CONTRACT AMENDMENT #3

SIGNATURE AND COVER PAGE

State Agency Department of Health Care Policy and Financing	**Original Contract Number** 18-101452
Contractor Kaiser Permanente	**Amendment Contract Number** 18-101452A3
Current Contract Maximum Amount Initial Term State Fiscal Year 2018 No Maximum Extension Terms State Fiscal Year 2019 No Maximum State Fiscal Year 2020 No Maximum State Fiscal Year 2021 No Maximum State Fiscal Year 2022 No Maximum Total for All State Fiscal Years No Maximum	**Contract Performance Beginning Date** The Effective Date or July 1, 2020 **Current Contract Expiration Date** June 30, 2021

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 Kaiser Permanente DocuSigned by: Laura English 067F200FBB24480... 8/20/2020 Date: _____	**STATE OF COLORADO** Jared Polis, Governor Department of Health Care Policy and Financing Kim Bimestefer, Executive Director DocuSigned by: K Bix 0B6A84797EA8493... By: Kim Bimestefer, Executive Director 8/28/2020 Date: _____

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:
Greg Tanner
BBE0F4C030DC45C...
By:_____
Department of Health Care Policy and Financing
Greg Tanner, Controller

Amendment Effective Date: 8/28/2020

1. PARTIES

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

2. TERMINOLOGY

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

3. AMENDMENT EFFECTIVE DATE AND TERM

A. Amendment Effective Date

This Amendment shall not be valid or enforceable until the Amendment Effective Date shown on the Signature and Cover Page for this Amendment. The State shall not be bound by any provision of this Amendment before that Amendment Effective Date, and shall have no obligation to pay Contractor for any Work performed or expense incurred under this Amendment either before or after of 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 or June 30, 2021, whichever is earlier.

4. PURPOSE

The purpose of the Original Contract is to set forth the terms under which the Contractor will serve as one of Colorado's Children's Basic Health Plan program (CHP+) Managed Care Organizations (MCOs) that will provide health care services to CHP+ eligible members. The purpose of the Amendment is to revise Exhibit B-1 Statement of Work.

5. MODIFICATIONS

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

Exhibit B-1, Statement of Work is modified as follows:

A. Section 6, Client Eligibility, Subsections 6.7, 6.7.1 are modified 6.7.1.5 as follows:

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

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

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

B. Section 7 Customer Service, Subsection 7.13 is modified as follows:

Subsection 7.13.3 is added as follows:

7.13.3 In establishing and maintaining the network adequacy standards, the Contractor considers:

7.13.3.1 The anticipated CHP+ enrollment.

7.13.3.2 The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area.

7.13.3.3 The numbers, types and specialties of network providers required to furnish the contracted CHP+ services.

7.13.3.4 The number of network providers accepting/not accepting new CHP+ members.

7.13.3.5 The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members.

7.13.3.6 The ability of providers to communicate with limited English proficient members in their preferred language.

7.13.3.7 The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications and accessible equipment for members with physical or mental disabilities.

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

C. Section 8, Covered Services is modified to add the following Subsections:

8.6.3 Contractor shall ensure providers are scheduling non-symptomatic well care physical examinations/mental wellness checkups within thirty (30) calendar days unless an appointment is required sooner to ensure the recommended screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule and all U.S. Preventative Services Task Force (USPSTF) behavioral health recommendations with a Grade of A or B.

8.6.6.1 In accordance with 2103(c)(5) of the Social Security Act, Contractor shall cover Medication Assistance Treatment (MAT) for Opioid Use Disorders (OUDs) and tobacco cessation.

8.15.4.1.1 In accordance with CRS 10-16-139(5) The Contractor shall include coverage and reimbursement for behavioral health screenings using a validated screening tool for behavioral health; coverage and reimbursement may be no less extensive than the coverage and reimbursement for the annual physical examination.

8.15.4.1.2 In accordance with 2103(c)(5) of the Social Security Act, Contractor shall identify a strategy to facilitate the used of validated behavioral health clinical assessment tools for the purpose of determining a diagnosis, evaluated the current level of functioning and develop treatment recommendations.

8.15.4.4 The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or SUD benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor).

8.15.4.5 The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service.

8.15.4.6 The Contractor covers all medically necessary covered treatments for covered BH diagnoses regardless of any co-occurring conditions.

8.18.4 In accordance with CRS 25.5.5-422.2. on or after January 1, 2020, the Contractor shall not:

8.18.4.1 Impose any prior authorization requirements on any prescription medication approved by the Food and Drug Administration (FDA) for the treatment of substance use disorders.

8.18.4.2 Impose any step therapy requirements as a prerequisite to authorizing coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

8.18.4.3 Exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medication and services were court ordered.

D. Section 10 Service Delivery is modified as follows:

Subsection 10.2.1.22.1 Routine physicals is hereby deleted in its entirety and replaced with the following:

10.2.1.22.1 Routine well care/physicals/mental wellness checkups.

Behavioral Health Network Time and Distance Table is moved from Subsection 10.2.1.11 to Subsection 10.2.1.13.2.

Subsection 10.2.4.2 is hereby deleted in its entirety and replaced with the following:

10.2.4.2 Contractor must establish mechanisms to ensure all network providers comply with the timely access requirements to ensure compliance with 42 C.F.R. §438.206(c)(1)(vi) and (v).

Subsection 10.5.3.1.2 is hereby deleted in its entirety and replaced with the following:

10.5.3.1.2 The Contractor shall conduct an initial screening of each Member's needs within 90 days of the effective date of enrollment.

10.5.3.1.2.1 The Contractor shall make subsequent attempts to conduct an initial screening of each Member's needs if the initial attempt to contact the Member is unsuccessful.

10.5.3.1.2.2 Develop an individual treatment plan as necessary based on the needs assessment and to avoid duplication of treatment.

E. Section 11 Compliance is modified as follows:

Subsection 11.1.2.2 is added as follows:

11.1.2.2 In accordance with 42 C.F.R. 438.210(e), Contractor must ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Subsection 11.1.12 is hereby deleted in its entirety and replaced with the following:

11.1.12 Expedited authorization decisions must provide notice as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. Contractor may extend the seventy-two (72) hour time frame by up to fourteen (14) calendar days if:

F. Section 14 Member and Provider issues is modified as follows:

Subsection 14.1.3.15 is modified to add the following:

14.1.3.15.1.13 Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language:

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

14.1.3.15.1.13.2 A statement providing information about contacting the office of the ombudsman for BH care if the Member believes his or her rights under the MHPAEA have been violated.

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

Subsection 14.1.4.1.1.1 is added as follows:

14.1.4.1.1.1. Contractor is required to inform providers and subcontractors about enrollee grievance, appeal and state review rights, state review procedures and timeframes at the time they enter the contract.

Subsection 14.1.5.1.1 is added as follows:

14.1.5.1.1 Contractor is required to inform providers and subcontractors about enrollee grievance, appeal and state review rights, state review procedures and timeframes at the time they enter the contract.

G. Section 15 Reporting is modified as follows:

Subsection 15.3.3.1 is hereby deleted and replaced with the following:

15.3.3.1 DELIVERABLE: Network Capacity and Services Report

Subsection 15.3.3.2 is hereby deleted and replaced with the following

15.3.3.2 DUE: Quarterly, January 30th, April 30th, July 31st, and October 30th

H. Section 16 Reimbursement is modified as follows:

Subsection 16.4.1 is hereby deleted in its entirety and replaced with the following:

16.4.1 The Contractor agrees, in accordance with Federal regulations (42. C.F.R. 457.1226, cross referencing to 42.C.F.R. 438.106), managed care organizations (MCOs) must not hold the Member liable for the following:

16.4.1.1 The MCO's debts, in the event of the entity's solvency.

16.4.1.2 Covered services provided to the enrollee for which the State does not pay the MCO or for which the State, MCO does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement.

16.4.1.3 Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO covered the services directly.

Subsection 16.5.1.2.4.3 is added as follows:

16.5.1.2.4.3 The Contractor shall compile an Audited Annual Financial Statement that includes, at a minimum, the following:

16.5.1.2.4.3.1 Annual internal financial statements, including balance sheet and income statement.

16.5.1.2.4.3.2 Audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP). The audited annual financial statements must be certified by an independent public accountant and the Contractor's Chief Financial Officer or their designee.

16.5.1.2.4.4 The Contractor shall submit their Audited Annual Financial Statement that covers the entirety of the previous State Fiscal Year to the Department in a format approved by the Department for review and approval. If format changes are required by the Department, the Department will provide sixty (60) days advance notice to the Contractor prior to requiring the implementation of the requested changes.

16.5.1.2.4.4.1 DELIVERABLE: Audited Annual Financial Statement

16.5.1.2.4.4.2 DUE: No later than six (6) months from the end of the Contractor's fiscal year that the statement covers. Any changes to the Contractor's fiscal year shall be reported to the Department at least sixty (60) days prior to implementation.

I. Section 19 Additional Federal Requirements is modified as follows:

Subsection 19.1.3 is added as follows:

19.1.3 If the Department learns that a Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, the Department:

19.1.3.1 Must notify the Secretary of the Department of Health and Human Services (Secretary) of the noncompliance.

19.1.3.2 May continue an existing agreement with the Contractor unless the Secretary directs otherwise.

19.1.3.3 May not renew or extend the existing agreement with the Contractor unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

J. Section 22 is added as follows:

Section 22 - State Managed Care Network

22.1 The Contractor shall ensure the successful transition of all necessary functions of the State Managed Care Network (SMCN) to the Contractor in accordance with the guidance and timeline provided by the Department. Transition activities shall include, but are not limited to, the following:

22.1.1 Configuring systems and key operations

22.1.2 Updating Member and provider communications for Department approval. Communications shall include, but are not limited to:

22.1.2.1 Member handbook

22.1.2.2 Member ID cards

22.1.2.3 Member letters

22.1.2.4 Contractor website

22.1.2.5 Provider manuals

22.1.3 Training member service and provider outreach centers to answer stakeholder questions regarding the transition of SMCN functions.

22.1.4 Updating provider contracting activities, as necessary, to ensure continuity of care.

22.1.5 Providing documentation, reports, data, records, systems, deliverables and other information requested by the Department to prepare for the transition.

22.1.6 Participating in an operational readiness review.

22.1.7 Participating in any other activities reasonably necessary to prepare for transition.

K. Section 23 is added as follows:

Section 23 – Contract Alignment and Revision

23.1 The Contractor acknowledges the need to continually improve the CHP+ program and provisions of the Contract.

23.2 The Contractor shall collaborate with the Department to revise the Contract to enhance performance standards and more closely align with the Department's goals related to improving member health outcomes, quality, and affordability through controlling program costs. Contract revisions shall include, but are not limited to, the following areas:

23.2.1 The consistent application of evidence-based programs that will improve member health and cost management for targeted conditions and populations.

23.2.2 The development and implementation of cost trend goals.

22.2.3 The development and implementation of quality outcome metrics.

23.3 The Contractor shall collaborate with the Department to improve encounter data and flat file submission.

L. Exhibit C Rates is added as follows:

I. CAPITATION RATES

State Fiscal Year 2020-21 rates will be effective on the later of the Effective Date or July 1, 2020.

The Contractor shall earn the following monthly capitation rate payments shown in the following table, adjusted by age and poverty level of the client's family.

Age	Under 101% FPL	101% to 156% FPL	157% to 200% FPL	201% to 260% FPL
Ages less than 2	243.43	243.14	243.64	243.21
Ages 2 through 5	150.86	150.86	150.86	150.86
Ages 6 through 18	184.91	185.09	185.05	184.99

M. Exhibit K, Member Handbook Requirements is modified as follows:

Subsection 1.1.7 is deleted in its entirety and replaced with the following:

1.1.7 Pursuant to section 1 932(b)(3)(B)(i) of the Social Security Act, the Contractor shall inform Members of those services available as a CHP+ benefit but explain that these services are not covered by the Contractor because of moral or religious objections, including any cost sharing. The Contractor shall inform the Member how and where to access benefits that are not covered under by the Contractor because of moral or religious objections. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor shall furnish information on how and where to obtain the service.