice of adverse action letter where it describes how to file an appeal and where to mail it.

1.18.7 Within thirty (30) calendar days of notice of appeal, Contractor shall provide the administrative record from the informal reconsideration meeting to the Department including, additional information from the audit, but not limited to:

1.18.7.1 Data analysis summaries.

1.18.7.2 Field and desk review summaries.

1.18.7.3 Overpayment determinations.

1.18.7.4 Any reports showing claims repriced by the Contractor.

1.18.7.5 Documentation of Provider relations communications.

1.18.7.6 All written communications with Providers.

1.18.7.7 All Provider education given to Providers.

1.18.8 Within thirty (30) calendar days of notice of appeal, Contractor shall provide the Department with an executive summary of the appealed case. It shall contain, but is not limited to, all of the following:

1.18.8.1 A chronological narrative of Contractor's activities.

1.18.8.2 A statement of the nature of the dispute.

1.18.8.3 The amount in controversy.

1.18.8.4 A summary of the Provider's basis and rationale for appeal.

1.18.8.5 A point-by-point refutation of, or agreement with, the Provider's basis and rationale for appeal with specific citation to supporting evidence in the record.

1.18.8.6 The curriculum vitae of the reviewer(s).

1.18.8.7 If the issues involve recoding, copies of the pages of the applicable coding manual and other learned resources that support Contractor's recoding methodology and rationale.

1.18.8.8 If the issues involve rules, regulations, policies or statutes, copies of the rules, regulations, policies and/or statutes upon which Contractor relied.

1.18.8.9 If the issues involve calculations, the relevant fee schedules and methodology and explanations for how the Contractor made its calculations.

1.18.8.10 Recommended resolutions, if any.

1.19 LITIGATION PHASE

1.19.1 Contractor shall prepare for, and participate in, all steps of any litigation as requested by the Department or the Colorado Attorney General's Office. Such steps include, but are not limited to:

1.19.1.1 Pre-settlement conferences.

1.19.1.2 Settlement conferences.

1.19.1.3 Trial setting conferences.

1.19.1.4 Hearings.

1.19.2 Contractor's litigation assistance shall include, but is not limited to, all of the following:

1.19.2.1 Providing all information and supporting documentation as reasonably requested by the Department for the litigation.

1.19.2.2 Supporting its technical and professional findings.

1.19.2.3 Answering all questions regarding the litigation from the Department or the Attorney General's Office.

1.19.2.4 Appearing at hearings to provide appropriate testimony or answer questions.

1.19.2.5 Providing appropriate personnel and experts, at Contractor's expense, as requested by the Department.

1.19.2.6 Providing its professional opinion regarding the grounds of the litigation, and suggesting any appropriate course of action for, or defense of, Contractor's position to the Department. Testify regarding its findings, information, supporting documentation and its professional opinion, if requested by the Department or the Attorney General's Office.

1.19.2.7 Contractor's responsibility to assist the Department with any litigation relating to any of the Work completed by Contractor shall survive the termination of this Contract.

1.19.2.7.1 DELIVERABLE: Information and supporting documentation as requested by the Department for the litigation.

1.19.2.7.2 DUE: Within ten (10) Business Days or earlier as requested by the Department or the Attorney General's Office, unless the Department extends this due date.

1.19.3 Contractor shall participate in conferences either in person or, with the prior permission of the judge, by teleconference, as directed by the Department's legal representatives.

1.19.4 Contractor shall ensure that reviewers, physician reviewers, Contractor's Medical Director and others, as requested by the Department, are available either in-person, or by telephone when approved, to participate at settlement conferences, at depositions and at court proceedings.

1.19.5 Upon request, Contractor shall describe its analytic methods used to identify cases for audit and its statistical methods used to calculate an overpayment.

1.20 RESERVED

1.21 FRAUD AND FALSE CLAIMS

1.21.1 Contractor shall notify the Department when it identifies or suspects Provider fraud or false claims at any stage of a Review Project.

1.21.2 Suspected Fraud

1.21.2.1 Suspected fraud includes identification or intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to the individual or some other person, whether it constitutes possible criminal fraud under federal or state law or violation of federal or state civil false claims statutes.

1.21.2.2 Upon discovery of suspected fraud or other findings described above, Contractor shall immediately make a verbal report to the Department's contract manager. Contractor shall submit written documentation to the Department within two (2) Business Days of the verbal report. The verbal and written reports to the Department shall include all details of the findings and concerns, including a chronology of Contractor actions that resulted in the reports. The report shall identify any affected claims that have been discovered. Contractor shall provide any claims data associated with its report. The written report shall be in a format that is specified and approved by the Department.

1.21.2.3 Contractor shall not take any kind of recovery action or initiate any kind of activity against a Provider where fraud is suspected.

1.21.2.4 Contractor shall not take any action that may interfere with an investigation of possible fraud by the Department, the MFANU, or any other law enforcement entity. Contractor shall assist the Department, the MFANU or any other law enforcement entity as requested with any investigation and any civil or criminal cases by the State or Federal governments, including

false claims act cases.

1.21.2.5 Contractor shall temporarily suspend any review activities or actions related to any Provider that Contractor suspects is involved in fraudulent activity.

1.21.3 Upon Department request, Contractor shall temporarily suspend all review activities or actions related to any Provider.

1.21.4 Contractor shall abandon a project and stop all work on it, when requested to do so by the Department.

1.22 QUALITY CONTROL

1.22.1 Quality Control Review Plan

1.22.2.1 Contractor shall develop a Quality Control Review Plan ("QC Review Plan") to be used by the Department to assess the accuracy of Contractor's audit determinations. The QC Review Plan will be used to assess the accuracy of Contractor's audit determinations.

1.22.2.2 The QC Review Plan is subject to Department approval and shall include all of the following:

1.22.2.2.1 Review guidelines supported by Department rules, Colorado statutes, and federal regulations or, if state or federal rules and regulations are silent and/or do not exist, are supported by evidence based clinical criteria.

1.22.2.2.2 A method or tool by which the Department can determine whether the criteria for Automated Reviews was met or whether Contractor should have performed a Complex Review instead.

1.22.2.2.3 A process and method by which the Department can determine all of the following:

1.22.2.2.4 The accuracy of Contractor's Improper Payment determination.

1.22.2.2.5 The accuracy of Contractor's error type (ex: no documentation, insufficient documentation, medically unnecessary, incorrect coding) and subtype for each claim determination.

1.22.2.2.6 The clarity and accuracy of Contractor's language used to communicate with the Provider regarding Improper Payment.

1.22.2.2.7 The appropriateness of Contractor's language used to communicate with the Provider regarding the clinical evidence contained in the medical record that justifies the claim determination.

1.22.2.2.8 The accuracy of the Contractor's beneficiary liability determination.

1.22.2.2.8.1 DELIVERABLE: Updates and Changes to QC Review Plan

1.23.2.2.8.2 DUE: Within two (2) weeks of any changes.

1.23.2.3 At the Department's request, Contractor shall provide all documents and information associated with an audit and all documentation/information that justifies Contractor's audit rationale and overpayment determinations, including but not limited to, the statutes, rules and regulations, and coding references that support the audit within one (1) Business Day of the Department's request.

1.23.2.4 Contractor shall allow for a minimum ten (10) Business Days following receipt of audit documentation/information, for the Department to conduct a quality assurance review. During

this review period, Contractor shall not send a notice of adverse action letter to a Provider that is the subject of the quality assurance review.

1.23.2.5 If the Department determines that there are errors in accuracy, comprehensiveness or quality, Contractor shall make all changes directed by the Department. After the Department's notification, Contractor, at the direction of the Department, shall recode and re-price the claims. Contractor shall only send the notice of adverse action letter once the Contractor has made all changes.

1.23.3 Quality Control Review of Audits

1.23.3.1 Contractor shall develop a quality control system to ensure the accuracy, comprehensiveness and quality of all audits performed by Contractor. Contractor shall conduct quality control reviews of all audits that Contractor conducted.

1.23.3.2 Contractor shall develop procedures for the quality control reviews and submit the procedures to the Department for approval. Contractor shall perform the quality reviews per the approved procedures. Contractor shall not perform quality control reviews prior to the Department's approval of the procedures.

1.23.3.2.1 DELIVERABLE: Procedures for quality reviews

1.23.3.2.2 DUE: No later than fifteen (15) Business Days after the Operational Start Date or after any changes to the procedures.

1.23.3.3 Contractor shall not have the same staff conducting the quality reviews who were involved in the underlying audit.

1.23.3.4 Contractor shall immediately correct its errors, once identified during the quality control review.

1.23.3.5 Contractor shall not send a notice of adverse action letter to a Provider if the audit that resulted in the notice of adverse action letter has not been subject to Contractor's quality control review or the results of the review revealed errors in accuracy, comprehensiveness or quality.

1.24 PROVIDER EDUCATION

1.24.1. Provider Education Plan

1.24.1.1. Contractor shall develop a Provider Education Plan. Contractor shall conduct Provider education at least once a quarter.

1.24.1.2. The Provider Education Plan shall contain, at a minimum, all of the following:

1.24.1.2.1. Availability to conduct informal conferences or phone calls with providers or provider associations to discuss the RAC program, its processes, and program's findings.

1.24.1.2.2. Plan to conduct provider outreach and education activities including notifying providers of audit policies and protocols.

1.24.1.2.3. The identification of common billing trends or issues that result in erroneous payments. Issues may include, but are not limited to:

1.24.1.2.3.1. Incorrect coding.

1.24.1.2.3.2. Incomplete coding.

1.24.1.2.3.3. Untimely billing.

1.24.1.2.4. The methods Contractor will utilize to communicate the trends and issues and corrective actions to Providers. These methods may include, but are not limited to:

1.24.1.2.4.1. Direct mailings.

1.24.1.2.4.2. Pamphlets/brochures.

1.24.1.2.4.3. Website.

1.24.1.2.4.4. Webinars.

1.24.1.2.4.5. In-person presentations.

1.24.1.2.4.6. Telephone conferences.

1.24.1.2.4.7. Contractor shall deliver the Provider Education Plan to the Department for review and approval.

1.24.1.2.4.8. Contractor shall modify the Provider Education Plan upon Department request. Contractor shall submit all modifications to the Department for approval prior to implementing the modified Provider Education Plan.

1.24.1.2.4.9. Once the Department has notified Contractor of its acceptance of the Provider Education Plan or of an updated Provider Education Plan, Contractor shall implement all requirements of that plan and perform all Provider education according to the Provider Education Plan. The Contractor shall not implement the Provider Education Plan until the Department accepts the Plan or modification of the Plan.

1.24.1.2.4.10. All requirements, due dates, and milestones contained in the most recently approved Provider Education Plan or updated Provider Education Plan shall be considered to be requirements, due dates, and milestones of this Contract.

1.24.1.2.4.11. Contractor shall follow all plans, standards, processes and procedures of the most recently approved Provider Education Plan.

1.24.1.2.4.11.1. DELIVERABLE: Provider Education Plan.

1.24.1.2.4.11.2. DUE: Within ten (10) Business Days following the completion of a Review Project.

1.24.1.2.4.11.3. DELIVERABLE: Updates and Changes to Provider Education Plan

1.24.1.2.4.11.4. DUE: Within two (2) weeks of the Department requesting the changes

1.24.1.2.4.12. Contractor shall not initiate Provider education without Department approval as to content, form and forum.

1.24.1.2.4.13. Contractor shall prepare all written education materials and presentation materials and provide the materials to the Department for approval. Contractor shall not engage in education program activities, nor distribute written education materials, without the express prior approval of the Department.

1.24.1.2.4.13.1. DELIVERABLE: All presentation and written education materials that will be

distributed.

1.24.1.2.4.13.2. DUE: Thirty (30) calendar days prior to use.

1.24.1.2.4.14. Contractor shall implement the most recently approved Provider Education Plan and shall complete all requirements of that plan. Contractor shall not implement any portion of the Provider Education Plan prior to the Department's approval of that plan unless directed to do so in writing by the Department.

1.24.2. Contractor shall identify common Provider billing trends or issues that result in large erroneous overpayments. If the issues resulting in erroneous overpayments can be addressed and corrected through educational efforts, Contractor shall initiate an education program to Providers throughout the state on why some errors are consistently being made and the methods to avoid making the errors.

1.24.3. Contractor shall deliver written education materials as directed by the Department. The Department may deliver Contractor's written education materials through the Department's Medicaid bulletin, newsletters, the Department's website, and Provider group publications.

1.24.4. At the Department's request, Contractor shall deliver Provider education written materials in person, via webinar, telephone conference, Contractor's Provider web portal or other mass media. In such a case, Contractor shall arrange the times, places and means of presentation, in consultation with the Department and the affected Providers, groups or associations. Contractor shall set up and schedule any education presentations. Contractor shall maintain a list of Providers attending the education presentations and shall provide the attendee list to the Department within one (1) Business Day of the Department's request. The Department may require that Department staff be present at any in person meeting, webinar, or telephone conference.

1.24.5. At the request of the Department, Contractor shall develop written materials on topics of the Department's choosing related to the Work and intended for Department distribution to Providers, legislators, stakeholders or other persons.

1.24.6. Contractor shall not speak for, nor represent that it speaks for, the Department, or Department policy.

1.24.7. Contractor shall notify the Department and obtain Department approval prior to attending and participating in any Provider/association meetings, presentations or conferences pertaining to the Work.

1.24.8. At the request of the Department, Contractor shall participate, in person or via telephonic conferences, in meetings with Provider groups, health care associations and others designated by the Department, when such meetings relate to the Work.

1.25 PROCESS IMPROVEMENTS

1.25.1. Contractor shall provide written recommendations for improvements in Department payment systems, processes, laws, rules, billing instructions and policies when shortcomings are identified. Contractor shall provide written recommendations to the Department within ten (10) Business Days of the discovery of shortcomings.

1.25.2. Contractor shall provide written identification of exploitable gaps in the Department's benefit plans, rules, regulations, reimbursement policies, contracts, billing instructions, existing/historic claims processing edits and audits that enable Providers to receive payments to which they are not

(or should not be) entitled. Contractor shall provide written identification to the Department within ten (10) Business Days of the discovery of exploitable gaps.

1.26 PAYMENT ADDRESS

1.26.1. The Department will instruct the Contractor of the applicable payment address.

1.26.2. If Contractor receives a Provider check directly, Contractor shall forward the check to the Department along with all accompanying documentation. Before forwarding the check, Contractor shall make copies of and otherwise document these payments. A copy shall be included in the appropriate case file.

1.26.3. When the Department receives a Provider refund check, the Department will notify Contractor.

1.26.4. Contractor acknowledges that federal or State law may change pertinent to the Work and shall cooperate fully with the Department to make any necessary changes to the Contract to accommodate new or amended legal requirements.

1.27 OFFSET AND REPAYMENT PLANS

1.27.1. Contractor shall notify the Department when a Provider requests to repay the Department through an offset against future Provider payments.

1.27.2. Contractor shall, upon Department approval, validate that an offset is appropriate and validate its calculation.

1.27.3. Contractor shall complete all offsets, as approved, through interChange at the claim level, which would adjust claims and via the system, interChange will recalculate the FFP.

1.27.4. If the Provider would like a repayment plan, Contractor shall relay to the Department the request from the Provider. The Department will handle the request and work with the Provider to establish the repayment plan. A repayment plan may be requested in addition to an offset plan.

1.27.5. Contractor shall receive contingency payments under the repayment plan only for payments received, deposited, and cleared, including refunded and offset amounts.

1.27.6. In the event of a settlement during the appeal process for an amount less than the total amount of the calculated overpayment, the Department shall compensate the Contractor based upon the settlement amount rather than the total amount of the overpayment that was subject of the appeal.

1.27.7. If the Department finds that there is substantial evidence that an audit scenario is inaccurate resulting in provider refunds, Contractor shall return the contingency fee based upon the refunds within thirty (30) days of notice from the Department. The Contractor will provide any necessary assistance to the Department to facilitate the return of any monies repaid by the provider pursuant to the inaccurate audit.

1.28 INFORMATION TECHNOLOGY

1.28.1. Data Security

1.28.1.1. Contractor shall have and maintain contingency plans and a disaster recovery plan designed to restore any loss of protected information and to enable continuation of critical business processes for protection of the security of electronic PHI while operating in emergency mode.

1.28.1.2. Contractor shall ensure that all electronic mail communications that contain PHI are either sent

securely, sent encrypted, or both.

1.28.1.3. Contractor shall encrypt PHI on removable media.

1.28.1.4. If Contractor uses encryption software that the Department does not possess or license, Contractor shall pay all costs associated with acquiring and maintaining the software for the Department.

1.28.1.5. Contractor shall not send passwords to open encrypted files via the same media or transmission method as was used to send the original files.

1.28.1.6. When Contractor submits data to the Department in electronic format, Contractor shall securely send that data. Contractor's systems shall contain control to maintain information integrity and security.

1.28.1.7. Contractor's systems shall contain controls to maintain information integrity and security.

1.28.2. Cyber Security and Technical Safeguards

1.28.2.1. Contractor shall observe the State of Colorado Information Security Policies, as published and updated by the Office of Cyber Security.

1.28.2.2. Contractor shall notify the Department within twenty-four (24) hours of discovery of:

1.28.2.3. Unauthorized systems access.

1.28.2.3.1. Compromised data.

1.28.2.3.2. Loss of data integrity.

1.28.2.3.3. Inability to transmit or process data.

1.28.2.4. In event of a breach of the security of sensitive data, including PHI, Contractor shall immediately notify the Department to report all suspected loss or compromise of sensitive data within twenty-four (24) hours of the suspected loss or compromise and shall work with the Department regarding recovery and remediation. Contractor shall be responsible for notifying all Colorado residents whose sensitive data may have been compromised as a result of a breach of security caused by Contractor.

1.28.2.5. Contractor shall meet the same personnel security standards as State employees as outlined in the Colorado Information Security Policies, Personnel Security, P-CCSP-012.

1.28.2.6. Contractor shall establish appropriate restrictions and safeguards against unauthorized access to all non-public data.

1.28.2.7. Contractor shall secure background checks on any employees with access to Department data to ensure that they have not been convicted of any program-related felonies and that they are not excluded from federal participation.

1.28.2.8. Contractor shall ensure that staff with access to PHI are trained regarding their obligations under HIPAA and the Health Information Technology Portability and Clinical Health (HITECH) Act.

1.28.2.9. Contractor shall implement all other necessary technical safeguards required by 45 C.F.R. §§160 and 164.

1.29 DEPARTMENT PRIOR APPROVAL

1.29.1. Contractor shall not initiate any kind of correspondence, send notice of adverse action letters or begin recovery activities without the prior review and approval of the Department.

1.29.2. Contractor shall not compromise or waive any claims without the Department's prior written approval.

1.29.3. Contractor shall not alter, change, forgive or excuse any written delivered demand for overpayment without the prior approval of the Department.

1.29.4. Contractor shall not compromise, release and/or settle an identified or possible overpayment without the prior approval of the Department.

1.29.5. Contractor shall obtain Department approval before giving any response, whether written or oral, to providers regarding the outcomes of audits or final overpayment determinations following the informal reconsideration meeting.

1.29.6. Contractor shall not arrange a repayment plan with a Provider.

1.29.7. Contractor shall suspend any work or activities under this Scope of Work upon request of the Department.

1.30 PROHIBITED ACTIVITIES

1.30.1. Contractor shall not develop or market products to Providers which inform them how to and/or assist them in circumventing the audits and reviews within the Work under this Contract.

1.30.2. Contractor shall not use, advertise, or promote information for commercial benefit concerning this Contract without the Department's prior written approval.

1.30.3. Contractor shall not use the Department's name or logo in any widely distributed materials, or in any mass media, without the **prior written permission** of the Department.

1.31 CORRECTIVE ACTION PLAN

1.31.1. If the Department identifies a violation of this Contract, or other non-compliance with this Contract, the Department will notify the Contractor of the occurrence in writing.

1.31.2. In response to the written request from the Department, Contractor shall investigate any Contract compliance issues and submit to the Department a written response within ten (10) calendar days. Upon request, the Department may allow additional time to the Contractor to investigate and report.

1.31.3. Contractor's written response shall include, at a minimum, all of the following:

1.31.3.1. The efforts that the Contractor took to investigate the issue.

1.31.3.2. The outcome of the Contractor's review.

1.31.3.3. The corrective action taken.

1.31.4. At the Department's request Contractor shall draft and provide a corrective action plan ("CAP") detailing Contractor's steps necessary to come into contractual compliance. The CAP shall include implementation steps and deadlines to fully implement the CAP.

1.31.5. Upon receipt of Contractor's written response, the Department may accept, modify or reject the proposed CAP. Modifications and rejections will be accompanied by a written explanation from the Department.

1.31.6. Contractor shall make all changes to the CAP as directed by the Department. Unless otherwise agreed to by the Department in writing, Contractor shall submit replacement portions or a complete revised version of the CAP within five (5) Business Days following receipt of Department comments.

1.31.7. Contractor shall implement the CAP after receiving the Department's approval.

1.32 PERFORMANCE STANDARDS

1.32.1. Baseline Performance Standards

1.32.1.1. Contractor shall meet or exceed all Baseline Performance Standards at all times during the term of this Contract. The "Baseline Performance Standards" under this Contract are as follows:

1.32.1.1.1. Respond to all Providers' requests for reviews of the completed preliminary audit results, exit conference requests, and informal reconsiderations within the statutory timeframes prescribed in subsection 25.5-4-301(3.3)(l), C.R.S.

1.32.1.1.2. Respond to 95% of provider questions and requests for information within two (2) business days after receiving the request.

1.32.1.1.3. Regarding formal appeals and litigation, deliver all necessary documentation to satisfy requests from an Administrative Law Judge (ALJ), the Colorado Attorney General's Office, and the Department within Department-specified timelines.

1.32.1.1.4. Maintain, at a minimum, ninety-five percent (95%) accuracy in its audit test work and results, defined by the appeal overturn rate, not including settlement negotiations.

1.32.1.1.5. Not exceed twenty percent (20%) turnover rate of the total adverse determinations within a batch mailing cycle, either at the point of informal reconsideration or formal appeal. Turnovers resulting from circumstances beyond the control of Contractor shall not be included in this calculation, for instance, in the event a Provider submits additional documentation that caused a turnover, and such additional documentation was not available to Contractor during the audit.

1.32.1.1.6. For Automated Audits, send notice of adverse action letters within sixty (60) days of the start of the audit.

1.32.1.1.7. For Complex Reviews, send all notice of adverse action letters within sixty (60) calendar days following the informal reconsideration meeting.

1.32.1.1.8. Provide copies of all notice of adverse action letters sent to Providers to the Department within one (1) Business Day of dispatch via the HMS Portal.

1.32.1.1.9. Provide copies of all informal reconsideration letters sent to Providers to the Department within one (1) Business Day of dispatch via the HMS Portal.

1.32.1.1.10. Contractor shall be subject to correction action plan requirements outlined in Section 1.31 above if the Department determines that Contractor is not meeting any Baseline Performance Standards.

1.33 REPORTING REQUIREMENTS

1.33.1. General Reporting Information

1.33.1.1. Contractor shall provide all reports listed in this section in the format directed by the Department and containing the information requested by the Department.

1.33.1.2. All reports are subject to the Department's review and approval. Contractor shall make all corrections to the reports as requested by the Department within five (5) Business Days of the Department's request. When needed, Contractor may request an extension prior to the end of the five (5) business days given for the initial request.

1.33.1.3. Contractor shall verify the accuracy and timeliness of reports, letters and data, screen them for completeness, logic, and consistency, and proof the contents for spelling, grammatical, and mathematical errors so that any such errors may be corrected before submission to the Department.

1.33.2. Monthly Status Report of Review Project

1.33.2.1. Contractor shall submit a "Monthly Status Report" to the Department, within five (5) Business Days after the end of each month.

1.33.2.2. Contractor's Monthly Status Report shall have a section describing the current status of all open Review Projects, including, but not limited to, the following information:

1.33.2.2.1. Review Project name, number and date span.

1.33.2.2.2. Providers associated with each Review Project (by name and Medicaid ID number).

1.33.2.2.3. Means by which improper payments were identified, or the project's particular methodology or purpose.

1.33.2.2.4. Possible fraud identified reported to the Department.

1.33.2.2.5. Number of medical records requested from each Provider and the date span of the review.

1.33.2.2.6. Type and date of correspondence mailed to Providers.

1.33.2.2.7. Date of exit interviews, and for which Providers.

1.33.2.2.8. Initial sum total overpayment recoupment amount identified for the entire Review Project, the amount recovered and the amount outstanding.

1.33.2.3. Contractor's Monthly Status Report shall have a section describing the current known status of prior Review Projects that are in formal appeal or active litigation. The section shall contain, but not be limited to:

1.33.2.3.1. Review Project name, number and date span.

1.33.2.3.2. Providers associated with the Review Project (by name and Medicaid Provider ID number).

1.33.2.3.3. Dollar amount on appeal.

1.33.2.3.4. Reason for the appeal.

1.33.2.3.5. Case developments in the preceding month.

1.33.2.4. Contractor's Monthly Status Report shall have a section describing all of the following summary data for all Review Projects active in the preceding month:

1.33.2.4.1. Sum total of all initial overpayments identified in the prior month.

1.33.2.4.2. Sum total of all overpayments still in queue for all open Review Projects (including those on appeal) as of the last day of the month.

1.33.2.4.3. Appeal statistics.

1.33.2.4.4. Call center statistics.

1.33.2.5. Contractor's Monthly Status Report shall have a section describing Contractor's Provider education and outreach activities accomplished during the previous month, and upcoming activities planned.

1.33.2.5.1. Update of Audit Project Plan.

1.33.2.5.2. Contractor's monthly status report shall include an update to the audit project plan.
1.33.2.5.3. Action Items.

1.33.2.5.4. Contractor's monthly status report shall have a section describing Contractor and Department "to do" and action items.

1.33.2.5.5. DELIVERABLE: Monthly Status Report of Review Projects

1.33.2.5.6. DUE: Within five (5) Business Days after the end of each month.

1.33.3. Completed Review Project Addendum

1.33.3.1. When a Review Project is complete through the informal reconsideration phase, Contractor shall prepare a separate addendum to the monthly status report (of no more than two (2) pages in length) describing its activities, findings, results and lessons learned through informal reconsideration (e.g., problems encountered, Provider education performed, Provider stories and complaints, Provider rationale when disputing Contractor findings, roadblocks, process improvements and recommendations for administrative, systems or regulatory changes).

1.33.3.2. Contractor's summary report shall contain all of the following:

1.33.3.3. Wrap-up of the total amount recovered.

1.33.3.2.2. Recovery ratio (sum of all initial notice of adverse action letter amounts divided by the total sum of actual recoveries associated with them).

1.33.3.2.3. Informal reconsideration request rate (number of claims with requests for informal reconsideration divided by the total number of claims with initial notice of adverse action letters).

1.33.3.2.4. Informal reconsideration reversal rate (number of claims reversed on reconsideration divided by the number requested for informal reconsideration);

1.33.3.2.5. Contractor shall describe the reason for each informal reconsideration reversal, if any.

1.33.3.2.6. Number and dollar amount of claims appealed to formal hearing.

1.33.4. Annual Report

1.33.4.1. Contractor shall submit the annual report to the Department within twenty (20) Business Days after the end of the State's fiscal year, June 30th:

1.33.4.1.1. An Executive Summary Report of all Contractor activities, global recovery by year since Contract inception, significant lessons learned, recommendations and conclusions on all projects for the preceding State Fiscal Year.

1.33.4.1.2. An annual Provider report for distribution to Provider organizations and associations containing:

1.33.4.1.3. Common review findings.

1.33.4.1.4. Information on how to prevent similar findings in future reviews.

1.33.4.1.5. Resource information.

1.33.4.1.6. Information and results of quality control efforts and how Contractor is improving those review standards.

1.33.4.1.7. Report of post audit activities conducted, as outlined in Section 1.20.

1.33.4.1.8. Other information as directed by the Department.

1.33.4.1.8.1. DELIVERABLE: Annual Report

1.33.4.1.8.2. DUE: Within twenty (20) Business Days after the end of the State's fiscal year.

1.33.5. Ad Hoc Reports

1.33.5.1. The contractor shall produce ad hoc written and electronic reports, as requested by the Department. Ad hoc reports include but are not limited to:

1.33.5.1.1. Issues identified and discussed in meetings.

1.33.5.1.2. Issues regarding all of the reviews for one Provider type.

1.33.5.1.3. Legislative or auditor's inquiry.

1.33.5.1.4. Requests made by CMS for reports regarding audit activities and recoveries.

1.33.5.1.5. Work matters identified by the Department.

1.33.5.2. Contractor shall respond to ad hoc requests made by the Department within three (3) Business Days of the request. The ad hoc requests may include, but are not limited to correspondence, reports, data, or other information related to this Statement of Work. When needed, Contractor may request an extension prior to the end of the three (3) business days given for the initial request.

1.33.6. Peer Reports

1.33.6.1. Contractor shall produce graphical representations of a Provider's billing activity and the billing activity of that Provider's peers, and deliver the report to the Provider, when requested by the Department.

2. COMPENSATION AND INVOICING

2.1 COMPENSATION

2.1.1 The compensation under the Contract shall consist of the following:

2.1.1.1. Contractor's sole compensation for the Work in this Contract are the contingency fees below.

2.1.1.2. Contractor will be paid monthly, in arrears, a contingency fee of the total dollar amount of overpayments recovered and received through Contactor's audits during the full Contract period. Pursuant to § 25.5-4-301(3.3)(c)(I), C.R.S. Contractor's compensation is contingent upon the amount of overpayments the state recovers from a provider.

2.1.1.3. The contractor shall not receive a contingency fee for any amounts of underpayments discovered.

2.1.1.4. Contingency fees are based upon the recovery principal amounts only. Contractor will not receive a contingency fee on interest or penalty recoveries including waiver of overpayment due to an untimely notice of adverse action under subsection (3.3)(l)(VIII). The Department shall approve all notice of adverse action letters within ten (10) days of receipt from Contractor so that all adverse action letters are timely mailed to providers.

2.1.1.5. In some cases, the MFANU may need to proceed with a criminal investigation of Provider(s) before a recovery can be pursued. The State may also file cases to add penalties to recoveries under the Federal False Claims Act, 31 U.S.C. § 3729, et seq. the State False Medicaid Claims Act, §§25.5-4-304 through 25.5-4-306, C.R.S. or any Colorado False Claims Act. In the event that a recovery case is referred for fraud investigation or action, Contractor will not receive a percentage of any eventual recovery, unless the case is referred back for administrative recovery action or unless the Department allows, upon the advice and counsel of its attorneys, for concurrent recovery and fraud actions.

2.1.1.6. Reimbursement of Contractor's costs in performing reviews and audits under this Contract shall be deemed included in the contingency fees due Contractor. All costs associated with the Work under this Contract shall be the responsibility of Contractor, including, but not limited to:

2.1.1.6.1. Data storage.

2.1.1.6.2. Audit costs.

2.1.1.6.3. Postage.

2.1.1.6.4. Travel.

2.1.1.6.5. Copying.

2.1.1.6.6. Reporting.

2.1.1.6.7. Communications.

2.1.1.6.8. Insurance.

2.1.1.6.9. Retrieving interChange data from the Department.

2.1.1.6.10. Work for litigation and ALJ Hearings.

2.1.2. Contingency Fees

2.1.2.1. The contingency fees to be paid by the Department to Contractor for the Work are: (1) Contingency Fee Percentage Rate of 18% of recovered overpayments for Automated Reviews, and (2) Contingency Fee Percentage Rate of 18% of recovered overpayments for Complex Reviews, subject to adjustment in accordance with Section 2.1.2.3 below.

2.1.2.2. Contingency fees will be calculated based on when recovery payments are received by the Department from the Provider through Contactor's audits during the full Contract period and invoiced in accordance with Section 2.3.1 below.

2.1.2.3. The total Contingency Fee Percentage Rate in the Contract shall not exceed the percentage set forth in § 25.5-4-301(3)(b)(b)(I), C.R.S. and 42 C.F.R. § 455.510 and shall be in compliance with state and federal law.

2.1.2.3.1. In the event that the Federal government decreases the maximum contingency fee percentage rate such that the total of the Contingency Fee Percentage Rates is greater than the maximum contingency fee percentage rate allowed by the Federal government for a Medicaid RAC, the Department will decrease the Contingency Fee Percentage Rates. The Department will decrease the Contingency Fee Percentage Rates so that the total of the Contingency Fee Percentage Rates is equal to the Federal government's rate for a Medicaid RAC. The Department may make this modification through the use of an option letter.

2.1.2.3.2 All Department Data (defined in Exhibit H) captured in the FraudCapture™ Platform (defined in Exhibit H) as part of the Services will be extracted by Contractor and turned over to the Department in accordance with the takeover provisions of the Contract.

2.1.2.3.3 The federal government may approve a Recovery Audit Contractor to be paid for work outside the normal scope of post-payment RAC reviews. If such federal program requirements become available or if other payment methodologies to provide additional services are approved in a State Plan Amendment (SPA), such methodologies and additional services shall be defined by the parties and added to this Agreement by Amendment. The payment methodology, amounts allowed, and scope of additional services are contingent upon the approval and funding by the Centers for Medicaid and Medicare Services (CMS).

2.2 PROVIDER PAYMENTS

2.2.1. Rebilling

Contractor shall inform the Department within forty-five (45) calendar days following the issuance of a notice of adverse action letter or a notice of adverse action letter on reconsideration if the Provider is electing to rebill where the Provider has provided such information to the Contractor.

2.2.1.1. Re-Billed Claims.

2.2.1.2. Providers may rebill claims after a denial by the Contractor for a complex inpatient audit finding for the "place of service" review or for other reviews where repricing is not possible or feasible and where Providers are permitted to rebill.

2.2.1.3. The previous denial related to an inpatient audit finding for the "place of service" review would have resulted in the recovery of the full inpatient claim and an associated contingency fee

would have been paid to the Contractor.

2.2.1.4. On a quarterly basis, Contractor will perform a reconciliation of claims for which Contractor previously invoiced and was paid its fee for the "place of service" recoveries, or for other recoveries where repricing is not possible or feasible, and where Providers are permitted to rebill. Any associated qualifying rebilled claims submitted by the Provider within the sixty (60) day period after the inpatient or other claim offset, a submitted single payment from a provider, or satisfaction in full of a Provider payment plan shall be reconciled pursuant to the following subsections.

2.2.1.5. If a contingency fee for previously identified savings from a denied version of a "place of service" audit finding has been (a) invoiced by Contractor and a payment has been received by Contractor from the State for the fee associated with the savings and (b) if the valid qualifying outpatient rebilled claim is approved by Contractor, Contractor will refund the difference between the fee received for the original recovery amount and the fee due to Contractor after the valid rebill of the outpatient claim.

2.2.1.6. The criteria for a valid qualifying outpatient rebill credit is where Contractor determines that the rebilled claim has Bill Type = 13X (any last character), the same Provider ID, the same Patient ID, the same Bill From Date, the same Bill To Date, and the same or similar services (Diagnosis & Procedure Codes). If the valid qualifying outpatient rebill amount is greater than the original inpatient recovery amount, Contractor shall refund the fee received for the original inpatient claim overpayment. If contractor neither invoices within 60 days nor sends the mutually agreed upon credit, then the state may deduct any credit due past 60 days from a subsequent invoice payment

2.2.2. Provider Payment

2.2.2.1. If Contractor receives a Provider refund check directly, Contractor shall forward the check to the Department along with all accompanying documents. Before forwarding the check, Contractor shall make copies of and otherwise document these payments. Contractor shall include a copy in the appropriate case file.

2.2.2.2. The Department will notify Contractor of any payments received.

2.2.2.3. Contractor acknowledges Federal regulations may change and shall cooperate fully with the State to make any necessary changes to the Contract to accommodate new or changed Federal regulations and their requirements.

2.2.3. Offset and Repayment Plans

2.2.3.1. Contractor shall notify the Department when a Provider requests to repay the Department through an offset against future Provider payments.

2.2.3.2. The Contractor will initiate all offset collections. Contractor shall, upon Department request, validate that an offset is appropriate and validate its calculation.

2.2.3.3. If the Provider would like a repayment plan, Contractor shall relay to the Department the request from the Provider. The Department will handle the request and work with the Provider to establish the repayment plan. A repayment plan may be requested in addition to an offset plan.

2.3 INVOICING AND PAYMENT PROCEDURES

2.3.1. Submittal of Invoices

2.3.1.1. Contractor shall not invoice the Department for any part of a recovery that has not been realized.

2.3.1.2. Recoveries by single payment are realized when the full amount of the recovery is received and deposited by the Department.

2.3.1.3. Recoveries by rebilling will be reported to Contractor by the Department when the transmittals are completed.

2.3.1.4. Recoveries by offsets plans will be reported to Contractor by the Department when the full amount of the recovery has been offset.

2.3.1.5. Recoveries by repayment plans are realized by the amount of each payment received and deposited.

2.3.1.6. Contractor shall invoice the Department by the fifteenth (15^{th}) of the following month, for payments received, rebillings completed, or offset plan completed in the prior month. The invoice shall contain:

2.3.1.7. Invoice Number.

2.3.1.8. Invoice Date.

2.3.1.9. Line Item description corresponding to the contingency fees payment owed from the balance tracking report for each Provider and notice of adverse action letter.

2.3.1.10. Adjustments, credits and debits, including fee adjustments due to valid qualifying Provider re-billing of prior overpayments where the original full inpatient claim was offset or repaid by any means, if any, with explanations and calculations.

2.3.1.11. An attestation by Contractor's Project Manager that the invoice is complete and accurate.

2.3.1.12. The net amount owed to the Contractor for the month.

2.3.1.13. Other pertinent information necessary to support the invoice, its attachments, summaries or details.

2.3.1.14. Other information, as directed by the Department.

2.3.1.15. The contractor shall include with the invoice statement a Provider balance tracking spreadsheet.

2.3.1.16. The Department will verify the invoice statement. Incomplete invoices will be rejected and unpaid.

2.3.1.17. At the Department's request and using a process approved by the Department, the Contractor shall calculate the dollar amounts for federal financial payments (FFP) for all identified overpayments that are successfully recovered. The contractor shall provide the data in a format that is approved by the Department at the time of invoicing.

2.3.2. Payment of Invoices

2.3.2.1. The Department shall remit payment to the Contractor, for all amounts shown on an invoice, after the Department's acceptance of that invoice. Acceptance of an invoice shall not imply the

acceptance or sufficiency of any Work performed or Deliverables submitted to the Department during the month for which the invoice covers or any other month. The Department shall not make any payment on an invoice prior to its acceptance of that invoice.

2.3.2.2. The Department will round all payment amounts to the nearest whole cent.

2.3.2.3. The Department will review the submitted invoice, and compare the information contained in the invoice to the Department's information. The Department will only accept an invoice after it has reviewed the information contained on the invoice and determined that all amounts are correct.

2.3.2.4. In the event that the Department determines that all information on an invoice is correct, the Department shall notify the Contractor of its acceptance of the invoice, in writing.

2.3.2.5. In the event that the Department determines that any information on an invoice is incorrect, the Department will notify the Contractor of this determination and what is incorrect on the invoice. The contractor shall correct any information the Department determined to be incorrect and resubmit that invoice to the Department for review.

2.3.2.5.1. The Department will review the invoice to ensure that all corrections have been made.

2.3.2.5.2. If all information on the resubmitted invoice is correct, the Department will accept the invoice.

2.3.2.5.3. If any information on the resubmitted invoice is still incorrect, then the Department will return the invoice to the Contractor for correction and resubmission.

2.3.2.6. In the event that Contractor reasonably believes that the calculation or determination of any payment is incorrect, Contractor shall notify the Department of the error immediately upon determination of the error. The Department will review the information presented by the Contractor 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.