CONTRACT AMENDMENT #5

SIGNATURE AND COVER PAGE

State Agency Department of Health Care Policy and Financing	**Original Contract Number** 18-101452
Contractor Kaiser Permanente	**Amendment Contract Number** 18-101452A5
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** July 1, 2017 **Current Contract Expiration Date** June 30, 2022

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 **Laura English, Chief Financial Officer** Kaiser Permanente DocuSigned by: Laura English 067F200FBB24480... By: Laura English, Chief Financial Officer 6/17/2021 Date: _____	**STATE OF COLORADO** **Jared S. Polis, Governor** Department of Health Care Policy and Financing Kim Bimestefer, Executive Director DocuSigned by: 0B6A84797EA8493... By: Kim Bimestefer, Executive Director 6/17/2021 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:_____
Greg Tanner, Controller: Department of Health Care Policy and Financing

6/17/2021
Amendment Effective Date:_____

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.

4. PURPOSE

The purpose of the Original Contract is to renew the contract for State Fiscal Year 2022, and set forth the terms under which the Contractor will serve as one of Colorado's Child Health Plan Plus (CHP+) Managed Care Organizations (MCOs) that will provide health care services to CHP+ eligible members. The purpose of this Amendment is for increased alignment with the Department's overall goals of improving health, furthering performance outcomes, and reducing the cost of care for Coloradans. In alignment with those objectives, key modifications include improving the exchange of necessary data and information to more effectively monitor program performance and member health, establishing increased alignment between CHP+

and Medicaid, identifying and pursuing areas of opportunity to improve operational processes and performance, and creating mechanisms for collaborating in the sharing of ideas and best practices.

5. MODIFICATIONS

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

A. Exhibit B-1, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit B-2, Statement of Work, attached. All references to Exhibit B-1 shall henceforth be a reference to Exhibit B-2.

B. Exhibit C-2, Rates, is hereby deleted in its entirety and replaced with Exhibit C-3, Rates, attached. All references to Exhibit C-2 shall henceforth be a reference to Exhibit C-3.

C. Exhibit F-1, Data Specifications, is hereby deleted in its entirety.

D. Exhibit G, Colorado Medical Home Standards, is hereby deleted in its entirety.

E. Exhibit H, Non-Reimbursement for Serious Reportable Events, is hereby deleted in its entirety.

F. Exhibit I-1, Medical Home Provider Incentive Payment Program, is hereby deleted in its entirety.

G. Exhibit K-1, Member Handbook Requirements, is hereby deleted in its entirety.

H. Exhibit L, Contractor Disclosure Template, is hereby deleted in its entirety.

I. Exhibit J, Fluoride Varnish program, is hereby deleted in its entirety and replaced with Exhibit F, Fluoride Varnish Program, attached. All references to Exhibit J shall henceforth be a reference to Exhibit F.

J. Subsection U, Non-Solicitation of Department Employees, is hereby added to Section 20, General Provisions:

U. Non-Solicitation of Department Employees:

Contractor shall not recruit any employee of the Department for employment with Contractor during the term of this Contract, except that Contractor may accept applications from Department employees that are submitted independently by the employee.

Contractor shall notify the Department if it hires any former employee of the State of Colorado to perform any Work under this Contract. Contractor shall not permit former State of Colorado employees to perform the same work under the Contract that they performed for the State of Colorado, regardless of length of time former employee has been separated from the State of Colorado.

Contractor shall not hire any of the Department's Senior Executive Team, Office Directors, Division Directors, or Section Managers for a period of six months following that individual's termination of employment from the Department without the express, written consent of the Department's Executive Director. In accordance with §24-18-201, C.R.S., Contractor shall also not hire any employee of the Department, regardless of position, who was directly involved with this Contract or the Work for a period of six months following that individual's termination of employment from the Department.

If Contractor hires an employee or former employee of the Department in violation of this section, Contractor shall pay the Department an amount equal to 12 times the

employee's monthly salary at the time of termination of their employment with the Department as liquidated damages. The parties agree that quantifying losses arising from Contractor's breach of this section is inherently difficult because they represent the direct and indirect costs of recruitment, training, and lost productivity related to replacing personnel, and further stipulate that the agreed upon sum is not a penalty, but rather a reasonable measure of damages, given the nature of the losses that may result from employee replacement.

K. Section 23, HIPAA Covered Entity Status and Requirements, is hereby added to this Contract:

23. HIPAA COVERED ENTITY STATUS AND REQUIREMENTS

A. The Contractor has been determined, pursuant to federal law and regulations governing the privacy of certain health information, as a HIPAA Covered Entity and, to the extent applicable, shall comply with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d - 1320d-8 ("HIPAA") and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160 and 164 (the "Privacy Rule") and other applicable laws, as amended. If the Contractor status changes, the parties will execute an amendment to that effect.

B. The Contractor understands and acknowledges that HIPAA permits the exchange of Protected Health Information between covered entities when they have a relationship with the same individual and the exchange is necessary to coordinate the covered functions of each program and is for the purposes of payment and health care operations. Accordingly, no Business Associate Agreement is required between the Contractor and the State for the purposes of this Contract.

6. LIMITS OF EFFECT AND ORDER OF PRECEDENCE

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

EXHIBIT B-2, STATEMENT OF WORK

1. CHILD HEALTH PLAN PLUS PROGRAM

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

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

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

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

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

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

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

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

1.3.2. Establishing increased alignment between CHP+ and Medicaid;

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

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

1.3.5. Ensuring long-term sustainability of CHP+.

2. TERMINOLOGY

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

2.1.1. Adverse Benefit Determination – The denial or limited authorization of a requested service, including determinations based on the type or level or service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit; reduction suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure of the Contractor to act with the timeframes provided in 42 CFR 438.408(b)(1) – (2) regarding the standard resolution of Grievances and Appeals; and the denial of an enrollee's request to dispute a financial liability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.1.18. Colorado interChange - The Department's Medicaid Management Information System and supporting services, which includes: Fiscal Agent Operations Services, Provider Web Portal, online Provider enrollment, claims processing and payment, Electronic Data Interchange

(EDI), Electronic Document Management System (EDMS), Provider call center, help desk, and general information technology functionality and business operations

2.1.19. Colorado Revised Statutes (C.R.S.) – The legal codes of Colorado; the codified general and permanent statutes of the Colorado General Assembly.

2.1.20. Colorado's 10 Winnable Battles – Public health and environmental priorities that have known, effective solutions focusing on healthier air, clean water, infectious disease prevention, injury prevention, mental health and substance use, obesity, oral health, safe food, tobacco and unintended pregnancy. The initiative is overseen by the Colorado Department of Public Health and Environment.

2.1.21. Comprehensive Risk Contract – A risk contract between the Department and an MCO that covers comprehensive services that includes inpatient Hospital Services and any of the following services, or any three or more of the following services: outpatient Hospital Services, rural health clinic services, Federally Qualified Health Center (FQHC) services, other laboratory and x-ray services, Nursing Facility service, family planning services, physician services, and home health services as defined in 42 C.F.R. § 438.2.

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

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

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

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

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

2.1.27. Cultural Competence - The provision of all Covered Services by Participating Providers in a manner respectful of the attitudes and health practices of Members from diverse racial, ethnic, religious, age, gender, sexual orientation, and Disability groups, including but not limited to, language capability, Participating Provider awareness of cultural difference (e.g., medical beliefs; family involvement in medical decisions) and knowledge of special health issues common to racial and ethnic groups (e.g., illnesses common to immigrants; differences in pharmacological dosages for different age, gender and racial groups).

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

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

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

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

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

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

2.1.34. Early intervention services and supports or Early Intervention, (EI) - Services described in CRS 27-10.5 part 7, including education, training, and assistance in child development, parent education, therapies, and other activities for infants and toddlers zero through two (0-2) years of age and their families, that are designed to meet the developmental needs of infants and toddlers, which include, but are not limited to, cognition, speech, communication, physical, motor, vision, hearing, social-emotional and self-help skills.

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

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

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

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

2.1.37.2. Serious impairment to bodily functions.

2.1.37.3. Serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

2.1.44. FDA - The Federal Food and Drug Administration.

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

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

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

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

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

2.1.50. Grievance – An expression of dissatisfaction about any matter other than an Adverse Benefit Determination, including but not limited to, quality of care or services provided and aspects of interpersonal relationships such as rudeness of Provider or employee, or failure to respect the Member's rights as defined at 42 C.F.R. § 438.400 (b).

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

2.1.52. Health Care Professional - A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed clinical social worker, registered respiratory therapist, certified respiratory therapy technician, or pharmacist.

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

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

2.1.55. HIPAA - The Health Insurance Portability and Accountability Act of 1996.

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

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

2.1.58. Identification Card - Membership card provided to the Member by Contractor upon Enrollment in the Contractor's MCO. The Identification Card shall include, at a minimum, the Member's name, the Contractor's name, and the Member's effective date of Enrollment,

and information which will enable the Member to contact the Contractor's MCO for assistance.

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

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

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

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

2.1.63. Managed Care Organization (MCO) – An entity that has or is seeking to qualify for, a Comprehensive Risk Contract and that is a federally qualified Health Maintenance Organization that meets the advanced directives requirements; or any public or private entity that meets the Advance Directives requirements and is determined by the Secretary to make the services it provides to its CHP+ enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other CHP+ beneficiaries within the area served by the entity, and meets the solvency standards of 42 C.F.R. § 438.116 as defined in 42 C.F.R. § 438.2.

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

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

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

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

2.1.68. Medical Loss Ratio (MLR) – Percent of a premium used to pay for medical claims and activities that improve the quality of care; a basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees.

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

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

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

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

2.1.73. Member – Any individual enrolled in the Contractor's MCO.

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

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

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

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

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

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

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

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

2.1.82. Ownership or Control Interest – An individual or entity that: has an ownership interest totaling five percent (5%) or more; has an Indirect Ownership Interest equal to five percent (5%) or more; has a combination of direct and Indirect Ownership Interests equal to five percent (5%) or more; owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five percent (5%) of the value of the property or assets of the other entity; is an officer or director of an entity that is organized as a corporation; or is a partner in an entity that is organized as a partnership.

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

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

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

2.1.86. PHI - Protected Health Information.

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

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

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

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

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

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

2.1.93. Protected Health Information (PHI) – Any Protected Health Information, including, without limitation any information whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes, but is not limited to, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act.

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

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

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

2.1.97. Provider Network - The Participating Providers in the Contractor's MCO.

2.1.98. Provider Preventable Conditions – Hospital-acquired conditions that were not present on admission (POA) as an inpatient and that alter the condition or diagnosis of the individual receiving care.

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

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

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

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

2.1.103. Service Area - Those counties within the State of Colorado in which:

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

2.1.103.2. The Contractor has assured access to Covered Services under this Contract; and,

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

2.1.104. Significant Business Transaction – Any business transaction or series of transactions that, during any one (1) Fiscal Year, exceed the lesser of twenty-five thousand dollars ($25,000.00) or five percent (5%) of the Contractor's total operating expenses.

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

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

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

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

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

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

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

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

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

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

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

2.1.116. Utilization Review – A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, Referrals, procedures or settings.

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

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

2.1.119. Work Product – The tangible and intangible results of the Work, whether finished or unfinished, including drafts. Work Product includes, but is not limited to, documents, text, software (including source code), research, reports, proposals, specifications, plans, notes, studies, data, images, photographs, negatives, pictures, drawings, designs, models, surveys, maps, materials, ideas, concepts, know-how, and any other results of the Work. "Work Product" does not include any Contractor Pre-Existing Material that is used, without modification, in the performance of the Work.

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

3. CONTRACTOR'S GENERAL REQUIREMENTS

3.1. The Contractor shall be solely responsible for all tasks and deliverables to be completed, services to be rendered and performance standards to be met under the work outlined in this Contract.

3.2. The Contractor may be privy to internal policy discussions, contractual issues, price negotiations, confidential medical information, Department financial information, and advance knowledge of legislation. In addition to all other confidentiality requirements of the Contract, the Contractor shall also consider and treat any such information as confidential and shall only disclose it in accordance with the terms of the Contract.

3.3. The Contractor shall work cooperatively with Department staff and, if applicable, the staff of other State contractors to ensure the completion of the Work. The Department may, in its sole discretion, use other Contractors to perform activities related to the Work that are not contained in the Contract or to perform any of the Department's responsibilities. In the event of a conflict between

Contractor and any other State contractor, the State will resolve the conflict and Contractor shall abide by the resolution provided by the State.

3.4. The Contractor shall inform the Department on current trends and issues in the healthcare marketplace and provide information on new technologies in use that may impact the Contractor's responsibilities under the work outlined in this Contract.

3.5. The Contractor shall maintain complete and detailed records of all meetings, system development life cycle documents, presentations, project artifacts and any other interactions or Deliverables related to the project described in the Contract. The Contractor shall make such records available to the Department upon request, throughout the term of the Contract.

3.6. The Contractor shall use the Department-developed definition for the following terms, when applicable and when available: Appeal; co-payment; durable medical equipment; emergency room care; emergency services; excluded services; Grievance; habilitation services and devices; health insurance; home healthcare; hospice services; Hospitalization; Hospital outpatient care; medically necessary; network; non-participating Provider; physician services; plan; preauthorization; prescription drug coverage; Primary Care physician; PCP; Participating Provider; capitation; Provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care.

3.7. Deliverables

3.7.1. All Deliverables shall meet Department-approved format and content requirements. The Department will specify the number of copies and media for each Deliverable.

3.7.2. Each Deliverable will follow the Deliverable submission process as follows:

3.7.2.1. Contractor shall submit each Deliverable to the Department for review and approval.

3.7.2.2. For all documentation, creation, review and acceptance cycle:

3.7.2.2.1. Contractor shall gather and document requirements for the Deliverable.

3.7.2.2.2. Contractor shall create a draft in the Department-approved format for the individual Deliverable.

3.7.2.3. Contractor shall Perform internal quality control review(s) of the Deliverable including, but not limited to:

3.7.2.3.1. Readability

3.7.2.3.2. Spelling

3.7.2.3.3. Grammar

3.7.2.3.4. Completion

3.7.2.3.5. Adherence to all required templates or development of templates.

3.7.2.4. All modifications shall include version control and tracked changes.

3.7.2.5. The Department will review the Deliverable and may direct Contractor to make changes to the Deliverable. Contractor shall make all changes within ten (10) Business Days following the Department's direction to make the change unless the Department provides a longer period in writing.

3.7.2.6. Changes the Department may include, but are not limited to, modifying portions of the Deliverable, requiring new pages or portions of the Deliverable, requiring resubmission of

the Deliverable or requiring inclusion of information or components that were left out of the Deliverable.

3.7.3. The Department may also direct the Contractor to provide clarification or provide a walkthrough of any Deliverable to assist the Department in its review. Contractor shall provide the clarification or walkthrough as directed by the Department.

3.7.4. Once the Department has received an acceptable version of the Deliverable, including all changes directed by the Department, the Department will notify Contractor of its acceptance of the Deliverable in writing. A Deliverable shall not be deemed accepted prior to the Department's notice to Contractor of its acceptance of that Deliverable.

3.7.5. Contractor shall employ an internal quality control process to ensure that all Deliverables are complete, accurate, easy to understand and of high quality. Contractor shall provide Deliverables that, at a minimum, are responsive to the specific requirements for that Deliverable, organized into a logical order, contain accurate spelling and grammar, are formatted uniformly, and contain accurate information and correct calculations. Contractor shall retain all draft and marked-up documents and checklists utilized in reviewing Deliverables for reference as directed by the Department.

3.7.6. If any due date for a Deliverable falls on a day that is not a business day, then the due date shall be automatically extended to the next business day, unless otherwise directed by the Department.

3.7.7. All due dates or timelines that reference a period of days, months or quarters shall be measured in calendar days, months and quarters unless specifically stated as being measured in business days or otherwise. All times stated in the Contract shall be considered to be in Mountain Time, adjusted for Daylight Saving Time as appropriate, unless specifically stated otherwise.

3.7.8. No Deliverable, report, data, procedure or system created by Contractor for the Department that is necessary to fulfilling Contractor's responsibilities under the Contract, as determined by the Department, shall be considered proprietary.

3.7.9. If any Deliverable contains ongoing responsibilities or requirements for Contractor, such as Deliverables that are plans, policies or procedures, then Contractor shall comply with all requirements of the most recently approved version of that Deliverable. Contractor shall not implement any version of any such Deliverable prior to receipt of the Department's written approval of that version of that Deliverable. Once a version of any Deliverable described in this subsection is approved by the Department, all requirements, milestones and other Deliverables contained within that Deliverable shall be considered to be requirements, milestones and Deliverables of this Contract.

3.7.10. Any Deliverable described as an update of another Deliverable shall be considered a version of the original Deliverable for the purposes of this subsection.

3.8. Stated Deliverables and Performance Standards

3.8.1. Any section within this Statement of Work headed with or including the term "DELIVERABLE" or "PERFORMANCE STANDARD" is intended to highlight a Deliverable or performance standard contained in this Statement of Work and provide a clear due date for the Deliverables. The sections with these headings are for ease of reference not intended to expand or limit the requirements or responsibilities related to any Deliverable or performance standard, except to provide the due date for the Deliverables.

3.9. Communication Requirements

3.9.1. Communication with the Department

3.9.1.1. The Contractor shall enable all Contractor staff to exchange documents and electronic files with the Department staff in formats compatible with the Department's systems. The Department currently uses Microsoft Office 2016 and/or Microsoft Office 365 for PC. If the Contractor uses a compatible program that is not the system used by the Department, then the Contractor shall ensure that all documents or files delivered to the Department are completely transferrable and reviewable, without error, on the Department's systems.

3.9.1.2. The Contractor shall provide the Department with a listing of the following individuals within the Contractor's organization, that includes cell phone numbers and email addresses:

3.9.1.2.1. An individual who is authorized to speak on the record for media, legislative or other requests regarding the work, the Contractor or any issues that arise that are related to the work.

3.9.1.2.2. An individual who is responsible for any written communications, surveys, in-person meetings, call center scripting, electronic distribution lists for Network Providers, Prospective Network Providers, Prospective Members, Members, Prospective Partners or any Marketing related to the Work, savings and Care Coordination utilization reports.

3.9.1.2.3. Back-up communication staff that can respond in the event that the other individuals listed are unavailable.

3.9.1.3. The Department will use a transmittal process to provide the Contractor with official direction within the scope of the Contract. The Contractor shall comply with all direction contained within a completed transmittal. For a transmittal to be considered complete, it must include, at a minimum, all of the following:

3.9.1.3.1. The date the transmittal will be effective.

3.9.1.3.2. Direction to the Contractor regarding performance under the Contract.

3.9.1.3.3. A due date or timeline by which the Contractor shall comply with the direction contained in the transmittal.

3.9.1.3.4. The signature of the Department employee who has been designated to sign transmittals.

3.9.1.3.4.1. The Department will provide the Contractor with the name of the person it has designated to sign transmittals on behalf of the Department, who will be the Department's primary designee. The Department will also provide the Contractor with a list of backups who may sign a transmittal on behalf of the Department if the primary designee is unavailable. The Department may change any of its designees from time to time by providing notice to the Contractor through a transmittal.

3.9.1.4. The Department may deliver a completed transmittal to the Contractor in hard copy, as a scanned attachment to an email, or through a dedicated communication system, if such a system is available.

3.9.1.4.1. If a transmittal is delivered through a dedicated communication system or other electronic system, then the Department may use an electronic signature to sign that transmittal.

3.9.1.5. If the Contractor receives conflicting transmittals, the Contractor shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, to obtain direction. If the Department does not provide direction otherwise, then the transmittal with the latest effective date shall control.

3.9.1.6. In the event that the Contractor receives direction from the Department outside of the transmittal process, it shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, and have the Department confirm that direction through a transmittal prior to complying with that direction.

3.9.1.7. Transmittals may not be used in place of an amendment, and may not, under any circumstances be used to modify the term of the Contract or any compensation under the Contract. Transmittals are not intended to be the sole means of communication between the Department and the Contractor, and the Department may provide day-to-day communication to the Contractor without using a transmittal.

3.9.1.8. The Contractor shall retain all transmittals for reference and shall provide copies of any received transmittals upon request by the Department.

3.9.2. Communication with Members, Providers and Other Entities

3.9.2.1. The Contractor shall maintain consistent communication, both proactive and responsive, with Members, Network Providers, and other partners, and promote communication among Network Providers.

3.9.2.2. The Contractor shall create, document, and implement a Communication Plan that specifies how the Contractor shall maintain necessary communication with all Members, Network Providers, and partners. The Communication Plan shall include:

3.9.2.2.1. A description of the purpose and frequency of communications with Members, Network Providers, and other partners.

3.9.2.2.2. The communication methods the Contractor plans to use. Communication methods may consist of written communications, in-person meetings, one-on one support, electronic communication and any other method the Contractor deems appropriate.

3.9.2.2.3. A contingency plan with specific means of immediate communication with Members and Providers and a method for accelerating the internal approval and communication process to address urgent communications or crisis situations.

3.9.2.2.4. A general plan for how the Contractor shall address communication deficiencies or crisis situations, including how the Contractor shall increase staff, contact hours or other steps the Contractor shall take if existing communication methods for Members or Providers are insufficient.

3.9.2.3. The Contractor shall review and update the Communication Plan at least annually and submit to the Department for review and approval.

3.9.2.3.1. DELIVERABLE: Communication Plan

3.9.2.3.2. DUE: Within ten (10) Business Days after the Effective Date

3.9.2.4. The Contractor shall review its Communication Plan on an annual basis and determine if any changes are required to account for any changes in the Work, in the Department's processes and procedures or in the Contractor's processes and procedures. The Contractor shall submit an Annual Communication Plan Update that contains all changes from the most recently approved prior Communication Plan, Annual Communication Plan Update or Interim Communication Plan Update or shall note that there were no changes.

3.9.2.4.1. DELIVERABLE: Annual Communication Plan Update

3.9.2.4.2. DUE: Annually, by July 31st of each year

3.9.2.5. The Contractor shall modify the Communication Plan as directed by the Department to account for any changes in the work, in the Department's processes and procedures or in the Contractor's processes and procedures, or to address any communication related deficiencies determined by the Department.

3.9.2.5.1. DELIVERABLE: Communication Plan Update

3.9.2.5.2. DUE: Within ten (10) Business Days following the receipt of the request from the Department, unless the Department allows for a longer time in writing.

3.10. Start-Up and Closeout Periods

3.10.1. The Contractor shall have a Start-Up and a Closeout Period.

3.10.2. Start-Up Period

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

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

3.10.2.3. The Operational Start Date shall not occur until the Contractor has completed all requirements of the Start-Up Period, including the completion of the Start-Up Plan.

3.10.3. Start-Up Plan

3.10.3.1. During the Start-Up Period, the Contractor shall create a Start-Up Plan that contains, at a minimum, all of the following:

3.10.3.1.1. A description of all activities, timelines, milestones and Deliverables necessary for the Contractor to be fully able to perform all Work by the Operational Start Date.

3.10.3.1.2. A listing of all personnel involved in the Start-Up and what aspect of the Start-Up they are responsible for.

3.10.3.1.3. The Contractor may be required to participate in an operational readiness review at the direction of the Department, including a desk audit and/or Site Review covering, but not limited to the following:

3.10.3.1.3.1. Administrative staffing and resources.

3.10.3.1.3.2. Delegation and oversight of MCO, PCP, or entity responsibilities.

3.10.3.1.3.3. Provider communications.

3.10.3.1.3.4. Grievances and Appeals.

3.10.3.1.3.5. Member communication, services and outreach.

3.10.3.1.3.6. Provider Network Management.

3.10.3.1.3.7. Program Integrity/Compliance.

3.10.3.1.3.8. Case management/Care Coordination/service planning.

3.10.3.1.3.9. Quality improvement.

3.10.3.1.3.10. Utilization review.

3.10.3.1.3.11. Financial reporting and monitoring.

3.10.3.1.3.12. Financial solvency.

3.10.3.1.3.13. Claims management.

3.10.3.1.3.14. Encounter Data and enrollment information management.

3.10.3.1.4. Staff hiring and training.

3.10.3.1.5. Infrastructure for data collection and exchanges, billing and reimbursement.

3.10.3.1.6. Test system compatibility.

3.10.3.1.7. Adherence to security protocols.

3.10.3.1.8. Established Provider Networks and agreements.

3.10.3.1.9. Member and Provider materials and education.

3.10.3.1.10. Activities to fully transition the services described in the Contract from a prior contractor.

3.10.3.1.11. Policy and Procedures Manual that contains the policies and procedures for all systems and functions necessary for the Contractor to complete its obligations under the Contract.

3.10.3.1.12. Business Continuity Plan described in Section 3.11.

3.10.3.1.13. The risks associated with the Start-Up Period and a plan to mitigate those risks.

3.10.3.1.14. Data as needed for the Department rate setting process.

3.10.3.1.15. Demonstration that they have the capacity to serve the expected Enrollment in that Service Area.

3.10.3.2. The Contractor shall deliver the Start-Up Plan to the Department for review and approval.

3.10.3.2.1. DELIVERABLE: Start-Up Plan

3.10.3.2.2. DUE: Within five (5) Business Days after the Effective Date

3.10.3.3. The Contractor shall update the Start-Up Plan based on the Department's request and resubmit the Start-Up Plan for review and approval.

3.10.3.3.1. DELIVERABLE: Start-Up Plan Update

3.10.3.3.2. DUE: Within five (5) Business Days from the Department's request for an update

3.10.3.4. The Contractor shall implement the Start-Up Plan upon the Department's approval of the Start-Up Plan.

3.10.3.5. The Contractor shall not engage in any Work under the Contract, other than the Work described above in the Start-Up Period, prior to the Operational Start Date.

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

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

3.10.3.6.2. DUE: Upon the Effective Date

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

3.10.4. Closeout Period

3.10.4.1. The Closeout Period shall begin on the earlier of ninety (90) days prior to the end of the last renewal year of the Contract or notice by the Department of non-renewal. The Closeout Period shall end on the day that the Department has accepted the final Deliverable for the Closeout Period, as determined in the Department-approved and updated Closeout Plan, and has determined that the closeout is complete.

3.10.4.2. This Closeout Period may extend past the termination of the Contract. The Department will perform a closeout review to ensure the Contractor has completed all requirements of the Closeout Period. If the Contractor has not completed all of the requirements of the Closeout Period by the date of the termination of the Contract, then any incomplete requirements shall survive termination of the Contract.

3.10.4.3. During the Closeout Period, the Contractor shall complete all for the following:

3.10.4.3.1. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department, and complete all steps, Deliverables and milestones contained in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

3.10.4.3.2. Provide to the Department, or any other Contractor at the Department's direction, all reports, data, systems, Deliverables and other information reasonably necessary for a transition as determined by the Department or included in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

3.10.4.3.3. Ensure that all responsibilities under the Contract have been transferred to the Department, or to another Contractor at the Department's direction, without significant interruption.

3.10.4.3.4. Notify any Subcontractors of the termination of the Contract, as directed by the Department.

3.10.4.3.5. Notify all Members that the Contractor shall no longer be the CHP+ MCO as directed by the Department. The Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, the Contractor shall deliver these notifications to all Members, but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.

3.10.4.3.5.1. DELIVERABLE: Member Notifications

3.10.4.3.5.2. DUE: Sixty (60) days prior to termination of the Contract

3.10.4.3.6. Notify all Providers that the Contractor shall no longer be the CHP+ MCO as directed by the Department. The Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, the Contractor shall deliver these notifications to all Providers, but in no event shall the Contractor deliver any such notification prior to approval of that notification by the Department.

3.10.4.3.6.1. DELIVERABLE: Provider Notifications

3.10.4.3.6.2. DUE: Sixty (60) days prior to termination of the Contract.

3.10.4.3.7. Continue meeting each requirement of the Contract as described in the Department-approved and updated Closeout Plan, or until the Department determines that a specific requirement is being performed by the Department or another contractor, whichever is sooner. The Department will determine when any specific requirement is being performed by the Department or another Contractor, and will notify the Contractor of this determination for that requirement.

3.10.5. Closeout Planning

3.10.5.1. Closeout Plan

3.10.5.1.1. The Contractor shall create a Closeout Plan that describes all requirements, steps, timelines, milestones and Deliverables necessary to fully transition the services described in the Contract from Contractor to the Department or to another Contractor after the termination of the Contract. The Closeout Plan shall also designate an individual to act as a closeout coordinator, who will ensure that all requirements, steps, timelines, milestones and Deliverables contained in the Closeout Plan are completed and work with the Department and any other contractor to minimize the impact of the transition on the Department. Contractor shall deliver the Closeout Plan to the Department for review and approval.

3.10.5.1.1.1. DELIVERABLE: Closeout Plan

3.10.5.1.1.2. DUE: 30 days after Effective Date of contract

3.10.5.1.2. The Contractor shall update the Closeout Plan, at least annually, to include any technical, procedural or other changes that impact any steps, timelines or milestones contained in the Closeout Plan, and deliver this Closeout Plan Update to the Department for review and approval.

3.10.5.1.2.1. DELIVERABLE: Closeout Plan Update

3.10.5.1.2.2. DUE: Annually, by July 31st of each year

3.11. Business Continuity

3.11.1. The Contractor shall create a Business Continuity Plan that Contractor shall follow in order to continue operations after a Disaster or a Business Interruption. The Business Continuity Plan shall include, but is not limited to, all of the following:

3.11.1.1. How Contractor shall replace staff that has been lost or is unavailable during or after a Business Interruption so that the Work is performed in accordance with the Contract.

3.11.1.2. How Contractor shall back-up all information necessary to continue performing the Work, so that no information is lost because of a Business Interruption.

3.11.1.2.1. In the event of a Disaster, the plan shall also include how Contractor shall make all information available at its back-up facilities.

3.11.1.3. How Contractor shall minimize the effects on Members and Providers of any Business Interruption.

3.11.1.4. How Contractor shall communicate with the Department during the Business Interruption and points of contact within Contractor's organization the Department can contact in the event of a Business Interruption.

3.11.1.5. Planned long-term back-up facilities out of which Contractor can continue operations after a Disaster.

3.11.1.6. The time period it will take to transition all activities from Contractor's regular facilities to the back-up facilities after a Disaster.

3.11.2. Contractor shall deliver the Business Continuity Plan to the Department for review and approval.

3.11.2.1. DELIVERABLE: Business Continuity Plan

3.11.2.2. DUE: Within 30 Business days after the Effective Date

3.11.3. Contractor shall review its Business Continuity Plan at least semi-annually and update the plan as appropriate to account for any changes in Contractor's processes, procedures or circumstances. Contractor shall submit an Updated Business Continuity Plan that contains all changes from the most recently approved prior Business Continuity Plan or Updated Business Continuity Plan or shall note that there were no changes.

3.11.3.1. DELIVERABLE: Updated Business Continuity Plan

3.11.3.2. DUE: Annually, by July 31st of each year.

3.11.4. In the event of any Business Interruption, Contractor shall implement its most recently approved Business Continuity Plan or Updated Business Continuity Plan immediately after Contractor becomes aware of the Business Interruption. In that event, Contractor shall comply with all requirements, Deliverables, timelines and milestones contained in the implemented plan.

3.12. Accreditation

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

3.12.1.1. Accreditation status, survey type, and level;

3.12.1.2. Accreditation results including recommended actions, corrective action plans, or findings; and

3.12.1.3. Expiration date of the accreditation.

3.13. Federal Financial Participation Related Intellectual Property Ownership

3.13.1. In addition to the intellectual property Ownership rights specified in the Contract, the following subsections enumerate the intellectual property Ownership requirements the Contractor shall meet during the term of the Contract in relation to federal financial

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.13.1.8.3. All necessary data files.

3.13.1.8.4. User and operation manuals and other documentation.

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

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

3.14. Performance Reviews

3.14.1. The Department may conduct performance reviews or evaluations of the Contractor in relation to the Work performed under the Contract.

3.14.2. The Department may work with the Contractor in the completion of any performance reviews or evaluations or the Department may complete any or all performance reviews or evaluations independently, at the Department's sole discretion.

3.14.3. The Contractor shall provide all information necessary for the Department to complete all performance reviews or evaluations, as determined by the Department, upon the Department's request. The Contractor shall provide this information regardless of whether the Department decides to work with the Contractor on any aspect of the performance review or evaluation.

3.14.4. The Department may conduct these performance reviews or evaluations at any point during the term of the Contract, or after termination of the Contract for any reason.

3.14.5. The Department may make the results of any performance reviews or evaluations available to the public, or may publicly post the results of any performance reviews or evaluations.

3.15. Renewal Options and Extensions

3.15.1. The Department may, within its sole discretion, choose to not exercise any renewal option in the Contract for any reason. If the Department chooses to not exercise an option, it may reprocure the performance of the Work in its sole discretion.

3.15.2. The Parties may amend the Contract to extend beyond five (5) years, in accordance with the Colorado Procurement Code and its implementing rules, in the event that the Department determines the extension is necessary to align the Contract with other Department contracts, to address State or Federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the Work.

3.15.2.1. In the event that the Contract is extended beyond five (5) years, the annual maximum compensation for the Contract in any of those additional years shall not exceed the Contract maximum amount for the prior State Fiscal Year (SFY) plus the annual percent increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the Denver-Boulder-Greeley metropolitan area for the calendar year ending during that prior SFY. If the CPI-U for Denver-Boulder-Greeley is for some reason not available as specified in this subsection, the increase shall be equal to the percent increase in the CPI-U (U.S.) for the same period.

3.15.3. The limitation on the annual maximum compensation shall not include increases made specifically as compensation for additional Work added to the Contract.

3.16. State System Access

3.16.1. If Contractor requires access to any State computer system to complete the Work, Contractor shall have and maintain all hardware, software and interfaces necessary to access the system without requiring any modification to the State's system. Contractor shall follow all State policies, processes and procedures necessary to gain access to the State's systems.

3.17. Protection of Systems Data

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

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

3.17.2.1. Contractor provides physical or logical storage of State Records;

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

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

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

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

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

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

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

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

3.17.4. Colorado Information Security Policy (CISP) Compliance

3.17.4.1. Contractor shall assess its compliance with the CISPs, in effect at the time of the assessment, issued by the Governor's Office of Information Technology ("OIT") posted at www.oit.state.co.us/about/policies under Information Security.

3.17.4.2. For the purposes of reviewing and assessing compliance with the CISPssn, the Contractor shall consider itself to be both the Information Technology Service Provider (ITSP) and Business Owner.

3.17.4.3. Contractor shall deliver to the State the signed CISP Attestation, on a form provided by the Department, indicating that Contractor has assessed its compliance with the CISPs and has developed a plan to correct, in a timely manner, any security vulnerabilities identified during the assessment.

3.17.4.3.1. DELIVERABLE: CISP Attestation

3.17.4.3.2. DUE: Within 30 Business Days after the Effective Date

3.17.4.4. Contractor shall assess its compliance with the CISPs on an annual basis and deliver to the State the signed CISP Attestation, on a form provided by the Department.

3.17.4.4.1. DELIVERABLE: Annual CISP Attestation

3.17.4.4.2. DUE: July 30, 2021, and annually, by June 30th of each year thereafter

3.17.4.5. Contractor shall cause its Subcontractors to comply with the CISPs and to assess their compliance on at least and annual basis. If any Subcontractor's assessment determines that the Subcontractor is not in compliance, then Contractor shall ensure that Subcontractor corrects, in a timely manner, any security vulnerabilities identified during the assessment.

3.17.5. Health and Human Services HIPAA Security Rule Risk Assessments

3.17.5.1. Contractor shall deliver to the State the signed HHS Attestation, on a form provided by the Department, indicating that Contractor has conducted a risk assessment of its operations related to the services provided under this Contract that satisfies the requirement of 45 CFR. §164.308(a)(1)(ii)(A) (the "HIPAA Security Rule"), and that Contractor has developed a plan to correct, in a timely manner, any vulnerabilities in administrative, technical, or physical safeguards identified during the assessment.

3.17.5.1.1. DELIVERABLE: HHS Attestation

3.17.5.1.2. DUE: Within 30 Business Days after the Effective Date

3.17.5.2. Contractor shall conduct an annual risk assessment of its operations related to the services provided under this Contract that satisfies the requirement of the HIPAA Security Rule and deliver to the State the signed HHS Attestation, on a form provided by the Department.

3.17.5.2.1. DELIVERABLE: Annual HHS Attestation

3.17.5.2.2. DUE DATE: July 30, 2021, and annually, by June 30th of each year thereafter

3.17.5.3. Contractor shall cause its Subcontractors to comply with the HIPAA Security Rule and assess their compliance on at least an annual basis. If any Subcontractor's assessment determines that the Subcontractor is not in compliance, then Contractor shall ensure that Subcontractor corrects, in a timely manner, any vulnerabilities in administrative, technical, or physical safeguards identified during the assessment.

3.17.6. Subject to Contractor's reasonable access security requirements and upon reasonable prior notice, Contractor shall provide the State with scheduled access for the purpose of inspecting and monitoring access and use of State Records, maintaining State systems, and evaluating physical and logical security control effectiveness.

3.17.7. Contractor shall perform background checks on all of its respective employees and agents performing services or having access to State Records provided under this Contract. A background check performed during the hiring process shall meet this requirement. Contractor shall perform a background check on any employee if the Contractor becomes aware of any reason to question the employability of an existing employee. Contractor shall require all Subcontractors to meet the standards of this requirement.

3.17.7.1. Contractor shall deliver to the State the signed Background Check Attestation, on a form provided by the Department, indicating that background checks have been completed on employees participating in operations related to this Contract.

3.17.7.1.1. DELIVERABLE: Background Check Attestation

3.17.7.1.2. DUE: July 30, 2021

3.17.7.2. If Contractor shall have access to Federal Tax Information under the Contract, Contractor shall agree to the State's requirements regarding Safeguarding Requirements for Federal Tax Information and shall comply with the background check requirements defined in IRS Publication 1075 and §24-50-1002, C.R.S.

3.18. Data Handling

3.18.1. The State, in its sole discretion, may securely deliver State Records directly to Contractor. Contractor shall maintain these State Records only within facilities or locations that

Contractor has attested are secure, including for the authorized and approved purposes of backup and disaster recovery purposes. Contractor may not maintain State Records in any data center or other storage location outside the United States for any purpose without the prior express written consent of the State.

3.18.2. Contractor shall not allow remote access to State Records from outside the United States, including access by Contractor's employees or agents, without the prior express written consent of OIS. Contractor shall communicate any request regarding non-U.S. access to State Records to the Security and Compliance Representative for the State. The State shall have sole discretion to grant or deny any such request.

4. CONTRACTOR SERVICE AREA AND PERSONNEL

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

4.1.1. The Service Area for the Contractor includes the following counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson

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

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

4.4. The Contractor may request to change their service area at least six (6) months prior to the Contractor's expected expansion date, Contractor shall provide the Department with a written request, and a service plan analysis when seeking to expand into a new Service Area. Such written notice and analysis shall include, but not be limited to:

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

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

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

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

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

4.7. The Contractor shall notify the Department of plans to discontinue providing Covered Services to Members within a county or counties within the Contractor's Service Area, by providing no less than six (6) months prior written notice to the Department of the Contractor's intent to discontinue such services. Such written notice shall include, but not be limited to:

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

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

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

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

4.8. Personnel

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

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

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

4.8.2. The Contractor shall take into consideration the diversity of the community and the members it serves when hiring its Key Personnel and other Personnel.

4.8.3. Contractor shall provide qualified Key Personnel and Other Personnel as necessary to perform the Work throughout the term of the Contract.

4.8.3.1. Contractor shall provide the Department with a list of names and contact information for the Key Personnel and other relevant management/supervisory staff assigned to the Contract.

4.8.3.1.1. DELIVERABLE: Management/supervisory staff contact information

4.8.3.1.2. DUE: Within five (5) Business Days following the Effective Date

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

4.8.3.2.1. DELIVERABLE: Updated management/supervisory staff contact information

4.8.3.2.2. DUE: Within five (5) Business Days following the Department's request for an update

4.8.4. If any of Contractor's Key Personnel or Other Personnel are required to have and maintain any professional licensure or certification issued by any federal, state or local government agency, then Contractor shall make copies of such current licenses and certifications available to the Department.

4.8.4.1. DELIVERABLE: All current professional licensure and certification documentation as specified for Key Personnel or Other Personnel

4.8.4.2. DUE: Within Five (5) Business Days of receipt of updated licensure or upon request by the Department

4.8.5. The Contractor shall provide the Department with an Organizational Chart listing all positions within the Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure and the names of the individuals fulfilling each position.

4.8.5.1. DELIVERABLE: Organizational Chart.

4.8.5.2. DUE: Five (5) Business days after the Effective Date.

4.8.6. The Contractor shall provide the Department with an updated Organizational Chart within five (5) business days of any change in Key Personnel or request from the Department for an updated Organizational Chart. The Contractor shall deliver to the Department an interim plan for fulfilling any vacant position's responsibilities and the plan for filling the vacancy.

4.8.6.1. DELIVERABLE: Updated Organizational Chart

4.8.6.2. DUE: Within five (5) Business Days from any change in Key Personnel or from the Department's request for an updated Organizational Chart.

4.8.7. Contractor shall not change individuals in Key Personnel positions without prior notification to the Department. Any individual replacing Key Personnel shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department.

4.8.8. Contractor shall submit notification to the Department of any change in Key Personnel, along with the candidate's resume and copies of required professional license(s)/certification(s).

4.8.8.1. DELIVERABLE: Change in Key Personnel Notification

4.8.8.2. DUE: Within ten (10) Business Days following the Contractor's identification of a potential replacement.

4.8.9. Key Personnel may be temporarily replaced due to sickness, family emergencies, or other kinds of approved leave. In such cases, the Department will be notified of the individual that will be filling in for the employee.

4.8.10. Personnel Availability

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

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

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

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

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

4.8.10.6. The Contractor shall respond to all telephone calls, voicemails and emails from the Department within one (1) Business Day of receipt by the Contractor.

4.8.11. Key Personnel

4.8.11.1. The Contractor shall designate individuals based in Colorado to hold the following Key Personnel positions:

4.8.11.1.1. Program Manager– One (1) full-time employee.

4.8.11.1.1.1. The Program Manager shall:

4.8.11.1.1.1.1. Be a senior management position.

4.8.11.1.1.1.2. Serve as the Contractor's primary point of contact for the Contract, Contract performance, and all day-to-day operational issues. The Program Manager shall work out of an office within the Contractor's Service Area, unless otherwise approved by the Department in writing.

4.8.11.1.1.1.3. Be accountable for all other Key Personnel and Other Personnel and ensure appropriate staffing levels throughout the term of the Contract.

4.8.11.1.1.1.4. Monitor all phases of the project in accordance with work plans or timelines or as determined between the Contractor and the Department.

4.8.11.1.1.1.5. Ensure the completion of all work in accordance with the Contract's requirements. This includes, but is not limited to, ensuring the accuracy, timeliness and completeness of all Work.

4.8.11.1.1.1.6. Oversee operational procedures, business processes, and reporting.

4.8.11.1.1.1.7. Participate in Department-led meetings to discuss the progress and direction of the Program.

4.8.11.1.1.2. The Program Manager shall have the following qualifications:

4.8.11.1.1.2.1. Experience designing and/or administering health programs and developing health care policy.

4.8.11.1.1.2.2. Experience managing projects or contracts of similar scope and size.

4.8.11.1.1.2.3. Knowledge of and experience with health care delivery system reforms and Medicaid and CHP+ programs, including federal and state regulations.

4.8.11.1.1.2.4. Senior management decision-making authority regarding the Contract.

4.8.11.1.2. Quality Improvement Director

4.8.11.1.2.1. The Quality Improvement Director shall:

4.8.11.1.2.1.1. Be a management level position.

4.8.11.1.2.1.2. Be accountable for development and implementation of quality improvement programs, and all aspects of measuring and assessing Program outcomes.

4.8.11.1.2.1.3. Direct and coordinate all quality improvement activities.

4.8.11.1.2.1.4. Ensure alignment with federal and state guidelines.

4.8.11.1.2.1.5. Set internal performance goals and objectives.

4.8.11.1.2.2. The Quality Improvement Director shall have the following qualifications:

4.8.11.1.2.2.1. Minimum of a bachelor's degree in nursing, public health or strongly related field. Master's level preferred.

4.8.11.1.2.2.2. Minimum of five (5) years of professional experience in healthcare quality improvement.

4.8.11.1.2.2.3. Knowledge and experience in the following areas:

4.8.11.1.2.2.3.1. Accreditation standards, including National Committee on Quality Accreditation (NCQA).

4.8.11.1.2.2.3.2. Outcomes and performance measurement, including HEDIS and HEDIS-like Behavioral Health measures.

4.8.11.1.2.2.3.3. Compliance and regulation enforcement.

4.8.11.1.3. Health Information Technology (Health IT) and Data Director

4.8.11.1.3.1. The Health IT and Data Director shall:

4.8.11.1.3.1.1. Facilitate data sharing among the Contractor, the State, and Network Providers.

4.8.11.1.3.1.2. Ensure the implementation and operation of technological tools required to perform the Work.

4.8.11.1.3.1.3. Identify opportunities to reduce redundancy in workflows and data systems.

4.8.11.1.3.1.4. Assist Network Providers to maximize the use of EHRs and Health Information Exchange, as appropriate.

4.8.11.1.3.1.5. Develop the organization's strategy and be accountable for operations related to the receipt and processing of:

4.8.11.1.3.1.5.1. Client enrollment spans

4.8.11.1.3.1.5.2. Capitation payments

4.8.11.1.3.1.5.3. Encounter Data

4.8.11.1.3.1.5.4. Admission, discharge, and transfer data

4.8.11.1.3.2. The Health IT and Data Director shall have the following qualifications:

4.8.11.1.3.2.1. Experience directing a health information technology program.

4.8.11.1.3.2.2. Experience supporting health care practices.

4.8.11.1.3.2.3. Expertise in health data analytics.

4.8.11.1.4. Utilization Management Director

4.8.11.1.4.1. The Utilization Management Director shall:

4.8.11.1.4.1.1. Lead and develop the Utilization Management program and manage the medical review and authorization process.

4.8.11.1.4.1.2. Oversee the medical appropriateness and necessity of services provided to Members.

4.8.11.1.4.1.3. Analyze and monitor utilization trends, identify problem areas and recommend action plans for resolution.

4.8.11.1.4.2. The Utilization Management Director shall have the following qualifications:

4.8.11.1.4.2.1. Registered Nurse or equivalent Health Care Professional with necessary Behavioral Health clinical experience and medical knowledge.

4.8.11.1.4.2.2. Minimum of five years' cumulative experience in Utilization Management and managed care.

4.8.11.1.4.2.3. Knowledge of quality improvement, disease management, and case management.

4.8.12. Other Personnel Responsibilities

4.8.12.1. Contractor shall use its discretion to determine the number of Other Personnel necessary to perform the Work in accordance with the requirements of this Contract.

4.8.12.2. If the Department has determined that Contractor has not provided sufficient Other Personnel to perform the Work in accordance with the requirements of this Contract, Contractor shall provide all additional Other Personnel necessary to perform the Work in accordance with the requirements of this Contract at no additional cost to the Department.

4.8.12.3. Contractor shall ensure that all Other Personnel have sufficient training and experience to complete all portions of the Work assigned to them. Contractor shall provide all necessary training to its Other Personnel, except for State-provided training specifically described in this Contract.

4.8.13. Subcontractors

4.8.13.1. The Contractor may subcontract to complete a portion or portions of the Work required by the Contract.

4.8.13.2. The Contractor shall not enter into any subcontract in connection with its obligations under this Contract without providing notice to the Department. The Department may reject any such subcontract, and the Contractor shall terminate any subcontract that is rejected by the Department and shall not allow any Subcontractor to perform any Work after that Subcontractor's subcontract has been rejected by the State.

4.8.13.3. The Contractor shall provide the organizational name of each Subcontractor and all items to be worked on by each Subcontractor to the Department.

4.8.13.3.1. DELIVERABLE: Name of each Subcontractor and items on which each Subcontractor shall work

4.8.13.3.2. DUE: The later of 30 days prior to the Subcontractor beginning work or the Effective Date

4.8.13.4. No subcontract, which the Contractor enters into with respect to performance under the Contract, shall in any way relieve the Contractor of any responsibility for the performance of duties under this Contract. The Contractor retains all responsibility for adherence to all standards and requirements within this Contract, including those delegated to any entity.

4.8.13.4.1. A wholly owned subsidiary of the Contractor shall not be considered a Subcontractor.

4.8.13.5. The Contractor shall ensure that all subcontracts are executed in accordance with 42 C.F.R. § 438.230.

4.8.13.6. The Contractor shall notify the Department of the termination of any subcontract.

4.8.13.6.1. DELIVERABLE: Notice of Subcontractor Termination

4.8.13.6.2. DUE: At least sixty (60) calendar days prior to termination for all general terminations and within two (2) Business Days of the decision to terminate for quality or performance issue terminations.

5. CHILD HEALTH PLAN PLUS CONTRACTOR

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

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

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

5.2.2. The Contractor shall meet the solvency standards set forth in C.R.S. §10-16-411, et seq., and its implementing regulations and any other applicable regulations. The Contractor shall notify the Department, within two (2) business days, of having knowledge or reason to believe that it does not meet the solvency standards specified herein. Failure to meet the solvency standards and/or failure to notify the Department as required by this section may be grounds for the immediate termination of this Contract by the Department for default.

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

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

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

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

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

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

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

5.6.2. Is posted publicly on the Contractor's website.

5.6.2.1. The Contractor shall submit the Organizational Governance Plan to the Department.

5.6.2.1.1. DELIVERABLE: Organizational Governance Plan

5.6.2.1.2. DUE: Within 30 Business days after Effective Date

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

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

5.6.2.3.1. DELIVERABLE: Updated Organizational Governance Plan

5.6.2.3.2. DUE: Within thirty (30) days after the new change in governance is discovered

6. MEMBER ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

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

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

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

6.1.2.1. CHP+ Child (N1)

6.1.2.2. CHP+ Prenatal (N2)

6.1.2.3. CHP+ Newborn (N4)

6.1.2.4. CHP+ Prenatal PE (K2)

6.1.2.5. CHP+ Child PE (K7)

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

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

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

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

6.3. Enrollment

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

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

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

6.3.3.1. The Contractor shall not discriminate against Clients eligible to Enroll on the basis of financial viability, race, color, national origin, sex, sexual orientation, gender identity, or Disability and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or Disability. The Contractor shall also not discriminate against Clients eligible to Enroll on the basis of health status or need for health care services.

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

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

6.3.6. The Department will automatically re-Enroll Members into the Contractor's MCO that was in effect at the time of their loss of CHP+ eligibility if there is a loss of eligibility of two (2) months or less.

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

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

6.3.8. Enrollment of a Newborn

6.3.8.1. The Contractor shall furnish Covered Services to newborns of mothers who are Members, who are determined CHP+ eligible, from the date of birth up to thirty (30) calendar days or until the last day of the first full month following birth, whichever is sooner. If determined CHP+ eligible, the Department will Enroll the newborn into the Contractor's MCO upon receipt of the newborn's state identification number, with a date of enrollment equivalent to the newborn's CHP+ eligibility effective date.

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

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

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

6.3.8.2. Newborns shall have 12 months of continuous coverage from their date of birth.

6.3.9. Enrollment of Presumptively Eligible Members

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

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

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

6.3.10. Enrollment During Hospitalization

6.3.10.1. If a Potential Member of the Contractor's Managed Care Organization is an inpatient of a Hospital at 11:59 p.m. the day before his/her Enrollment is scheduled to take effect, and the Potential Member is currently enrolled to a mutually exclusive assignment plan or currently enrolled to another CHP+ MCO, Enrollment shall be postponed until the first day of the month following discharge.

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

6.4. Annual Open Enrollment Period

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

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

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

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

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

6.5. Disenrollment

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

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

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

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

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

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

6.5.2.1.4. Child welfare eligibility status.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.5.2.2.3. The Member's diminished mental capacity.

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

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

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

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

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

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

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

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

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

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

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

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

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

6.5.5.2. Without Cause, during open Enrollment

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

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

6.5.5.3. Without Cause, after initial Passive Enrollment

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

6.5.5.4. Disenrollment due to Medicaid Coverage

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

6.5.6. Effective Date of Disenrollment

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

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

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

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

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

6.5.7. Disenrollment Postponed Due to Inpatient Hospital Stay

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

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

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

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

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

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

6.6. Continuity of Care

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

6.6.1.1. The Contractor shall inform any new Member that they may continue to receive Covered Services from the Member's current Provider for sixty (60) calendar days from the date of Enrollment in the Contractor's MCO. The Member may only continue to receive Covered Services from the Member's current Provider if the Member is in an ongoing course of treatment with that Provider and the previous Provider agrees as specified in C.R.S. §25.5-5-406(1)(g).

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

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

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

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

7. MEMBER ENGAGEMENT

7.1. Person-and-Family Centered Approach

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

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

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

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

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

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

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

7.2. Cultural Responsiveness

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

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

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

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

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

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

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

7.2.5.1. Readily accessible is defined as electronic information and services that comply with modern accessibility standards, such as Section 508 of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and Successor versions.

7.2.6. Language Assistance Services

7.2.6.1. The Contractor shall provide language assistance services as described in 42 C.F.R. § 438.10, for all Contractor interactions with Members and for all Covered Services.

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

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

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

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

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

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

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

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

7.2.6.4.2. Written translation in Prevalent Languages.

7.2.6.4.3. Auxiliary aids and services for Members with Disabilities.

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

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

7.2.7. Written Materials for Members

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

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

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

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

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

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

7.2.7.5.1. The Contractor shall write all published information provided to Members, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department.

7.2.7.5.2. The Contractor shall publish all written materials provided to Members using a font size no smaller than twelve (12) point.

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

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

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

7.3. Member Communication

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

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

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

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

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

7.3.4.1.1. Member's name;

7.3.4.1.2. State ID;

7.3.4.1.3. Purpose of the contact;

7.3.4.1.4. Date, time, and method of contact

7.3.4.1.5. The outcome of the contact

7.3.4.2. The Contractor's Member contact center shall be open, at a minimum, from 8:00 a.m. to 5:00 p.m. Mountain Time (MT) every Business Day. Voice Message will be available twenty-four (24) hours a day, seven (7) days a week for after hour's coverage.

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

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

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

7.3.5. General Member Information Requirement

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

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

7.3.5.1.2. Contractor's Email address.

7.3.5.1.3. Contractor's website address.

7.3.5.1.4. State relay information.

7.3.5.1.5. The basic features of an MCO.

7.3.5.1.6. The Service Area covered by the Contractor.

7.3.5.1.7. CHP+ benefits

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

7.3.5.1.9. A Provider Directory.

7.3.5.1.9.1. DELIVERABLE: Provider Directory

7.3.5.1.9.2. DUE: Five (5) days prior to the Operational Start Date

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

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

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

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

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

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

7.3.6. Member Rights and Responsibilities

7.3.6.1. The Contractor shall establish and maintain written policies and procedures regarding the rights and responsibilities of Members that incorporate the rights and responsibilities identified by the Department in this Contract. These policies and procedures shall include the components described in this Section and address the elements listed in Member Handbook Requirements.

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

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

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

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

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

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

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

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

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

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

7.3.6.4.1. Members.

7.3.6.4.2. Member's families.

7.3.6.4.3. Providers.

7.3.6.4.4. Case workers.

7.3.6.4.5. Stakeholders.

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

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

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

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

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

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

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

7.3.7.2. Member Handbook

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

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

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

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

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

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

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

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

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

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

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

7.3.7.2.1.8.3. An explanation that Post-Stabilization Care Services means Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition when the Contractor does not respond to a request for pre-approval within one (1) hour, the Contractor cannot be contacted, or the Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a Managed Care Entity physician is not available for consultation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.3.7.2.3.1. DELIVERABLE: Updated Member Handbook

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

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

7.3.8. Contractor Website

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

7.3.8.1.1. Contractor's contact information.

7.3.8.1.2. Member rights and responsibilities.

7.3.8.1.3. Member handbook.

7.3.8.1.4. Grievance and Appeal procedures and rights.

7.3.8.1.5. General functions of the Contractor.

7.3.8.1.6. Contractor's formulary.

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

7.3.8.1.7.1. Names, as well as any group affiliations.

7.3.8.1.7.2. Street addresses.

7.3.8.1.7.3. Telephone numbers.

7.3.8.1.7.4. Website URLs, as appropriate.

7.3.8.1.7.5. Specialties, as appropriate.

7.3.8.1.7.6. Whether Network Providers will accept new Members.

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

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

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

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

7.3.8.1.10. Access to Care Standards

7.3.8.1.11. Colorado Crisis Services information.

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

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

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

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

7.3.9. Termination of Provider Agreement

7.3.9.1. Upon termination of a Network Provider's agreement, for any reason, the Contractor shall make a good faith effort to give written notice of termination of a Network Provider by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Network Provider, as required in 42 C.F.R. § 438.10(f)(1).

7.3.9.1.1. DELIVERABLE: Notice to Members of Network Provider Termination

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

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

7.3.10. Information on Grievance and Appeals Process

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

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

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

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

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

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

7.3.10.1.6. The method for obtaining a State Review.

7.3.10.1.7. The rules that govern representation at the State Review

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

7.3.11. Member Material Review Process

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

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

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

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

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

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

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

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

7.3.12. Electronic Distribution of Federally Required Information

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

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

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

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

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

7.3.12.1.5. The Member is informed that the information is available in paper form without charge upon request and the Contractor provides the information upon request within five (5) Business Days.

7.4. Marketing

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

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

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

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

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

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

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

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

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

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

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

8. GRIEVANCE AND APPEALS

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

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

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

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

8.3.1.1. The requirements and timeframes for filing.

8.3.1.2. The availability of assistance with filing.

8.3.1.3. The toll-free number to file orally.

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

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

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

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

8.4. Grievances

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

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

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

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

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

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

8.4.4.3. The Grievance or Appeal involves clinical issues.

8.4.5. The Contractor shall send the Member written acknowledgement of each Grievance within two (2) business days of receipt.

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

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

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

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

8.4.7.1.2. Give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

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

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

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

8.4.10.1. If the Department is contacted by a Member, family members or caregivers of a Member, advocates, or other individuals/entities with a Grievance regarding concerns about the care or lack of care a Member is receiving, the Contractor shall address all issues as soon as possible after the Department has informed the Contractor of the concerns. The Contractor shall keep the Department informed about progress on resolving concerns in real time, and shall advise the Department of final resolution.

8.5. Notice of Adverse Benefit Determination

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

8.5.1.1. Is in writing.

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

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

8.5.1.4. Is in an easily understood language and format.

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

8.5.1.6. Explains the reasons for the Adverse Benefit Determination.

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

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

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

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

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

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

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

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

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

8.5.1.13.3. 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.

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

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

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

8.5.3.2. At least five (5) days prior to the date of Adverse Benefit Determination if the Contractor has verified information indicating probable beneficiary fraud.

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

8.5.3.3.1. The Member has died.

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

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

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

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

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

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

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

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

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

8.5.3.5. As expeditiously as the Member's health condition requires, but no longer than ten (10) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

8.5.3.5.1. The Contractor may extend the ten (10) calendar day service authorization notice timeframe of up to fourteen (14) additional days if the Member or the Provider requests extension; or if the Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

8.5.3.5.2. If the Contractor extends the ten (10) day service authorization notice timeframe, it must give the Member written notice of the reason for the extension and inform the Member of the right to file a Grievance if they disagree with the decision

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

8.5.3.7. For cases in which a Provider, or the Contractor, determine that following the standard authorization timeframe could seriously jeopardize the Member's life or health or his/her ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

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

8.6. Appeal Process

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

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

8.6.2.1. The Contractor shall, within two (2) business days of Contractor receipt of the Member's or Provider's request for Appeal, send the Member a letter notifying the Member how they may receive a copy of the case file related to the Appeal and how they can submit additional information whether in writing or in person to the Contractor.

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

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

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

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

8.6.4.3. The Grievance or Appeal involves clinical issues.

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

8.6.5.1. Within sixty (60) calendar days from the date of the Contractor's notice of Adverse Benefit Determination.

8.6.5.2. Either orally or in writing.

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

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

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

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

8.6.10. The Contractor shall give the Member and the Member's representative an opportunity, sufficiently in advance before and during the Appeals process, to examine the Member's case file, including Medical Records and any other documents and records free of charge and sufficiently in advance of the resolution timeframe.

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

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

8.6.13. Resolution and Notification of Appeals

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

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

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

8.6.13.2.1. The Contractor shall provide the Member with written notice within two (2) calendar days after the extension of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member. The Contractor shall establish and maintain an expedited review process for Appeals when the Contractor determines from a request from the Member or when the Network Provider indicates, in making the request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

8.6.13.2.2. If the Contractor denies a request for expedited resolution of an Appeal, the Contractor shall transfer the Appeal to the standard timeframe for Appeal resolution and give the Member prompt oral notice of the denial and a written notice within two (2) calendar days after receiving the request for expedited resolution.

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

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

8.6.13.2.5. The Contractor shall provide the Member with written notice within two (2) calendar days and make a reasonable effort to give the Member prompt oral notice of the reason for any extension to the timeframe for processing an expedited Appeal that is not requested by the Member and inform the Member of the right to file a Grievance if they disagree with that decision.

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

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

8.6.13.4. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date of reversal if the services were not furnished while the Appeal was pending and if the Contractor or State Review Officer reverses a decision to deny, limit, or delay services.

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

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

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

8.6.13.6.2. How the Member can request a State Review.

8.6.14. State Review

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

8.6.14.1.1. The Member has one hundred and twenty (120) calendar days from the date of a notice of an adverse Appeal resolution to request a State Review.

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

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

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

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

8.6.15. Expedited State Review

8.6.15.1. When the Appeal is heard first through the Contractor's Appeal process, the Department's Office of Appeals will issue a final agency decision for an expedited State Review decision

as expeditiously as the Member's health condition requires, but no later than 72 hours from the Department's receipt of a hearing request for a denial of service that:

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

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

8.7. Grievance and Appeals Report

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

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

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

8.7.2.2. The date received.

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

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

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

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

8.7.2.6.1. DELIVERABLE: Grievance and Appeals Report

8.7.2.6.2. DUE: Forty-five (45) days after the end of the reporting quarter.

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

9. NETWORK DEVELOPMENT AND ACCESS STANDARDS

9.1. Establishing a Network

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

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

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

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

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

9.1.4.1. Public and Private providers, including independent practitioners.

9.1.4.2. Federally Qualified Health Centers (FQHC).

9.1.4.3. Rural Health Clinics (RHC).

9.1.4.4. Community Mental Health Centers (CMHC).

9.1.4.5. Substance Use Disorder Clinics

9.1.4.6. School Based Health Centers (SBHC).

9.1.4.7. Indian Health Care Providers.

9.1.4.8. Essential Community Providers (ECP).

9.1.4.9. Providers capable of billing both Medicare and Medicaid.

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

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

9.1.6.1. The anticipated number of Members.

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

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

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

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

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

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

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

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

9.1.7.1. The Contractor may use mechanisms such as telemedicine to address geographic barriers to accessing clinical Providers from diverse backgrounds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.2. Provider Credentialing and Re-credentialing

9.2.1. The Contractor shall ensure that all contracted Network Providers are credentialed and ensure that re-credentialing of all individual practitioners occurs at least every three (3) years.

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

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

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

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

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

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

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

9.2.4. Contractor shall terminate its health care Provider contracts for provision of services to Members with contracted Providers if such Provider fails to revalidate Enrollment, as required by 42 C.F.R. § 455.414, regardless of Provider type, when the Provider is no longer identified as a Participating Provider in the Colorado interChange.

9.3. Access to Care Standards

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

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

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

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

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

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

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

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

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

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

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

Provider Network Time and Distance Standards

	Urban County		Rural County		Frontier County	
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Adult Primary Care Providers	30	30	45	45	60	60
Pediatric Primary Care Providers	30	30	45	45	60	60
Gynecology, OB/GYN*	30	30	45	45	60	60
fPediatric Specialty Care / PT / OT / ST** Providers	30	30	45	45	100	100
Adult Specialty Care Providers	30	30	60	60	100	100
Pharmacy	10	10	30	30	60	60
Hospitals (acute care);	20	20	30	30	60	60
Psychiatrists and other psychiatric prescribers, for adults	30	30	60	60	90	90
Psychiatrists and other psychiatric prescribers; serving children	30	30	60	60	90	90
Mental Health Provider; serving adults	30	30	60	60	90	90

Mental Health Provider; serving children	30	30	60	60	90	90
Substance Use Disorder Provider; serving adults	30	30	60	60	90	90
Substance Use Disorder Provider; serving children	30	30	60	60	90	90

* obstetrician-gynecologist

** physical therapy, occupational therapy, speech therapy

9.3.11. The Contractor shall ensure that its Provider Network has a sufficient number of Providers so that each Member has their choice of at least two (2) Providers within their zip code or within the maximum distance for their county classification. For Rural and Frontier areas, the Department may adjust this requirement based on the number and location of available Providers.

9.3.11.1. In the event that there are less than two (2) practitioners that meet the Provider standards within the defined area for a specific Member, then the Contractor shall not be bound by the requirements of the prior paragraph for that Member.

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

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

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

9.3.12.1. Adult Primary Care Providers: One (1) practitioner per eighteen hundred (1,800) adult Members.

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

9.3.12.3. Pediatric Primary Care Providers: One (1) practitioner per eighteen hundred (1,800) child Members.

9.3.12.4. Physician specialist: One (1) physician specialist per eighteen hundred (1,800) Members.

9.3.12.4.1. Physician Specialist includes physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology

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

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

9.3.12.5.1. Pediatric physician specialist includes Pediatric physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.

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

9.3.12.6. Adult mental health Providers: One (1) practitioner per eighteen hundred (1,800) adult Members.

9.3.12.7. Pediatric mental health Providers: One (1) practitioner per eighteen hundred (1,800) child Members.

9.3.12.8. Substance use disorder Providers: One (1) practitioner per eighteen hundred (1,800) Members

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

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

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

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

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

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

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

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

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

9.3.17.1. Urgent Care – within twenty-four (24) hours after the initial identification of need.

9.3.17.2. Outpatient Follow-up Appointments – within seven (7) days after discharge from a Hospitalization.

9.3.17.3. Non-urgent, Symptomatic Care Visit – within seven (7) days after the request.

9.3.17.4. Well Care Visit – within one (1) month after the request; unless an appointment is required sooner to ensure the provision of screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule.

9.3.17.5. Emergency Behavioral Health Care – by phone within fifteen (15) minutes after the initial contact, including TTY accessibility; in person within one (1) hour of contact in Urban and suburban areas, in person within two (2) hours after contact in Rural and Frontier areas.

9.3.17.6. Non-urgent, Symptomatic Behavioral Health Services – within seven (7) days after a Member's request.

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

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

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

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

9.3.18.1. Utilizing out-of-network Providers.

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

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

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

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

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

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

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

9.3.23. Out of Network Providers

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

a Provider that is not within its network promptly, and without compromising the Member's quality of care or health.

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

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

9.4. Network Changes and Deficiencies

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

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

9.4.1.2. Availability, or capacity of Covered Services.

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

9.4.1.4. A plan to correct any network deficiency.

9.4.1.4.1. DELIVERABLE: Network Changes and Deficiencies

9.4.1.4.2. DUE: Within five (5) days after the Contractor's knowledge of the change or deficiency.

9.5. Network Adequacy Plan and Report

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

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

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

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

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

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

9.5.1.6. Cultural and language expertise of Providers.

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

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

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

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

9.5.2.1. DELIVERABLE: Network Adequacy Plan

9.5.2.2. DUE: Annually, on July 31.

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

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

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

9.5.3.2.1. DELIVERABLE: Network Report

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

10. CONTRACTOR'S HEALTH PLAN ADMINISTRATION REQUIREMENTS

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

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

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

10.1.2.1. Member identification and risk stratification

10.1.2.2. Member engagement and outreach

10.1.2.3. Wellness promotion

10.1.2.4. Utilization of evidence-based and promising practices

10.1.2.5. Programs for managing Department identified health conditions, and

10.1.2.6. Care Coordination for Members utilizing CHP+ services.

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

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

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

10.1.4.2. Perinatal, prenatal and postpartum care for women.

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

10.1.4.4. Early interventions and supports

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

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

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

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

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

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

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

10.2. Community and Social Determinants of Health

10.2.1. The Contractor shall recognize that the conditions in which Members live also impact their health and well-being and establish relationships and communication channels with community organizations that provide resources such as economic assistance, food, housing, energy assistance, childcare, education and job training in the region.

10.2.2. The Contractor shall actively work to establish and strengthen relationships with effective community organizations, state agencies, and programs in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts.

10.2.2.1. The Contractor shall establish and strengthen relationship with, but not limited to, the following organizations, programs, agencies, and statewide efforts:

10.2.2.1.1. Colorado Crisis Services

10.2.2.1.2. Colorado Managed Service Organizations

10.2.2.1.3. Early Intervention Colorado

10.2.2.1.4. Temporary Assistance for Needy Families (TANF)

10.2.2.1.5. Early Head Start and Head Start Programs

10.2.2.1.6. Healthy Steps

10.2.2.1.7. Nurse-Family Partnership

10.2.2.1.8. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

10.2.2.1.9. Supplemental Nutrition Assistance Program (SNAP)

10.2.2.1.10. Local School Districts

10.2.2.1.11. Any other organizations, programs, and agencies, as identified by the Department

10.3. PCP Selection and Assignment

10.3.1. The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a PCP at any time.

10.3.2. The Contractor shall provide Members with a meaningful choice in selecting a PCP. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a PCP.

10.3.3. Contractor shall have written policies and procedures for assigning each of its Members, who have not selected a PCP at the time of Enrollment, to a PCP or clinic.

10.4. Health Needs Assessment

10.4.1. The Contractor shall ensure that a Member-appropriate, individual health needs assessment is completed by the Member within ninety (90) days after the effective date of Enrollment, and at any other time necessary, as part of the onboarding process to capture basic information about a Member's individual health needs. The Contractor shall:

10.4.1.1. Make subsequent attempts to conduct an initial screening of each Member's needs if the initial attempt to contact the Member is unsuccessful.

10.4.1.2. Use the results of the assessment to inform Member outreach and Care Coordination activities.

10.4.1.3. Work with Network Providers to develop an individual treatment plan as necessary based on the needs assessment and to avoid duplication of treatment.

10.4.1.4. Ensure individual needs assessment allows for the screening of Special Health Care Needs.

10.5. Care Coordination

10.5.1. The Contractor shall ensure Care Coordination is part of the Contractor's population health strategy and in compliance with the requirements specified in 42 CFR § 438.208.

10.5.2. The Contractor shall use a person- and family-centered approach to Care Coordination, which takes into consideration the preferences and goals of Members and their families and connects them to the resources required to carry out needed care and follow up.

10.5.3. The Contractor shall create policies and procedures to ensure:

10.5.3.1. Each Member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Member, and Members are provided information on how to contact their designated person or entity.

10.5.3.2. Care is coordinated for the Member within a practice, as well as between the practice and other Network Providers and community organizations and shall ensure that Care Coordination is provided to Members who are transitioning between health care settings.

10.5.3.2.1. The Contractor shall ensure the coordination of services provided to the Member:

10.5.3.2.1.1. Between settings of care, including appropriate discharge planning for short term and long-term Hospital and institutional stays;

10.5.3.2.1.2. With the services the enrollee receives from any other MCO;

10.5.3.2.1.3. With the services the enrollee receives in CHP+FFS; and

10.5.3.2.1.4. With the services the enrollee receives from community and social support Providers.

10.5.3.3. Timely coordination of services and supports between Primary Care Providers, Behavioral Health Providers, specialists, and community organizations to ensure information is communicated appropriately, and interventions are provided appropriately to meet the needs of the Member.

10.5.4. The Contractor's Care Coordination programs and/or procedures shall comprise:

10.5.4.1. A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being.

10.5.4.2. Deliberate interventions for specific Members who require more intense and extended assistance

10.5.4.3. Mechanisms to increase access for Members to appropriate care and reduce unnecessary utilization of costly emergency services and limited specialty care resources.

10.5.5. The Contractor shall ensure that Care Coordination:

10.5.5.1. Is available to all Members.

10.5.5.2. Is provided at the point of care whenever possible.

10.5.5.3. Addresses both short and long-term health needs.

10.5.5.4. Is culturally responsive.

10.5.5.5. Respects Member preferences.

10.5.5.6. Supports regular communication between care coordinators and the practitioners delivering services to Members.

10.5.5.7. Is documented, for both medical and non-medical activities.

10.5.5.8. Addresses potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial and spiritual needs in order to achieve optimal health, wellness or end-of-life outcomes, according to Member preferences.

10.5.5.9. Protects Member privacy.

10.5.6. The Contractor shall ensure that each Provider furnishing services to Members maintains and shares, as appropriate, a health record in accordance with professional standards.

10.5.7. The Contractor shall ensure that Care Coordination tools, processes, and methods are available to Network Providers.

10.5.8. The Contractor shall develop and disseminate practice guidelines to Network Providers and, upon request, to Members and potential Members.

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

10.5.8.1.1. Perinatal, prenatal and postpartum care for women.

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

10.5.8.1.3. Well child care.

10.5.8.2. The Contractor shall adopt practice guidelines that consider the needs of Members.

10.5.8.3. The Contractor shall adopt practice guidelines in consultation with Network Providers.

10.5.8.4. The Contractor shall review and update practice guidelines periodically as appropriate.

10.5.8.5. The Contractor shall ensure guidelines are consistent with decisions regarding Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply.

10.5.9. Members with Special Health Care Needs

10.5.9.1. The Contractor shall ensure Care Coordination activities for Members with Special Health Care Needs consist of the following:

10.5.9.1.1. Mechanisms to assess Members identified as a Person with Special Health Care Needs within thirty (30) calendar days in order to identify any ongoing special conditions of the Member that requires a course of treatment or regular care monitoring.

10.5.9.1.2. Mechanisms to review and revise Members treatment or service plan upon reassessment of functional need for Members with Special Health Care Needs, at least every 12 months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

10.5.9.1.3. Mechanisms to assess the quality and appropriateness of care furnished to Members with Special Health Care Needs, and in accordance with any applicable state quality assurance and Utilization Review standards.

10.5.9.1.4. Mechanisms to allow Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

10.5.9.1.5. Mechanisms to coordinate health care services for Members with Special Health Care Needs with other agencies or entities.

10.5.9.2. Early Intervention (EI) Services and Supports

10.5.9.2.1. The Contractor shall provide EI Services and Support by participating in the EI trust, in accordance with C.R.S. 27-10.5-709.

10.5.9.2.2. The Contractor shall develop a process in coordination with Colorado Department of Human Services (CDHS) to ensure EI Services and Support are provided which shall include, but not be limited to the following steps:

10.5.9.2.2.1. CDHS will notify the Contractor of a CHP+ Member's eligibility for EI Services and Supports.

10.5.9.2.2.2. Within thirty (30) calendar days of notification from CDHS, the Contractor shall submit funds in the amount established by the EI Program in the eligible CHP+ Member's name.

10.5.9.2.2.3. Within ninety (90) days after CDHS determines that the CHP+ Member is no longer eligible for the EI Program, for the purposes of C.R.S 10-16-104(1.3), CDHS shall notify the Contractor. All unused monies deposited in the EI trust on behalf of the CHP+ Member that are not expended before the Member became ineligible for the EI Program shall be returned to the Contractor.

10.5.9.2.2.4. No later than April 1 of each Contract year, CDHS shall provide the Contractor with a report specifying the amount of benefits paid to certified Early Intervention Service Brokers for services provided to an eligible Member during the prior calendar year, including the amount paid to each certified Early Intervention Service Broker and the services provided to an eligible Member.

10.5.9.2.3. The Contractor shall not be responsible for services funded by the trust and shall ensure that any qualified Early Intervention Provider that receives reimbursement for services funded by the trust fund shall accept such reimbursement as payment in full for services under C.R.S. Section 10-16-104(1.3), and shall not seek additional reimbursement from either the eligible Member's family or the carriers.

10.6. Provider Support

10.6.1. The Contractor shall serve as a point of contact for Network Providers regarding services and programs, regional resources, clinical tools, and general administrative information.

10.6.2. The Contractor shall support Network Providers that are interested in integrating Primary Care and Behavioral Health services; enhancing the delivery of team-based care by leveraging all staff; advancing business practices and use of health technologies; participating in value-based payment structures; and other activities designed to improve Member health and experience of care.

10.6.3. The Contractor shall provide practice support to Network Providers to support them with implementing the Contractor's population management and Care Coordination activities.

10.6.4. The Contractor shall support Network Providers in implementing and utilizing telehealth solutions.

10.6.5. The Contractor shall ensure adequate informational support for Network Providers, while being mindful of not duplicating existing materials.

10.6.6. The Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for the following topics:

10.6.6.1. General information about CHP+ and the Contractor's role and purpose.

10.6.6.2. The Contractor's process for handling Appeals and Grievances.

10.6.6.3. Available Member resources, including the Member Provider Directory.

10.6.6.4. Clinical resources, such as screening tools, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled.

10.6.6.5. Community-based resources, such as child care, food assistance, housing assistance, utility assistance and other non-medical supports.

10.6.7. The Contractor shall act as a liaison between the Department and its other contractors, partners and Providers.

10.6.8. The Contractor shall ensure that the Contractor's Provider communications adhere to Colorado CHP+ brand standards.

10.6.9. The Contractor shall support the delivery of evidence-based medicine by Network Providers.

10.6.10. The Contractor shall assist Providers in resolving barriers and problems, including, but not limited to all of the following:

10.6.10.1. Provider Enrollment in the Colorado interChange system

10.6.10.2. Member eligibility and coverage policies

10.6.10.3. Service authorization and Referral

10.6.10.4. Member and PCP assignment

10.6.11. The Contractor shall establish a timely process for responding to and resolving barriers and problems reported by Providers related to the Contractor's payment and benefits systems, including but not limited to the following:

10.6.11.1. Billing and claims payment

10.6.11.2. Provider credentialing

10.6.11.3. Provider contracting

10.6.11.4. Service authorization

10.6.12. The Contractor shall develop trainings and host forums for ongoing Provider Training regarding the Program and the services the Contractor offers, and promote participation in state and local training programs.

10.6.12.1. The Contractor shall ensure that trainings and updates on the following topics are made available to the Contractor's Network Providers:

10.6.12.1.1. Colorado CHP+ and Medicaid eligibility and application processes.

10.6.12.1.2. CHP+ benefits.

10.6.12.1.3. Access to Care standards.

10.6.12.1.4. The Contractor's Population Management Programs

10.6.12.1.5. Cultural responsiveness.

10.6.12.1.6. Member rights, Grievances, and Appeals.

10.6.12.1.7. Quality improvement initiatives

10.6.12.1.8. Other trainings identified in consultation with the Department.

10.6.13. The Contractor shall educate and inform Network Providers about the tools and systems available to the Providers, including, but not limited to, the following:

10.6.13.1. Care Coordination Tools, Data, or Reports

10.6.13.2. Risk Stratification Tools, Data, or Reports

10.6.13.3. Colorado interChange (MMIS)

10.6.13.4. PEAK website and PEAKHealth mobile app

10.6.13.5. Regional health information exchange

10.6.14. The Contractor shall provide practice-level data and reports to Network Providers, and assist Providers with data analysis and reporting. Training shall include utilizing data to improve care for complex Members, improve care for Members with Department identified health conditions, implement wellness and prevention strategies, and identify Members who require additional services.

10.6.15. The Contractor shall train and support Providers in implementing and utilizing health information technology (Health IT) systems and data. The Contractor shall keep up to date with changes in Health IT in order to best support Providers.

10.6.16. The Contractor shall facilitate clinical information sharing by supporting Network Providers in connecting electronic health records (EHRs) with the regional health information exchange (HIE).

10.6.16.1. The Contractor shall promote the use of Office of the National Coordinator for Health Information Technology (ONC) Interoperability Standards for PCP EHR systems, to improve data exchange. These standards can be found at https://www.healthit.gov/policy-researchers-implementers/interoperability.

10.7. Health Plan Administration Annual Report

10.7.1. The Contractor shall submit an Annual Health Plan Administration Report to the Department including, but not limited to the following:

10.7.1.1. The Contractor's Member Engagement activities, including procedures for:

10.7.1.1.1. Outreaching to and onboarding newly Enrolled Members

10.7.1.1.2. PCP selection and assignment

10.7.1.1.3. Ensuring services are delivered in a culturally competent manner, including language assistance services provided by the Contractor

10.7.1.1.4. Utilizing the results of Member satisfaction surveys, and interventions to improve Member experience

10.7.1.1.5. Obtaining Member feedback for Member materials

10.7.1.1.6. Identifying issues or barriers related to member outreach and engagement, and steps taken to resolve or mitigate issues

10.7.1.2. A comprehensive description of the Contractor's population health management strategy

10.7.1.3. A comprehensive description of the Contractor's Care Coordination activities

10.7.1.4. A description of the community organizations, state agencies, and programs the Contractor actively collaborates with to provide comprehensive services to CHP+ Members

10.7.1.5. A comprehensive description of supports the Contractor provides to Network Providers, including:

10.7.1.5.1. The types of information and administrative support, Provider trainings, and data and technology support the Contractor offers to Network Providers.

10.7.1.5.2. Any tools provided to Providers for the purposes of screening and/or coordinating care for Members

10.7.1.5.3. Practice Transformation supports the Contractor offers to Network Providers, including any value based payment strategies the Contractor uses to financially support Network Providers.

10.7.1.5.4. A description of the Contractor's policies and procedures for enforcing Providers credentialing and enrolling in the Colorado interChange.

10.7.1.5.5. DELIVERABLE: Annual Health Plan Administration Report

10.7.1.5.6. DUE: September 30, 2022 and annually, by the last business day of September

10.7.1.6. The Contractor shall collaborate with the Department to develop an Annual Health Plan Administration Report Template.

11. COVERED SERVICES

11.1. The Contractor shall administer and manage the delivery of all services covered under the CHP+ benefit for Members, which means the Contractor shall:

11.1.1. Provide Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under the established minimum essential benefit for the CHP+ program.

11.1.2. Determine the Medical Necessity of Covered Services and shall make benefit and coverage determinations in a manner that is fully consistent with the terms of this Contract.

11.1.3. Assume comprehensive risk for all CHP+ Covered Services.

11.1.4. Take full responsibility for providing and arranging for the provision of all Medically Necessary Covered Services.

11.2. The Contractor shall ensure access to care for all Members for only those Covered Services described in Exhibit E, Covered Services and Copayments, and Exhibit J, Fluoride Varnish Program Details, under the terms of this Contract.

11.3. The Contractor shall provide a guarantee that the Contractor shall not avoid costs for services covered in this Contract by referring Members to publicly supported health care resources.

11.4. As the administrator of the CHP+ benefit, the Contractor shall employ strategic health care management practices described throughout the Contract in administering the benefit, create financial incentives to drive quality care and have strong Member experience protections.

11.5. The Contractor shall administer the CHP+ Benefit in a manner that is fully integrated with the entirety of the Work outlined in the Contract thereby creating a seamless experience for Members and Providers.

11.6. The Contractor shall demonstrate a commitment to the following principles in administering the CHP+ Benefit:

11.6.1. Recovery and Resilience: Treatment that supports Members in making positive changes in their behaviors so they can improve their health and life outcomes. Positive changes are achieved by sharing information, building skills, and empowering Members to make changes by leveraging individual strengths and protective factors. The benefits of recovery and resilience principles extend across ages and settings and can be particularly helpful for low-income children.

11.6.2. Trauma-informed: Treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences on Members' health.

11.6.3. Least Restrictive Environment: The provision of community-based supports and services that enable individuals with serious mental illness and other disabilities to live in the community to the greatest extent possible and as appropriate.

11.6.4. Culturally Responsive: Providers and provider staff deliver effective, understandable, and respectful care in a manner compatible with Members' cultural health beliefs, practices and preferred language.

11.6.4.1. The Contractor shall develop policies and procedures, as needed, on how the Contractor shall respond to requests from participating Providers for interpreter services.

11.6.5. Prevention and Early Intervention: Broad community-wide efforts to reduce the impact of mental health and substance use disorders on individuals and communities that include, but are not limited to, the following:

11.6.5.1. Improving the public's understanding of mental health and substance use disorders.

11.6.5.2. Normalizing mental health and substance use disorders as legitimate and treatable health issues.

11.6.5.3. Actively promoting emotional health.

11.6.5.4. Promoting education and public awareness of mental health and substance use disorder symptoms.

11.6.5.5. Increasing access to effective treatment and supporting individual recovery.

11.6.6. Evidence-based: Treatment is provided in accordance with the best available research and clinical expertise.

11.6.7. Member and Family Centered Care: Services and supports are provided in the best interest of the individual to ensure that the needs of the individual and family are being addressed. Systems, services, and supports are based on the strengths and needs of the entire family or community.

11.7. The Contractor shall furnish information about the services that the Contractor does not cover because of moral or religious objections to the Department whenever it adopts such a policy during the term of the contract.

11.8. The Contractor would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if the Contractor objects to the service on moral or religious grounds.

11.9. Specific Services and Responsibilities

11.9.1. Mental Health, Behavioral Health, and Substance Use Disorder Services

11.9.1.1. The Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

11.9.1.1.1. To meet the requirements of 42 CFR 440.395, the Contractor shall cover, in addition to services covered under the state plan, any behavioral health services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K.

11.9.1.2. In accordance with CRS 10-16-139(5), 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.

11.9.1.3. 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 medically necessary covered Behavioral Health services.

11.9.1.4. In accordance with CRS 25.5.5-422.2, the Contractor shall not:

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

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

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

11.9.2. Prescription Drugs

11.9.2.1. The Contractor shall establish a drug formulary for all Covered Drugs with its own prior authorization criteria. The formulary must include at minimum, the same drugs furnished under the established minimum essential benefit for the CHP+ program.

11.9.2.2. The Contractor shall develop and maintain a process to authorize and provide coverage of any Medically Necessary Drugs unmet by the Contractor's formulary. The Contractor shall ensure that the program includes the following criteria:

11.9.2.2.1. Provision of a telephonic or telecommunication response within twenty-four (24) hours of a request for prior authorizations.

11.9.2.2.1.1. If additional information is needed for making an authorization decision regarding covered outpatient drugs, the Contractor must:

11.9.2.2.1.1.1. Provide telephonic or telecommunications notice of the authorization decision within 24 hours of receiving complete information from the prescriber/requestor.

11.9.2.2.1.1.2. Work with the prescriber/requestor to ensure all additional documentation is provided in a timely manner to ensure access to the drug is not delayed.

11.9.2.2.2. Prescription of at least a seventy-two (72) hour supply of outpatient Covered Drugs in an Emergency situation, with the exception of drugs referred to in section 42 USC 1396r-8(d)(2) of the Act. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well-being.

11.9.3. Emergency and Post-Stabilization Services

11.9.3.1. The Contractor shall cover and pay for Emergency Services and Post-Stabilization Care Services as specified in 42 C.F.R. § 438.114 and 42 C.F.R. § 422.113(c).

11.9.3.2. The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor.

11.9.3.3. The Contractor shall cover and pay non-contracted Providers for Emergency Services no more than the amount that would have been paid if the service had been provided by a Network Provider.

11.9.3.4. The Contractor shall not refuse to cover treatment obtained under either of the following circumstances:

11.9.3.4.1. A Member had an Emergency Medical Condition in which the absence of immediate medical attention would not necessarily have had the outcomes specified in the definition of Emergency Medical Condition.

11.9.3.4.2. A representative of the Contractor instructs the Member to seek Emergency Services.

11.9.3.5. The Contractor shall not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or Fiscal Agent not notifying the Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

11.9.3.6. The Contractor shall not hold a Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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

11.9.3.7.1. Members temporarily out of the Service Area may receive out-of-area Emergency Services and Urgently Needed Services.

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

11.9.3.9. The Contractor acknowledges that the attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge; that determination is binding on the Contractor for coverage and payment.

11.9.3.10. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's Provider Network that are pre-approved by the Contractor.

11.9.3.11. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's network that are not pre-approved by the Contractor, but administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

11.9.3.11.1. The Contractor does not respond to a request for pre-approval within one (1) hour.

11.9.3.11.2. The Contractor cannot be contacted.

11.9.3.11.3. The Contractor and the treating Provider cannot reach an agreement concerning the Member's care and a plan Provider is not available for consultation. In this situation, the Contractor shall give the treating Provider the opportunity to consult with a plan Provider and the treating Provider may continue with care of the Member until a plan Provider is reached or one of the criteria in 42 C.F.R. § 422.113(c)(3) is met.

11.9.3.12. The Contractor shall limit charges to Members for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Member if he or she had obtained the services through the Contractor.

11.9.3.13. The Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved shall end when:

11.9.3.13.1. A plan Provider with privileges at the treating Hospital assumes responsibility for the Member's care.

11.9.3.13.2. A plan Provider assumes responsibility for the Member's care through transfer.

11.9.3.13.3. The Contractor and the treating Provider reach an agreement concerning the Member's care.

11.9.3.13.4. The Member is discharged.

11.9.3.14. Nothing in this section shall preclude the Contractor from conducting a retrospective review consistent with these rules regarding emergency and Post-Stabilization Care Services.

11.9.3.15. Verification of Medical Necessity for Emergency Services

11.9.3.15.1. The Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services.

11.9.3.15.2. The Contractor shall not deny benefits for conditions which a reasonable person outside of the medical community would perceive as Emergency Medical Conditions.

11.9.3.15.3. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

11.9.4. Alternative Services

11.9.4.1. The Contractor shall cover services or settings for enrollees that are in lieu of those covered under the state plan if:

11.9.4.1.1. The state determines that the alternative service or setting is a medically appropriate substitute for the covered service or setting under the state plan.

11.9.4.1.2. The state determines that the alternative service or setting is a cost-effective substitute for the covered service or setting under the state plan.

11.9.4.2. The Member shall not be required by the Contractor to use the alternative service or setting.

11.10. Copayments

11.10.1. The Contractor shall be authorized to impose copayments for Members, not to exceed the amounts specified in Exhibit E Covered Services and Copayments.

11.10.2. All cost sharing and co-payments, if greater than zero, shall be implemented and imposed in accordance with 42 C.F.R. §447.50 through 42 C.F.R. §447.82.

11.10.3. The Contractor shall not charge cost sharing for the following eligibility categories:

11.10.3.1. Pregnant women

11.10.3.2. American Indians

11.10.3.3. Native Alaskans

11.10.4. The Contractor may invoice Members for unpaid co-payments if payment is not made at the time of service.

11.10.5. For fees or premiums charged by the Contractor to Members in excess of amounts specified in Exhibit E, the Contractor may be liable for penalties of up to $25,000.00 or double the

amount of the charges, whichever is greater. The Department will deduct from the penalty the amount of overcharge and return it to the affected Members.

11.11. Service Limits

11.11.1. The Contractor shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

11.11.2. The Contractor shall ensure that services supporting beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

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

11.11.4. The Contractor may place appropriate limits on a service as follows:

11.11.4.1. On the basis of criteria applied under the CHP+ State Plan, such as Medical Necessity.

11.11.4.2. For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose.

11.11.4.2.1. The Contractor shall ensure that mental health and substance use disorder benefits are in compliance with parity requirements, as specified in 42 C.F.R. § 457.496.

11.11.4.2.1.1. The Contractor shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees, whether or not the benefits are furnished by the same managed care plan.

11.11.4.2.1.2. The Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

11.11.4.2.1.3. The Contractor may only apply a non-qualitative treatment limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQTL in the same benefit classification of the enrollee's medical/surgical benefits.

11.11.4.2.2. For Utilization Management, provided family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning to be used.

11.11.5. The Contractor shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's condition or disease.

11.11.6. The Contractor shall inform Members, or their families/designated representative, by email, phone, or mail of the approved timeframe for select authorized services, so that Members, or their representatives, are aware of how long the services have been authorized for and

therefore may request a continuation of and/or additional services if needed. The Contractor shall record and document its notification of Members and families.

11.11.7. The Contractor shall establish clear and specific criteria for discharging Members from treatment.

11.11.7.1. The Contractor shall include these criteria in Member materials and information.

11.11.7.2. The Contractor shall note individualized criteria for discharge agreed upon by Member and Provider in the Member's health care record and modified, by agreement, as necessary.

11.11.8. The Contractor shall not be liable for any Covered Services provided prior to the date a Member is enrolled under this Contract or after the date of disenrollment.

11.11.9. The Contractor shall not hold a Member liable for Covered Services:

11.11.9.1. Provided to the Member, for which the Department does not pay the Contractor.

11.11.9.2. Provided to the Member, for which the Department or Contractor does not pay the Provider that furnishes the service under a contract, Referral, or other arrangement

11.11.9.3. Furnished under a contract, Referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Contractor provided the services directly

11.11.10. The Contractor shall not prohibit or restrict a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:

11.11.10.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

11.11.10.2. Any information the Member needs to decide among all relevant treatment options.

11.11.10.3. The risks, benefits, and consequences of treatment or non-treatment.

11.11.10.4. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

11.12. Utilization Management

11.12.1. The Contractor shall ensure access to and appropriate utilization of covered services.

11.12.2. The Contractor shall establish and maintain a documented Utilization Management Program and Procedures, in compliance with 42 CFR 457.496 and 42 CFR 438.210, that includes, at a minimum, the following:

11.12.2.1. Description of its Utilization Management program structure and assignment of responsibility for Utilization Management activities to appropriate individuals.

11.12.2.2. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

11.12.2.3. Identification of the type of personnel responsible for each level of Utilization Management decision-making.

11.12.2.4. Standards for Utilization Management personnel to consult with the ordering Provider prior to denial or limitation of requested/provided services.

11.12.2.5. Policies and procedures for the use and periodic review of written clinical decision making criteria based on clinical evidence.

11.12.2.6. Provider Dispute resolution

11.12.2.7. Description of a Provider Dispute Resolution process which follows Division of Insurance Provider Dispute Resolution requirements and timelines.

11.12.2.7.1. DELIVERABLE: Utilization Management Program and Procedures

11.12.2.7.2. DUE: September 30, 2021 and thirty (30) days after any significant change is made.

11.12.3. The Contractor shall implement the Contractor's documented Utilization Management Program and Procedures.

11.12.4. The Contractor's Utilization Management process shall in no way impede timely access to services.

11.12.5. The Contractor shall have mechanisms for Providers and Members on how they can obtain the Utilization Management decision-making criteria upon request.

11.12.6. The Contractor shall not provide incentives, through conditional or contingent payments or by any other means, for those making the determination to deny, limit, or discontinue Medically Necessary services.

11.12.7. The Contractor shall provide education and ongoing guidance to Members and Providers about its Utilization Management program and protocols.

11.13. FQHC And RHC Encounter Reimbursement

11.13.1. The Contractor shall reimburse the FQHC or RHC by at least the Encounter Rate in accordance with 10 CCR 2505-10 § 8.700.6 and the CHP+ State Plan for each FQHC or RHC visit, for services identified in 10 CCR 2505-10 § 8.700.3 for allowable costs identified in 10 CCR 2505-10 § 8.700.5. The Department reserves the right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

11.13.1.1. Each FQHC and RHC has an Encounter Rate calculated in accordance with 10 CCR 2505-10 § 8.700.6C.

11.13.1.2. The Department will notify the Contractor of changes to the FQHC and RHC rates and rules.

11.13.1.3. The Department conducts quarterly accuracy audits with FQHCs and RHCs. Should the Department recognize any discrepancy in FQHC or RHC payments (less than the full Encounter Rate), the Contractor is responsible for reimbursing the FQHC or RHC the difference of the Encounter payment and the initial reimbursement amount. FQHC and RHC visits are defined in 10 CCR 2505-10 § 8.700.1.

11.13.2. If multiple services are provided by an FQHC or RHC within one (1) visit, the Contractor shall require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. The Contractor shall pay the FQHC or RHC at least the Encounter Rate.

11.13.3. The Contractor shall submit the Encounter Data for FQHC and RHC visits to the Department per the specifications provided in Section 13.1.6.

11.13.3.1. DELIVERABLE: FQHC and RHC Encounter Data

11.13.3.2. DUE: Within thirty (30) days before the end of each calendar year quarter

11.13.4. The Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs and is required to complete the documentation located at https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms upon the Department's request.

11.13.5. Contractor shall ensure the utilization and paid amounts for FQHC Encounters in flat files matches those sent to the Department for the Managed Care Accuracy Audit Review (MCAAR).

11.14. Indian Health Services Providers Reimbursement

11.14.1. The Contractor shall reimburse any Indian Health Care Provider (IHCP) enrolled in CHP+ as an FQHC but not a Network Provider at least the Encounter Rate.

11.14.1.1. The Contractor shall reimburse IHCPs not enrolled in CHP+ as an FQHC, regardless of whether they are Network Providers, the applicable Encounter Rate published annually in the Federal Register by the Indian Health Service (IHS), or in the absence of a published Encounter Rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.

11.14.1.2. If the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under FFS or the applicable Encounter Rate published annually in the Federal Register by the Indian Health Service (IHS), the State must make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under FFS or the applicable Encounter Rate.

11.14.2. The Contractor shall pay ninety percent (90%) of all clean claims from I/T/U Network Providers (whether in individual or group practice or who practice in shared health facilities) within thirty (30) days of the date of receipt and pay ninety-nine percent (99%) of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) days of the date of receipt.

11.15. Physician Incentive Plans

11.15.1. The Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

11.15.1.1. Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any Member.

11.15.2. The Contractor shall only operate physician incentive plans if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

11.15.3. If the Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the Contractor shall ensure that the physician or physician group has adequate stop-loss protection.

11.15.3.1. DELIVERABLE: Physician Incentive Plan

11.15.3.2. DUE: On the Effective Date or upon implementation of a physician incentive plan

12. THIRD PARTY PAYER LIABILITY AND COORDINATION OF BENEFITS

12.1. The Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing Covered Services under this Contract as required pursuant to 42 U.S.C. § 1397gg(e)(1)(B). All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the CHP+ program.

12.1.1. Potential liable third parties shall include carriers offering health or casualty insurance to any individual, and an entity or program that is or may be liable to pay all or part of the expenditures on behalf of a Member. The Contractor shall provide information to the Department regarding commercial third-party resources that it identifies.

12.2. The Contractor shall submit to the Department's Fiscal Agent, electronically via the Provider portal, any third-party payers identified by the Contractor. The Contractor shall submit to the Department's Fiscal Agent the following information:

12.2.1.1. Member's state identification number.

12.2.1.2. Member's full name

12.2.1.3. Identification of the health carrier or health plan

12.2.1.4. Member's health plan identification and group numbers

12.2.1.5. Policy holder's full name

12.2.1.6. Member's relationship to policyholder.

12.2.1.6.1. DELIVERABLE: Third Party Resource Identification

12.2.1.6.2. DUE: Within five (5) Business Days electronically to the Fiscal Agent's Provider portal from the time when the third-party resource is identified by Contractor.

12.3. The Contractor shall inform Members, in its written communications and publications, that when a third party is primarily liable for the payment of the costs of a Member's medical benefits, the Member shall comply with the protocols of the third party, including using Providers within the third party's network, prior to receiving non-emergency medical care.

12.4. The Contractor shall also inform its Members that failure to follow the Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that the Contractor would have been liable to pay. If the Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to the Contractor or the Network Provider for payment or cost of the care or services.

12.5. The Contractor shall not restrict access to Covered Services due to the existence of possible or actual third-party liability.

12.6. The Contractor shall identify and pursue third party payers in the case of an accident or incident where coverage should be paid by the property and casualty coverage or other accident liability policy.

12.7. In the case of accident or casualty coverage, the Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by the Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor.

12.8. The Contractor has the right to be subrogated to the Member's rights to the extent of the Covered Services received under this Contract. This includes the Contractor's right to bring suit against the third party in the Members name. The Contractor's right of reimbursement shall have first priority over any claim of a Member to be fully compensated for claims paid by it in connection with such injury or illness.

12.9. In addition to compensation paid to the Contractor under the terms of this Contract, the Contractor may retain as income all amounts recovered from third party resources, up to the Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by the Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

12.10. Coordination of Benefits

12.10.1. The Contractor shall identify and coordinate with all third parties against whom a Member may have a claim for payment or reimbursement for Covered Services so that no more than 100% of Covered Services incurred will be paid on behalf of the Member.

12.10.2. None of the above rules as to coordination of benefits shall serve as a barrier to the Member first receiving Covered Services from the Contractor, but neither shall the Contractor be prohibited from exercising its full rights to coordinate benefits with other health care payers who may cover the Member.

13. DATA, ANALYTICS, CLAIMS PROCESSING AND DEPARTMENT REQUESTS FOR INFORMATION

13.1. Central Role of Data and Analytics

13.1.1. The Contractor shall use data and analytics to successfully operate the CHP+ Program. Data and information are used for a range of management, coordination and care activities, such as process improvement, population health management, federal compliance, claims processing, outcomes tracking and cost control.

13.1.1.1. The Contractor shall understand the key cost drivers within its Service Area and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

13.1.1.1.1. The Contractor shall be responsible for monitoring utilization of low value services and analyzing cost categories that are growing faster than would normally be expected.

13.1.1.1.2. The Contractor shall incorporate risk adjusted utilization expectations into its analytic procedures as Members with more complex conditions and needs are expected to use more resources.

13.1.1.2. The Contractor shall possess the resources and capabilities to leverage existing data systems and analytics tools or create new ones as necessary to perform the Work, conscious to avoid the creation of duplicative systems.

13.1.2. The Contractor shall ensure that it meets all federal regulations regarding standards for privacy, security, electronic health care transaction and individually identifiable health information, the privacy regulations found at 42 C.F.R. Part 2, 45 C.F.R. § 160, 162 and 164, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the American Recovery and Reinvestment Act of 2009 (ARRA)/HITECH Act (P.L. 111-005), and State of Colorado Cyber Security Policies. See Colorado Cyber Security Policies at http://oit.state.co.us/ois/policies.

13.1.3. The Contractor shall control the use or disclosure of Protected Health Information (PHI) as required by the HIPAA Business Associate agreement or as required by law. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the HIPAA privacy requirements.

13.1.4. The Contractor shall create a data governance policy that describes the circumstances when the Contractor shall allow other entities, including Providers and community organizations, full access to Member level data will be shared.

13.1.4.1. The Contractor shall submit its Data Governance Policy to the Department.

13.1.4.1.1. DELIVERABLE: Data Governance Policy

13.1.4.1.2. DUE: Operational Start Date

13.1.4.2. The Contractor shall update the data governance policy annually by July 31.

13.1.4.2.1. DELIVERABLE: Annual Data Governance Policy Update

13.1.4.2.2. DUE: Annually, July 31

13.1.5. Claims Processing System

13.1.5.1. The Contractor shall maintain a claims processing system to reimburse Providers Covered Services under the terms of this Contract and produce Encounter claims.

13.1.5.2. The Contractor shall promptly pay claims submitted by Providers, consistent with the claims payment procedures as required by C.R.S. §10-16-106.5, as amended.

13.1.5.3. The Contractor shall meet the requirements of FFS timely payment, per 42 CFR 447.46, including the paying of ninety percent (90%) of all clean claims from practitioners (i.e. those who are in individual or group practice or who practice in shared health facilities) within thirty (30) days of the date of receipt; and paying ninety-nine percent (99%) of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) days of the date of receipt.

13.1.5.4. The Contractor shall ensure that the date of receipt is the date that the Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

13.1.5.4.1. A clean claim means one that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a claim with errors originating in the Department's claims system. It does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

13.1.5.5. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 C.F.R. §§ 95.1 and 95.7, the Department will file all claims for reimbursement of payments to the Contractor with CMS within two (2) years after the calendar quarter in which the Department made the expenditure. The Contractor and the Department will work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file the Contractor’s claims or capitation payments within two (2) years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 C.F.R. § 95.19, no claims or capitations will be paid to the Contractor for any period of time disallowed by CMS.

Furthermore, the Department will recover from the Contractor all claims and capitations paid to the Contractor for any period of time disallowed by CMS.

13.1.6. Encounter Data Reporting

13.1.6.1. The Contractor shall electronically submit all Encounter Data for Covered Services, following the Colorado Medical Assistance Program policy rules found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). The Contractor shall ensure that the quality and timeliness of its Encounter Data meets the state's standards.

13.1.6.2. The Contractor shall submit Medical Encounter Data in the ANSI ASC X12N 837 format directly to the Department's Fiscal Agent using the Department's data transfer protocol. The Contractor shall submit any 837 format Encounter claims, reflecting paid, adjusted or denied by the Contractor, via a regular monthly batch process. The Contractor shall submit all Encounter claims in accordance with the following:

13.1.6.2.1. Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

13.1.6.2.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

13.1.6.2.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

13.1.6.3. The Contractor shall submit all Pharmacy Encounter Data to the Department's Rx Contractor electronically. The Contractor shall submit the following type of electronic transactions for pharmacy Encounters.

13.1.6.3.1. National Council for Prescription Drug Programs (NCPDP) (pharmacy claim)

13.1.6.4. The Contractor shall submit accurate Encounter Data no later than one hundred twenty (120) days following the date on which the Contractor adjudicated a Provider claim. If the Contractor is unable to make a submission during a certain month, the Contractor shall notify the Department of the reason for the delay and the estimated date when the Department can expect the submission.

13.1.6.5. The Contractor shall make an adjustment to Encounter claims when the Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If the Department discovers errors or a conflict with a previously adjudicated Encounter claim, the Contractor shall adjust or void the Encounter claim within fourteen (14) calendar days of notification by the Department.

13.1.6.5.1. The Contractor shall submit monthly data certifications for all Encounter Data used for rate setting, in compliance with 42 C.F.R. § 438.604 and 438.606 and 457.950. The Contractor shall ensure that the data certification includes certification that data submitted is accurate, complete and truthful, and that all paid Encounters are for Covered Services provided to or for enrolled Members. This certification shall be provided by either the Chief Executive Officer or Chief Financial Officer or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

13.1.6.5.1.1. DELIVERABLE: Certified Encounter Data submission

13.1.6.5.1.2. DUE: Monthly, on the last Business Day of the month

13.1.6.6. The Contractor shall submit its raw Encounter Data, excluding data protected by 42 C.F.R. Part 2, to the Colorado All-Payer Claims Database (APCD) in accordance with the guidelines found in the most current version of the Center for Improving Value in Health Care: Colorado All-Payer Claims Database Data Submission Guide found at http://www.colorado.gov/hcpf.

13.1.6.7. The Contractor shall comply with changes in Department data format requirements as necessary. The Department reserves the right to change format requirements following consultation with the Contractor, and retains the right to make the final decision regarding format submission requirements.

13.1.6.8. The Contractor shall use the eligibility and Enrollment reports to identify and confirm Membership and provide a definitive basis for payment adjustment and reconciliation. Such data transmissions and Enrollment reports shall include:

13.1.6.8.1. HIPAA compliant X12N 270/271 Eligibility Verification transaction

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

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

13.1.6.8.4. HIPAA X12N 834 Daily Roster.

13.1.6.8.5. HIPAA X12N 834 Monthly Roster: Generated on the first Business Day of the month.

13.1.6.8.6. Colorado interChange Encounter Reconciliation Report

13.1.7. Flat File Submission

13.1.7.1. The Contractor shall on a quarterly basis electronically submit a flat file table to the Department that contains all Encounters for that State Fiscal Year, with one record per Encounter, which the Contractor shall certify as accurate, complete, and truthful based on the Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer or Chief Financial Officer or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

13.1.7.1.1. The Department will provide the Contractor with the specifications for the Flat File Submission. The Department will provide ninety (90) days advance notice to the Contractor prior to modifying specifications.

13.1.7.1.2. The Department will conduct a quality review of the submission to determine if flat file meets the required specifications.

13.1.7.1.2.1. The Contractor shall be responsible for the accuracy of flat file submissions.

13.1.7.1.2.2. The Contractor shall submit a flat file that contains 90% of paid claim lines within 30 days of the claim paid month.

13.1.7.1.2.3. The contractor shall submit a flat file that contains 99% of paid claim lines within 90 days of the claim paid month.

13.1.7.1.2.4. Flat file accuracy is determined quarterly for completeness of data fields, and annually for completeness of inclusion of all claims.

13.1.7.1.2.4.1. DELIVERABLE: Flat File Submission

13.1.7.1.2.4.2. DUE: Quarterly, fifteen (15) days after the State Fiscal Year quarter ends.

13.1.8. Colorado Immunization Information System (CIIS)

13.1.8.1. Contractor shall work with the Colorado Department of Public Health and Environment to submit immunization information for all covered Members to the Colorado Immunization Information System (CIIS) on at least a monthly basis per CIIS's Health Level 7 or Flat file specifications.

14. OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

14.1. Continuous Quality Improvement

14.1.1. The Contractor shall implement and maintain an ongoing comprehensive quality assessment and performance improvement program (Quality Improvement Program) that complies with 42 C.F.R. § 438.310-370.

14.1.2. The Contractor shall take into consideration the federal definition of quality when designing its program. The Centers for Medicare and Medicaid Services (CMS) defines quality as the degree to which the Contractor increases the likelihood of desired outcomes of its Members through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge and interventions for performance improvement.

14.1.3. The Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for the MCO.

14.2. Quality Improvement Program

14.2.1. The Contractor's Quality Improvement Program shall align with the Department's Quality Strategy and include population health objectives as well as clinical measures of quality care. Quality Improvement Program activities shall, at a minimum, consist of the following:

14.2.1.1. Performance improvement projects.

14.2.1.2. Collection and submission of performance measurement data, including Member experience of care.

14.2.1.3. Mechanisms to detect both underutilization and overutilization of services.

14.2.1.4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by the Department, and in accordance with any applicable state quality assurance and utilization review standards.

14.2.1.4.1. Mechanisms to review and revise reassessment of functional need for Members with special health care needs, at least every 12 months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

14.2.1.4.2. Mechanisms to allow Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

14.2.1.5. Quality of Care Concerns

14.2.1.6. External Quality Review.

14.2.1.7. Advisory committees and learning collaboratives.

14.2.2. The Contractor shall develop and submit a Quality Improvement Plan to the Department and/or its designee outlining how the Contractor plans to implement its Quality Improvement Program. The Contractor shall make reasonable changes to the Quality Improvement Plan at the Department's direction.

14.2.2.1. DELIVERABLE: Quality Improvement Plan

14.2.2.2. DUE: Due within 30 business days after the Effective Date

14.2.3. Upon Department approval, the Contractor shall implement the Quality Improvement Plan.

14.2.4. The Contractor shall review and update the Quality Improvement Plan at least one time annually.

14.2.4.1. DELIVERABLE: Quality Improvement Plan Update

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

14.2.5. The Contractor shall create an Annual Quality Report to the Department and/or designee, detailing the progress and effectiveness of each component of its Quality Improvement Program. The Contractor shall include the following, at a minimum, in the report:

14.2.5.1. A description of the techniques the Contractor used to improve its performance

14.2.5.2. A description of the qualitative and quantitative impact the techniques had on quality

14.2.5.3. The status and results of each Performance Improvement Project conducted during the year

14.2.5.4. Any opportunities identified for improvement

14.2.6. The Contractor shall submit the Annual Quality Report to the Department for review and approval.

14.2.6.1. DELIVERABLE: Annual Quality Report

14.2.6.2. DUE: Annually, by the last Business Day in September.

14.3. Performance Improvement Projects

14.3.1. The Contractor shall conduct Performance Improvement Projects designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

14.3.2. The Contractor shall complete Performance Improvement Projects annually to facilitate the integration of project findings and information into the overall quality assessment and improvement program, and to produce new information on quality of care each year.

14.3.3. The Contractor shall conduct at least one (1) PIP that is designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

14.3.3.1. The Contractor shall conduct Performance Improvement Projects on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a particular topic.

14.3.4. The Contractor shall have the capacity to conduct up to two (2) additional Performance Improvement Projects upon request from CMS after Year 1 of the Contract.

14.3.5. The Contractor shall ensure that Performance Improvement Projects include the following:

14.3.5.1. Measurement of performance using objective quality indicators.

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

14.3.5.3. Evaluation of the effectiveness of the interventions.

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

14.3.6. The Contractor shall participate in an annual Performance Improvement Project learning collaborative hosted by the Department that includes sharing of data, outcomes, and interventions.

14.3.7. The Contractor shall submit Performance Improvement Projects for validation by the Department's External Quality Review Organization (EQRO) to determine compliance with requirements set forth in 42 C.F.R. § 438.350, and as outlined in External Quality Review Organization Protocol for Validating Performance Improvement Projects. These requirements include:

14.3.7.1. Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction

14.3.7.2. Mechanisms to detect both under-utilization and over-utilization of services

14.3.7.3. Mechanisms designed to assess the quality and appropriateness of care furnished to Members with special health care needs

14.3.7.4. Measurement of performance using objective valid and reliable quality indicators

14.3.7.5. Implementation of system interventions to achieve improvement in quality

14.3.7.6. Empirical evaluation of the effectiveness of the interventions

14.3.8. The Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report described in 14.2.5.

14.4. Performance and Operation Measurement

14.4.1. The Contractor shall participate in the measurement and reporting of performance measures required by the Department, with the expectation that this information will be placed in the public domain.

14.4.2. The Contractor shall consult with the Department to develop measurement criteria, reporting frequency and other performance measurement components. The Department will determine the final measurement criteria.

14.4.3. The Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

14.4.4. The Contractor shall provide data, as requested, to enable the Department or its designee to calculate the performance measures, unless the data is already in the Department's possession.

14.4.5. The Contractor shall work to improve performance for measures established by the Department.

14.4.6. The Contractor shall collaborate with the Department in identifying additional performance and outcomes based measures to improve ongoing program monitoring, accountability, and overall administration of the CHP+ program.

14.4.7. The Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

14.4.8. The Contractor shall electronically submit, on a quarterly basis, a Performance Measurement Deliverable, that contains all measures identified by the Department.

14.4.8.1. The Contractor shall ensure that the Performance Measurement Deliverable is complete, contains all required elements, and submitted in a template provided by the Department.

14.4.8.1.1. The Deliverable shall include, at a minimum, all of the following:

14.4.8.1.1.1. Outcome measures

14.4.8.1.1.1.1. Emergency Department (ED) Admissions

14.4.8.1.1.1.2. Well Child Visits

14.4.8.1.1.1.3. Prenatal Care, Post-Partum Care

14.4.8.1.1.1.4. Claim Payment Statistics

14.4.8.1.2. The Contractor shall submit the Quarterly Performance Measurement Deliverable in a template provided by the Department for review and approval.

14.4.8.1.2.1. DELIVERABLE: Quarterly Performance Measurement Deliverable

14.4.8.1.2.2. DUE: Forty-five (45) days after the end of the 90-day claims runout period.

14.4.8.1.3. If the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated deliverable that corrects all errors and includes all omitted data or information. The Contractor shall submit the updated deliverable to the Department within ten (10) days from the Department's request for the updated deliverable.

14.4.8.1.3.1. DELIVERABLE: Updated Quarterly Performance Measurement Deliverable

14.4.8.1.3.2. DUE: Ten (10) days from the Department's request for the updated deliverable.

14.4.9. The Contractor shall electronically submit, on a monthly basis, a Health Plan Operation Measures Deliverable, that contains all measures identified by the Department.

14.4.9.1. The Contractor shall ensure that the Health Plan Operation Measures Deliverable is complete, contains all required elements, and submitted in a template provided by the Department.

14.4.9.1.1. The Deliverable shall include, at a minimum, all of the following:

14.4.9.1.1.1. Customer Service Reporting

14.4.9.1.1.2. Provider Service Reporting

14.4.9.1.2. The Contractor shall submit the Monthly Health Plan Operation Measures Deliverable in a template provided by the Department for review and approval.

14.4.9.1.2.1. DELIVERABLE: Monthly Health Plan Operation Measures Deliverable

14.4.9.1.2.2. DUE: Fourteen (14) days after the end of the reporting month.

14.4.9.1.3. If the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated Deliverable that corrects all errors and includes all omitted data or information. The Contractor shall submit the updated Deliverable to the Department within ten (10) business days from the Department's request for the updated Deliverable.

14.4.9.1.3.1. DELIVERABLE: Updated Monthly Health Plan Operation Measures Deliverable

14.4.9.1.3.2. DUE: Ten (10) business days from the Department's request for the updated Deliverable.

14.4.10. HEDIS Report

14.4.10.1. The Contractor shall calculate and submit specific HEDIS measures as determined by collaboration between the Department and the Contractor's quality improvement committee.

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

14.4.10.3. The Contractor shall use the results and data from the HEDIS Report and to inform the Contractor's Quality Improvement Plan.

14.4.10.4. The Contractor shall contract with an external entity to perform an external audit of the HEDIS measures according to HEDIS and EQRO protocols.

14.4.10.4.1. The Contractor shall work to resolve any issues identified by the external auditor and make all necessary changes to ensure issues are corrected in a timely fashion.

14.4.10.5. The Contractor shall provide an annual HEDIS Report to the Department. This report shall meet the following requirements:

14.4.10.5.1. The HEDIS Report shall contain all HEDIS measures determined by the Department for that year.

14.4.10.5.2. The HEDIS Report shall follow the format approved by the Department and be delivered for review and approval

14.4.10.5.2.1. DELIVERABLE: HEDIS Report

14.4.10.5.2.2. DUE: Annually, by June 30th for the report covering the state Fiscal Year that ends on that day

14.4.11. Occurrence Rates

14.4.11.1. The Contractor shall provide occurrence rates for the identified measures per the specifications provided by the Department no later than December 16th each year for the previous calendar year.

14.4.11.1.1. Measure DEV: Developmental Screening in the First Three Years of Life. CHP+ plan shall provide rates using CPT code 96110.

14.4.11.1.1.1. DELIVERABLE: Occurrence Rates

14.4.11.1.1.2. DUE: No later than December 16th for the previous calendar year

14.4.11.1.1.3. If specifications for this measure change, the Department will notify the Contractor as soon as possible to ensure the changes may be implemented by the Contractor for the reporting period for which the changes are implemented.

14.5. Member Experience of Care

14.5.1. The Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor and Network Providers.

14.5.2. The Contractor shall use tools to measure Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, call center data, and Grievance and Appeals data.

14.5.3. The Contractor shall assist the Department or it's designated vendor with the annual administration of the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for children to measure Member satisfaction with Network Providers.

14.5.3.1. The Contractor shall work with the Department to provide sample frames for the CHP+ population for the CAHPS survey in accordance with NCQA deadlines.

14.5.3.2. The Contractor shall develop strategies with the Department to increase Member participation in the CAHPS survey.

14.5.4. The Contractor shall inform the Department if they conduct any additional surveys of Members and share findings with the Department.

14.5.5. The Contractor shall use the results and data from CAHPS and all other surveys conducted by the Contractor to inform the Contractor's Quality Improvement Plan.

14.5.6. The Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

14.5.6.1. The Contractor shall develop a corrective action plan for a Network Provider when a pattern of complaint is detected, when trends in decreasing Member satisfaction are detected, or when a serious complaint is reported.

14.6. Mechanisms to Detect Overutilization and Underutilization of Services

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

14.6.2. The Contractor shall develop policies that more effectively support Member accountability for utilization of health services over an extended period of time, such as a Provider lock-in policy.

14.7. Quality of Care Concerns

14.7.1. The Contractor shall investigate any alleged Quality of Care (QOC) concerns, which are defined as concerns raised by the Department or Providers, or concerns discovered by the Contractor. The Contractor shall not consider Member complaints about care to be QOC concerns and should process these complaints as Grievances, unless the Department instructs otherwise.

14.7.1.1. The Contractor shall have a system for identifying and addressing all alleged QOC concerns.

14.7.2. When a QOC concern is raised, the Contractor shall investigate, analyze, track, trend and resolve QOC concerns by doing the following, but not limited to:

14.7.2.1. Investigate the QOC issue(s).

14.7.2.2. Follow-up with the Member to determine if the Member's immediate health care needs are being met.

14.7.2.3. Refer QOC issues to the Contractor's peer review committee, when appropriate.

14.7.2.4. Refer or report the QOC issue to the appropriate regulatory agency and Child or Adult Protective Services for further research, review or action, when appropriate.

14.7.2.5. Notify the appropriate regulatory or licensing board or agency when the affiliation of a Network Provider is suspended or Terminated due to QOC concerns.

14.7.2.6. Notify the Department that the Contractor has received a QOC.

14.7.2.7. Document the incident in a QOC summary to be sent to the Department. This file shall include, at a minimum:

14.7.2.7.1. The name and contact information of the originator of the QOC concern.

14.7.2.7.2. A description of the QOC concern including issues, dates and involved parties.

14.7.2.7.3. All steps taken during the QOC investigation and resolution process.

14.7.2.7.4. Corrective action(s) implemented and their effectiveness.

14.7.2.7.5. Evidence of the QOC resolution.

14.7.2.7.6. A copy of the acknowledgement and resolution letter.

14.7.2.7.7. Any Referral made by the Contractor to peer review, a regulatory agency or a licensing board or agency.

14.7.2.7.8. Any notification made by the Contractor to a regulatory or licensing agency or board.

14.7.2.7.9. Any outcome of the review as determined by the Contractor.

14.7.2.8. For QOC concerns involving Network Providers, the Contractor may use the process of its professional review committee, as set forth in Sections 12-36.5-104 and 12-36.5-104.4, C.R.S.

14.7.2.9. The Contractor shall submit a letter to the Department, upon request, that includes a brief description of the QOC concern, the efforts that the Contractor took to investigate the concern and the outcome of the review as determined by the Contractor.

14.7.2.9.1. The Contractor shall include a description of whether the issue was found to be a QOC issue and what action the Contractor intends to take with the Provider(s) involved.

14.7.2.9.2. The Contractor shall not include in its letter the names of the persons conducting the investigation or participating in a peer review process.

14.7.2.9.3. The Contractor shall inform the Department if it refers the matter to a peer review process.

14.7.2.9.4. The Contractor shall send the complete letter within ten (10) Business Days of the Department's request. Upon request from the Contractor, the Department may allow additional time to investigate and report.

14.7.2.9.4.1. DELIVERABLE: QOC Letter

14.7.2.9.4.2. DUE: Within ten (10) Business Days of the Department's request

14.8. External Quality Review

14.8.1. Annually, the Contractor shall participate in an external independent Site Review and performance measure validation in order to review compliance with Department standards and Contract requirements. External quality review activities shall be conducted in accordance with federal regulations 42 C.F.R. § 438 and the CMS mandatory activity protocols.

14.8.2. The Contractor shall participate in an external quality review that includes a review of the:

14.8.2.1. Contractor’s administration of the Contract as a CHP+ MCO

14.8.3. The Contractor shall participate in an annual external review that may include, but is not limited to, the following:

14.8.3.1. Medical Record review. For external review activities involving Medical Record abstraction, the Contractor shall obtain copies of the Medical Records from the sites in which the services reflected in the Encounter occurred at no cost to the Department or its vendors.

14.8.3.2. Performance improvement projects and studies.

14.8.3.3. Surveys.

14.8.3.4. Network adequacy during the preceding 12 months.

14.8.3.5. Calculation and audit of quality and utilization indicators.

14.8.3.6. Administrative data analyses.

14.8.3.7. Review of individual cases.

14.8.3.8. Care Coordination record review.

14.8.3.9. Provider site visits.

14.8.3.10. Encounter Data validation.

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

14.9. Advisory Committees and Learning Collaboratives

14.9.1. To ensure the CHP+ Program is effectively serving Members and Providers, the Contractor shall collaborate with the Department to identify opportunities to engage Stakeholders, and assist in the development of multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the Program overall and guiding the improvement of program performance.

14.9.2. The Contractor shall participate in ad hoc advisory committees and learning collaboratives to monitor specific program activities and share lessons learned, as identified by the Department and as appropriate.

14.9.3. Quality Improvement Committee

14.9.3.1. The Contractor shall have its Quality Improvement Director participate in the Department's Quality Improvement Committee (IQuIC) to provide input and feedback regarding quality improvement priorities, performance improvement topics, measurements and specifics of reporting formats and timeframes, and other collaborative projects.

14.10. CHP+ MCO Biannual Leadership Meeting

14.10.1. The Contractor shall host a biannual meeting with Department leadership (to include the Executive Director) to present and review the following:

14.10.1.1. Performance reports that summarize Contractor performance on key Contractor responsibilities and member outcomes.

14.10.1.2. Areas of opportunity and challenge to be addressed for Contractor to improve performance, including barriers to properly address those opportunities and challenges.

14.10.1.3. Provider areas of opportunity and where the Department can be of assistance.

14.11. Ad Hoc Quality Reports

14.11.1. The Contractor shall provide to the Department or its agents any information or data relative to the Contract. In such instances, and at the direction of the Department, the Contractor shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested.

14.11.1.1. The Contractor shall have at least thirty (30) calendar days, or a timeframe mutually agreed upon between the Department and the Contractor, to fulfill such requests.

14.11.1.2. The Contractor shall certify that data and information it submits to the Department is accurate.

15. COMPLIANCE AND PROGRAM INTEGRITY

15.1. Program Integrity Compliance Program Requirements

15.1.1. The Contractor shall have a program in place for ensuring compliance with the CHP+ and Managed Care Program rules, Contract requirements, state and federal regulations and confidentiality regulations, and a program to detect Fraud, Waste and Program Abuse. The Contractor shall ensure that all aspects of the system are focused on providing high-quality services that are of Medical Necessity in accordance with Contract requirements.

15.1.2. The Contractor shall comply with all applicable CMS regulations in 42 C.F.R. § 438 and 42 C.F.R. § 457.

15.1.3. The Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the Contract shall have a compliance program to implement and maintain arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Program Abuse.

15.1.4. The compliance program shall be approved by the Contractor's Program Manager and Compliance Officer.

15.1.5. The Contractor shall ensure that the compliance program, at a minimum includes:

15.1.5.1. Written policies and procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract and all applicable federal and state requirements.

15.1.5.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

15.1.5.3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under the Contract.

15.1.5.4. A system for training and education for the Compliance Officer, the Contractor's Key Personnel, and the Contractor's employees for the federal and state standards and requirements under the Contract.

15.1.5.4.1. The Contractor shall ensure that this training is conducted in a manner that allows the Department to verify that the training has occurred.

15.1.5.5. Effective lines of communication between the Compliance Officer and the Contractor's employees.

15.1.5.6. Enforcement of standards through well publicized disciplinary guidelines.

15.1.5.7. Establishment and implementation of procedures and a program integrity infrastructure that includes adequate systems and staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract. The Contractor shall ensure that the system includes:

15.1.5.7.1. Processes for monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.

15.1.5.7.2. Processes to screen all Provider claims processed or paid by the Contractor collectively and individually, for Suspected Fraud, Waste or Program Abuse.

15.1.5.7.3. Processes to identify Overpayments to Providers, including but not limited to, instances of up-coding, unbundling of services, services that were billed for but never rendered, inflated bills for services and goods provided or any other improper payment.

15.1.5.7.4. Processes to recover Overpayments to Providers.

15.1.5.7.5. Processes to identify and promptly report to the Department instances of Suspected Fraud, Waste and Program Abuse.

15.1.5.7.6. Processes for Member verification of services. Specifically, to provide individual notices to all or a statistically significant sample of Members who received services to verify and report whether services billed by Providers were actually received by Members.

15.1.5.8. Requirements for Network Providers to report to the Contractor when they have received an Overpayment, to return the Overpayment to the Contractor, and to notify the Contractor in writing of the reason for the Overpayment within sixty (60) calendar days after the date on which the Overpayment was identified.

15.1.5.9. The Contractor, if it makes or receives annual payments under the Contract –of at least $5,000,000.00, shall have written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

15.1.5.10. The Contractor shall comply with the Department policies related to recoveries of Overpayments.

15.1.6. The Contractor shall have a process for the prompt Referral to the Department of all cases where the agency or entity has actual and reasonable cause to believe that there is Suspected Fraud and Waste, Program Abuse and Patient Abuse, neglect, and exploitation, and false representation. The process shall be aligned with applicable requirements set forth in Statement of Work Section.

15.1.6.1. Neglect is the willful failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, including any neglect that constitutes a criminal violation under state law.

15.1.6.2. Exploitation includes any wrongful taking or use of funds or property of a patient residing in a health care facility or board and care facility that constitutes a criminal violation under state law.

15.1.6.3. False representation is any inaccurate statement that is relevant to a claim for reimbursement and is made by a Provider or Client who has actual knowledge of the truth or false nature of the statement, or by a Provider or Client who has actual knowledge of the truth or false nature of the statement, or by a Provider or Client acting in deliberate ignorance of or with reckless disregard for the truth of the statement.

15.2. Compliance Plan Requirements

15.2.1. The Contractor shall have a documented Compliance Plan that implements all elements of the Compliance Program.

15.2.2. The Contractor shall ensure adequate and dedicated staffing and resources needed in order to successfully implement the Compliance Plan and routinely monitor Providers and Clients to detect and prevent aberrant billing practices, potential Fraud, Waste, Program Abuse and promptly address potential compliance issues and problems.

15.2.3. The Contractor shall ensure the Compliance Plan, at minimum, includes:

15.2.3.1. A risk assessment of the Contractor's various Fraud, Waste, and Program Abuse and program integrity processes.

15.2.3.2. An outline of activities proposed for the next reporting year regarding compliance and audit activities, including, but not limited to:

15.2.3.2.1. Conducting prospective, concurrent, and/or post-payment reviews of claims, including, but not limited to Medical Records reviews, data mining, and desk audits;

15.2.3.2.2. Verifying Provider adherence to professional licensing and certification requirements;

15.2.3.2.3. Verifying Provider records and other documentation to ensure services billed by Providers were actually rendered;

15.2.3.2.4. Reviewing goods provided and services rendered for Fraud, Waste and Program Abuse;

15.2.3.2.5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).

15.2.3.2.5.1. The Contractor shall not include activities related to administrative billing issues, such as financial statement audits.

15.2.3.3. An outline of activities proposed for the next reporting year regarding education of federal and state laws and regulations related to CHP+ Program Integrity against Fraud, Waste, and Program Abuse to ensure that all of its officers, directors, managers, and employees know and understand the provisions of the Contractor's Compliance Program.

15.2.3.4. An outline of activities proposed for the next reporting year regarding Provider education of federal and state laws and regulations related to CHP+ Program Integrity against Fraud, Waste, and Program Abuse and on identifying and educating targeted Providers with patterns of incorrect billing practices and/or Overpayments.

15.2.3.5. Descriptions of specific controls in place for prevention and detection of Overpayments and potential or Suspected Fraud, Waste, and Program Abuse, including but not limited to:

15.2.3.5.1. automated pre-payment claims edits;

15.2.3.5.2. automated post-payment claims edits; and

15.2.3.5.3. desk audits on post-payment review of claims.

15.2.3.6. Work plans for the next year regarding conducting both announced and unannounced site visits and field audits to providers defined as high-risk (i.e. providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

15.2.4. The Contractor shall submit its Compliance Plan to the Department for review and approval. The Contractor shall only submit finalized Compliance Plans; the Department will not accept draft versions.

15.2.4.1. DELIVERABLE: Compliance Plan

15.2.4.2. DUE: Annually, by July 31

15.2.5. The Contractor shall modify the Compliance Plan as requested by the Department within ten (10) Business Days following the receipt of the Department's requested changes.

15.2.5.1. DELIVERABLE: Compliance Plan revisions and changes

15.2.5.2. DUE: Within ten (10) Business Days following the Department's request

15.3. Reports and Disclosures

15.3.1. The Contractor shall follow all requirements in this Statement of Work Section 15.3 to notify the Department of all work, activities, and events occurring under the requirements of Statement of Work Section 15.1.

15.3.1.1. Reports Requiring Monthly Notification

15.3.1.1.1. The Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a one (1) month period.

15.3.1.1.2. The Contractor shall report, at minimum:

15.3.1.1.2.1. All recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including whether the Overpayment was related to an audit or Fraud case, and dates when Overpayments were recovered;

15.3.1.1.2.2. All suspended claim reimbursements and payments to a Provider, including information whether the suspension is related to an audit or a credible allegation of fraud case and dates of when reimbursements and payments were suspended;

15.3.1.1.2.3. All Provider circumstance changes where a Provider is no longer in the Contractor's network, but was not removed for cause, including providing information on why the Provider was withdrawn;

15.3.1.1.2.4. Any Provider terminations not based on quality or performance or for cause, including but not limited to:

15.3.1.1.2.4.1. A change in Ownership or control of a Provider;

15.3.1.1.2.4.2. A Provider voluntarily withdrawing from the MCE's network; and

15.3.1.1.2.4.3. The death of a Provider.

15.3.1.1.2.4.4. The Contractor shall provide the following:

15.3.1.1.2.4.4.1. Date of removal;

15.3.1.1.2.4.4.2. Reason for the termination;

15.3.1.1.2.4.4.3. Numbers of Members served by the Provider; and

15.3.1.1.2.4.4.4. Plan to ensure that Members receive continuous services.

15.3.1.1.2.4.5. Any other information as specified by the Department

15.3.1.1.3. The Contractor shall use the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

15.3.1.1.3.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report

15.3.1.1.3.2. DUE: Within 10 (ten) Business Days after the end of each month.

15.3.1.1.4. The Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten (10) Business Days following the receipt of the Department's requested changes.

15.3.1.1.4.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

15.3.1.1.4.2. DUE: Within ten (10) Business Days following the Department's request

15.3.1.2. Reports Requiring Semi-Annual Notification

15.3.1.2.1. The Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a six (6) month period.

15.3.1.2.2. The six (6) month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

15.3.1.2.3. The Contractor shall use the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

15.3.1.2.4. The Contractor shall report, at minimum:

15.3.1.2.4.1. All audits or reviews which have been started, are on-going or completed as part of the Compliance Program and Compliance Plan, including issue(s) being reviewed or audited, the status of the review or audit, the start and end dates of services covered by the review or audit, and the start and end dates of the review or audit;

15.3.1.2.4.2. All instances of Suspected Fraud, Waste and Program Abuse, discovered and reported to the Department, including the suspected issue, the start and end dates of the services suspected to involve Fraud, the approximate amount of the claims affected and the date of report to the Department;

15.3.1.2.4.3. All verification conducted of Member services, including the number of notices sent to Members to verify and report whether services billed by Providers were actually received by Members, the number of responses received, number of responses warranting further action.

15.3.1.2.4.4. All identified and recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including whether the Overpayment was related to an audit or Fraud case, dates of when Overpayments were identified, and dates when Overpayments were recovered; and

15.3.1.2.4.5. Any other information as specified by the Department.

15.3.1.2.5. The Contractor shall not include activities related to administrative billing issues, such as reviews of financial statements or credit balances.

15.3.1.2.5.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Report

15.3.1.2.5.2. DUE: Within forty-five (45) days of the end of the six (6) month reporting period

15.3.1.2.6. The Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten (10) Business Days following the receipt of the Department's requested changes.

15.3.1.2.6.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

15.3.1.2.6.2. DUE: Within ten (10) Business Days following the Department's request

15.3.1.3. Disclosures Requiring Prompt Notification

15.3.1.3.1. Provider Terminations

15.3.1.3.1.1. The Contractor shall notify the Department of its decision to terminate any existing Network Provider on the basis of quality or performance issues or for cause per 10 CCR 2505-10, Section 8.076.1.7

15.3.1.3.1.2. The Contractor shall provide the following:

15.3.1.3.1.2.1. Provider's name and identification number;

15.3.1.3.1.2.2. Date of removal;

15.3.1.3.1.2.3. Number of Members served by the Provider;

15.3.1.3.1.2.4. Reason for the termination;

15.3.1.3.1.2.5. Narrative describing how the Contractor intends to provide or services for affected Members after the termination; and

15.3.1.3.1.2.6. Any information as required by the Department.

15.3.1.3.1.2.6.1. DELIVERABLE: Notice of Network Provider Termination for Quality of Performance or For Cause

15.3.1.3.1.2.6.2. DUE: Within two (2) Business Days of the decision to terminate for quality or performance issue terminations or terminations for cause

15.3.1.3.2. Changes in Member Circumstances Affecting Eligibility

15.3.1.3.2.1. In accordance with 42 C.F.R. 438.608 (a)(3), the Contractor shall promptly notify the Department when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including, but not limited to, all of the following:

15.3.1.3.2.1.1. Changes in the Member's residence.

15.3.1.3.2.1.2. The death of a Member.

15.3.1.3.2.2. The Contractor shall use the Provider/Member Change in Circumstance Disclosure template.

15.3.1.3.2.3. The Contractor shall provide the following:

15.3.1.3.2.3.1. The Member's name;

15.3.1.3.2.3.2. Medicaid ID number;

15.3.1.3.2.3.3. Date of change;

15.3.1.3.2.3.4. Description of the change; and

15.3.1.3.2.3.5. Any information as required by the Department.

15.3.1.3.2.3.6. DELIVERABLE: Member Change in Circumstance Disclosure

15.3.1.3.2.3.7. DUE: Within five (5) business days of becoming aware of a change in the Member's circumstances that may affect the Member's eligibility.

15.3.1.3.3. Reporting of Identified Overpayments

15.3.1.3.3.1. In accordance with 42 C.F.R. 438.608(a)(2) the Contractor shall promptly notify the Department when it identifies an overpayment, specifying if the overpayment is due to potential fraud.

15.3.1.3.3.2. The Contractor shall provide the following:

15.3.1.3.3.2.1. The Provider's name;

15.3.1.3.3.2.2. The Providers Medicaid ID number;

15.3.1.3.3.2.3. The date of identification;

15.3.1.3.3.2.4. The amount identified;

15.3.1.3.3.2.5. A description of the nature of the overpayment; and

15.3.1.3.3.2.6. Any information as required by the Department.

15.3.1.3.3.2.6.1. DELIVERABLE: Overpayment Identification Disclosure

15.3.1.3.3.2.6.2. DUE: Within five (5) business days of identifying the overpayment.

15.3.1.4. Disclosures Requiring Notification within 30 Days

15.3.1.4.1. Provider Licensure and Professional Review Actions

15.3.1.4.1.1. The Contractor shall report all adverse licensure and professional review actions it has taken against any Provider, in accordance with 45 C.F.R. Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank and to the appropriate state regulatory board. Following list of reportable actions:

15.3.1.4.1.1.1. Malpractice payments;

15.3.1.4.1.1.2. Licensure and certification actions;

15.3.1.4.1.1.3. Negative actions or findings;

15.3.1.4.1.1.4. Adverse actions;

15.3.1.4.1.1.5. Health Care-related Criminal Convictions;

15.3.1.4.1.1.6. Health Care-related Civil Judgments;

15.3.1.4.1.1.7. Exclusions from Federal or state health care programs; and

15.3.1.4.1.1.8. Other adjudicated actions of decisions.

15.3.1.4.1.1.8.1. DELIVERABLE: Notification of Adverse Licensure of Professional Review

15.3.1.4.1.1.8.2. DUE: Must be submitted to the Department and National Practitioner Data Bank within 30 days following the action being reported.

15.3.1.5. Disclosures Requiring Notification within 60 Days

15.3.1.5.1. Overpayments and Excess Capitation Payments

15.3.1.5.1.1. Within sixty (60) calendar days of identifying any Overpayments, per 42 C.F.R 438.608(d)(2), and any excess capitation payments, the Contractor shall report and return an Overpayment to the Department.

15.3.1.5.1.2. The Contractor shall provide the following:

15.3.1.5.1.2.1. Client information;

15.3.1.5.1.2.2. Claims information;

15.3.1.5.1.2.3. Encounter Data information;

15.3.1.5.1.2.4. Paid amounts:

15.3.1.5.1.2.5. Provider information;

15.3.1.5.1.2.6. Dates of when Overpayment was identified and recovered;

15.3.1.5.1.2.7. Recovery amounts;

15.3.1.5.1.2.8. Capitation information; and

15.3.1.5.1.2.9. Any information as required by the Department.

15.3.1.5.1.3. The Contractor shall use the Overpayment and Recovery Disclosure template.

15.3.1.5.1.3.1. DELIVERABLE: Overpayment and Recovery Notification Disclosure

15.3.1.5.1.3.2. DUE: Within sixty (60) calendar days of identifying capitation or other payments.

15.4. Fraud, Waste, and Program Abuse

15.4.1. The Contractor shall temporarily suspend all review activities or actions related to any Provider upon request of the Department.

15.4.2. The Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

15.4.3. The Contractor shall provide expert assistance to the Department, and its Recovery Audit Contractor, as requested by the Department, related to review of overpayments, abuse, suspension of payments, or termination of a Network Provider, or the investigation of Suspected Fraud by a Network Provider.

15.4.4. The Contractor shall provide expert assistance that includes, but is not limited to, the following topics:

15.4.4.1. Any reports made pursuant to this section.

15.4.4.2. Any Medical Records review or Medical Necessity findings or determinations made pursuant to this Contract.

15.4.4.3. Provider treatment and business practices.

15.4.4.4. Provider billing practices and patterns.

15.4.4.5. The Contractor shall meet with the Department, or its contractors to explain any reports or findings made pursuant to the section. It shall cooperate with and provide assistance with any review, recovery effort, informal reconsideration, Appeal or investigation conducted by the federal or state government, law enforcement, the Program Integrity Section, the Department's contractors, federal or state auditors, or any other entity engaged in program integrity functions.

15.4.5. The Contractor shall not take any kind of recovery action or initiate any kind of activity against a Network Provider when possible Fraud is suspected without the approval of the Department.

15.4.6. The Contractor shall not take any action that might interfere with an investigation of possible Fraud by the Department or any other law enforcement entity. The Contractor shall assist the Department, or any other law enforcement entity as requested with any preliminary or full investigation.

15.4.7. The Contractor shall temporarily suspend all review activities or actions related to any Provider which the Contractor suspects is involved in fraudulent activity. The Contractor shall continue its investigation as requested by the Department.

15.5. Provider Fraud

15.5.1. The Contractor shall notify the Department when it identifies or suspects possible Provider Fraud as the result of any activities in its performance of the Contract, including any Utilization Management or review activities.

15.5.2. Upon identification or suspicion of suspected Provider Fraud, the Contractor shall use the MCO Suspected Fraud Written Notice template to notify the Department in writing.

15.5.3. The Contractor shall provide the following, at minimum:

15.5.3.1. Written documentation of the findings;

15.5.3.2. Information on any verbal or written reports;

15.5.3.3. Copies of any written reports;

15.5.3.4. All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, in a mutually agreed upon format.

15.5.3.5. Information on the identification of any affected claims that have been discovered;

15.5.3.6. Any claims data associated with its report (in a mutually agreed upon format, if possible); and

15.5.3.7. Any information as required by the Department.

15.5.3.7.1. DELIVERABLE: Managed Care Suspected Fraud Written Notice

15.5.3.7.2. DUE: Within three (3) Business Days from the initial discovery to the Department

15.5.3.8. The Contractor shall provide any additional information which supplements or modifies the Managed Care Suspected Fraud Written Notice within three (3) Business Days following the receipt of a request for the same by the Department.

15.5.3.8.1. DELIVERABLE: Managed Care Suspected Fraud Written Notice Revisions and Additional Information

15.5.3.8.2. DUE: Within three (3) Business Days following the Department's request

15.6. Member Fraud

15.6.1. The Contractor shall notify the Department when it identifies or suspects possible Member Fraud as the result of any activities in its performance of the Contract, including any Utilization Management or review activities.

15.6.2. Upon identification or suspicion of suspected Member Fraud, the Contractor shall use the Managed Care Suspected Member Fraud Written Notice template and send the complete form and accompanying documentation to the Department at report.clientfraud@state.co.us.

15.6.3. The Contractor shall provide the following, at minimum:

15.6.3.1. All verbal and written reports related to the Suspected Fraud;

15.6.3.2. All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, the Member's State ID number, and Member's date of birth if applicable;

15.6.3.3. Information regarding the identification of any affected claims that have been discovered;

15.6.3.4. Any claims data associated with its report (in a mutually agreed upon format, if possible); and

15.6.3.5. Any information as required by the Department.

15.6.3.5.1. DELIVERABLE: Managed Care Suspected Member Fraud Written Notice

15.6.3.5.2. DUE: Within three (3) business days from the initial discovery to the Department

15.7. Suspension of Payments Due to a Credible Allegation of Fraud

15.7.1. The Contractor shall suspend payments due to a Credible Allegation of Fraud in full or in part only at the direction of the Department, in accordance with 42 C.F.R. § 455.23.

15.7.2. The Contractor shall release suspended payment amounts to the Provider within one payment cycle when directed to do so by the Department.

15.7.3. The Contractor shall not suspend payment when law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

15.7.4. The Department may suspend payments to the Contractor if the Contractor is under investigation for a Credible Allegation of Fraud.

15.8. Quality Improvement Inspection, Monitoring and Site Reviews

15.8.1. The Contractor shall enable and support the Department or its designee to conduct Site Reviews of the Contractor's, Subcontractors' or Providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in its sole discretion to determine compliance with applicable Department regulations and the requirements of this Contract.

15.8.2. Site Reviews may include but are not limited to determining compliance with state and federal requirements, contracts and Provider agreements, service provision and billing procedures, and Provider Manuals. Contractor shall cooperate with Department Site Review activities to monitor Contractor performance.

15.8.3. The Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

15.8.4. The Contractor shall allow the Department or its designee to conduct an emergency or unannounced review for instances including, but not limited to, Member safety, quality of care, and Suspected Fraud or financial viability. The Department may determine when an emergency review is required in its sole discretion.

15.8.5. The Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

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

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

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

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

15.8.9.1. The Department may extend the time frame for corrective action in its sole discretion. The Department may also reduce the time frame for corrective action if delivery of Covered Services for Members is adversely affected or if the time reduction is in the best interests of Members, as determined by the Department.

15.8.9.2. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.

15.8.9.3. The Department will not accept any data submitted by the Contractor to the Department or its agents after the last site visit day towards compliance with the visit in the written report. The Department will only apply this data toward the corrective action plan.

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

15.8.11. In the event that the Site Reviewers wish to inspect a Network Provider location, Contractor shall ensure that:

15.8.11.1. Network Providers make staff available to assist in the audit or inspection effort.

15.8.11.2. Network Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

15.9. Prohibitions

15.9.1. The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. The Contractor shall not pay a Network Provider for provider-preventable conditions, as identified in 42 C.F.R. § 438(g). The Contractor shall ensure that Network Providers identify provider-preventable conditions that are associated with claims for CHP+ payment or with courses of treatment furnished to CHP+ patients for which CHP+ payment would otherwise be available.

15.9.1.1. The Contractor shall create a Provider Preventable Conditions Report that includes all provider-preventable conditions. The Contractor shall submit this report to the Department on an annual basis.

15.9.1.1.1. DELIVERABLE: Provider Preventable Conditions Report

15.9.1.1.2. DUE: Annually, no later than July 31 of each year.

15.9.2. The Contractor shall ensure all Network Providers are enrolled in the Colorado interChange system consistent with Provider disclosure, screening, and Enrollment requirements, and no payment is made to a Network Provider pursuant to this Contract if a Network Provider is not enrolled with the state in the Colorado interChange system.

15.9.3. The Department will not make payment to the Contractor, if the Contractor is:

15.9.3.1. An entity that could be excluded from under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

15.9.3.2. An entity that has a contract for the administration, management or provision of medical services, the establishment of policies, or the provision of operation support, for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act or an individual described in in the section on prohibited affiliations or that has been excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.

15.9.3.3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

15.9.3.3.1. Any individual or entity excluded from participation in federal health care programs.

15.9.3.3.2. Any individual or entity that would provide those services through an excluded individual or entity.

15.9.3.4. The Contractor shall not pay a Provider or Subcontractor, directly or indirectly, for the furnishing of any good or service if:

15.9.3.4.1. The Provider or Subcontractor is excluded from participation in federal health care programs.

15.9.3.4.2. The Provider of Subcontractor has a relationship described in the section on prohibited affiliations.

15.9.4. Prohibited Affiliations

15.9.4.1. The Contractor is prohibited from having a relationship with an individual or entity that is excluded from participation in any federal health care program as described in Sections 1128 and 1128A of the Social Security Act.

15.9.4.2. The Contractor shall not knowingly have a relationship with:

15.9.4.2.1. A director, officer, or partner who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.2. A Subcontractor which is, or is affiliated with a person/entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the, Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.3. A person with Ownership or more than five (5) percent of the Contractor's equity who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.4. An employment, consulting, or other arrangement with an individual or entity for the provision of the contracted items or services who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.2.5. A Provider which is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

15.9.4.3. The Contractor shall provide written disclosure to the Department of any prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, as defined in 438.608(c)(1).

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

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

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

15.9.4.4.3. 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.

15.9.5. Prohibited Payments

15.9.5.1. The Contractor shall not make payments:

15.9.5.1.1. For an item or service, other than an emergency item or service, not including items or services furnished in an emergency room of a Hospital, furnished:

15.9.5.1.1.1. Under the plan by an individual or entity during any time period when the individual or entity is excluded from participation under title V, XVII, or XX or under title XIX pursuant to § 1128, 1128A, 1156, or 1842(j)(2);

15.9.5.1.1.2. At the medical direction or on the prescription of a physician, during the period when the physician is excluded from participation under title V, XVIII, or XX or under title XIX pursuant to § 1128, 1128A, 1156, or 1842(j)(2), and when the person furnishing such item or service knew, or had reason to know, of the exclusion; or

15.9.5.1.1.3. By an individual or entity to whom the Department has failed to suspend payments during any period when there is a pending investigation of a Credible Allegation of Fraud against the individual or entity, unless the Department determines there is a good cause not to suspend such payments; or

15.9.5.1.2. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;

15.9.5.1.3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the CHP+ State Plan; or

15.9.5.1.4. For home health care services provided by an agency or organization, unless the agency provides the Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

15.10. General Compliance and Program Integrity Requirements

15.10.1. Mental Health Parity

15.10.1.1. Contractor shall comply with all regulations within 42 C.F.R. Part 438, subpart K regarding parity in mental health and substance use disorder benefits, and submit all necessary documentation and reporting required to the Department to establish and demonstrate compliance with 42 C.F.R. Part 438, subpart K.

15.10.1.2. Contractor shall comply with all regulations within HB-1269 and demonstrate that the plan offered by the carrier complies with C.R.S 10-16-104 (5.5) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

15.10.2. Health Information Systems

15.10.2.1. The Contractor shall comply with the following, aligning with the Department's implementation timeline:

15.10.2.1.1. The Contractor shall implement and maintain a secure, standards-based application program interface (API) which provides current members, or their personal representatives, with access to specified claims and encounter data, certain clinical information, and information about covered outpatient drugs.

15.10.2.1.1.1. The API shall comply with the requirements of 42 CFR § 438.242 and 45 CFR § 170.215.

15.10.2.1.2. The Contractor shall implement and maintain an API that makes complete and accurate provider directory information available through a public-facing digital endpoint on the Contractor's website.

15.10.2.1.2.1. The API shall meet the requirements of 42 CFR § 438.242 as well as the provider directory information specified in § 438.10.

15.10.2.1.3. The Contractor shall comply with the requirements of 42 CFR § 438.62 through the development and maintenance of a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213.

15.10.2.1.3.1. The USCDI data classes and elements received from other plans must be incorporated into the Contractors' records about the member.

15.10.2.1.3.2. At the request of a member, the Contractor must incorporate into its records such member data with a date of service on or after January 1, 2016, from any other payer that has provided coverage to the member within the preceding 5 years.

15.10.2.1.3.3. Any time during a member's enrollment with Contractor and up to 5 years after disenrollment, the Contractor must send, upon a member's request, all such data to any other payer that currently covers the member, or a payer that the member specifically requests to receive the data classes and elements included in the USCDI content standards.

15.10.3. Business Transaction Disclosures

15.10.3.1. The Contractor shall submit, full and complete information about:

15.10.3.1.1. The Ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the 12-month period ending on the date of the request; and

15.10.3.1.2. Any Significant Business Transactions between the Contractor and any Wholly Owned Supplier, or between the Contractor and any Subcontractor, during the 5-year period ending on the date of the request.

15.10.3.1.2.1. DELIVERABLE: Disclosure of Business Transactions

15.10.3.1.2.2. DUE: Within thirty-five (35) calendar days following a request by the Department or by the Secretary of the Department of Health and Human Services.

15.10.4. Ownership or Control Disclosures

15.10.4.1. The Contractor shall disclose to the Department information regarding Ownership or Control Interests in the Contractor at the time of submitting a Provider application, at the time of executing the Contract with the State, at Contract renewal or extension, and within thirty-five (35) calendar days of either a change of Ownership or a written request by the Department.

15.10.4.2. The Contractor shall include the following Ownership and control disclosure information in a form to be provided by the Department:

15.10.4.2.1. The name, title and address of any individual or entity with an Ownership or Control Interest in the Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

15.10.4.2.2. Date of birth and Social Security Number of any individual with an Ownership or Control Interest in the Contractor.

15.10.4.2.3. Tax identification number of any corporation or partnership with an Ownership or Control Interest in the Contractor, or in any Subcontractor in which the Contractor has a five percent (5%) or more interest.

15.10.4.2.4. Whether an individual with an Ownership or Control Interest in the Contractor is related to another person with an Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling; or whether an individual with an Ownership or Control Interest in any Subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with Ownership or Control Interest in the Contractor as a spouse, parent, child, or sibling.

15.10.4.2.5. The name of any other Provider (other than an individual Provider or Group of Providers), Fiscal Agent, or managed care entity in which an owner of the Contractor has an Ownership or Control Interest.

15.10.4.2.6. The name, title, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

15.10.4.2.6.1. DELIVERABLE: Ownership or Control Disclosures

15.10.4.2.6.2. DUE: Annually on July 31 and within thirty-five (35) calendar days of either a change of Ownership or a written request by the Department.

15.10.5. Conflict of Interest

15.10.5.1. The Contractor shall comply with the conflict of interest safeguards described in 42 C.F.R. §438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

15.10.5.2. The term "conflict of interest" means that:

15.10.5.2.1. The Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

15.10.5.2.2. The relationship between the third party and the Department is such that one party's interests could only be advanced at the expense of the other's interests.

15.10.5.2.3. A conflict of interest exists even if the Contractor does not use information obtained from one party in its dealings with the other.

15.10.5.3. The Contractor shall submit a full disclosure statement to the Department, setting forth the details that create the appearance of a conflict of interest.

15.10.5.3.1. DELIVERABLE: Conflict of Interest Disclosure Statement

15.10.5.3.2. DUE: Within ten (10) Business Days of learning of an existing appearance of a conflict of interest situation.

15.10.6. Subcontracts and Contracts

15.10.6.1. The Contractor shall disclose to the Department copies of any existing subcontracts and contracts with Providers upon request.

15.10.6.2. The Contractor shall ensure that no Member is billed by a Subcontractor or Provider for any amount greater than would be owed if the Contractor provided the services directly or in violation of 25.5-4-301(1)(a)(I), (II) and (II.5), C.R.S.

15.10.6.2.1. DELIVERABLE: Subcontracts and Provider Contracts

15.10.6.2.2. DUE: Within five (5) Business Days of the Department's Request.

15.10.7. Screening of Employees and Contractors

15.10.7.1. The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the HHS-OIG.

15.10.7.2. The Contractor shall screen all of its employees and Subcontractors against the HHS-OIG's List of Excluded Individuals (LEIE) prior to hire or contracting and at least monthly thereafter to determine whether they have been excluded from participation in Medicaid.

15.10.7.3. If the Contractor determines that one of its employees or Subcontractors has been excluded, the Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery to the Department.

15.10.7.3.1. DELIVERABLE: Notification of Discovery of Excluded Employee or Subcontractor

15.10.7.3.2. DUE: Within five (5) Business Days of discovery

15.10.8. Disclosure of Information on Persons Convicted of Crimes

15.10.8.1. Upon submitting a Provider application, upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date of a written request by the Department, the Contractor shall disclose the identity of any person who:

15.10.8.1.1. Has an Ownership or Control Interest in the Contractor, or who is a Managing Employee of the Contractor; and

15.10.8.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX services program, or Title XXI of the Social Security Act.

15.10.8.1.2.1. DELIVERABLE: Disclosure of Information on Persons Convicted of Crimes

15.10.8.1.2.2. DUE: January 1, 2020 and annually thereafter within thirty-five (35) calendar days of either a change of Ownership or a written request by the Department.

15.10.9. Security Breaches and HIPAA Violations

15.10.9.1. In the event of a breach of the security of sensitive data the Contractor shall immediately notify the Department and the Office of Information Technology (OIT) of all suspected loss or compromise of sensitive data within five (5) Business Days of the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

15.10.9.2. The Contractor shall comply with the requirements of C.R.S. § 6-1-716 and any other applicable state and federal laws and regulations.

15.10.9.3. The Contractor shall report all HIPAA violations as described in the HIPAA Business Associates Addendum.

15.10.9.3.1. DELIVERABLE: Security and HIPAA Violation Breach Notification

15.10.9.3.2. DUE: Within five (5) Business Days of becoming aware of the breach

15.10.10. Maintenance of Records

15.10.10.1. The Contractor shall ensure that all Subcontractors and Providers comply with all record maintenance requirements of the Contract.

15.10.10.2. Notwithstanding any other requirement of the Contract, the Contractor shall retain and require Subcontractors to retain, as applicable, enrollee Grievance and Appeal records in accordance with 42 C.F.R. § 438.416, base data in accordance with 42 C.F.R. § 438.5(c), MLR reports in accordance with 42 C.F.R. § 438.8(k), and the data, information, and documentation specified is 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610 for a period of no less than ten (10) years.

15.10.11. Inspection and Audits

15.10.11.1. The Contractor shall allow the Department, CMS, HHS-OIG, the Comptroller General and their designees to inspect and audit any records or documents of the Contractor or its Subcontractors and shall allow them to, at any time, inspect the premises, physical facilities and equipment where CHP+-related activities or Work is conducted.

15.10.11.2. Notwithstanding any other provision in the Contract, the Contractor shall allow the Department, CMS, the HHS-OIG, the Comptroller General and their designees this authority for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

15.10.11.3. The Contractor shall allow CMS or its agent or designated contractor and the Department or its agent to conduct unannounced, on-site inspections for any reason.

15.10.11.4. In the event that right of access is requested, the Contractor and/or its Subcontractors or Providers shall:

15.10.11.4.1. Make staff available to assist in any audit or inspection under the Contract.

15.10.11.4.2. Provide adequate space on the premises to reasonably accommodate Department, state or federal or their designees' personnel conducting all audits, Site Reviews or inspections.

15.10.11.4.3. The Secretary of Health and Human services, the Department of Health and Human Services, and the Department have the right to audit and inspect any books or records of the Contractor or its Subcontractors pertaining to the ability of the Contractor or its Subcontractor's ability to bear the risk of financial losses.

15.10.11.4.4. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of the Contractor's, Subcontractor's or Providers' provision of care.

15.10.11.4.5. The Contractor shall allow access to the Contractor's claims system and claims data by Department staff for program integrity activities.

15.10.11.4.6. In consultation with the Department, the Contractor shall participate in compliance monitoring activities and respond to any Department or designee request for information related to compliance monitoring, including Encounter Data analysis and Encounter Data validation (the comparison of Encounter Data with Medical Records). The Department may request other information or analyses needed for compliance monitoring.

15.10.11.5. The Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five (5) Business Days.

15.10.11.6. Must have staff available to assist in any audit or inspection under the Contract.

15.11. Financial Reporting

15.11.1. Audited Annual Financial Statement

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

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

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

15.11.1.1.3. 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.

15.11.1.1.3.1. DELIVERABLE: Audited Annual Financial Statement

15.11.1.1.3.2. 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.

15.11.2. The Contractor shall submit other financial reports and information as requested by the Department or its designee.

15.11.3. The Contractor shall assist the Department in verifying any reported information upon the Department's request. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:

15.11.3.1. Fact-checking.

15.11.3.2. Auditing reported data.

15.11.3.3. Performing site visits.

15.11.3.4. Requesting additional information.

15.11.4. If the Department determines that there are errors or omissions in any reported information, the Contractor shall produce an updated report that corrects all errors and includes all omitted data or information. The Contractor shall submit the updated report to the Department within fourteen (14) days from the Department's request for the updated report.

15.11.4.1. DELIVERABLE: Updated Financial Reports or Statements

15.11.4.2. DUE: Fourteen (14) days from the Department's request for the updated report or statement.

15.12. Solvency

15.12.1. The Contractor shall notify the Department, upon becoming aware of or having reason to believe that it does not, or may not, meet the solvency standards, established by the State for Health Maintenance Organizations.

15.12.2. The Contractor shall not hold liable any Member for the Contractor's debts, in the event the Contractor becomes insolvent.

15.12.3. The Contractor shall not hold liable any Member for covered services provided to the Member, for which the Department does not pay the Contractor, or for which the Department or Contractor does not pay the provider that furnished the service under a contractual, referral, or other arrangement.

15.12.4. The Contractor shall not hold liable any Member for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the Contractor covered the services directly.

15.12.5. The Contractor shall provide assurances satisfactory to the Department that its provision against the risk of insolvency is adequate to ensure that Members will not be liable for the Contractor's debt, in the event the Contractor becomes insolvent.

15.12.5.1. DELIVERABLE: Solvency Notification

15.12.5.2. DUE: Within two (2) Business Days of becoming aware of a possible solvency issue.

15.13. Warranties and Certifications

15.13.1. The Contractor shall disclose to the Department if it is no longer able to provide the same warranties and certifications as required at the Effective Date of the Contract.

15.14. Actions Involving Licenses, Certifications, Approvals and Permits

15.14.1. Provider Insurance

15.14.1.1. The Contractor shall ensure that Network Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this contract. Minimum insurance requirements shall include, but are not limited to all the following:

15.14.1.1.1. Physicians participating in the Contractor's MCO shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and one million five-hundred thousand dollars ($1,500,000.00) in aggregate per year.

15.14.1.1.2. Facilities participating in the Contractor's MCO shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and three million dollars ($3,000,000.00) in aggregate per year.

15.14.1.1.3. Sections 15.14.1.1.1 and 15.14.1.1.2 shall not apply to physicians and facilities in the Contractor's network which meet any of the following requirements:

15.14.1.1.3.1. The physician or facility is a public entity or employee pursuant to §24-10-103, C.R.S. of the Colorado Governmental Immunity Act, as amended.

15.14.1.1.3.2. The physician or facility maintains any other security acceptable to the Colorado Commissioner of Insurance, which may include approved plan of self-insurance, pursuant to §13-64-301, C.R.S., as amended.

15.14.1.1.4. The Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such coverage, the Contractor shall notify the Department of such cancellation within two (2) Business Days of when the coverage is cancelled.

15.14.2. The Contractor shall notify the Department of:

15.14.2.1. Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of Section 10, 16, -401, et seq., C.R.S. as a Health Maintenance Organization.

15.14.2.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

15.14.2.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

15.14.2.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

15.14.2.3.2. DUE: Within two (2) Business Days of Contractor's notification.

15.15. Federal Intermediate Sanctions

15.15.1. The Department may implement any intermediate sanctions, as described in 42 CFR 438.702, if the Contractor:

15.15.1.1. Fails substantially to provide Medically Necessary services that the Contractor is required to provide, under law or under its Contract –with the Department, to a Member covered under the Contract.

15.15.1.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the CHP+ program.

15.15.1.3. Acts to discriminate among Members on the basis of their health status or need for health care services.

15.15.1.4. Misrepresents or falsifies information that it furnishes to CMS or to the Department.

15.15.1.5. Misrepresents or falsifies information that it furnishes to a Member, Potential Member, or health care Provider.

15.15.1.6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.

15.15.1.7. Has distributed directly, or indirectly through any agent or independent contractor, Marketing Materials that have not been approved by the State or that contain false or materially misleading information.

15.15.1.8. Has violated any of the other applicable requirements of sections 1903(m), 1932, or 1905(t) of the Act and any implementing regulations.

15.15.2. Notice of Sanction and Pre-Termination Hearing

15.15.2.1. Before imposing any of the intermediate sanctions specified in this section, the State must give the affected entity timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

15.15.2.2. Before terminating any contracts with the Contractor, the State must provide the Contractor a pre-termination hearing.

15.15.2.3. Prior to a pre-termination hearing, the State must provide Contractor with the following:

15.15.2.4. Written notice of its intent to terminate, the reason for termination, and the time and place of the hearing,

15.15.2.5. After the hearing, the State must provide the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination, and

15.15.2.6. For an affirming decision, give enrollees of the Contractor notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

15.15.3. Payments provided for under the Contract shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

15.16. Termination Under Federal Regulations

15.16.1. The Department may terminate this Contract for cause and Enroll any Member enrolled with the Contractor in another Plan, or provide their CHP+ benefits through other options included in the State plan, if the Department determines that the Contractor has failed to:

15.16.1.1. Carry out the substantive terms of its contracts.

15.16.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

15.16.2. Before terminating the Contractor's Contract as described in this section, the Department will:

15.16.2.1. Provide the Contractor a cure notice that includes, at a minimum, all of the following:

15.16.2.1.1. The Department's intent to terminate.

15.16.2.1.2. The reason for the termination.

15.16.2.1.3. The time and place for the pre-termination hearing.

15.16.2.2. Conduct a pre-termination hearing.

15.16.2.3. Give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

15.16.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department will send a written termination notice to the Contractor that contains the Effective Date of the termination.

15.16.2.4.1. Upon receipt of the termination notice, the Contractor shall give Members enrolled with the Contractor notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHP+ services following the effective date of termination.

15.16.3. Once the Department has notified the Contractor of its intent to terminate under this section, the Department may give Members enrolled with the Contractor written notice of the Department's intent to terminate the Contract.

15.16.4. The Department may choose to impose any of the following intermediate sanctions if the Contractor violates any applicable requirements of sections 1903(m) or 1932 of the Social Security Act and its implementing regulations:

15.16.4.1. Allow Members enrolled with the Contractor to Disenroll immediately, without cause;

15.16.4.2. Suspend all new Enrollments to the Contractor's managed care capitation initiative, after the date the Secretary or the Department notifies the Contractor of a determination of violation of any requirement under sections 1903(m) or 1932 of the Act; and

15.16.4.3. Suspend payments for all new Enrollments to the Contractor's managed care capitation initiative until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

15.16.5. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the Work ends, Contractor shall not be paid for that Work. If the state paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the Work was to be performed after the date the legal authority ended, the payment for that Work should be returned to the state. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that Work in its payments to Contractor, Contractor may keep the payment for that Work even if the payment was made after the date the program or activity lost legal authority.

16. COMPENSATION AND INVOICING

16.1. Summary of Compensation to the Contractor

16.1.1. Compensation to The Contractor shall consist of the following:

16.1.1.1. One actuarially certified monthly Capitated Payment, as specified in Exhibit C, Rates, for each active Member assigned to the Contractor on the first day of the month and for Members whose Enrollment starts from the 2nd through the 17th of the month. The Department will set the monthly Capitated Payment rates at the actuarially certified point estimate in accordance with 42 C.F.R. § 438.3.

16.2. Process for Capitated Payments

16.2.1. The Department will calculate the number of active Members enrolled in the Contractor's Managed Care Organization based on the Enrollment information in the Colorado interChange.

16.2.2. The Department will remit all Capitated Payments through the Colorado interChange via electronic funds transfer to a bank account designated by the Contractor. The Department will provide the Contractor with a monthly payment report through the Colorado interChange.

16.2.2.1. The Contractor shall ensure the accuracy of direct deposit information provided to the Department and update such information as needed.

16.2.3. The Department will remit all Capitated Payments to the Contractor within the month for which the payment applies.

16.2.3.1. In the event that the Contractor is not compensated for a Member in a month for which the Contractor should have been compensated, per Department records, the Department will compensate the Contractor for that Member retroactively.

16.2.4. The Department will remove Third Party Recovery amounts from the calculation of the Monthly Capitation Rates. The Department will not seek recovery of reimbursement from the Contractor.

16.2.5. The monthly Capitated Payment shall be considered payment in full for all Covered Services set forth in this Contract.

16.3. Deliveries

16.3.1. The Contractor shall receive payment for delivery services provided to Members over the age of 19 through a case rate payment. The payment, which is set forth in this Contract, includes facility and professional service costs related to the delivery and post-partum care. One payment shall be made for each delivery regardless of the number of births associated with that delivery.

16.3.2. In order to receive payment for deliveries, the Contractor shall submit, to the Department, a cover letter and an electronic Excel spreadsheet in the format provided by the Department. Documentation of the delivery, e.g., a claim record of delivery, must accompany the request for payment. The request for payment shall be submitted to the Department no later than one hundred and fifty (150) days following the delivery.

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

16.3.4. The Department will adjudicate the Contractor's request for payment within ninety (90) days of receipt of all documentation of the delivery.

16.4. Newborn Services

16.4.1. The Department will share the cost of newborn services with the Contractor through a reinsurance model, at a per claim basis, if the cost exceeds a specific dollar threshold, and according to the terms in this section.

16.4.2. The reinsurance model shall comprise the following components:

16.4.2.1. Attachment point – the dollar threshold amount that a claim must exceed in order to initiate reimbursement through the Department's reinsurance model.

16.4.2.1.1. At least two (2) years of historical claims data will be used to determine claims paid amount distribution to inform the decision around the attachment point level.

16.4.2.2. Risk sharing percentage – the share of cost percentage between the Department and the Contractor on a claim's paid amount above the attachment point.

16.4.3. Reimbursement for newborn services whose cost exceeds the attachment point will only be made for eligible services. In order to qualify for the reinsurance model, claims must meet the following criteria:

16.4.3.1. Member must be eligible for CHP+ at the time of service.

16.4.3.2. Member must be enrolled into the Contractor's plan at the time of service.

16.4.3.3. Total claim paid amount must be above the attachment point of the reinsurance model.

16.4.3.4. Member's age must be less than two (2) years old.

16.4.3.4.1. Age will be based on capitation paid for the month of service

16.4.3.5. Revenue codes must be 0100, 0101, 0110-0160, 0164, 0167, 0169, 0170-0174, 0179, 0200-0219 or bill type 11X, 12X, 89X.

16.4.3.6. Professional fees must be excluded.

16.4.3.7. Start date of service for the claim must be within the timely filing deadline.

16.4.4. Cost Sharing Calculations

16.4.4.1. The Contractor shall be held solely responsible for final incurred costs to the Contractor for eligible services up to $50,000.00 per claim. The Department will reimburse the Contractor for eligible services in excess of $50,000.00, utilizing the following risk sharing percentage:

Attachment Point	MCO Share	State Share
$50,000.00	25%	75%

16.4.4.2. The payment amount will be calculated as the difference between total claim paid amount and the attachment point multiplied by the State share as indicated in the table above. A single payment shall be made to the Contractor for all reimbursement requests submitted within a quarter.

16.4.4.3. Reimbursement amount for eligible services will be based on the attachment point and risk sharing percentage effective during the State Fiscal Year in which a service was rendered.

16.4.4.4. To be considered for reimbursement, the request submitted to the Department must reflect net paid claims amount by the Contractor.

16.4.4.4.1. The Contractor shall ensure that all available third-party liability benefits are exhausted before reimbursement through the Department's reinsurance model is initiated.

16.4.5. Reimbursement Process

16.4.5.1. In order to receive reimbursement, the Contractor shall submit a cover letter and an electronic Excel spreadsheet to the Department in the format provided by the Department. Documentation of the eligible service(s) shall accompany the request for payment. The request for payment shall be submitted to the Department no later than 60 days following the quarter in which a claim was paid.

16.4.5.1.1. The Contractor shall certify all data submitted are accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer, the Chief Financial Officer or another individual who has delegated signatory authority and who reports directly to the Chief Executive Officer or Chief Financial Officer.

16.4.5.2. The Department will verify the submitted data no later than thirty (30) days after receiving the reinsurance report from the Contractor at the end of each quarter.

16.4.5.3. The Department will adjudicate the Contractor's request for payment within sixty (60) days of receipt of all documentation of the service.

16.4.5.4. The Contractor shall report to the Department any retroactive adjustment that is made on submitted and verified claims that reduce the claims total paid amount below the attachment point within one hundred and fifty (150) days after the adjustment was made.

16.4.5.5. The Department reserves the right to review all relevant documentation for the submitted claims. The Contractor shall document and provide supporting information for the submitted claims. The Department reserves the right to exclude claims from reimbursement that do not have any supporting information or documentation.

16.4.5.6. The Department reserves the right to review claims paid amount for reasonableness and to request supporting documentation as necessary.

16.4.5.7. The Department will have the final decision on all cost sharing calculations.

16.4.6. Medical Loss Ratio (MLR) Reporting

16.4.6.1. The Contractor shall exclude the reimbursed amount from the reinsurance model as revenue in the MLR report.

16.4.6.2. The Contractor shall exclude the State's share of claims paid amount above the attachment point of the reinsurance model from the claims incurred line in the MLR report.

16.4.7. Future Rate Setting

16.4.7.1. All claims reimbursed by the reinsurance model will have their claim paid amount readjusted to be net of the State Share reimbursement when included as base data for rate-setting.

16.4.7.2. The Department will review and update the parameters and criteria of the reinsurance model annually. All changes of the reinsurance model will be presented to the Contractor before the capitation rates model is finalized.

16.5. COVID Vaccine Administration Reimbursement

16.5.1. The Department will exclude COVID vaccine administration reimbursement rates from CHP+ capitations and the Contractor will receive payment for COVID vaccine administration provided to Members through a case rate payment.

16.5.2. In order to receive payment for COVID vaccine administration, the Contractor shall submit a cover letter and an electronic Excel spreadsheet to the Department in the format provided by the Department.

16.5.3. The request for payment shall be submitted to the Department no later than sixty (60) days following the quarter in which a claim was paid.

16.5.3.1. The Contractor shall provide additional documentation as requested by the Department.

16.5.4. The Department will adjudicate the Contractor's request for payment within ninety (90) days of receipt of the COVID vaccination report from the Contractor at the end of each quarter.

16.5.4.1. The Department will validate the Member's CHP+ eligibility and enrollment prior to the claim payment.

16.5.5. All revenue and cost incurred for the administration of COVID vaccines will be excluded from future rate setting and rate reconciliation processes, including any risk-sharing mechanism such as Medical Loss Ratio calculation.

16.6. Actions impacting existing rates

16.6.1. The Contractor shall inform the Department prior to making changes to rate payment methodologies, Provider recoupments, or other financial adjustments that may impact the underlying assumptions the rate is built on. The Contractor shall notify the Department at least thirty (30) days in advance prior to making any such changes.

16.7. Payment Calculation Disputes

16.7.1. In the event that the Contractor believes that the calculation or determination of any payment is incorrect, the Contractor shall notify the Department of its dispute within thirty (30) days of the receipt of the payment. The Department will review calculation or determination and may make changes based on this review. The determination or calculation that results from the Department's review shall be final. No disputed payment shall be due until after the Department has concluded its review.

16.8. Recoupments

16.8.1. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) days, the Department shall deduct the overpayments from the next payment to the Contractor

16.8.2. The Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, the Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within ninety (90) days of termination.

16.8.3. Payments made by the Department to the Contractor due to the Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

16.8.4. Where Membership is disputed between two Contractors, the Department will be final arbitrator of Membership and shall recoup any Capitated Payments. The Contractor's obligation to refund all calculated rebates continues subsequent to termination of the Contract.

16.9. Closeout Payments

16.9.1. Notwithstanding anything to the contrary in this Contract, all payments for the final month of this Contract shall be paid to Contractor no sooner than ten (10) days after the Department has determined that Contractor has completed all of the requirements of the Closeout.

16.10. Medical Loss Ratio (MLR)

16.10.1. The Contractor shall calculate and report the MLR according to the instructions provided on the MLR template and the guidance provided in 42 C.F.R. § 438.8(a).

16.10.2. Annual measurement periods will align with the state Fiscal Year, beginning on July 1 and ending on June 30 of the subsequent calendar year.

16.10.3. The Contractor shall submit an MLR report to the Department, for each MLR reporting year, that includes:

16.10.3.1. Total incurred claims.

16.10.3.2. Expenditures on quality improvement activities.

16.10.3.3. Expenditures related to activities compliant with program integrity requirements.

16.10.3.4. Non-claims costs.

16.10.3.5. Premium revenue.

16.10.3.6. Taxes.

16.10.3.7. Licensing fees

16.10.3.8. Regulatory fees.

16.10.3.9. Methodology(ies) for allocation of expenditures.

16.10.3.10. Any credibility adjustment applied if the MLR reporting year experience is partially credible.

16.10.3.10.1. Any credibility adjustment shall be added to the reported MLR calculation before calculating any remittances.

16.10.3.10.2. The Contractor shall not add a credibility adjustment to the calculated MLR if the MLR reporting year experience is fully credible.

16.10.3.11. The calculated MLR.

16.10.3.12. Any remittance owed to the state, if applicable.

16.10.3.13. A comparison of the information reported with the audited financial report.

16.10.3.14. A description of the aggregation method used to calculate total incurred claims.

16.10.3.15. The number of Member months.

16.10.4. All data provided by the Contractor for the purpose of MLR calculation shall use actual costs.

16.10.4.1. The Contractor shall allow for three (3) months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five (5) months.

16.10.4.2. The Contractor shall submit the completed MLR calculation on the Department approved template and provide supporting data and documentation per 42 CFR 438.8(k), including, but not limited to, all Encounters, certified financial statements and reporting, and flat files, in compliance with the Department guidelines, for the measurement period by January 15. The Contractor shall submit Encounter claims in compliance with requirements in Section 13.1.6.

16.10.4.2.1. DELIVERABLE: MLR calculation template and supporting data and documentation

16.10.4.2.2. DUE: Annually, by January 15th of each year

16.10.4.3. The Contractor's Medical Spend is audited supplemental data provided in the Contractor's annual financial reporting will be verified using Encounter Data submitted through flat file submission on a secure server, until such time that the Department deems it appropriate for such Encounter Data submissions to be sent through the Colorado interChange.

16.10.4.4. MLR Target: The Contractor shall have an MLR of at least eighty-five percent (85%). The Contractor shall calculate an age-cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department.

16.10.4.5. The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

16.10.4.5.1. The Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

16.10.4.5.2. The Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

16.10.4.5.3. The Contractor shall ensure that shared expenses, including expenses under the terms of a management contract, are apportioned pro rata to the contract incurring the expense.

16.10.4.5.4. The Contractor shall ensure that expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, are borne solely by the reporting entity and are not apportioned to the other entities.

16.10.4.5.5. The numerator is the sum of the Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's Fraud reduction activities.

16.10.4.6. The Contractor shall round the MLR to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.

16.10.4.6.1. The Contractor shall aggregate data for all CHP+ eligibility groups covered under this Contract.

16.10.4.7. If the Contractor's MLR does not meet or exceed the MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:

16.10.4.7.1. Reimbursement amount shall equal the difference between the adjusted earned revenue and the net qualified medical expenses divided by the MLR target.

16.10.4.7.2. The Contractor shall reimburse the Department within thirty (30) days of the Department finalizing the MLR validation. The Department will designate the MLR rebate and initiate the recovery of funds process by providing notice to the Contractor of the amount due, pursuant to 10 CCR 2505-10 § 8.050.3 A-C Provider Appeals, as well as § 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

16.10.4.7.2.1. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with the Contractor any adjustments that must be made to the Contractor's calculated MLR.

16.10.4.7.2.2. The Contractor shall submit all encounters, audited financial statements and reporting, and flat files for the measurement period, before the Department can validate the MLR.

16.10.5. Subcontracted Claims Adjudication Activities

16.10.5.1. The Contractor shall require any Subcontractors providing claim adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

16.10.6. In any instance where the Department makes a retroactive change to the capitation payments for an MLR reporting year where the MLR report has already been submitted to the Department, the Contractor shall:

16.10.6.1. Re-calculate the MLR for all MLR reporting years affected by the change; and

16.10.6.2. Submit a new MLR report meeting the applicable requirements.

16.10.6.2.1. DELIVERABLE: MLR Calculation Template

16.10.6.2.2. DUE: Annually on January 15

16.10.7. Adjusted MLR Target

16.10.7.1. The Contractor shall collaborate with the Department to develop MLR Quality Targets, thresholds, processes, and identifying quality metrics for the purpose of measuring Contractor performance and overall Program improvement.

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EXHIBIT C-3, RATES

STATE FISCAL YEAR 2021-22

MONTHLY CAPITATION RATES

State Fiscal Year 2021-22 rates will be effective on the later of the Effective Date or July 1, 2021.

The Contractor shall earn the following full risk rates shown in the following table, adjusted by age and poverty level of the Member's family:

Rates Effective Date: 07/01/2021 – 06/30/2022

Rate Cells	Age Group	FPL	SFY22 Payment Rate
CHP01	00-01	0-100%	$314.59
CHP02	00-01	101-156%	$314.59
CHP03	00-01	157-200%	$314.59
CHP04	00-01	201-260%	$314.59
CHP05	02-05	0-100%	$156.63
CHP06	02-05	101-156%	$156.63
CHP07	02-05	157-200%	$156.63
CHP08	02-05	201-260%	$156.63
CHP09	06-18	0-100%	$189.19
CHP10	06-18	101-156%	$189.19
CHP11	06-18	157-200%	$189.19
CHP12	06-18	201-260%	$189.19
CHP13	19+	0-100%	$449.02
CHP14	19+	101-156%	$449.02
CHP15	19+	157-200%	$449.02
CHP16	19+	201-260%	$449.02
Deliveries	19+	Total	$6,667.96

EXHIBIT F, FLOURIDE VARNISH PROGRAM

1.1. "Moderate to high caries risk children" means those children identified, using the Oral Health Assessment, with indicators that contribute to infant / child caries risk.

1.2. Effective September 1, 2010, trained medical personnel may administer fluoride varnish for moderate to high caries risk CHP+ children, ages zero through four, in conjunction with an oral evaluation and counseling with a Primary Caregiver after performing a risk assessment. Risk assessment forms may be found at:

http://www.cavityfreeatthree.org/sites/default/files/risk_assessment_form_dental.pdf

1.3. Documentation should be part of the Client's Medical Record. Medical personnel who can bill directly for these services include MDS, DOS and nurse practitioners. Trained medical personnel employed through qualified Physician offices or clinics can provide these services and bill using the Physician's or nurse practitioner's CHP+ Provider number.

1.4. Children ages zero through four (until the day before their fifth birthday), assessed as moderate to high caries risk children are eligible to receive this service and both services must be provided together.

1.5. In order to provide this benefit and receive reimbursement, the medical Provider must have participated in on-site training from the cavity-free at three team or have completed module two (child oral health) and module six (fluoride varnish) at the "Smiles for Life" curriculum at:

http://www.smilesforlifeoralhealth.org/

(Under Online Courses tab – Children, and Fluoride Varnish)

1.6. It is also recommended that Providers view the videos on the lap-to-lap child exam and the application for fluoride varnish at:

http://www.smilesforlifeoralhealth.org/

(Under Resource tab, video)

1.7. Documentation for this training should be saved in the event of an audit.

1.8. Dental Providers inclusive of unsupervised dental hygienists are also able to provide these services. While encouraged, no additional training is required for qualified dental personnel.

1.9. The maximum allowable benefit per eligible and high-risk child will be two times per calendar year. Dental offices and medical offices are encouraged to communicate with one another to avoid duplication of services and/or nonpayment of services.

1.10. The billing procedures for medical personnel are as follows:

1.10.1. Children ages zero through two:

1.10.1.1. Medical Practice: D1206 (topical fluoride varnish) and D0145 (oral evaluation for a patient under three years of age and counseling with Primary Caregiver) must be billed together.

1.10.1.2. Federally Qualified Health Centers and Rural Health Clinics: D1206 (topical fluoride varnish) and D0145 (oral evaluation for a patient under three years of age and counseling with Primary Caregiver) must be itemized on the claim. ICD 10 codes are: Z01.20 Encounter for dental examination and cleaning without abnormal findings and Z01.21

Encounter for dental examination and cleaning with abnormal findings.

1.10.2. Children ages three through four:

1.10.2.1. Medical Practice: D1206 (topical fluoride varnish) and D0190 (dental screening) must be billed together.

1.10.2.2. Federally Qualified Health Centers and Rural Health Clinics: D1206 (topical fluoride varnish), D0190 (dental screening) and D0999 (dental screening) must be itemized on the claim. ICD 10 codes are: Z01.20 Encounter for dental examination and cleaning without abnormal findings and Z01.21 Encounter for dental examination and cleaning with abnormal findings.