CONTRACT AMENDMENT #1

SIGNATURE AND COVER PAGE

State Agency Department of Health Care Policy and Financing	**Original Contract Number** 18-101454
Contractor Rocky Mountain Health Maintenance Organization, Inc. dba Rocky Mountain Health Plans	**Amendment Contract Number** 18-101454A1
Current Contract Maximum Amount Initial Term State Fiscal Year 2018 — No Maximum Extension Terms State Fiscal Year 2019 — No Maximum State Fiscal Year 2020 — No Maximum State Fiscal Year 2021 — No Maximum State Fiscal Year 2022 — No Maximum Total for All State Fiscal Years — No Maximum	**Contract Performance Beginning Date** The Effective Date **Current Contract Expiration Date** June 30, 2019

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	STATE OF COLORADO
Rocky Mountain Health Maintenance Organization, Inc. dba Rocky Mountain Health Plans	John W. Hickenlooper, Governor Department of Health Care Policy and Financing Kim Bimestefer, Executive Director
By: Name & Title of Person Signing for Contractor	By: Kim Bimestefer, Executive Director
Date: 12/12/18	Date: 12/15/18

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

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

Amendment Effective Date: 12/20/18

1. PARTIES

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

2. TERMINOLOGY

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

3. AMENDMENT EFFECTIVE DATE AND TERM

A. Amendment Effective Date

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

B. Amendment Term

The Parties' respective performances under this Amendment and the changes to the Contract contained herein shall commence on the Amendment Effective Date shown on the Signature and Cover Page for this Amendment and shall terminate on the termination of the Contract or June 30, 2019, whichever is earlier.

4. PURPOSE

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

5. MODIFICATIONS

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

A. Section V, Definitions, is hereby deleted in its entirety and replaced with the following:

The following terms shall be construed and interpreted as follows:

A. "Business Day" means any day in which the State is open and conducting business, but shall not include Saturday, Sunday or any day on which the State observes one of the holidays listed in §24-11-101(1) C.R.S.

B. "Contract" means this agreement, including all attached Exhibits, all documents incorporated by reference, all referenced statutes, rules and cited authorities, and any future modifications thereto.

C. "Contract Funds" means the funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under this Contract.

D. "Contractor Pre-Existing Material" means 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.

E. "CORA" means the Colorado Open Records Act, §§24-72-200.1 et. seq., C.R.S.

F. "End of Term Extension" means the time period defined in **§2.D.**

G. "Effective Date" means the date on which this Contract is approved and signed by the Colorado State Controller or designee, as shown on the Signature and Cover Page for this Contract.

H. "Exhibits" means the following exhibits attached to this Contract:

i. EXHIBIT A: HIPAA Business Associates Addendum

ii. EXHIBIT B: Statement of Work

iii. EXHIBIT C: Rates

iv. EXHIBIT D: Sample Option Letter

v. EXHIBIT E: Covered Services and Copayments

vi. EXHIBIT F: Data Specifications

vii. EXHIBIT G: Colorado Medical Home Standards

viii. EXHIBIT H: Non-Reimbursement for Serious Reportable Events

ix. EXHIBIT I: Medical Home Provider Incentive Payment Program

x. EXHIBIT J: Fluoride Varnish Program Details

xi. EXHIBIT K: Member Handbook Requirements

xii. EXHIBIT L: Contractor Disclosure Template

xiii. EXHIBIT M: Administrative and Medical Services

xiv. EXHIBIT N: Encounter Submission and System Processing

I. "Extension Term" means the time period defined in §2.C.

J. "Goods" means any movable material acquired, produced, or delivered by Contractor as set forth in this Contract and shall include any movable material acquired, produced, or delivered by Contractor in connection with the Services.

K. "Incident" means any accidental or deliberate event that results in or constitutes an imminent threat of the unauthorized access or disclosure of State Confidential Information or of the unauthorized modification, disruption, or destruction of any State Records.

L. "Initial Term" means the time period defined in **§2.B**.

M. "Party" means the State or Contractor, and "Parties" means both the State and Contractor.

N. "PCI" means payment card information including any data related to credit card holders' names, credit card numbers, or the other credit card information as may be protected by state or federal law.

O. "PII" means personally identifiable information including, without limitation, any information maintained by the State about an individual that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information. PII includes, but is not limited to, all information defined as personally identifiable information in §24-72-501 C.R.S.

P. "PHI" means 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.

Q. "Services" means the services to be performed by Contractor as set forth in this Contract, and shall include any services to be rendered by Contractor in connection with the Goods.

R. "State Confidential Information" means any and all State Records not subject to disclosure under CORA. State Confidential Information shall include, but is not limited to, PII, PHI, PCI, Tax Information, and State personnel records not subject to disclosure under CORA.

S. "State Fiscal Rules" means that fiscal rules promulgated by the Colorado State Controller pursuant to §24-30-202(13)(a).

T. "State Fiscal Year" means a 12 month period beginning on July 1 of each calendar year and ending on June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in that calendar year.

U. "State Purchasing Director" means the position described in the Colorado Procurement Code and its implementing regulations.

V. "State Records" means any and all State data, information, and records, regardless of physical form, including, but not limited to, information subject to disclosure under CORA.

W. "Subcontractor" means third-parties, if any, engaged by Contractor to aid in performance of the Work.

X. "Tax Information" means federal and State of Colorado tax information including, without limitation, federal and State tax returns, return information, and such other tax-related information as may be protected by federal and State law and regulation. Tax Information includes, but is not limited to all information defined as federal tax information in Internal Revenue Service Publication 1075.

Y. "Work" means the delivery of the Goods and performance of the Services described in this Contract.

Z. "Work Product" means 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.

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

B. Section 8, Reporting - Notification, Subsection A, Litigation Reporting, is hereby deleted in its entirety and replaced as follows:

A. Litigation Reporting

If Contractor is served with a pleading or other document in connection with an action before a court or other administrative decision making body, and such pleading or document relates to this Contract or may affect Contractor's ability to perform its obligations under this Contract, Contractor shall, within 10 days after being served, notify the State of such action and deliver such pleading or document to the State's principal representative identified in **§16**.

C. Section 9, Contractor Records, Subsection A, Maintenance, is hereby deleted in its entirety and replaced as follows:

A. Maintenance

Contractor shall maintain a file of all documents, records, communications, notes and other materials relating to the Work (the "Contractor Records"). Contractor Records shall include all documents, records, communications, notes and other materials maintained by Contractor that relate to any Work performed by Subcontractors, and Contractor shall maintain all records related to the Work performed by Subcontractors required to ensure proper performance of that Work. Contractor shall maintain Contractor Records until the last to occur of: (i) a period of ten (10) years after the date this Contract expires or is terminated, (ii) a period of ten (10) years after final payment under this Contract is made, (iii) a period of ten (10) years after the resolution of any pending Contract matters, or (iv) if an audit is occurring, or Contractor has received notice that an audit is pending, a period of ten (10) years after such audit is completed and its findings have been resolved (the "Record Retention Period").

D. Section 9, Contractor Records, Subsection B, Inspection, is hereby deleted in its entirety and replaced with the following:

B. Inspection

Contractor shall permit the State, CMS, the Office of Inspector General, the Comptroller General or their designees to audit, inspect, examine, excerpt, copy and transcribe Contractor Records at any time during the Record Retention Period. Contractor shall make Contractor Records available during normal business hours at Contractor's office or place of business, or at other mutually agreed upon times or locations. The State, CMS, the Office of Inspector General, the Comptroller General or their designees, in their discretion, may inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted at any time.

E. The first sentence in Section 10.A., Confidentiality, is hereby deleted and replaced with the following:

Contractor shall hold and maintain, and cause all Subcontractors to hold and maintain, any and all State Records that the State provides or makes available to Contractor for the sole and exclusive benefit of the State, unless those State Records are otherwise publicly available at the time of disclosure.

F. Section 10.C., Use, Security, and Retention, is hereby deleted in its entirety and replaced with the following:

C. Use, Security, and Retention

Contractor shall use, hold and maintain State Confidential Information in compliance with any and all applicable laws and regulations in facilities located within the United States, (unless written permission has been provided by the State in advance), and shall maintain a secure environment that ensures confidentiality of all State Confidential Information wherever located. Contractor shall provide the State with access, subject to Contractor's reasonable security requirements, for purposes of inspecting and monitoring access and use of State Confidential Information and evaluating security control effectiveness. Upon the expiration or termination of this Contract, Contractor shall return State Records provided to Contractor or destroy such State Records and certify to the State that it has done so, as directed by the State. If Contractor is prevented by law or regulation from returning or destroying State Confidential Information, Contractor warrants it will guarantee the confidentiality of, and cease to use, such State Confidential Information.

G. Section 17.A., Work Product, is hereby deleted in its entirety and replaced with the following:

A. Contractor assigns to the State and its successors and assigns, the entire right, title, and interest in and to all causes of action, either in law or in equity, for past, present, or future infringement of intellectual property rights related to the Work Product and all works based on, derived from, or incorporating the Work Product. Provided that Contractor is not otherwise prohibited by law from granting, and only to the extent the Work Product contains Contractor Pre-Existing Material, Contractor hereby grants the State an irrevocable, perpetual, nonexclusive, royalty-free, world-wide license to use, execute, reproduce, display, perform, and distribute copies of Contractor Pre-Existing Material, but only as they are incorporated into and form a part of the Work Product developed for the State pursuant to the Contract. Whether or not Contractor is under contract with the State at the time, Contractor shall execute applications, assignments, and other documents, and shall render all other reasonable assistance requested by the State, to enable the State to secure patents, copyrights, licenses and other intellectual property rights related to the Work Product. To the extent that any Work Product is a work made for hire under 17 U.S.C. §101, the Parties intend the Work Product to be works made for hire.

H. Section 20.B., Subcontracts, is hereby deleted in its entirety and replaced with the following:

B. Contractor shall not enter into any subcontract in connection with its obligations under this Contract without the prior, written approval of the State. For these purposes, a written agreement between Contractor and its subsidiary(ies) to perform Work shall not be considered a subcontract. Contractor shall submit to the State a copy of each such subcontract upon request by the State. All subcontracts entered into by Contractor in connection with this Contract shall comply with all applicable federal and state laws and regulations, shall provide that they are governed by the laws of the State of Colorado, and shall be subject to all provisions of this Contract.

I. The table following Section 21, A., Compliance with Applicable Law, is hereby deleted in its entirety and replaced with the following:

Age Discrimination Act of 1975, as amended	42 U.S.C. 6101, *et seq.*
Age Discrimination in Employment Act of 1967	29 U.S.C. 621-634
Americans with Disabilities Act of 1990 (ADA)	42 U.S.C. 12101, *et seq.*
Clean Air Act	42 U.S.C. 7401, *et seq.*
Equal Employment Opportunity	E.O. 11246, as amended by E.O. 11375, amending E.O. 11246 and as supplemented by 41 C.F.R. Part 60
Equal Pay Act of 1963	29 U.S.C. 206(d)
Federal Water Pollution Control Act, as amended	33 U.S.C. 1251, *et seq.*
Immigration Reform and Control Act of 1986	8 U.S.C. 1324b
Section 504 and 508 of the Rehabilitation Act of 1973, as amended	29 U.S.C. 794
Title VI of the Civil Rights Act of 1964, as amended	42 U.S.C. 2000d, *et seq.*
Title VII of the Civil Rights Act of 1964	42 U.S.C. 2000e
Title IX of the Education Amendments of 1972, as amended	20 U.S.C. 1681
Section 1557 of the Patient Protection and Affordable Care Act (ACA)	42 U.S.C. 18116

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

K. Exhibit C, Rates, is hereby deleted in its entirety and replaced with Exhibit C-1, Rates, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit C, shall be deemed to reference to Exhibit C-1.

L. Exhibit E, Covered Services and Copayments, is hereby deleted in its entirety and replaced with Exhibit E-1, Covered Services and Copayments, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit E, shall be deemed to reference to Exhibit E-1.

M. Exhibit F, Data Specifications, is hereby deleted in its entirety and replaced with Exhibit F-1, Data Specifications, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit F, shall be deemed to reference to Exhibit F-1.

N. Exhibit K, Member Handbook Requirements, is hereby deleted in its entirety and replaced with Exhibit K-1, Member Handbook Requirements, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit K, shall be deemed to reference to Exhibit K-1.

O. Exhibit M, Administrative and Medical Services, is hereby deleted in its entirety and replaced with Exhibit M-1, Administrative and Medical Services, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit M, shall be deemed to reference to Exhibit M-1.

P. Exhibit N, Encounter Submission and System Processing, is hereby deleted in its entirety and replaced with Exhibit N-1, Encounter Submission and System Processing, attached hereto and incorporated by reference into the Contract. All references within the Contract to Exhibit N, shall be deemed to reference to Exhibit N-1.

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-1, STATEMENT OF WORK

1. TERMINOLOGY

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

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

1.1.2. Adverse Benefit Determination – The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

The reduction, suspension, or termination of a previously authorized service.

The denial, in whole or in part, of payment for a service.

The failure to provide services in a timely manner, as defined by the state.

The failure to act within the timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under 42 C.F.R. §438.52(b)(2)(ii), to obtain services outside of the network.

The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

1.1.3. Appeal - A request for review of an Adverse Benefit determination, by a CHP+ Member, or Provider acting on the Member's behalf.

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

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

1.1.6. 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.

1.1.7. CAHPS (Consumer Assessment of Healthcare Providers and Systems) Health Plan Survey – A survey conducted annually by the Department's External Quality Review Organization.

1.1.8. Capitation Payment- The payment the Department makes periodically to the Contractor on behalf of each enrolled recipient enrolled under a contract for the provision of medical services under the State plan. The Department makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

1.1.9. Care Coordination - The process maintained by the Contractor of identifying, screening and assessing Members' needs, identification and Referral to appropriate services, and coordinating and monitoring of an individualized treatment plan. This treatment plan shall

also include a strategy to ensure that all Members and/or authorized family Members or guardians are involved in treatment planning and consent to the medical treatment.

1.1.10. Cause - For the purpose of Disenrollment from the Contractor's Plan, Cause shall mean:

1.1.10.1. Administrative error on the part of the Department or the Contractor, including but not limited to, Enrollment of a Client that does not reside in the Contractor's Service Area, or a system error;

1.1.10.2. A change in Member's residence to an area not in the Contractor's Service Area;

1.1.10.3. Inability of the Contractor to provide an appropriate level or quality of care to a Member;

1.1.10.4. As documented by the Department, the inability of the Contractor to provide Covered Services to the Member, after reasonable efforts have been made by the Contractor and the Member to resolve issues to their mutual satisfaction;

1.1.10.5. Fraud or other intentional misconduct, including but not limited to non-payment of applicable fees by the Member or Subscriber, knowing misuse of Covered Services by Member or Subscriber, knowing misrepresentation of Membership status by Member or Subscriber;

1.1.10.6. An egregious, ongoing pattern of behavior by the Member or Subscriber that is abusive to a Provider(s), staff or other patients; or, disruptive to the extent that the Contractor's ability to furnish Covered Services to the Member or other patients is impaired;

1.1.10.7. A Member's receipt of other health care coverage;

1.1.10.8. The admission of a Member into any Federal, State, or county institution for the treatment of mental illness, narcoticism, or alcoholism, or into any correctional facility; or,

1.1.10.9. Any other reason satisfactory to the Department.

1.1.11. Child Health Plan *Plus* or CHP+ - The Marketing name for the Colorado Children's Basic Health Plan program.

1.1.12. Client - An individual who has been determined eligible for, and has enrolled in CHP+.

1.1.13. 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.

1.1.14. CMS - The federal Centers for Medicare and Medicaid Services.

1.1.15. Cold Call Marketing - Any unsolicited personal contact by the Contractor with Potential Members for the purpose of marketing.

1.1.16. Communication Disability - An expressive or receptive impairment that creates a barrier to communication between a Member and a person not familiar with that Member.

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

1.1.18. Contractor's Plan – The list of Providers available to eligible Members, and those Covered Services and responsibilities undertaken or provided by the Contractor to eligible Members in accordance with the terms and conditions of this Agreement.

1.1.19. 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 State funded plan provides (SMCN).

1.1.20. 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.

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

1.1.22. 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).

1.1.23. 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. "Desk Audit" means the review of materials submitted upon request to the Department or its agents for quality assurance activities.

1.1.24. 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.

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

1.1.26. 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.

1.1.27. Early intervention services and supports or Early Intervention, (EI) - Services described in C.R.S. 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.

1.1.28. 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 C.C.R. 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.

1.1.29. Effective Date of Enrollment - Except for newborns as specified in the Member Handbook, and as otherwise agreed by the Contractor pursuant to 6.3.1.6, the Effective Date of Enrollment shall be 12:00 a.m. on the first day of the month following notification of Member Enrollment by the Department to the Contractor during the previous month, as specified hereunder.

1.1.30. Eligibility Period - The twelve (12) month Eligibility Period for all Clients covered under the Children's Basic Health Plan which starts on the received date of an approved application.

1.1.31. Emergency Medical Condition - A medical condition as defined in 42 C.F.R. §438.114(a) as: 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 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments to bodily functions, or serious dysfunction of any bodily organ or part.

1.1.32. Emergency Services - Those services, as defined in 42 C.F.R. §438.114(a) which are Covered inpatient and outpatient services and are furnished by a Provider that is qualified to furnish these services under this title and that are needed to evaluate or stabilize an emergency medical condition.

1.1.33. Encounter - An instance of a Member going to a provider and receiving services.

1.1.34. Encounter Claims Data- Claims data resulting from an occurrence of examination or treatment of a patient by a medical practitioner or in a medical facility. Mental health care is also included if provided under the auspices of this Contract.

1.1.35. Encounter Rate - The rate established by the Department to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers / Clinics (RHCs). This Encounter Rate shall be reimbursed per Medical Encounter and Mental Health Encounter. Encounters with more than one health professional, and multiple Encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first Encounter, suffers illness or injury requiring additional diagnosis or treatment. A Medical Encounter and a Mental Health Encounter on the same day and at the same location shall count as two separate Encounters.

1.1.36. Enhanced Ambulatory Patient Grouping (EAPG) System - A classification system designed specifically for the grouping of similar procedures performed during outpatient visits that utilize similar amounts of resources. EAPG is not applicable to all business models.

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

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

1.1.39. Essential Community Provider (ECP) - Providers that historically serve medically needy or medically indigent patients 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 Section 25.5-5-404(2) C.R.S.

1.1.40. Experimental" or "Investigational" means any treatment, procedure, drug or device that has been reviewed and found by the Department to be experimental or investigational or the treatment, procedure, drug or device has been reviewed by the Contractor and found not to meet all of the eligible for coverage criteria below with respect to the particular illness or disease to be treated, or a treatment, procedure, drug or device. Eligible for coverage criteria include:

1.1.40.1. The treatment, procedure, drug or device must have final approval from the Food and Drug Administration (FDA), if applicable;

1.1.40.2. The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the treatment, procedure, drug or device on health outcomes;

1.1.40.3. The treatment, procedure, drug or device must improve or maintain the net health outcome;

1.1.40.4. The treatment, procedure, drug or device must be as beneficial as any established alternative; and

1.1.40.5. The improvements in health outcomes must be attainable outside the Investigational settings.

1.1.40.6. Additionally, the treatment, procedure, drug or device must be Medically Necessary and not excluded by any other Contract exclusion.

1.1.41. FDA - The Federal Food and Drug Administration.

1.1.42. Federally Qualified Health Center (FQHC) A Provider defined in 10 C.C.R. 2505-10, §8.700.1., 42 C.F.R. part 405, subpart X, §2401, and at 42 C.F.R. Part 491, with the exception of §491.3.

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

1.1.44. Grievance – A formal expression of dissatisfaction about any matter other than an adverse benefit determination .

1.1.45. 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, and certified respiratory therapy technician.

1.1.46. Health Maintenance Organization (HMO) - An entity contracting with the Department that meets the definition of managed care organization as defined in C.R.S. §10-16-102.

1.1.47. Healthcare Effectiveness Data and Information Set (HEDIS) - A Data and Information Set developed and maintained by the National Committee for Quality Assurance.

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

1.1.49. Hospital - An institution which:

1.1.49.1. Is licensed by the state as a Hospital;

1.1.49.2. Has a Utilization Review program that meets Medicare conditions of participation;

1.1.49.3. Is primarily engaged in providing medical care and treatment for sick and injured persons on an inpatient basis through medical, diagnostic and major surgical facilities, under the supervision of a staff of Physicians and with twenty-four-hour-a-day nursing service; and,

1.1.49.4. Is certified by Medicare or, in the case of a specialty care center not eligible for Medicare certification, meets criteria established or recognized by the Department in accordance with any applicable state and federal statute or regulation.

1.1.50. Hospital Services - Those Medically Necessary Covered Services for patients 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.

1.1.51. Identification Card - Membership card provided to the Member by Contractor upon Enrollment in the Contractor's Plan. 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 Plan for assistance.

1.1.52. Independent Living - The ability of a Member with a Disability to function at home, work and in the community-at-large to the greatest extent possible and in the least restrictive manner.

1.1.53. Indian - An individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to at 42 C.F.R. §136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian Health Care Providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through Referral under Contract Health Services.

1.1.54. 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).

1.1.55. interChange – Colorado's Medicaid Management Information System (MMIS) Platform. InterChange will provide core MMIS and support services, including:

1.1.55.1. Fiscal Agent Operations Services.

1.1.55.2. Medical Assistance Web Portal.

1.1.55.3. Online Provider Enrollment.

1.1.55.4. Case Management.

1.1.55.5. Electronic Data Interchange (EDI).

1.1.55.6. Electronic Document Management System (EDMS).

1.1.55.7. Provider Call Center with Customer Relationship Management (CRM) Software.

1.1.55.8. Help Desk, including Interactive Voice Response (IVR) software.

1.1.55.9. General functionality of other systems, services, and/or contracts that currently exist or will interface with the future MMIS.

1.1.55.10. General IT functionality and business operations.

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

1.1.57. Managed Care Organization (MCO) - An entity contracting with the Department that meets the definition of Managed Care Organization in 42 C.F.R. §438.2.

1.1.58. Marketing or Marketing Activities - Any activity defined in 42 C.F.R. §438.104.

1.1.59. 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.

1.1.60. Medical Encounter - A face-to-face Encounter between a center client and physician, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist podiatrist or clinical social worker providing the applicable services set forth in 10 C.C.R. 2505, § 8.700.4 for FQHCs and 10 C.C.R. 2505, § 8.740.4 for RHCs.

1.1.61. Medical Home - An appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child.

1.1.62. Medically Necessary or "Medical Necessity" - A Covered Service shall be deemed Medically Necessary if, in a manner consistent with accepted standards of medical practice, it is:

1.1.62.1. Consistent with the symptom, diagnosis and treatment of a Member's medical condition;

1.1.62.2. Widely accepted by the practitioner's peer group as effective and reasonably safe based upon scientific evidence;

1.1.62.3. Not Experimental, Investigational, Unproven, Unusual or Not Customary;

1.1.62.4. Not solely for cosmetic purposes;

1.1.62.5. Not solely for the convenience of the Member, Subscriber, Physician or other Provider;

1.1.62.6. The most appropriate level of care that can be safely provided to the Member; and,

1.1.62.7. Failure to provide the Covered Service would adversely affect the Member's health.

1.1.62.8. When applied to inpatient care, Medically Necessary further means that Covered Services cannot be safely provided in an ambulatory setting.

1.1.63. Medical Record - The collection of personal information, which relates an individual's physical or mental condition, medical history, or medical treatment, that is obtained from a single health care Provider, medical care institution, Member of the Contractor's Plan, or the spouse, parent or legal guardian of a Member.

1.1.64. Member – Any Client who is Enrolled in the Contractor's Plan.

1.1.65. 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 Plan.

1.1.66. Mental Health Encounter – A face-to-face visit between an FQHC or RHC patient and a clinical psychologist or clinical social worker for applicable services.

1.1.67. Monthly Premium Payment - The monthly premium paid by the Department to the Contractor for each Member in each income category, as specified in Exhibit C, Rates.

1.1.68. 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.

1.1.69. Operational Start Date - When the Department authorizes Contractor to begin fulfilling its obligations under the Contract.

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

1.1.71. 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.

1.1.72. Passive Enrollment - Enrollment of eligible CHP+ clients within a geographical service area into a Contractor's Plan, subject to the Member's election not to accept Enrollment and to choose a different Enrollment.

1.1.73. Persons with Special Health Care Needs or Special Health Care Needs - Persons as defined in 10 C.C.R. 2505-10, §8.205.9, et seq. and 42 C.F.R. 438.208(c).

1.1.74. Physician - Any doctor licensed to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered.

1.1.75. Poststabilization Care Services - Those 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.

1.1.76. Potential Member – A recipient who is subject to Enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a Member.

1.1.77. Prevalent Languages - Spanish is the only non-English prevalent language under this agreement for the Service Area as established by the state.

1.1.78. 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.

1.1.79. 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 Plan, 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.

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

1.1.81. Provider - Any individual or group Physician, Physician practice, Hospital, dentist, pharmacy, Physician assistant, certified nurse practitioner, or other licensed, certified or registered Health Care Professional that has entered into a professional service agreement to serve the Contractor's Members.

1.1.82. 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.

1.1.83. Provider Network - The Participating Providers in the Contractor's Plan.

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

1.1.85. Qualified Service Organization (QSO) – Defined in 42 C.F.R. § 2.11, as amended, and consistent with such definition, will include an entity that provides professional services to prevent or treat child abuse or neglect that has entered into a written agreement with a substance abuse program as defined at 42 C.F.R. § 2.11 under which that entity: (1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by the regulations codified at 42 C.F.R. Part

2; and (2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by such regulations.

1.1.86. Referral or Written Referral - Any form of written communication or other permanent record by the Contractor and/or authorized Participating Provider that authorizes a Member to seek care from a Provider other than the PCP.

1.1.87. Rural County - A county in the Contractor's service area with a total population of less than 100,000 people as determined by the most recent decennial census.

1.1.88. Rural Health Clinic (RHC) - A Provider defined in 10 C.C.R. 2505-10, §8.700.1., 42 C.F.R. part 405, subpart X, §2401, and at 42 C.F.R. Part 491.

1.1.89. Safe Harbor Standard - Regulatory standards established by 45 C.F.R. § 156.235 using the provider list, for Colorado, established by the U.S. Department of Health and Human Services by demonstrating that at least twenty (20) percent of available ECPs in the plan's service area participate in the Contractor's provider network(s). In addition to achieving twenty (20) percent participation of available ECPs, the issuer offers contracts during the coverage year to:

1.1.89.1. All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and

1.1.89.2. At least one ECP in each ECP category listed below in each county in the service area, where an ECP in that category is available.

1.1.89.2.1. Federally Qualified Health Center (FQHC) and FQHC "Look-Alike" Clinics, Native Hawaiian Health Centers;

1.1.89.2.2. Rural Health Clinics / Centers (RHC);

1.1.89.2.3. Ryan White Providers / Ryan White HIV/AIDS Providers;

1.1.89.2.4. Family Planning Provider, Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics;

1.1.89.2.5. Indian Providers / Tribal and Urban Indian Organization Providers;

1.1.89.2.6. Hospitals - DSH and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals; and,

1.1.89.2.7. Other ECP Providers, STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

1.1.90. Serious Reportable Events or Never Events - 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.

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

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

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

1.1.91.3. The Department and the Contractor have agreed that the Contractor will provide Covered Services to Members.

1.1.92. Site Review - The visit of Department staff or designees to the site or the administrative office(s) of a Participating Provider and/or the Contractor and its Participating Providers, not including scheduled meetings.

1.1.93. Subscriber - The parent or legal guardian of a Member.

1.1.94. Definition Removed

1.1.95. Temporarily Absent - When the Member has temporarily left the Contractor's Service Area, but intends to return within a reasonable period of time, such as a vacation trip.

1.1.96. Urban County - A county in the Contractor's service area with a total population equal to or greater than 100,000 people as determined by the most recent decennial census.

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

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

1.1.99. 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, or effectiveness of a covered benefit.

2. CONTRACTOR'S GENERAL REQUIREMENTS

2.1. 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.

2.2. 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 Department will resolve the conflict and Contractor shall abide by the resolution provided by the Department.

2.3. All persons employed by Contractor or Subcontractors to perform work under this Contract shall be Contractor's or Subcontractors' employee(s) for all purposes hereunder and shall not be employees of the State for any purpose as a result of this Contract. All Subcontracts must

fulfill the requirements of 42 C.F.R. §§ 438.230 and 438.6(l) that are appropriate to the service or activity delegated under subcontract.

2.3.1. A wholly owned subsidiary of the Contractor shall not be considered a subcontractor.

2.4. Where policies, procedures, programs and plans are required by this Contract or Department regulations, the Contractor shall maintain and provide internal documents that clearly demonstrate all such requirements and the responsibilities of the Contractor. Where the Contractor is required to communicate to Providers, documentation may exist outside of the Contractor's internal policies and procedures, generally in the form of direct Provider correspondence or a Provider manual. Exception can be made for a single source for Provider and Contractor documents if the Contractor clearly specifies in the documents the role of the Contractor and the role of the Provider. Where the Contractor is required to communicate to Members, documentation may exist outside the Contractor's internal policies and procedures, generally in the form of direct Member correspondence or the Member Handbook.

2.5. The Contractor shall submit all Encounter Claims Data, and shall complete pay recovery costs for dates of service during which time this Contract was in effect, regardless of whether this Contract is terminated for any reason.

2.6. Deliverables

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

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

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

2.6.2.2. The Department will review the Deliverable and may direct Contractor to make changes to the Deliverable. Contractor shall make all changes within 5 Business Days following the Department's direction to make the change unless the Department provides a longer period in writing.

2.6.2.2.1. Changes the Department may direct 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.

2.6.2.2.2. The Department may also direct 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.

2.6.2.3. 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.

2.6.3. 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.

2.6.4. 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.

2.6.5. 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.

2.6.6. 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.

2.6.7. 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.

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

2.7.Stated Deliverables and Performance Standards

2.7.1. 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.

2.8.Communication Requirements

2.8.1. Communication with the Department

2.8.1.1. 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 2013 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.

2.8.1.2. 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:

2.8.1.2.1. The date the transmittal will be effective.

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

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

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

2.8.1.2.4.1. 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.

2.8.1.3. 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.

2.8.1.3.1. 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.

2.8.1.4. 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.

2.8.1.5. 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.

2.8.1.6. 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.

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

2.8.2. Communication with Members, Providers and Other Entities

2.8.2.1. The Contractor shall create a Communication Plan that includes, but is not limited to, all of the following:

2.8.2.1.1. A description of how the Contractor will communicate to Members any changes to the services those Members will receive or how those Members will receive the services.

2.8.2.1.2. A description of the communication methods, including things such as email lists, newsletters and other methods, the Contractor will use to communicate with Providers and Subcontractors.

2.8.2.1.3. The specific means of immediate communication with Members and a method for accelerating the internal approval and communication process to address urgent communications or crisis situations.

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

2.8.2.1.5. A listing of the following individuals within the Contractor's organization, that includes cell phone numbers and email addresses:

2.8.2.1.5.1. An individual who is authorized to speak on the record regarding the Work, the Contract or any issues that arise that are related to the Work.

2.8.2.1.5.2. An individual who is responsible for any website or marketing related to the Work.

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

2.8.2.2. The Contractor shall deliver the Communication Plan to the Department for review and approval.

2.8.2.2.1. DELIVERABLE: Communication Plan

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

2.8.2.3. 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.

2.8.2.3.1. DELIVERABLE: Annual Communication Plan Update

2.8.2.3.2. DUE: Annually, by June 30th of each year

2.8.2.4. The Department may request a change to the Communication Plan at any time 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. The Contractor shall modify the Communication Plan as directed by the Department and submit an Interim Communication Plan Update containing all changes directed by the Department.

2.8.2.4.1. DELIVERABLE: Interim Communication Plan Update

2.8.2.4.2. 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

2.8.3. The Contractor shall not engage in any non-routine communication with any Member, any Provider, the media or the public without the prior written consent of the Department.

2.8.4. The Contractor shall use the Department-developed definition for the following terms, when applicable: appeal; co-payment; durable medical equipment; emergency room care; emergency services; excluded services; grievance; habilitation services and devices; health insurance; home health care; 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; premium; provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care.

2.9.Business Continuity

2.9.1. Contractor shall create a Business Continuity Plan that Contractor will 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:

2.9.1.1. How Contractor will 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.

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

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

2.9.1.3. How Contractor will minimize the effects on Members and Providers of any Business Interruption.

2.9.1.4. How Contractor will 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.

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

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

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

2.9.2.1. DELIVERABLE: Business Continuity Plan

2.9.2.2. DUE: Within 10 Business days after the Effective Date

2.9.3. 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.

2.9.3.1. DELIVERABLE: Updated Business Continuity Plan

2.9.3.2. DUE: Semi-annually, by June 30th and December 31st of each year

2.9.4. 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.

2.10. Federal Financial Participation Related Intellectual Property Ownership

2.10.1. In addition to the intellectual property ownership rights specified in the Contract, the following subsections enumerate the intellectual property ownership requirements that the Contractor shall meet during the term of the Contract in relation to federal financial participation under 42 C.F.R. §433.112 and 42 C.F.R. §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 2.10 and only to the extent they apply to the Contractor. Notwithstanding any other provision in the Contract, any Exhibits or attachments, or in this Statement of Work (SOW), intellectual property ownership rights specified in the Contract or in this SOW 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 C.F.R. §433.112 and 45 C.F.R. §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.

2.10.2. To facilitate obtaining the desired amount of federal financial participation under 42 C.F.R. §433.112, the Department shall have all ownership rights, not superseded by other licensing restrictions, in all materials, programs, procedures, etc., designed, purchased, or developed by the Contractor and funded by the Department. If the Contractor uses Contract Funds to develop all necessary materials, programs, products, procedures, etc., and data and software to fulfill its obligations under the Contract, the Contractor shall document all Contract Funds used in the development of these materials, programs, procedures, etc. The Department shall have all ownership rights in data and software, or modifications thereof and associated documentation and procedures designed and developed to produce any systems, programs reports and documentation and all other work products or documents created under the Contract. The Department shall have these ownership rights, regardless of whether the work product was developed by the Contractor or any Subcontractor, for work products created in the performance of this Contract. The Department reserves, on behalf of itself, the Federal Department of Health and Human Services and its contractors, a royalty-free, non-exclusive and irrevocable license to produce, publish or otherwise use such software, modifications, documentation and procedures. Such data and software include, but is not limited to, the following:

2.10.2.1.1. All computer software and programs, which have been specifically designed or developed for the Department, or acquired by the Contractor on behalf of the Department, which are used and required solely and specifically in performance of the Contract.

2.10.2.2. 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.

2.10.2.3. All necessary data files.

2.10.2.4. User and operation manuals and other documentation which have been specifically designed or developed by Contractor or acquired by the Contractor solely for the purpose of performance of the Contract.

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

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

2.11. Performance Reviews

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

2.11.2. 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.

2.11.3. 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.

2.11.4. 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.

2.11.5. 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.

2.12. Renewal Options and Extensions

2.12.1. 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.

2.12.2. 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.

2.12.2.1. 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.

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

2.13. State System Access

2.13.1. 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. CONTRACTOR RESPONSIBILITIES AND REGULATORY COMPLIANCE

3.1. The Contractor shall provide administrative services under the terms set forth in this Contract and as set forth in Exhibit M, Administrative and Medical Services, attached and incorporated herein by reference. The Contractor shall be licensed pursuant to C.R.S. §10-16 Part 4, et seq., and the Department of Insurance as a Health Maintenance Organization.

3.2. 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.

3.3. 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.

3.4. The Contractor shall make a good faith effort to comply with managed care requirements for the Children's Health Insurance Program.

3.5. Mental Health Parity

3.5.1. Contractor shall submit all necessary documentation and reporting required to the Department to establish and demonstrate compliance with 42 C.F.R. Part 438, subpart K regarding parity in mental health and substance use disorder benefits.

4. HEALTH INSURANCE PROVIDERS FEE REPORTING

4.1. In the event that the Contractor is subject to any Health Insurance Providers Fee under 26 C.F.R. Part 57 and required to file a form 8963, then the Contractor shall create a Health Insurance Providers Fee Report to the Department that contains all of the following information:

4.1.1. A copy of the Form 8963 as well as copies of any corrected Form 8963s filed with the Internal Revenue Service (IRS).

4.1.2. The preliminary and final calculations of the fee from the IRS, even if the calculated fee was $0.00.

4.1.3. An allocation of the fee attributable to the Work under this Contract.

4.1.4. Any additional information related to the Health Insurance Providers Fee, as determined by the Department.

4.2. The Contractor shall deliver the Health Insurance Providers Fee Report for each year that it is required to file a form 8963 with the IRS.

4.2.1. DELIVERABLE: Health Insurance Providers Fee Report

4.2.2. DUE: Annually, no later than October 1st of each year in which the Contractor filed a form 8963

5. CONTRACTOR PERSONNEL

5.1. Personnel General Requirements

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

5.1.2. 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, within thirty (30) calendar days of the Contract's Effective Date. The organizational chart shall contain accurate and up-to-date telephone numbers and email addresses for each individual listed.

5.1.2.1. DELIVERABLE: Organizational Chart.

5.1.2.2. DUE: Thirty (30) calendar days from the Contract's Effective Date.

5.1.3. The Contractor shall deliver 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.

5.1.3.1. DELIVERABLE: Updated Organizational Chart.

5.1.3.2. DUE: Five (5) business days from any change in Key Personnel or from the Department's request for an updated Organizational Chart.

5.1.4. Contractor shall not permit any individual proposed for assignment to Key Personnel positions to perform any Work prior to the Department's approval of that individual to be assigned as Key Personnel.

5.1.5. Contractor shall not voluntarily change individuals in Key Personnel positions without the prior written approval of the Department. Contractor shall supply the Department with the name, resume and references for any proposed replacement whenever there is a change to Key Personnel. 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.

5.1.5.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position during a voluntary change

5.1.5.2. DUE: At least 5 Business Days prior to the change in Key Personnel

5.1.6. If any individual filling a Key Personnel position leaves employment with Contractor, Contractor shall propose a replacement person to the Department. The replacement person 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.

5.1.6.1. DELIVERABLE: Name(s), resume(s) and references for the person(s) replacing anyone in a Key Personnel position who leaves employment with Contractor

5.1.6.2. DUE: Within 10 Business Days following Contractor's receipt of notice that the person is leaving employment, unless the Department allows for a longer time in writing for Contractor to recruit a replacement.

5.1.7. The Department may request the removal from work on the Contract of employees or agents of the Contractor whom the Department justifies as being incompetent, careless, insubordinate, unsuitable or otherwise unacceptable, or who's continued employment on the Contract the Department deems to be contrary to the public interest or not in the best interest of the Department. For any requested removal of Key Personnel, the Department shall provide written notice to Contractor identifying each element of dissatisfaction with each Key Personnel, and Contractor shall have ten (10) business days from receipt of such written notice to provide the Department with a written action plan to remedy each stated point of dissatisfaction. The Contractor's written action plan may or may not include the removal of Key Personnel from work on the Contract.

5.1.8. 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 submit copies of such current licenses and certifications to the Department.

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

5.1.8.2. DUE: Within 5 Business Days of receipt of updated licensure or upon request by the Department.

5.2.Personnel Availability

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

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

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

5.2.4. 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 external or private stakeholders.

5.2.5. 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.

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

5.3.Key Personnel

5.3.1. Contractor shall designate people to hold the following Key Personnel positions:

5.3.1.1. Contract Manager

5.3.1.1.1. The Contract Manager shall be the Department's primary point of contact for contract and performance issues and responsibilities.

5.3.1.1.2. All communication between the Department and the Contractor shall be facilitated by the Contract Manager.

5.3.1.1.3. The Contract Manager shall ensure that all Contract obligations are in compliance with all state and federal laws, regulations policies and procedures and with the requirements of the Contract.

5.4.Training of Contractor's Employees

5.4.1. The Contractor shall make appropriate staff available to participate in periodic training programs, sponsored by the Department, at the Department's direction. These programs will be designed to provide technical assistance to the Contractor with policy interpretation and coordination of services.

5.4.2. The Contractor shall be responsible for providing any necessary Plan- or Policy-related training to Participating Providers and any Subcontractors.

5.5.Other Personnel Responsibilities

5.5.1. 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. 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.

5.5.2. 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 Department-provided training specifically described in this Contract.

5.5.3. Contractor may subcontract to complete a portion of the Work required by the Contract. The conditions for using a Subcontractor or Subcontractors are as follows:

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

5.5.3.1.1. DELIVERABLE: Name of each Subcontractor and items on which each Subcontractor will work

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

5.5.3.2. Department may review any subcontracts upon written request to the Contractor.

5.5.3.3. 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.

6. CLIENT ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

6.1. Any client determined eligible for the Program may be Enrolled in the Contractor's Plan, provided that the client resides within in the Contractor's service area. The Department certifies that Enrollment processes used by the Department shall be impartial to the Contractor and other HMO's participating in this Program, and shall reflect, to the greatest extent possible the informed choice of clients. The Contractor may, at any time, observe Enrollment processes maintained by the Department.

6.2. Eligibility Re-determination

6.2.1. A client may annually reapply to the Department or its designee and be re-evaluated to determine eligibility status.

6.2.2. The Department may re-determine the eligibility status at any time during the term of this Contract. If the Contractor, in a manner consistent with all applicable laws and regulations pertaining to patient confidentiality, informs the Department of any pregnancy and /or delivery of a Member, the Department shall make every appropriate effort to facilitate a determination of the Member's eligibility for Medicaid, and retroactively adjust the Member's Enrollment status accordingly.

6.2.3. 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.

6.3. Enrollment

6.3.1. Enrollment Requirements

6.3.1.1. Enrollment in the Contractor's Plan shall be voluntary.

6.3.1.2. If the Contractor has been notified of Member Enrollment status using reports and information from the Medicaid Management Information System (MMIS) and or the Colorado Benefits Management System (CBMS) or the PHP interface files or the HIPAA compliant x12n transactions as specified in section 6.6, the Effective Date of Enrollment shall be the first (1st) day of the following month. If the Contractor has not been notified of a Member's enrollment status on the PHP interface files or the HIPAA compliant X12N transactions, the Contractor shall not be responsible for coverage of the Member, except as otherwise agreed by the Contractor in writing or via electronic mail.

6.3.1.3. Except in cases related to Member Medicaid eligibility, for the purposes of this Contract, there shall be no retroactive Enrollment, unless agreed upon in specific, individual cases by the Department and Contractor in writing. In no event shall any Member be entitled to coverage by the Contractor for health care services rendered, supplies or drugs received or expenses incurred prior to the Effective Date of Enrollment. Expenses shall be considered incurred on the date the service or supply is rendered or received.

6.3.1.4. In addition to cases mentioned in 6.3.1.3, a Member's Medicaid eligibility determination may cause retroactive eligibility or retroactive Disenrollment from the Contractors plan.

6.3.1.5. If a Member, other than a newborn, is an inpatient of a Hospital on his/her Effective Date of Enrollment in the Contractor's Plan, the Contractor must notify the Department in writing within thirty (30) calendar days of discovery of such circumstance by the Contractor, 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. The Contractor will not be liable for Covered Services prior to the new Effective Date of Enrollment. The Department shall make appropriate adjustments to the amount of Monthly Premium Payment.

6.3.1.6. A Member may remain eligible for coverage, and Enrolled in the Contractor's Plan through 11:59 pm on the last day of the month in which his or her Eligibility Period expires, or month in which the Member's nineteenth (19th) birthday occurs (whichever is sooner), after which time eligibility for the Program and Enrollment in the Contractor's Plan shall be terminated. The Contractor shall have no further financial responsibility for the provision of Covered Services to such Members after the effective date of termination, except as required pursuant to Section 6.4. of this Contract.

6.3.1.7. 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).

6.3.1.8. The Contractor shall only accept Members who reside sufficiently near the office of a Provider in the Contractor's Plan for the Member to reach that Provider within a reasonable time and using available and affordable modes of transportation.

6.3.1.9. 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.

6.3.1.10. In accordance with the American Recovery and Reinvestment Act of 2009 section 5006(d), the Contractor shall:

6.3.1.10.1. Demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for American Indian enrollees who are eligible to receive services from such providers.

6.3.1.10.1.1. The Contractor shall exempt from premiums any American Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

6.3.1.10.1.2. The Contractor shall exempt from all cost sharing any American Indian who is currently receiving or has ever received an item or service furnished by an Indian health care provider through referral under contract health services.

6.3.1.10.1.3. The Contractor shall meet the requirements of FFS timely payment for all I/T/U providers in its network, including paying ninety (90) percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt.

6.3.1.10.1.4. The Contractor shall pay ninety-nine (99) percent 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.

6.3.1.10.2. Pay I/T/U providers, whether participating in the network or not, for covered managed care services provided to American Indian/Alaska Native Members enrollees who are eligible to receive services from the I/T/U. The Contractor shall pay I/T/U providers at either a rate that has been negotiated between the Contractor and the I/T/U provider, or if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

6.3.1.10.3. Permit an out-of-network I/T/U provider to refer an Indian enrollee to a network provider.

6.3.1.11. Pursuant to C.R.S. §25.5-8-110(9), there shall be a period of at least twenty (20) calendar days prior to expiration of every Member's Eligibility Period in which the Member may elect to Disenroll from the Contractor's plan and Enroll in another CHP+ plan participating in the Program. The Department shall issue notification to the Member of the option to Disenroll from the Contractor's plan and process any request for a change in Enrollment on or before the 21st of the month prior to the month in which the change shall become effective.

6.3.1.12. The Contractor shall provide all Enrollment notices, informational materials and instructional materials relating to Enrollment of Members in a manner and format that may be easily understood and, wherever possible, at a sixth grade reading level.

6.3.1.13. Contractor shall have in place a mechanism to help Members and Potential Members understand the requirements and benefits of the plan.

6.3.1.14. 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.

6.3.1.15. In the event that the Contractor limits the number of Clients it will accept, the Department will develop a procedure for how 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 of the Department's plan.

6.3.2. Effective Date of Enrollment

6.3.2.1. A Member, other than a newborn of a mother who is a Member, shall be Enrolled in the Contractor's Plan as follows:

6.3.2.1.1. If the Client has selected the Contractor's Plan during any period that is not during the Client's Open Enrollment Period, then the Enrollment shall be effective the first day of the month following the month in which the Client Enrolled.

6.3.2.1.2. If the Client has selected the Contractor's Plan during the Client's Open Enrollment Period, Enrollment shall be effective the first day of the month following the Client's Open Enrollment Period.

6.3.2.1.3. If the Client has selected to change Passive Enrollment to the Contractor's Plan on or before five (5) p.m. the last business day of the month, Enrollment shall be effective the first day of the next month.

6.3.3. Enrollment of a Newborn

6.3.3.1. 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. The Department will enroll the newborn into Contractor's Plan upon receipt of the newborn's state identification number.

6.4.Disenrollment

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

6.4.2. Disenrollment due to Medicaid Coverage.

6.4.2.1. The parties acknowledge and agree that due to eligibility criteria and demographic characteristic of the Children's Basic Health Plan and Medicaid programs, a significant number of Members may become eligible for the Medicaid program at some point during the twelve (12) month span of eligibility for the Children's Basic Health Plan. The Department shall be responsible for Disenrolling Members who have Medicaid coverage effective the first day of the month following the determination of Medicaid eligibility.

6.4.3. Contractor may only request Disenrollment of a Member from the Contractor's Plan for Cause. The Department shall review the Contractor's requests for Disenrollment and may grant or reject the Contractor's request at its discretion. A Disenrollment for Cause may only occur under the following circumstances:

6.4.3.1. Admission of the Member to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institution.

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

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

6.4.3.4. Child welfare eligibility status.

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

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

6.4.3.7. 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.

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

6.4.3.8.1. 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.

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

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

6.4.3.9. 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 Plan.

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

6.4.4. The Contractor shall provide one oral warning, to any Member exhibiting abusive behavior or intentional misconduct, stating that continuation of the behavior or misconduct will result in a request for Disenrollment. If the Member continues the behavior or misconduct after the oral warning, the Contractor shall send a written warning

that the continuation of the behavior or misconduct will result in Disenrollment from the Contractor's Plan. The Contractor shall send a copy of the written warning and a written report of its investigation into the behavior, to the Department, no less than thirty (30) calendar days prior to the Disenrollment. If the Member's behavior or misconduct poses an imminent threat to the Provider, to other Providers or Contractor or to other Members, the Contractor may request an expedited Disenrollment after it has provided the Member exhibiting the behavior or misconduct with an oral warning.

6.4.4.1. The Contractor shall provide the Department a copy of any written warning provided to a Member

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

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

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

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

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

6.4.5.3. The Member's diminished mental capacity.

6.4.5.4. 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.

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

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

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

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

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

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

6.4.7.1.3. 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.

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

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

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

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

6.4.7.2. Without Cause, during re-Enrollment

6.4.7.2.1. A Member may request Disenrollment, without Cause once every twelve (12) months during the Members Re-Enrollment period.

6.4.7.2.2. 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.

6.4.7.3. Without Cause, after initial Passive Enrollment

6.4.7.3.1. 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).

6.4.8. In the event that the Department grants a request for Disenrollment, either from the Contractor or from a Member, the effective date of that Disenrollment shall be no later than the first day of the second month following the month in which the Member or Contractor files the request. If the Department fails to either approve or deny the request in this timeframe, the request shall be considered approved.

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

6.4.10. If a current Member of a Contractor's Plan is an inpatient of a Hospital at 11:59 p.m. the day before that Member's Disenrollment from the Contractor's Plan is scheduled to take effect, Disenrollment shall be postponed until the Member is discharged from the Hospital. If the Member is discharged from the Hospital, the new Disenrollment date for that Member shall be the last day of the month following discharge.

6.4.10.1. If the Contractor is notified by a Provider that a Member's medical program has changed in the Provider portal during an inpatient stay, the Contractor shall notify the Department in writing.

6.4.11. The Contractor may issue a written request for clarification from the Department regarding the Enrollment status of a Member when such clarification is reasonably necessary for the Contractor to perform the obligations established hereunder. The Department or its designee shall issue such clarification in writing to the Contractor within five (5) business days of receipt of the Contractor's request, which shall include:

6.4.11.1. The Member's name and Program identification number.

6.4.11.2. The effective date of the Members Enrollment in the Contractor's Plan.

6.4.11.3. The effective date of the Members Disenrollment from the Contractor's Plan, if applicable.

6.4.12. The Department, in consultation with the Contractor, may establish any forms and/or procedures necessary to ensure that clarification of a Member's Enrollment status is provided to the Contractor in a timely and accurate manner.

6.4.12.1. If the Department or its designee fails to provide this information to the Contractor within the timeframe specified in section 6.4.11 above, the Contractor shall have no financial responsibility for Covered Services provided to the Member for the time period between the time the clarification should have been provided under section 6.4.1.1. and the time it is actually provided, and may invoice the Department for all Covered Services that have been provided to the Member during that period.

6.4.12.2. This invoice shall include, but is not limited to:

6.4.12.2.1. The dates on which Covered Services were provided to the Member.

6.4.12.2.2. The name and location of the Providers that rendered Covered Services to the Member.

6.4.12.3. The Department shall issue payment in full to the Contractor within thirty (30) calendar days of such receipt.

6.4.13. 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 6.4.18 of this Contract.

6.4.14. The Department may retroactively adjust Monthly Premium Payments so as to accurately reflect changes in the date of Member Disenrollment. The Department shall not retroactively change a Disenrollment date unless:

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

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

6.4.14.3. 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).

6.4.15. In the event that a Member is retroactively Disenrolled, the Department or its designee shall transmit notice of the transaction to the Contractor, which identifies the Member and the effective date of the Disenrollment. Additionally, such Disenrollment shall be reflected on the electronic Enrollment reports for the following month, depending on the date of the transaction. The Department may recoup payment for retroactive Disenrollments in accordance with the process established under section 16.2.3. The Department shall not recoup more than six (6) months' worth of Monthly Premium Payment for such adjustments.

6.4.16. The Department or its designee shall maintain complete monthly records of all retroactive Disenrollment transactions affecting the Contractor's Plan and shall provide an electronic copy of such records to the Contractor upon request.

6.4.17. In no event, except as required in section 6.4.18., shall any Member be entitled to coverage for any benefits with respect to health care services rendered, supplies or drugs received, or expenses incurred following termination of coverage. Expenses shall be considered incurred on the date the service or supply is rendered or received.

6.4.18. If a Member is receiving inpatient care on his or her effective date of Disenrollment from the Contractor's Plan, the Contractor shall be responsible for the coverage of Hospital Services until the Member is discharged, except when Disenrollment is due to fraud or abuse by the Member. Upon discharge, all responsibilities of the Contractor to the Member under this Contract shall cease.

6.5. The Department shall produce electronic enrollment reports to the Contractor on a daily and monthly basis for the purpose of identifying and confirming the Contractor's membership, and providing a definitive basis for the purpose of payment adjustments and reconciliation.

6.6. The Contractor shall use reports and information from the Medicaid Management Information System (MMIS) and or the Colorado Benefits Management System (CBMS) to verify the CHP+ eligibility and Enrollment in the Contractor's Plan for its Members. These reports shall include, at a minimum, all of the following:

6.6.1. HIPAA Compliant X12N transactions. The Contractor may use X12N transactions to verify CHP+ Enrollment in the Contractor's Plan and Capitation Payment processing for the Contractor's Plan.

6.6.1.1. HIPAA X12N 834N Health Care Enrollment and Maintenance standard transaction.

6.6.1.2. X12N 820 Premium Payment for Insurance Products.

6.6.2. interChange Proprietary Encounter File

6.6.3. interChange Proprietary Remittance Advice

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

6.7.1. Upon notification by the Department of a Member's Enrollment in the Contractor's Plan, annually, and upon Members request, the Contractor shall furnish each Member the information specified in 42 C.F.R. §438.10(f)(3) and:

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

6.7.1.2. 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 will issue to the Member. Contractor must notify Members annually of the online location and the Members right to request and receive a hard copy

6.7.1.3. In the event that the new Member has not designated a PCP at the time of Enrollment in the Contractor's Plan, 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 7.11.1 of this contract.

6.7.1.4. Issue a Provider Directory including the names, locations, telephone numbers, and qualifications, of English and Non-English languages spoken by current contracted Providers in Member's service area. Included will be identification of Providers that are not accepting new patients. This will include, at minimum, information on PCP's, specialist, and hospitals.

6.7.1.4.1. The Provider Directory may be accessible to Members online. If a Member requests a hard copy, Contractor will issue to the Member. Contractor must notify Members annually of the online location of the Provider Directory and the Members right to request and receive a hard copy of the Provider Directory.

6.7.2. In addition to the instance described in Section 6.7.1. above, the Contractor shall issue to each Member 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.

6.7.2.1. For the purpose of this provision, "substantive change" shall mean any change in the scope of Covered Services (i.e., types of service), the level of any Covered Service provided (e.g., maximum number of visits or benefit cost), or conditions under which a Covered Service is provided (e.g., authorization criteria). This provision shall in no way be construed as permitting the Contractor to unilaterally reduce the minimum scope or level of Covered Services required under this Contract. The Contractor may periodically update the Member Handbook document to reflect any changes to the scope, level or conditions of coverage offered in excess of the minimums required under this Contract.

6.7.3. If a substantial change to the Contractor's Provider Network occurs during the Contract Year, or upon written request of the Department, the Contractor shall issue a notice of an updated Provider Directory to all Members affected by the change.

6.7.4. The Contractor's Provider Directory may describe the language capabilities of Providers and/or other services the Contractor provides to ensure Cultural Competence.

6.7.5. The Contractor will provide a copy of the Provider Directory, and Member Handbook to any Members who request such materials by telephone or writing, within five (5) business days of the request.

6.7.6. The Contractor agrees to include a description of the Contractor's Plan in the Member Handbook. The description of the plan offered shall be reviewed and approved by the Department prior to its use by the Contractor. The Contractor agrees to provide the Department with current copies of the Member Handbook upon request.

6.7.7. Right to Services - Possession of the Contractor's Identification Card confers no right to services or other benefits of the Program. To be entitled to services or benefits, the holder of the card must, in fact, be a Member on whose behalf Monthly Premium Payment is committed by the Department to the Contractor or is otherwise entitled to services under this Contract. Therefore, any Applicant or other individual who is receiving services or other benefits for which he or she is not then entitled pursuant to the provisions of this Contract is personally responsible for the cost of all medical care.

6.7.8. Annual Open Enrollment Period - Pursuant to C.R.S. §25.5-8-110(9), there shall be a period of at least twenty (20) calendar days prior to expiration of every Member's Eligibility Period in which the Member may elect to Disenroll from the Contractor's Plan and Enroll in another CHP+ plan participating in the Program in their respective geographic region. The Department shall issue notification to the Member of the option to Disenroll from the Contractor's Plan and process any request for a change in Enrollment on or before the 21st of the month prior to the month in which the change shall become effective.

7. CUSTOMER SERVICE

7.1. Contractor must 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. Contractor agrees to provide customer service, at a minimum, on all days the Department is open.

7.2. The Contractor agrees to have eighty percent (80%) of CHP+ calls answered within thirty (30) seconds or less. This will be reported to CHP+ on a quarterly basis following the reporting schedule in 15.1.1.1. of this Contract.

7.3. The Contractor agrees to adequately staff and maintain a Member services and Grievance response function that operates during regular business hours and is responsible for the following:

7.3.1. Explaining the operation of the Contractor's Plan, including the role of the PCP, and what to do in an emergency or urgent medical situation.

7.3.2. Assisting Members in the selection of a PCP.

7.3.3. Explaining to Members how to make appointments and obtain services.

7.3.4. Accepting, recording and responding to Member Grievances, or oral expressions of dissatisfaction with the Contractor's plan.

7.4. The Contractor shall maintain a call center which includes a toll free and local line for all Member and Provider inquiries.

7.5. The Contractor shall provide access to interpreter services for non-English speaking Members and Text Telephone (TTY) / Telecommunications Device for the Deaf (TDD) line.

7.6. The Contractor's call center shall be open, at a minimum, from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday on all days the Department is open. Voice Message will be available twenty-four (24) hours a day, seven (7) days a week for after hour's coverage.

7.7. The Contractor's call center shall be staffed by personnel sufficiently knowledgeable about program policy and requirements to be able to respond immediately to inquiries from Providers and Members. This will include the ability to service in-person inquiries.

7.8. The Contractor shall maintain a pharmacy call center available to pharmacy Providers 24 hours a day 7 days a week.

7.9. Grievance and Appeals Procedures

7.9.1. The Contractor shall process prospective, concurrent, and retrospective reviews, and have in place procedures for Grievances and Appeals of Adverse Benefit Determinations that comply with the requirements concerning these activities contained in 10 C.C.R. 2505-10 §8.209 and 42 C.F.R. Pert 438 Subpart F in its entirety.

7.10. Information to Members and Potential Members

7.10.1. Contractor shall, upon request, make available to Enrollees and Potential Enrollees in the Contractor's Service Area information concerning the following:

7.10.1.1. Providers, including the identity, locations, credentials, English and Non-English languages spoken, and availability of health care Providers that participate with the Contractor's organization.

7.10.1.2. Enrollee rights and responsibilities.

7.10.1.3. Grievance and Appeal procedures, including the procedures available to an Enrollee and a health care Provider to express dissatisfaction or Appeal the failure of the organization to cover a service.

7.10.1.4. Information on covered items and services, including all items and services that are available to Enrollees under the Contract between the Department and the Contractor that are covered either directly or through a method of referral and prior authorization.

7.11. Provider Network

7.11.1. 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. The process must include at least the following features:

7.11.1.1. Upon notification of Enrollment by the Department or its designee, the Contractor shall make at least one attempt, in addition to the Member packet, to contact or notify the Member in order to provide information on options for selecting or changing a PCP. Contractor shall offer freedom of choice within its network of PCPs who are designated by the Contractor to provide services to Members Enrolled in the Contractor's Plan.

7.11.1.2. If a Member does not select a PCP within ten (10) calendar days of Enrollment, the Contractor shall make an automatic assignment, if this has not been done, taking into consideration such factors as current Provider relationships, language needs (to the extent they are known), and area of residence. Contractor must then notify the Member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCP's if desired.

7.11.1.3. If a Member requests a change in his or her PCP, Contractor shall grant the request to the extent reasonable and practical and in accordance with its policies for other Enrolled groups.

7.12. Changing Health Care Providers

7.12.1. The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP including when a PCP is terminated from the Contractor's Plan, or when a PCP change is ordered as part of the resolution to a formal Grievance proceeding.

7.12.2. In cases where a PCP or other Provider has been terminated from the Contractor's Plan, the Contractor shall provide notice to Members concerning changes in its Provider Network as specified at C.R.S. §10-16-705(7). 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.

7.12.3. Providers shall be deemed added to or deleted from the Contractor's Provider Directory as contracts between the Contractor and Providers begin or end. The Contractor shall give not less than forty-five (45) calendar days written notice to the Department if such contract activity would materially impair the Contractor's capacity to perform under this Contract. "Materially impair," as used in this clause, refers to any change in the Contractor's Provider Network that may create a disruption in the continuity of care for twenty-five (25) or more Members.

7.13. Provider Network Requirements

7.13.1. The Contractor shall maintain a network that is sufficient in numbers and types of Providers to assure that all Covered Services to Members will be accessible without unreasonable delay.

7.13.2. The Contractor shall demonstrate with respect to the Service Area, that it has the capacity to serve the expected Enrollment in that Service Area.

7.13.2.1. The Contractor shall also demonstrate that the organization maintains a sufficient number, mix, and geographic distribution of Providers of services to ensure services are provided to all members..

7.13.2.2. The Contractor shall make assurances that Covered Services to Members will be accessible without unreasonable delay.

7.13.2.2.1. The Contractor shall consider the following when establishing and maintaining the Provider network:

7.13.2.2.1.1. The anticipated CHP+ number of Members.

7.13.2.2.1.2. The expected utilization of Covered Services.

7.13.2.2.1.3. The numbers and types of Providers required to furnish the Covered Services.

7.13.2.2.1.4. The number of network Providers who are not accepting new CHP+ patients.

7.13.2.2.1.5. The geographic location of Providers and Members considering distance, travel time, the means of transportation ordinarily used by Members and whether the location provides physical access to Members with Disabilities.

7.14. Network Changes

7.14.1. Within ten (10) business days, the Contractor shall report in writing to the Department, all changes in Provider Networks related to quality of care, competence, or professional conduct.

7.14.2. Within ten (10) business days, the Contractor shall report to the Department, in writing, any changes greater than or equal to five percent (5%) in their Provider Networks in a thirty (30) calendar day period that are due to one or more of the following circumstances:

7.14.2.1. A Provider requests withdrawal.

7.14.2.2. The action is part of the Contractor's activities to obtain or retain National Committee on Quality Assurance (NCQA) accreditation.

7.14.2.3. A Provider fails to receive credentialing or re-credentialing from the Contractor.

7.14.2.3.1. Notwithstanding the above, the Contractor is not obligated to notify the Department of any Provider that fails to receive credentialing from the Contractor if the Provider was never represented by the Contractor as being a part of its Provider Network.

7.14.3. To help ensure State plan compliance with 42 C.F.R. §§ 455.410-440, and consistent with 42 C.F.R. § 438.602(b), Contractor shall employ measures to help ensure that the Contractor and all of their contracted, ordering or referring physicians or other professionals providing services under the State plan are enrolled in the interChange as a participating provider.

7.14.4. Contractor shall terminate its health care provider contracts for provision of services to Members with contracted Providers if such Provider fails to revalidate enrollment at least every 5 years 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 interChange.

7.14.5. If the Contractor fails to maintain an adequate network, as defined in C.R.S. §10-16-704, that provides Members with access to PCPs within a county in the Contractor's Service Area, the Department may designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible Members by providing the Contractor a thirty (30) calendar day written notice. If it is determined by the Department that the health or safety of Members are compromised by the lack of access this designation may occur immediately.

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

7.14.6.1. Such a request by a Contractor shall be submitted in writing to the Department at least forty-five (45) calendar days prior to the date of the change. The Department will approve or deny any such request within thirty (30) calendar days of such request. If the Department has not responded within thirty (30) calendar days, the request will be deemed approved.

7.14.6.2. The Department will only consider requests for a change in the Contractor's Service Area if the change includes counties in which the Contractor is licensed by the Colorado Division of Insurance to conduct business as a Health Maintenance Organization (HMO).The Contractor may discontinue providing Covered Services to Members within an entire county within the Contractor's Service Area, by providing no less than sixty (60) calendar days prior written notice to the Department of the Contractor's intent to discontinue such services. Such discontinuance of the provision of Covered Services shall be effective on the first day of the month following conclusion of the sixty (60) calendar day notice period.

7.14.7. 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:

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

7.14.7.2. Availability, or capacity of covered services.

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

7.14.7.4. A plan to correct any network deficiency.

7.14.8. DELIVERABLE: Network Changes and Deficiencies

7.14.9. DUE: Within five (5) days after the Contractor's knowledge of the change or deficiency.

7.15. Provider Network Reports

7.15.1. The Contractor agrees to provide a report which contains complete and accurate information regarding the names, addresses, and telephone numbers of Providers participating in the Contractor's Plan. This report is due within fifteen (15) calendar days of a request from the Department. This information shall be submitted in a format to be determined by the Department, in consultation with the Contractor.

8. COVERED SERVICES

8.1. Only those benefits described in Exhibit E, Covered Services and Copayments and Exhibit J, Fluoride Varnish Program Details, will be Covered Services under the terms of this Contract. Those benefits excluded in Exhibit E and Exhibit J will not be Covered Services. The Contractor shall, also, outline benefits and other coverage, specific to the Contractor's Plan, in the Member Handbook.

8.2. The Contractor shall 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. All such determinations shall be subject to the Contractor's Grievance and Appeals procedures.

8.3. The Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit E, Covered Services and Co-payments and Exhibit J, Fluoride Varnish Program Details. The Contractor shall provide Care Coordination, Utilization Management and disease management for Members to promote the appropriate and cost-effective utilization of Covered Services. The Contractor shall submit a plan to the Department on how Contractor will ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

8.4. The Contractor shall provide coverage of Emergency Services twenty-four (24) hours a day and seven (7) days a week, regardless of whether the facilities accessed by the Member participate in the Contractor's Plan.

8.4.1. Outpatient Follow-up Appointments - within seven (7) days after discharge from a hospitalization.

8.5. Contractor shall make Urgently Needed Services available within twenty-four (24) hours of request by the Member, or the Member's Provider(s), except when the Member is Temporarily Absent from the Service Area.

8.6. Non-Urgent, Non-Emergent Covered Services

8.6.1. Contractor shall make services available within thirty (30) calendar days for treatment of a Non-emergent, non-urgent medical problem. This thirty (30) calendar day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) calendar days.

8.6.2. Contractor shall schedule non-urgent, symptomatic care within seven (7) calendar days of the Member's request for services.

8.6.3. Contractor shall schedule non-symptomatic well care physical examinations within thirty (30) calendar days unless an appointment is required sooner to ensure the recommended screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule.

8.6.4. 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.

8.6.5. Non-urgent, Symptomatic Behavioral Health Services - within seven (7) days after a Member's request.

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

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

8.6.6. The Contractor shall provide mental health or substance use disorder benefits in the inpatient, outpatient and emergency care classifications of benefits within the scope of benefits stipulated in the Contract.

8.7. Contractor shall provide coverage, either directly or through its PCPs, to Members on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are not able to provide such coverage, Contractor shall have a back-up plan for instances where the PCP is not available.

8.8. Contractor shall have written policies and procedures describing how Members can receive coverage of Emergency Services or Urgently Needed Services while Temporarily Absent from the Contractor's Service Area.

8.9. Care Coordination

8.9.1. The Contractor is responsible for providing Care Coordination services for Members, and Members with Special Health Care Needs when appropriate.

8.9.2. The Contractor's Care Coordination system must be designed to coordinate the provision of services to its Members, and must promote and ensure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, Cultural Competence, and fiscal and professional accountability.

8.9.3. The Contractor will advertise their Care Coordination activities to other public and private agencies and shall provide information to Members regarding these public and private resources.

8.10. The Contractor shall provide the same standard of care for all Members regardless of eligibility category and shall make all Covered Services as accessible in terms of timeliness, amount, duration and scope, to Members, as those services are to non-CHP+ Member recipients within the same area.

8.11. 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.

8.12. The Contractor shall outline benefits and other coverage specific to the Contractor's Plan in the Member Handbook.

8.13. Determination of Covered Services

8.13.1. Those benefits excluded in Exhibit E, Covered Services and Co-payments and Exhibit J, Fluoride Varnish Program Details will not be Covered Services.

8.13.2. The Contractor shall determine the Medical Necessity of Covered Services, and shall make benefit and coverage determinations in a manner that is fully consistent with the

terms this Contract. All such determinations shall be subject to the Contractor's Grievance and Appeals procedures.

8.13.3. The Contractor shall create and consistently update a report describing the Contractor's Covered Services.

8.13.3.1. The Covered Services Report shall be delivered to the Department for review upon request of the Department, or at least annually.

8.13.3.1.1. DELIVERABLE: Covered Services Report.

8.13.3.1.2. DUE: Upon request and July 31 each year.

8.14. Corrective Actions

8.14.1. If at any time during the term of this Contract, the Department finds that a Member cannot reasonably access Covered Services because of the inability of Providers to accept additional Members, or for any other reason beyond the control of the Member, the Department may require the following corrective action process be implemented:

8.14.1.1. The Department or its designee will issue written notification to the Contractor regarding the inability of Members to access Covered Services due to inadequate capacity of Providers to accept additional Members as patients. Such notification will, to the greatest extent possible, include the names or identification numbers of Members having difficulty accessing services.

8.14.1.2. The Contractor shall issue a written response to the Department or its designee within ten (10) business days of receipt of the notification specifying the actions the Contractor is taking to correct the problem, and the date by which access to Covered Services will be ensured.

8.14.1.3. If the Contractor cannot ensure access to Covered Services within the timeframes specified above in Section 8.4, 8.5, and 8.6.1. through 8.6.5., the Contractor shall make all necessary arrangements with Providers that are not participating in the Contractor's Plan to ensure delivery of Covered Services to the Member until the problem is resolved.

8.15. Coverage Limitations and Copayments

8.15.1. The Contractor shall cover any service that is required under any State or Federal statute, regulation or rule, or is defined as Medically Necessary in Exhibit E, Covered Services and Copayments.

8.15.2. The Contractor shall not be liable for any Covered Services incurred prior to the Member's effective date of coverage under this Contract or after the date of termination of coverage, except in the case of an inpatient stay as specified in sections 6.3.1.5. and 6.4.10.

8.15.3. The Contractor shall not have a pre-existing condition exclusion period or post Enrollment waiting period for any Member.

8.15.4. The Contractor shall be authorized to impose copayments for Members that shall not exceed the amounts specified in Exhibit E Covered Services and Copayments.

8.15.4.1. 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.

8.15.4.2. 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.

8.15.4.3. 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.

8.15.5. The Contractor may invoice Members for unpaid co-payments if payment is not made at the time of service.

8.15.6. The Contractor may bill for multiple outstanding co-payments on a single invoice, but no invoice(s) shall exceed fifty dollars ($50) within any month and shall not include additional administrative charges.

8.15.7. The Contractor's co-payment policies shall be applied equally to all Members.

8.15.8. The Contractor shall not factor in increased utilization of Covered Services which is attributable solely to the non-collection of co-payments by the Contractor or Subcontractor in the calculation of future reimbursement rates by the Department.

8.15.8.1. The Contractor shall place appropriate limits on a service:

8.15.8.1.1. Based on criteria under the CHP+ State Plan, such as medical necessity.

8.15.8.1.2. For utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

8.15.8.1.3. For utilization control, provided that the services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

8.15.8.1.4. For utilization control, provided that family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used.

8.16. Covered Services Through Participating Providers

8.16.1. Covered Services shall be made available in the Service Area only through Participating Providers or non-Participating Providers authorized by the Contractor.

8.16.2. Except for Emergency Services and Urgently Needed Services, the Contractor shall have no liability or obligation to pay for any service or benefit sought or received by any Member from any non-Participating Provider unless:

8.16.2.1. Special arrangements or Referrals are made by a PCP or the Contractor, as specified in the Member Handbook; or

8.16.2.2. The Member is receiving a service as described in Section 10.5.4., Continuation of Care for Persons with Special Health Care Needs.

8.17. Coverage of Specific Services and Responsibilities

8.17.1. Emergency Services

8.17.1.1. 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.

8.17.1.2. Members temporarily out of the Service Area may receive out-of-area Emergency Services and Urgently Needed Services.

8.17.1.3. The Contractor shall not require prior authorization for Emergency Services or Urgently Needed Services.

8.17.1.4. The Contractor may not deny payment for Emergency Services if a non-contracted provider provides the Emergency Services or when a representative of the Contractor instructs the Member to seek Emergency Services.

8.17.1.5. The attending emergency physician, or the provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Contractor as responsible for coverage and payment.

8.17.1.6. The Contractor may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

8.17.1.7. The Contractor must allow the emergency services provider a minimum of ten (10) calendar days to notify the primary care provider, MCO, PIHP, PAHP, Contractor or applicable State entity of the enrollee's screening and treatment before refusing to cover the services based on a failure to notify.

8.17.1.8. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

8.17.2. Emergency Ambulance Transportation

8.17.2.1. The Contractor shall make reasonable efforts to ensure that Members within the Service Area shall have access to emergency ambulance transportation on a twenty-four (24) hour per day, seven (7) day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.

8.17.3. Verification of Medical Necessity for Emergency Services

8.17.3.1. The Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services.

8.17.3.2. The Contractor shall not deny benefits for conditions which a reasonable person outside of the medical community would perceive as Emergency Medical Conditions.

8.17.3.3. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

8.17.4. Post stabilization Care Services

8.17.4.1. The Contractor shall provide coverage for Post stabilization Care Services in compliance with 42 C.F.R. §438.114 and 42 C.F.R. §422.113(c).

8.17.4.2. The Contractor shall be responsible for coverage and payment of emergency services and post stabilization care services.

8.17.4.3. The Contractor shall cover and pay for emergency services, regardless of whether the Provider that furnishes the services has a contract with the Post-stabilization Care Services entity.

8.17.4.4. The Contractor shall not deny payment for treatment obtained when a Member had an emergency medical condition, including those cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition contained in 42 C.F.R. 438.114(a).

8.17.4.5. The Contractor shall be financially responsible for Post-stabilization Care Services obtained within or outside the Post-stabilization Care Services entity that have been pre-approved by a plan Provider or other entity representative.

8.17.4.6. The Contractor shall be financially responsible for Post-stabilization Care Services obtained within or outside the Post-stabilization Care Services entity that have not been pre-approved by a plan Provider or other entity representative, but administered to maintain the Member's stabilized condition within one (1) hour of a request to the entity for pre-approval of further post-stabilization care services.

8.17.4.7. The Contractor shall be financially responsible for Post-stabilization Care Services obtained within or outside the Post-stabilization Care Services entity that have not been pre-approved by a plan Provider or other entity representative, but administered to maintain, improve or resolve the Member's stabilized condition if:

8.17.4.7.1. The Contractor does not respond to a request for pre-approval within one (1) hour.

8.17.4.7.2. The Contractor cannot be contacted.

8.17.4.7.3. The Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care, and a plan physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 42 C.F.R. §422.113(c)(3) is met.

8.17.4.8. The Contractor shall limit charges to Members for Post-stabilization Care Services to an amount no greater than what the organization would charge the Member if he or she had obtained the services through a Managed Care Plan.

8.17.4.9. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends, when one of the following circumstances has been met:

8.17.4.9.1. A Contractor's physician with privileges at the treating hospital assumes responsibility for the Member's care.

8.17.4.9.2. A Contractor's physician assumes responsibility for the Member's care through transfer.

8.17.4.9.3. A Contractor's representative and the treating physician reach an agreement concerning the Member's care.

8.17.4.9.4. The Member is discharged.

8.18. Coverage of Prescription Drugs

8.18.1. The Contractor shall establish a drug formulary for all Medically Necessary Covered Drugs with its own prior authorization criteria. The formulary must include at minimum, the same drugs that the State funded plan provides (SMCN).

8.18.2. The Contractor shall provide a Covered Drug if there is a Medical Necessity which is unmet by the Contractor's formulary product.

8.18.3. Pursuant to 42 U.S.C. Section 1396r-8(d)(5), the Contractor shall develop and maintain a prior authorization program for covered outpatient drugs for any medically necessary conditions. The prior authorization program shall include the following:

8.18.3.1. Provision of a telephonic or telecommunication response within twenty-four (24) hours of a request for prior authorizations, and

8.18.3.2. The Contractor may authorize at least a seventy-two (72) hour supply of outpatient Covered Drugs in an Emergency situation when the prior authorization request is incomplete or additional information is needed. Emergency prior authorization shall be given retroactively if the drug had to be dispensed immediately for the Member's well-being.

8.19. Responsibility Regarding Psychiatric and Medical Diagnoses

8.19.1. Inpatient Hospital Services

8.19.1.1. The Contractor shall be responsible for inpatient Hospital stays regardless of the primary diagnosis that requires inpatient care.

8.19.1.2. The Contractor shall be financially responsible for the Hospital stay when the Member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric procedures.

8.19.1.3. The Contractor shall be financially responsible for inpatient services when the Member's primary diagnosis is psychiatric in nature, even when the psychiatric Hospitalization includes some medical conditions or procedures to treat a secondary medical diagnosis.

8.20. Coverage for Emergency Services

8.20.1. The Contractor shall not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms.

8.20.2. The Contractor shall be responsible for Emergency Services when the Member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures.

8.20.3. The Contractor shall be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis.

9. THIRD PARTY COORDINATION AND LIABILITY FOR COSTS

9.1. If any injury or illness to a Member has occurred for which a third party is liable and the Member has the right to recover damages from that third party, the Contractor shall provide Covered Services related to any such illness or injury. The Contractor shall have a lien on all funds recovered by the Member, up to the actual cost incurred by the Contractor, for the services and supplies provided to the Member. The Contractor may give notice of that lien to any party who may have contributed to the loss.

9.2. 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 losses or damages suffered in connection with such injury or illness.

9.3. All funds recovered from third parties up to the actual cost incurred by the Contractor for Covered Services provided to the Member, shall become the property of the Contractor.

9.4. The Contractor shall have the same rights the Department has under C.R.S. §25.5-4-205(4), for all months that the Client is a Member of the Contractor's Plan.

9.5. 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.

9.6. Potential third parties shall include any of the sources identified in 42 C.F.R. §433.138 relating to identifying third parties. The Contractor shall cooperate with the Department to obtain information from other state and federal agencies and the Contractor shall cooperate with the Department in obtaining information from commercial third party resources.

9.7. The Contractor shall actively pursue and collect from third party resources that have been identified except when the cost of pursuing recovery reasonably exceeds the amount that may be recovered by the Contractor.

9.8. To assist in third party recoveries the Contractor shall have all rights afforded to the Department under C.R.S. §25.5-4-301.

9.9. The Contractor shall not restrict access to Covered Services due to the existence of possible or actual third party liability.

9.10. The Contractor shall inform Members, in its written communications and publications that Members shall comply with the Contractor's protocols including using Providers within the Contractor's Plan, prior to receiving Non-emergency medical care. 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 Provider for payment or cost of the care or services.

9.11. 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.

9.12. The Contractor shall also inform its Members, in its written communications and publications, that failure to follow the third party's protocols will result in a Member being liable for the payment or the cost of any care or any service that the third party would have been liable to pay except that, if the third party or the service Provider substantively fails to communicate the protocols to the Member, the items or services the third party is liable for are non-reimbursable under the terms of this Contract and the Member is not liable to the Provider.

9.13. The Contractor shall include information in the Contractor's Member Handbook regarding its rights and the Member's obligations under this section of the Contract and C.R.S. §25.5-4-301.

9.14. The Contractor shall, on a quarterly basis, notify the Departments fiscal agent, as directed by the Department, of any third party payers identified by the Contractor. The Contractor shall submit the following information:

9.14.1. State identification number.

9.14.2. Member's social security number.

9.14.3. Member's relationship to policyholder.

9.14.4. Member's name, complete address, and telephone number.

9.14.5. Daytime telephone number where Member can be reached.

9.14.6. Covered Service recovered.

9.14.7. Date and amount of Covered Service recovered.

9.15. The Contractor shall provide a quarterly report to the Department describing all third party recovery efforts and amounts recovered. The report shall include items listed in 9.14 for each recovery, and all net amounts recovered from third party resources.

9.15.1. The Contractor shall deliver the report to the Department for review and approval.

9.15.1.1. DELIVERABLE: Third Party Recovery Report

9.15.1.2. DUE: Quarterly, according to the schedule in 15.1.1.1.

9.16. Coordination of Benefits

9.16.1. 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.

9.16.2. 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 as a licensed HMO.

9.16.3. The Contractor shall not be required to make such payment for circumstances in which it is not the primary payer.

10. SERVICE DELIVERY

10.1. The Contractor shall have written agreements with all Providers in its network.

10.2. Access

10.2.1. Access to Care Standards

10.2.1.1. The Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care to:

10.2.1.2. Serve all primary care and care coordination needs;

10.2.1.3. Serve all behavioral health needs; and

10.2.1.4. Allow for adequate Member freedom of choice amongst Providers.

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

10.2.1.6. 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.

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

10.2.1.7.1. 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.

10.2.1.8. 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 14.1.3.6 of this contract. The Contractor shall ensure that the directory is updated at least monthly and shall be made available to the Department.

10.2.1.9. 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. § 438.3(q)(1).

10.2.1.10. The Contractor shall ensure that its network complies with the time and distance standards in the following table:

PRIMARY AND SPECIALTY CARE NETWORK 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)
Pediatric Primary Care Providers	30	30	45	45	60	60
Pediatric Specialty Care / PT / OT / ST Providers	30	30	45	45	100	100
Gynecology, OB/GYN	30	30	45	45	60	60
Pharmacy	10	10	30	30	60	60
Hospitals (acute care)	20	20	30	30	60	60

10.2.1.11. The Contractor shall ensure that its network has a sufficient number of providers so that each Member has their choice of at least two (2) PCPs and OB/GYN 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.

10.2.1.11.1. 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.

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

The Contractor shall ensure that its behavioral health network meets the time and distance standards described in the table below for each practitioner type listed.

BEHAVIORAL HEALTH 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)
Hospitals (acute care)	20	20	30	30	60	60
Psychiatrists and other psychiatric prescribers; serving children	30	30	60	60	90	90
Mental Health Provider; serving children	30	30	60	60	90	90
Substance Use Disorder Provider; serving children	30	30	60	60	90	90

10.2.1.12. The Contractor shall ensure that its behavioral health network has a sufficient number of Providers so that each Member has their choice of at least two (2) behavioral health 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.

10.2.1.12.1. 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.

10.2.1.12.2. The Contractor shall use GeoAccess or a comparable service to measure the distance between the Members and the behavioral health providers in the Contractor's Region.

10.2.1.13. The Contractor shall ensure that its network meets the following practitioner to Members ratios and distance standards:

10.2.1.13.1. Pediatric primary care providers: One (1) PCP Provider per eighteen hundred (1,800) child Members.

10.2.1.13.1.1. PCP includes Physicians designated to practice Family Medicine and General Medicine.

10.2.1.13.1.2. 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.

10.2.1.13.2. Pediatric Physician Specialist to Members ratio: One (1) practitioner per eighteen hundred (1,800) child Members.

10.2.1.13.2.1. Physician specialist includes Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.

10.2.1.13.2.2. 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.

10.2.1.13.3. Pediatric mental health providers: One (1) practitioner per eighteen hundred (1,800) child Members.

10.2.1.13.4. Substance use disorder providers: One (1) practitioner per eighteen hundred (1,800) Members.

10.2.1.14. 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.

10.2.1.15. The Contractor shall provide for a Member to receive a second opinion from a qualified Health Care Professional within the network or arrange for the Member to obtain one outside the network if there is no other qualified Health Care Professional within the network, at no cost to the Member.

10.2.1.16. The Contractor shall ensure that all Members have appropriate access to certified nurse practitioners and certified nurse midwives, as set forth at 42 C.F.R. §438.102(a), as amended, through either Provider agreements or Referrals. This provision shall not be interpreted as requiring the Contractor to provide any services that are not Covered Services under this Contract.

10.2.1.17. The Contractor shall comply with all requirements described in 10 C.C.R. 2505-10, §8.205.5.and 42 C.F.R §438.207. The Contractor shall follow the Safe Harbor Standards in its network of Providers that serve predominately low-income, medically-underserved individuals, such as Health Care Providers defined in section 340B(a)(4) of the Public Health Service Act, and Providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as set forth by section 221 of Public Law 111–8.

10.2.1.18. The Contractor shall utilize best efforts to implement the Colorado Medical Home Standards set forth in Exhibit G, Children's Basic Health Plan Medical Home Standards, to ensure that all children on the CHP+ Program have access to a Medical Home.

10.2.1.19. The Contractor shall make assurances that Covered Services to Members will be accessible without unreasonable delay.

10.2.1.20. 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.

10.2.1.20.1. Indian or Tribal Members eligible to receive services from an Indian or Tribal Provider in the network are permitted to choose that Indian or Tribal Provider as their PCMP, as long as that provider has the capacity to provide services.

10.2.1.21. The Contractor shall establish clinically appropriate scheduling guidelines for various types of appointments necessary for the provision of primary and specialty care including, but not limited to:

10.2.1.21.1. Routine physicals.

10.2.1.21.2. Diagnosis and treatment of acute pain or injury.

10.2.1.21.3. Follow-up appointments for chronic conditions.

10.2.1.22. The Contractor shall ensure that its scheduling guidelines meet, at a minimum, all of the following standards:

10.2.1.22.1. Urgently Needed Services shall be provided within twenty-four (24) hours of notification of the Member's need for those services to the Member's PCP or the Contractor.

10.2.1.22.2. Outpatient Follow-up Appointments – within seven (7) days after discharge from a hospitalization.

10.2.1.22.3. Non-emergent, non-urgent medical problem shall be provided within thirty (30) calendar days. This thirty (30) calendar day standard does not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) calendar days.

10.2.1.22.4. Non-urgent, symptomatic care shall be scheduled within seven (7) calendar days of the Member's request for services.

10.2.1.22.5. Non-symptomatic well care physical examinations shall be scheduled within thirty (30) calendar days, unless an appointment is required sooner to ensure the recommended screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule.

10.2.1.22.6. 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.

10.2.1.22.7. Non-urgent, Symptomatic Behavioral Health Services – within seven (7) days after a Member's request.

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

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

10.2.1.22.8. The Contractor shall take actions necessary to ensure that all primary care, Care Coordination, and behavioral health services covered under this Contract are provided to Members with reasonable promptness, including but not limited to the following:

10.2.1.22.8.1. Utilizing out-of-network Providers.

10.2.1.22.9. 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.

10.2.1.22.10. 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.

10.2.1.23. The Contractor shall make these scheduling guidelines available to the Department for review prior to implementation.

10.2.1.24. In the event that the Department determines that the guidelines are unacceptable to the Department, then the Contractor shall immediately modify those guidelines to comply with the Department's request.

10.2.1.24.1. The Contractor shall communicate all scheduling guidelines in writing to Participating Providers.

10.2.1.24.2. The Contractor shall create and maintain an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and taking appropriate corrective action.

10.2.2. Out of Network Providers

10.2.2.1. 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.

10.2.2.2. 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 Plan 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 Plan.

10.2.2.3. 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 section 10.2.2. All payments from the Contractor to a Provider that is not within the Contractor's Plan shall be made in accordance with C.R.S. §25.5-4, unless otherwise negotiated between the Contractor and that Provider.

10.2.3. Geographic Access

10.2.3.1. The Contractor shall ensure that all Urban County, Rural County, and Frontier County Members it accepts have access to an Essential Community Provider within a travel time of thirty (30) miles or thirty (30) minutes, forty five (45) miles or forty five (45) minutes, ninety (90) miles or ninety (90) minutes respectively whichever area is larger, to the extent such services are available and Providers are qualified and willing to contract with the Contractor on reasonable terms offered by the Contractor.

10.2.4. Service Availability

10.2.4.1. The Contractor shall ensure that Members, including Members with Disabilities, have a point of access to appropriate services available on a 24-hour per day basis, and have written policies and procedures for how the Contractor will meet this requirement. The Contractor shall communicate this information to Participating Providers and Members and have a routine monitoring mechanism to ensure that Participating Providers promote and comply with these policies and procedures. These policies and procedures shall address, at a minimum, the following requirements:

10.2.4.1.1. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

10.2.4.2. If Participating Providers do not comply, the Contractor shall take corrective action and notify the Department of the action taken as required pursuant to 42 C.F.R. §438.206(c)(1)(vi).

10.3. Service Area Standards

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

10.3.2. At least sixty (60) calendar days prior to the Contractor's expected expansion date, Contractor shall provide the Department with written notice, and a service plan analysis when seeking to expand into a new Service Area or expand the eligibility categories served. Such written notice and analysis shall include, but not be limited to:

10.3.2.1. An analysis by the Contractor concerning whether its Provider Network is adequate to serve Members in the proposed county, able to provide the full scope of benefits, and can comply with the standards for access to care as specified in this Contract.

10.3.2.2. 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).

10.3.2.3. A demonstration that the Contractor has the capacity to serve the expected Enrollment in that Service Area.

10.3.2.4. A demonstration that the Contractor maintains a sufficient number, mix, and geographic distribution of Providers of services.

10.3.2.5. Assurances that Covered Services in Exhibit E to Members will be accessible without unreasonable delay.

10.3.3. The Contractor may discontinue providing Covered Services to Members within an entire county within the Contractor's Service Area, by providing no less than sixty (60) calendar days prior written notice to the Department of the Contractor's intent to discontinue such services. Such discontinuance of the provision of Covered Services shall be effective on the first day of the month following conclusion of the sixty (60) calendar day notice period.

10.3.4. If the Contractor fails to maintain an adequate network, as defined in C.R.S. §10-16-704, that provides Members with access to PCPs within a county in the Contractor's Service Area, the Department may designate that county as a mixed county for the purpose of offering the option of a CHP+ plan or the state's self-funded network to eligible Members by providing the Contractor a thirty (30) calendar day written notice. If it is determined by the Department that the health or safety of Members are compromised by the lack of access, this designation may occur immediately.

10.4. Selection and Assignment of PCPs

10.4.1. The Contractor's Plan shall provide the 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.

10.4.2. If a Member does not select a PCP, the Contractor shall assign the Member to a PCP and notify the Member, by telephone or in writing, of that Member's PCP's name, location, and office telephone number.

10.4.3. The Contractor shall in no way prohibit or restrict a Participating Provider, who is acting within the lawful scope of practice, from advising a Member about any aspect of his or her health status or medical care, advocating on behalf of a Member, advising about alternative treatments that may be self-administered, including the risks, benefits and consequences of treatment or non-treatment so that the Member receives the information needed to decide among all available treatment options and can make decisions regarding the Member's own health care, regardless of whether such care is a Covered Service under this Contract. This section shall not be construed as requiring the Contractor to provide any service, treatment or benefit that is not a Covered Service under this Contract.

10.5. Coordination of Care

10.5.1. The Contractor shall have written policies and procedures to ensure timely coordination with any of a Member's other Providers for the provision of Covered Services to that Member.

10.5.1.1. The Contractor shall implement these procedures in a manner that promotes and assures service accessibility, attention to individual needs, continuity of care, maintenance of health, and Independent Living. The policies and procedures shall also address the coordination and provision of Covered Services in conjunction with other medical and behavioral health plans that may be providing services to the Member and ensure that, in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 C.F.R. §§160 and 164.

10.5.2. The Contractor shall coordinate with the Member's mental health Providers, if the Member has mental health Providers, to facilitate the delivery of mental health services in conjunction with the provision of Covered Services, as appropriate.

10.5.2.1. The Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance disorder benefits, within the scope of benefits stipulated in the Contract.

10.5.3. In addition to efforts made as part of the Contractor's internal quality assessment and improvement program, the Contractor's Care Coordination system shall include, but is not limited to:

10.5.3.1. Procedures for, and the capacity to:

10.5.3.1.1. Provide an individual needs assessment after Enrollment, and at any other necessary time, that includes the screening for Special Health Care Needs. Special Health Care Needs may include, but are not limited to, mental health, high risk health problems, functional problems, language or comprehension barriers and other complex health problems.

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

10.5.3.2. The Contractor shall produce a treatment plan for enrollees with Special Health Care Needs who are determined through assessment to need a course of treatment or regular care monitoring. The treatment plan must be:

10.5.3.2.1. Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

10.5.3.2.2. Approved by the Contractor in a timely manner, if this approval is required by the Contractor, and

10.5.3.2.3. Any treatment plans produced by the Contractor shall be in accordance with any applicable State quality assurance and utilization review standards.

10.5.3.2.4. Establish treatment objectives, treatment follow-up, the monitoring of outcomes and a process to ensure that treatment plans are revised as necessary.

10.5.3.2.5. Accommodate the specific cultural and linguistic needs of the Contractor's Members and shall allow Members with Special Health Care Needs direct access to a specialist as appropriate for the Member's condition and medical needs.

10.5.3.3. Procedures designed to address those Members who may require services from multiple Providers, facilities and agencies and who require complex coordination of benefits and services.

10.5.3.3.1. The Contractor must also implement procedures to deliver care to and coordinate services for all enrollees for the following:

10.5.3.3.1.1. The services between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

10.5.3.3.1.2. The services the enrollee receives from any other MCO, PIHP, or PAHP;

10.5.3.3.1.3. The services the enrollee receives in FFS Medicaid or FFS CHP+; and

10.5.3.3.1.4. The services the enrollee receives from community and social support providers.

10.5.3.4. A strategy to ensure that all Members, and those Members' authorized family Members or guardians, are involved in treatment planning and consent to any medical treatment.

10.5.3.5. Procedures and criteria for making Referrals and coordinating care by specialists, subspecialists and community-based organizations that will promote continuity as well as cost-effectiveness of care.

10.5.3.6. Procedures to provide continuity of care for newly Enrolled Members to prevent disruption in the provision of Medically Necessary services. These procedures may include, but are not limited to, the following:

10.5.3.6.1. Appropriate Care Coordination staff trained to evaluate and handle individual case transition and care planning.

10.5.3.6.2. Assessment for determining if appropriate technology and equipment are available.

10.5.3.6.3. Procedures for evaluating adequacy of Participating Providers.

10.5.3.6.4. Clearly written criteria and procedures that are made available to all Participating Providers, staff and Members regarding how to initiate case planning.

10.5.3.6.5. Transitions of Care: The Contractor shall provide continuity of care for Members who are involved in multiple systems and experience service transitions from other Medical Assistance programs and delivery systems.

10.5.3.6.6. Continued Services to Members: The Contractor shall comply with the state's transition of care policy to ensure the continued access to services during a transition from one Medical Assistance program / MCO to another, as required in 42 C.F.R. § 438.62.

10.5.4. The Department may review any of the Contractor's procedures relating to Care Coordination and direct changes to the procedures that it determines to be in the best interest of the Department or the Members.

10.6. Persons with Special Health Care Needs

10.6.1. The Contractor shall have sufficient experienced Providers with the ability to meet the unique needs of all Members who are Persons with Special Health Care Needs. If necessary primary or specialty care cannot be provided within the Contractor's Plan, the Contractor shall make arrangements for Members to access these Providers outside the network. The Contractor shall implement procedures to share the results of its identification and assessment of that Member's needs with other Providers serving the Member with Special Health Care Needs, in order to prevent duplication of those activities.

10.6.2. The Contractor shall implement mechanisms within thirty (30) calendar days to assess each Member identified as a Person with Special Health Care Needs in order to identify any ongoing special conditions of the Member that requires a course of treatment or regular care monitoring.

10.6.3. The Contractor shall allow Persons with Special Health Care Needs who use specialists frequently for their health care to maintain these types of specialists as PCPs or be allowed direct access or a standing Referral to specialists for the needed care.

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

10.6.4.1. The Contractor shall inform any new Member who is a Person with Special Health Care Needs as defined in 10 C.C.R. 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 Plan. 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).

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

10.6.5. 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).

10.6.6. The Contractor shall establish and maintain procedures and policies to coordinate health care services for children with Special Health Care Needs with other agencies or entities such as those dealing with mental health and substance use disorders, public health, home and community-based care, Developmental Disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates.

10.7. Early Intervention Services and Support

10.7.1. Contractor will provide Early Intervention (EI) Services and Support as described in C.R.S. 27-10.5 part 7.

10.7.2. Contractor shall provide EI Services and Support by participating in the EI trust, in accordance with C.R.S. Section 27-10.5-709.

10.7.3. If Contractor does not meet the requirements specified in C.R.S. Section 27-10.5-709, Contractor shall develop a process in coordination with the Department to ensure EI Services and Support are provided in accordance with C.R.S. 27-10.5 part 7 which shall include, but not be limited to the following steps:

10.7.3.1. The Department will confirm CHP+ eligibility and Enrollment for CHP+ Members that are provided by the EI Program Coordinator.

10.7.3.2. Within thirty (30) calendar days of notification from the Department, the Contractor shall submit funds in the amount established by the EI Program in the approved CHP+ Member's name.

10.7.3.3. The Contractor shall, upon the CHP+ Members exit from early intervention services or discontinuation of CHP+ eligibility, notify the EI trust. All unused monies deposited in the EI trust on behalf of the eligible CHP+ Member, infant or toddler that are not expended shall be returned no later than ninety (90) calendar days after the end of the calendar year.

10.7.3.4. The EI Program Coordinator shall provide Contractor with a report specifying the amount of benefits paid to certified Early Intervention Service Brokers for services provided to an eligible infant or toddler during the prior calendar year, including the amount paid to each certified Early Intervention Service Broker and the services provided to an eligible infant or toddler no later than April first (1st) of each Contract year.

10.7.4. 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 infant's or toddler's family or the carrier.

10.8. Accommodation of Members with Disabilities or Special Health Care Needs

10.8.1. The Contractor shall promote accessibility and availability of Medically Necessary Covered Services, either directly or through subcontracts, to ensure that appropriate services and accommodations are made available to Members with a Disability or any Members with Special Health Care Needs. Covered Services for Members with Disabilities or Special Health Care Needs must be provided in such a manner that will promote Independent Living and Member participation in the community at large.

10.8.2. The Contractor shall facilitate culturally and linguistically appropriate care, by complying with the following requirements:

10.8.2.1. Establish and maintain policies to reach out to specific cultural and ethnic Members for prevention, health education and treatment for diseases prevalent in those groups.

10.8.2.2. Maintain policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation.

10.8.2.3. Make a reasonable effort to identify Members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Contractor of the language proficiency of Members during the Contractor's orientation calls or being served by Participating Providers, or improving access to health care through community outreach and Contractor publications.

10.8.2.4. Develop and provide cultural competency training programs, as needed, to the network Providers and Contractor staff regarding all of the following:

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

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

10.8.2.5. Make available written translation of Contractor materials, including Member Handbook, correspondence and newsletters.

10.8.2.5.1. Written Member information and correspondence shall be made available in languages spoken by prevalent non-English speaking Member populations within the Contractor's Service Area as directed by the Department or as required by 42 C.F.R. §438.

10.8.2.6. Develop policies and procedures, as needed, on how the Contractor will respond to requests from Participating Providers for interpreter services by a Qualified Interpreter. This shall occur particularly in Service Areas where language may pose a barrier so that Participating Providers can:

10.8.2.6.1. Conduct the appropriate assessment and treatment of non-English speaking Members, including Members with a Communication Disability.

10.8.2.6.2. Promote accessibility and availability of Covered Services, at no cost to Members.

10.8.2.7. Develop policies and procedures on how the Contractor will respond to requests from Members for interpretive services by a Qualified Interpreter or publications in alternative formats.

10.8.2.8. Make a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse and culturally competent clinical Providers that represent the racial and ethnic communities being served.

10.8.2.9. Provide access to interpretative services by a Qualified Interpreter for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.

10.8.2.10. Develop and maintain written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

10.8.2.11. Arrange for Covered Services to be provided through agreements with non-Participating Providers when the Contractor does not have the direct capacity to provide Covered Services in an appropriate manner, consistent with Independent Living, to Members with Disabilities.

10.8.2.12. Provide access to TDD or other equivalent methods for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.

10.8.2.13. Make Member information available for Members with visual impairments, including, but not limited to, Braille, large print or audiotapes. For Members who cannot read, Member information must be available on audiotape.

10.9. Preventative Health Services

10.9.1. The Contractor shall establish and maintain a comprehensive program of preventive health services for Members. The Contractor shall ensure that Members with a Disability have the same access to preventative health services as other Members. The program shall include written policies and procedures, involve Participating Providers and Members in their development and ongoing evaluation, and are a part of the Contractor's comprehensive quality assurance program as specified in Section 12 of this Statement of Work. The Contractor's program of preventive health services shall include, but is not limited to:

10.9.1.1. Risk assessment by a Member's PCP, or other qualified professionals specializing in risk prevention who are part of the Contractor's Participating Providers or under Contract to provide such services, to identify Members with chronic or high risk illnesses, a Disability or the potential for such conditions.

10.9.1.2. Health education and promotion of wellness programs, including the development of appropriate preventive services for Members with a Disability to prevent further deterioration. The Contractor shall also include the distribution of information to Members to encourage Member responsibility for following guidelines for preventive health.

10.9.1.3. Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk Members.

10.9.1.4. Procedures to identify priorities and develop guidelines for appropriate preventive services.

10.9.1.5. Processes to inform and educate Participating Providers about preventive services, involve Participating Providers in the development of programs and evaluate the effectiveness of Participating Providers in providing such services.

10.10. Services Delivered Only to Members

10.10.1. The Contractor shall ensure that Providers operating under the Contractor's Plan supply services only to Members. It is the responsibility of the Provider to verify that the individual receiving medical services is a Member on the date of service, whether the Contractor or the Department is responsible for reimbursement of the services provided and whether the Contractor has authorized a Referral or made special arrangements with a Provider, when appropriate. If a Provider has verified eligibility and Enrollment as specified by the Department, the Department will reimburse the Contractor for the claim if the Department is responsible for the reimbursement of that claim.

11. COMPLIANCE AND MONITORING

11.1. Utilization Management

11.1.1. The Contractor shall follow CMS regulations regarding Utilization Management in 42 C.F.R. §438, *et seq*.

11.1.2. The Contractor shall establish and maintain a utilization management program to monitor access to and appropriate utilization of covered services that is compliant with 42 C.F.R. §§438.905 and 438.910, *et seq*. The program shall be under the direction of an appropriately qualified clinician. Utilization determinations shall be based on written criteria and guidelines developed or adopted with involvement from practicing providers or nationally recognized standards. The utilization management process shall in no way impede timely access to services.

11.1.2.1. The Contractor may not impose Aggregate Lifetime/Annual Dollar Limit (AL/ADL) on Mental Health/Substance Use Disorder (MH/SUD) benefits.

11.1.3. 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, be made by a health care professional who has appropriate clinical expertise in treating the Member's medical, behavioral health, or long-term services and supports needs.

11.1.4. Utilization Management review shall be conducted under the direction of a qualified clinician.

11.1.5. The Contractor and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service.

11.1.6. The Contractor shall have a mechanism in effect to ensure consistent application of review criteria for authorization decisions and consultation with the requesting Provider when appropriate.

11.1.7. Prior authorization and benefit decisions shall involve a health care professional who has appropriate clinical expertise in treating the Members' condition or disease.

11.1.8. The Contractor shall notify the requesting Provider 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. The notice to the Provider may be oral or in writing.

11.1.9. The Contractor shall 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. Notice must meet the requirements listed in 42 C.F.R. §438.404.

11.1.10. Standard authorization decisions shall be made and the Member notified as expeditiously as the Members health condition requires, not to exceed ten (10) calendar days following the receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

11.1.10.1. The Member or Provider requests an extension.

11.1.10.2. The Contractor justifies to the Department a need for additional information and how the extension is in the Member's interest.

11.1.11. Expedited authorization decisions are those cases in which the Provider indicates that following the standard timeline could seriously jeopardize the Member's life or health or ability to maintain or regain maximum function.

11.1.12. Expedited authorization decisions must provide notice as expeditiously as the Members health condition requires and no later than three (3) business days after receipt of the request for service. Contractor may extend the three (3) business days' time frame by up to fourteen (14) calendar days if:

11.1.12.1. The Member or Provider requests an extension.

11.1.12.2. The Contractor justifies to the Department a need for additional information and how the extension is in the Member's interest.

11.1.13. The Contractor shall provide information to Members and Participating Providers, in appropriate formats, about how the Contractor's Utilization Management Program functions and is utilized to determine the Medical Necessity of Covered Services. This information shall include appropriate points of contact with the program, contact persons or numbers for information or questions, and information about how to initiate Appeals related to Utilization Management determinations.

11.1.14. The Contractor shall provide information to Members, at the time of the Member's Enrollment that includes, but is not limited to, the purpose of the Contractor's Utilization Management Program and how the program works.

11.1.15. The Contractor shall provide information to Participating Providers, at the time an agreement with that Provider is executed, that includes, but is not limited to, necessary information and guidelines to enable the Provider to understand and participate appropriately in the Utilization Management Program.

11.1.16. The Contractor shall maintain data systems sufficient to support Utilization Management review program activities and to generate management reports that enable the Contractor to effectively monitor and manage Covered Services, Grievances and Appeals and Disenrollments for reasons other than loss of CHP+ eligibility.

11.2. Serious Reportable and Never Events

11.2.1. The Contractor shall track all Serious Reportable Events as described in Exhibit H, Serious Reportable Events or Never Events and any service with the Present on Admission (POA) indicator at the time of a Hospital admission.

11.2.2. The Contractor or rendering Provider shall not bill the Member or CHP+ for POA related services.

11.2.3. Members shall not be billed for the balance of claims for the portion denied by CHP+.

11.2.4. Contractor shall not reimburse any Provider for the additional costs resulting from the Hospital Acquired Conditions (HAC) and Serious Reportable Events in Exhibit H.

11.2.5. Contractor shall keep a log of all inpatient Hospital claims that contain HAC, including a list of those that resulted in an overpayment.

11.2.6. Claims assigned to a higher Diagnosis Related Group (DRG) or DRG with Complications and Co-morbidities (CC) shall be reassigned to a lower DRG or DRG without CC when appropriate based on diagnoses that were not acquired during the Hospitalization.

11.2.7. The Contractor shall identify those claims assigned to a DRG with CC due to the presence of diagnoses and procedure codes different from the ones associated with Serious Reportable Events (SRE), as set forth in Exhibit H, that were acquired during the Hospital stay. In such instances, claim re-assignment to a DRG without CC may not be appropriate.

11.2.7.1. If the selected condition is present on admission and the claim was assigned to a DRG with CC, the claim shall remain in its original assignment.

11.2.8. The Contractor shall track reporting quarterly to conform to the State Fiscal Year (SFY). Contractor shall have ninety (90) days after the end of any quarter to provide data according to the reporting schedule in 15.1.1.1.

11.3. Site Reviews

11.3.1. The Department may conduct Site Reviews of the Contractor's, Subcontractors' or Participating Providers' locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary.

11.3.2. The Department will conduct these Site Reviews for the purpose of determining compliance by the Contractor with applicable Department regulations and the requirements of this Contract. In the event that right of access is requested under this section, the Contractor and/or its Subcontractors or Participating Providers shall, provide and make available staff to assist in the audit or inspection effort.

11.3.3. All inspections or audits will be conducted in a manner that will not unduly interfere with the performance of the Contractor's, Subcontractor's or Participating Providers' provision of care.

11.3.4. Contractor shall provide adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

11.3.5. An emergency or unannounced review may be required in instances where patient safety, quality of medical care, potential fraud or financial viability is at risk. The Department may determine when an emergency review is required in its sole discretion.

11.3.6. For Non-emergency 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 for mutually agreed upon dates for a Site Review.

11.3.6.1. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to the Contractor at least thirty (30) calendar days prior to the visit. The Contractor shall submit copies of policies, procedures, manuals, handbooks, reports, and other requested materials to facilitate the Department's Desk Audit prior to the Site Review. The Contractor shall have a minimum of thirty (30) calendar days to submit the required materials for Non-emergency reviews.

11.3.7. Where policies, procedures, programs, and plans are required by this Contract or Department regulations, the Contractor shall maintain and provide internal documents that clearly demonstrate all such requirements.

11.3.7.1. Such internal procedures must detail responsibilities of the Contractor, where the Contractor is required to communicate to Providers; documentation shall exist outside of the Contractor's internal policies and procedures, generally in the form of direct Provider correspondence or a Provider manual. Exceptions can be made for a single source for Provider and Contractor documents if the Contractor clearly specifies in the documents the role of the Contractor and the role of the Provider. Where the Contractor is required to communicate to Members, documentation shall exist outside the Contractor's internal policies and procedures, generally in the form of direct Member correspondence or the Member Handbook.

11.3.8. 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 as noted elsewhere in this section, or immediately on an emergency basis. Delays in the availability of such documents and records may subject the Contractor to remedial actions, as specified in this Contract. 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.

11.3.9. A written report of the site visit will be transmitted to the Contractor within forty five (45) calendar days of the Site Review. The Contractor shall be allowed thirty (30) calendar 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.

11.3.10. The Contractor shall respond to any required actions, if necessary, with a corrective action plan within thirty (30) calendar 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. 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 this Contract.

11.3.10.1. 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 the Members, as determined by the Department. 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.

11.3.10.2. Any data submitted by the Contractor to the Department or its agents after the last site visit day will not be accepted towards compliance with the visit in the written report. This data will only apply toward the corrective action plan.

11.3.11. The Department review staff shall notify the Department if the Contractor was found to be seriously out of compliance or uncooperative with the Site Review process or the corrective action plan.

11.3.12. The Site Review may include reviews of a sample of Participating Providers to ensure that Providers have been educated and monitored by the Contractor about the requirements under this Contract.

11.4. Contractor Review of Studies, Inspections, Site Reviews and Audits

11.4.1. The Department will submit the results of any studies, inspections, Site Reviews or audits of the Contractor, or its Subcontractors or Participating Providers, to the Contractor for review. The Contractor shall have thirty (30) Calendar Days to review the results of the study or audit prior to the Department releasing those results to the public. The Department may consider the Contractor's review or comments before releasing those results to the public.

11.5. Compliance Monitoring

11.5.1. Upon the Department's request, the Contractor shall submit to the Department any appropriate information necessary for the Department to issue a Certificate of Creditable Coverage on behalf of a Member whose eligibility for CHP+ has ended as the Department is required to do under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §1320d – 1320d-8, and its implementing regulations.

11.6. Other Monitoring Activities

11.6.1. The Contractor shall participate in and respond to other Department compliance monitoring activities, including but not limited to:

11.6.1.1. Appeals analysis to identify trends in the CHP+ Program and among CHP+ plans.

11.6.1.2. Other reviews as determined by the Department.

11.6.2. The Contractor shall authorize the accrediting entity to provide the Department a copy of its most recent accreditation review, including: 1) accreditation status, survey type, and level; 2) accreditation results, including any recommended actions or improvements,

corrective action plans, or summaries of findings; and 3) expiration date of the accreditation.

12. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

12.1. The Contractor shall maintain an internal quality assessment and performance improvement program that complies with all provisions of Subpart b of 42 C.F.R. §438.330.

12.2. The scope of the Contractor's internal quality assessment and performance improvement program shall be comprehensive and shall include, but not be limited to:

12.2.1. Practice Guidelines

12.2.1.1. The Contractor shall develop practice guidelines for the following:

12.2.1.1.1. Perinatal, prenatal and postpartum care for women.

12.2.1.1.2. Conditions related to Persons with a Disability or Special Health Care Needs.

12.2.1.1.3. Well child care.

12.2.1.2. The Contractor shall ensure that practice guidelines comply with the following requirements:

12.2.1.2.1. The guidelines are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in a particular field.

12.2.1.2.2. The guidelines consider the needs of the Member.

12.2.1.2.3. The guidelines are adopted in consultation with Participating Providers.

12.2.1.2.4. The Contractor reviews and updates the guidelines at least every two (2) years.

12.2.1.3. The Contractor shall disseminate the practice guidelines to all affected Providers and, upon request, to Members, the Department, other non-Members and the public at no cost.

12.2.1.4. The Contractor shall ensure that decisions regarding Utilization Management, Member education, Covered Services and other areas to which the guidelines apply are consistent with the guidelines.

12.3. Performance Improvement Projects (PIP)

12.3.1. The Contractor shall conduct 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.

12.3.2. PIPs shall follow all requirements as outlined in the External Quality Review Organization (EQRO) Protocol Validating PIPs, and as directed by the Department.

12.3.3. The Contractor shall conduct PIPs on topics selected by CMS when the Department is directed by CMS to focus on a particular topic.

12.3.3.1. At least once per year, the Department will review the impact and effectiveness of the quality assessment and performance improvement program of the Contractor, including 1) the Contractor's performance on the measures on which it is required to report; 2) the outcomes and trended results of each Contractor's performance improvement projects; and 3) the results of any efforts by the Contractor to support community integration for enrollees using long-term services and supports.

12.3.4. The Contractor shall report the status and results of each PIP as part of the annual EQRO quality report and when requested by the Department. The results of each PIP shall be submitted in sufficient detail to allow the Department to validate the projects.

12.3.5. The Contractor shall complete PIPs in a reasonable time period in order 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.

12.4. Performance Measurement Data

12.4.1. Healthcare Effectiveness Data and Information Set (HEDIS)

12.4.1.1. The Contractor shall calculate and submit specified HEDIS measures as determined by collaboration between the Department and the Contractor's quality improvement committee.

12.4.1.2. The Contractor shall analyze and respond to results indicated in the HEDIS measures.

12.4.1.3. The Contractor shall contract with an external entity to perform an external audit of the HEDIS measures according to HEDIS and EQRO protocols.

12.4.1.4. Any failed audit that nullifies more than three (3) required HEDIS measures is considered non-compliant with this requirement, and the Contractor shall make all necessary changes to ensure that the requirement is completed.

12.4.2. Mandatory Federal Performance Measurements

12.4.2.1. The Contractor shall calculate additional performance measures as required by the Department and CMS.

12.4.3. Member Satisfaction

12.4.3.1. In accordance with CHIPRA section 402(a)(2), CHP+ programs are required to report results from National Committee on Quality Assurance (NCQA) / AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, on an annual basis.

12.4.3.2. The Contractor shall monitor Member perceptions of accessibility and adequacy of services provided by the Contractor.

12.4.3.2.1. The Contractor shall use tools to measure these Member perception which shall include, at a minimum,

12.4.3.2.1.1. Member surveys,

12.4.3.2.1.2. Anecdotal information,

12.4.3.2.1.3. Grievance and Appeals data and

12.4.3.2.1.4. Enrollment and Disenrollment information.

12.4.3.3. The Contractor shall develop and implement a two (2) year CAHPS Health Plan Survey Corrective Action Plan for the Global Rating and Composite Measure areas of the CAHPS Health Plan Survey that report a score that is less than the National Medicaid fiftieth (50th) percentile of the NCQA HEDIS Benchmarks and Thresholds for Accreditation.

12.4.3.3.1. Modifications shall be made as requested by the Department.

12.4.3.4. The Contractor shall utilize CAHPS Health Plan Survey data to draft and implement a corrective action plan, as directed by the Department which may include, at a minimum:

12.4.3.4.1. CAHPS Health Plan Survey data.

12.4.3.4.2. A draft CAHPS Health Plan Survey final report provided by the Department.

12.4.3.4.3. A CAHPS Health Plan Survey final report provided by the Department.

12.4.3.5. The Contractor shall deliver the final CAHPS Health Plan Survey Corrective Action Plan to the Department for review and approval and to the Department's EQRO.

12.4.3.5.1. DELIVERABLE: CAHPS Health Plan Survey Corrective Action Plan.

12.4.3.5.2. DUE: Within 60 (sixty) days of the Department's provision of the draft CAHPS Health Plan Survey final report and supporting documentation to Contractor.

12.4.3.6. The Contractor shall submit a CAHPS Health Plan Survey Corrective Action Plan Status Update every six (6) months. Modifications to the CAHPS Health Plan Survey Corrective Action Plan may be made at this time when approved or required by the Department.

12.4.3.6.1. DELIVERABLE: Corrective Action Plan Status Update.

12.4.3.6.2. DUE: Every six (6) months.

12.4.3.7. At the end of the CAHPS Health Plan Survey Corrective Action Plan's two (2) year period, the Contractor shall submit a CAHPS Health Plan Survey Corrective Action Plan Final Report on its CAHPS Health Plan Survey Corrective Action Plan.

12.4.3.8. The CAHPS Health Plan Survey Corrective Action Plan Final Report shall include, at a minimum:

12.4.3.8.1. A summary of all Contractor's activities.

12.4.3.8.2. Contractor's successes in implementing the CAHPS Health Plan Survey Corrective Action Plan.

12.4.3.8.3. Any shortfalls in the CAHPS Health Plan Survey Corrective Action Plan and areas that need improvement.

12.4.3.8.4. Recommendations for improvement in the area of provider and health system performance.

12.4.3.9. The Contractor shall deliver the CAHPS Health Pan Survey Corrective Action Plan Final Report to the Department for review and approval.

12.4.3.9.1. DELIVERABLE: CAHPS Health Plan Survey Corrective Action Plan Final Report.

12.4.3.9.2. DUE: Upon completion of the CAHPS Health Plan Survey Corrective Action Plan's two (2) year period or as the timeframe is modified under Section 12.4.3.12 and 12.4.3.13

12.4.3.10. If, after the two (2) year corrective action plan period, the Contractor continues to receive any score that is less than the National Medicaid fiftieth (50th) percentile of the NCQA HEDIS Benchmarks and Thresholds for Accreditation, the Contractor shall work with the Department and the Department's EQRO to create a new CAHPS Health Plan Survey Corrective Action Plan under this Section.

12.4.3.11. The CAHPS Health Plan Survey Corrective Action Plan and modifications are subject to approval by the Department.

12.4.3.11.1. The Department will monitor progress on the CAHPS Health Plan Survey Corrective Action Plan until the Contractor meets the state performance goals.

12.4.3.11.2. The Department will notify the Contractor in writing when the CAHPS Health Plan Survey Corrective Action Plan is accepted and the Contractor is considered to have met goals with Department expectations and this Contract.

12.4.3.12. 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 the Members, as determined by the Department.

12.4.3.13. For CAHPS Health Plan Survey 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.

12.4.3.14. The Contractor shall comply with all provisions of the Department approved CAHPS Health Plan Survey Corrective Action Plan.

12.4.4. Mechanisms to Detect Over and Under Utilization

12.4.4.1. The Contractor shall implement and maintain mechanisms to detect over and underutilization of services. These mechanisms may incorporate those developed for the Contractor's Utilization Management Program.

12.4.5. Quality of Care Concerns

12.4.5.1. The Contractor shall investigate any alleged quality of care concerns.

12.4.5.2. In response to a request from the Department in relation to any quality of care concern, the Contractor shall submit a letter to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue and the outcome of the review as determined by the Contractor.

12.4.5.2.1. The outcome description shall include whether or not the issue was found to be a quality of care issue, and what action the Contractor intends to take with the Provider or Providers involved. The letter shall not include any names of the persons conducting the investigation or participating in any peer review process.

12.4.5.2.2. The letter shall be delivered to the Department within ten (10) business days of the Department's request. Upon request, the Department may allow additional time to investigate and report. If the Contractor refers the matter to a peer review process, it shall inform the Department of that referral.

12.4.5.3. Notwithstanding any other provision of this Contract, the Contractor may not disclose any information that is confidential by law.

12.4.5.4. After the letter is received by the Department, if there is a request for public disclosure pursuant to the Colorado Open Records Act at C.R.S. §24-72-203, the Department will assert any applicable exemptions and, if none apply, will petition the court pursuant to C.R.S. §24-72-204(6)(a). to prohibit disclosure.

12.4.6. Quality Improvement Committee

12.4.6.1. The Contractor shall have a Quality Improvement Committee.

12.4.6.1.1. The committee shall be comprised of appropriate Department staff, representatives from participating Health Maintenance Organizations, and external experts as necessary.

12.4.6.1.2. The purpose of the committee shall be to assess and implement measures of quality, access, and customer satisfaction in the delivery of Covered Services to Members.

12.4.6.1.3. The Contractor shall produce data and information as necessary to support the objectives of the Quality Improvement Committee, as mutually agreed by the parties.

12.4.6.2. The Contractor shall participate in the Department's Managed Care Quality Improvement Committee (MQuIC) to provide input and feedback regarding quality improvement priorities, performance improvement topics and measurements and specifics of reporting formats and time frames, and other collaborative projects.

12.4.7. Program Impact Analysis

12.4.7.1. The Contractor shall maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis.

12.4.7.2. Upon request by any Provider or Member, this information shall be made available to Providers and Members at no cost.

12.4.8. Quality Improvement Work Plan

12.4.8.1. The Contractor shall provide a quality improvement work plan to the Department.

12.4.8.1.1. The plan shall describe current and future quality assessment and performance improvement activities.

12.4.8.1.2. The plan shall integrate findings and opportunities for improvement identified in HEDIS, Balance Scorecard and Department Focused Goals Reporting, Member satisfaction surveys, PIPs and other monitoring and quality activities as required by the Department.

12.4.8.1.3. The plan is subject to the Department's approval.

12.4.8.1.3.1. DELIVERABLE: Quality Improvement Work Plan.

12.4.8.1.3.2. DUE: Annually, by September 30 of each year of the Contract.

12.4.9. External Review

12.4.9.1. The Contractor shall participate in an annual external independent review of quality outcomes, timeliness of, and access to the services covered under this Contract.

12.4.9.1.1. The external review may include but not be limited to all or any of the following:

12.4.9.1.1.1. Medical Record review.

12.4.9.1.1.2. Performance improvement projects and studies.

12.4.9.1.1.3. Surveys.

12.4.9.1.1.4. Calculation and audit of quality and utilization indicators.

12.4.9.1.1.5. Administrative data analyses.

12.4.9.1.1.6. Review of individual cases.

12.4.9.2. For external review activities involving Medical Record abstraction, the Contractor shall be responsible for obtaining copies of the Medical Records from the sites in which the services reflected in the Encounter occurred.

12.4.9.3. 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.

12.4.10. Health Information Systems

12.4.10.1. The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data pursuant to 42 C.F.R. §438.242. The system shall provide information on areas including, but not limited to, utilization, Grievances and Appeals, Encounters and Disenrollment.

12.4.10.2. The Contractor shall collect data on Member and Provider characteristics and on services furnished to Members.

12.4.10.3. The Contractor shall make all collected data available to the Department and to CMS upon request.

12.4.10.3.1. The Contractor shall ensure that data received from provider is accurate and complete by:

12.4.10.3.1.1. Verifying the accuracy and timeliness of reported data;

12.4.10.3.1.2. Screening the data for completeness, logic, and consistency; and

12.4.10.3.1.3. Collecting service information in standardized formats to the extent feasible and appropriate.

12.4.10.4. The Contractor shall make timely, good faith and reasonable efforts to work with the Department and any of the Department's contractors, as directed by the Department, in order to promote efficiency and the health and welfare of Members and meet the requirements and timelines set forth in the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) and subsequent rules.

12.4.10.5. Contractor shall prepare, for CHP+ Members, the required files for submission of medical and pharmacy claims and eligibility and Provider data to the Colorado All Payer Claims Database in compliance with HB10-1330, as codified in C.R.S. §25.5-1-204.

12.4.10.6. 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.

12.4.11. 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.

12.4.11.1. DELIVERABLE: Occurrence Rates

12.4.11.2. DUE: No later than December 16th for the previous calendar year

12.4.12. Measure DEV: Developmental Screening in the First Three Years of Life. CHP+ plan shall provide rates using CPT code 96110.

12.4.13. 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.

13. RESPONSIBILITIES OF THE CONTRACTOR, DEPARTMENT, AND MEMBERS

13.1. 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).

13.2. The Department will notify Clients upon determination of eligibility for the Program, that the individual Member has responsibility for tracking copayments and notifying the Department if copayments exceed the maximum.

13.3. The Contractor is responsible for outlining, in the Member Handbook, the Member's responsibility for tracking copayments and notifying the Department if copayments exceed the maximum allowed.

13.4. 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.

13.5. 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.

13.6. 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.

13.7. The Member is responsible for paying an annual Enrollment fee based upon a schedule established by the Department that reflects income level and number of children within the Member's family, as specified in Program rules.

13.8. Remedies: In addition to any other remedies provided for in this Contract, and without limiting its remedies otherwise available by law, the Department may exercise the following remedial actions if the Contractor substantially fails to satisfy or perform the duties and obligations in this Contract. Substantial failure to satisfy the duties and obligations of this Contract shall be defined to mean significant insufficient, incorrect, or improper performance, activities, or inaction by the Contractor. These remedial actions are as follows:

13.8.1. Suspend new Enrollment in Contractor's Plan; and/or

13.8.2. Require the removal of a particular geographic area, in which the failure exists, from the Contractor's Service Area; and/or

13.8.3. Request the removal from work on the Contract of Providers, employees or agents of the Contractor whom the Department justifies as being incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable, or whose continued employment on the Contract the Department deems to be contrary to the public interest or not in the best interest of the State; and/or

13.8.4. Deny payment or recover reimbursement for those services or obligations which have not been performed and which, due to circumstances caused by the Contractor, cannot be performed or if performed would be of no value to the Department. Denial of the amount of payment must be reasonably related to the value of work or performance lost to the Department; and/or,

13.8.5. Terminate this Contract for default, in accordance with Section 17.2, Termination for default, of this SOW.

13.8.6. The above remedies are cumulative and the Department, in its sole discretion, may exercise any or all of them individually or simultaneously.

13.8.7. Notice provided to the Contractor pursuant to this Section shall include a description of those actions/standards the Contractor must achieve to avoid remedial action(s) and a time frame in which such actions/standards must be implemented. Contractor losses due to remedial action shall not be returned to the Contractor upon achieving compliance.

14. MEMBER AND PROVIDER ISSUES

14.1. Member Issues

14.1.1. Member Services, Rights, Responsibilities, Grievances and Appeals

14.1.1.1. Contractor must comply with any applicable federal and state laws that pertain to Member rights and ensure that its staff and affiliated Providers take those rights into account when furnishing services to Members.

14.1.1.2. The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with all the following rights:

14.1.1.2.1. Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

14.1.1.2.2. Each Member is guaranteed 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.

14.1.1.2.3. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

14.1.1.2.4. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

14.1.1.2.5. Each Member is guaranteed the right to request and receive a copy of his or her Medical Records, and to request that they be amended or corrected, as specified in 45 C.F.R. Part 164.

14.1.1.2.6. Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor, subcontractors, Providers or the Department treats the Member.

14.1.1.2.7. To receive, from the Provider and at the times specified in 42 C.F.R. §489.102, information concerning the implementation of Advance Directives, including a clear and precise statement of limitation if the Provider cannot implement an Advance Directive on the basis of conscience.

14.1.1.2.7.1. The information shall include the Adult Member's rights under this Contract, the Contractor's policies regarding the implementation of those rights and a statement regarding the fact that Grievances concerning noncompliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment. Such information shall be provided in writing or an alternate format appropriate for the Member. Changes in state law shall be reflected in the Contractor's written material no later than ninety (90) calendar days after the effective date of the change.

14.1.1.3. The Contractor shall have written policies guaranteeing each Member's right to receive information on the managed care program and plan into which he/she is enrolled.

14.1.2. Member Responsibilities

14.1.2.1. 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 Exhibit K, Member Handbook Requirements.

14.1.2.2. The Contractor shall establish and maintain written requirements for Member participation and the responsibilities of Members in receiving Covered Services that are consistent with all responsibilities enumerated in 10 C.C.R. 2505 §8.205.2 and any amendments thereto.

14.1.3. Written Policies, Procedures and Information Relating to Members

14.1.3.1. 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 in its particular service area.

14.1.3.2. The Contractor shall ensure that all of the written materials meet the following requirements:

14.1.3.2.1. Are available in alternative formats upon request of the potential enrollee or enrollee at no cost.

14.1.3.2.2. Include taglines in the prevalent non-English languages in the state, as well as large print, 18 point font, explaining the availability of written translation or oral interpretation to understand the information provided.

14.1.3.2.3. Include taglines in the prevalent non-English languages in the state, as well as large print, 18 point font, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the MCP's member/customer service unit.

14.1.3.3. The Contractor shall make interpretation services, including oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language (ASL), free of charge to each enrollee.

14.1.3.4. That all written materials for potential enrollees and enrollees are in a font size no smaller than 12 point.

14.1.3.5. Include on all written materials a large print tagline (18 point font) and information on how to request auxiliary aids and services, including materials in alternative formats.

14.1.3.6. For each of the following provider types covered under this Contract - physicians, including specialists; hospitals; pharmacies; behavioral health providers; and Long-Term Services and Supports (LTSS) providers, as appropriate, the Contractor shall make the following information on the Contractor's network providers available to the enrollee in paper form upon request and electronic form:

14.1.3.6.1. Names, as well as any group affiliations,

14.1.3.6.2. Street addresses,

14.1.3.6.3. Telephone numbers,

14.1.3.6.4. Website URLs, as appropriate,

14.1.3.6.5. Specialties, as appropriate,

14.1.3.6.6. Whether network providers will accept new enrollees,

14.1.3.6.7. 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,

14.1.3.6.8. Whether network provider's offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

14.1.3.7. The Contractor shall ensure that its provider network information includes the following:

14.1.3.7.1. A paper provider directory must be updated at least monthly.

14.1.3.7.2. An electronic provider directory must be updated no later than 30 calendar days after the Contractor receives updated provider information

14.1.3.8. The Contractor shall make the provider directory available on the Contractor's website in a machine readable file and format as specified by the Secretary.

14.1.3.9. The Contractor and its subcontractors must have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services.

14.1.3.10. The Contractor shall provide to all Members, including new Members, a Member handbook. This Member handbook shall include general information about services offered by the Contractor and complete statements concerning Member rights and responsibilities as listed in this section within a reasonable time after the Contractor is notified of the Enrollment. The Member handbook shall include all of the minimum requirements listed in Exhibit K. The Department may review the Member handbook upon request and the Contractor shall make any changes to the Member handbook directed by the Department within forty-five (45) days of the Department's request.

14.1.3.10.1. The handbook information provided to the enrollee is considered to be provided if the Contractor:

14.1.3.10.1.1. Mails a printed copy of the information to the enrollee's mailing address.

14.1.3.10.1.2. Provides the information by email after obtaining the enrollee's agreement to receive the information by email.

14.1.3.10.1.3. Posts the information on its website and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. OR

14.1.3.10.1.4. Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

14.1.3.11. Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department. Written information shall be translated into other non-English languages prevalent in the Service Area, and provided in alternative formats as required in this Contract. The Contractor shall inform Members and potential Members that oral interpretation services are available for any language, that written information is available in prevalent languages and how the Member may access interpretation services free of charge. Prevalent population shall be established by the State.

14.1.3.12. The Contractor may provide Members with similar information, in the same manner as that information is provided to private or commercial enrollees, but shall also provide Members with additional information as appropriate to promote compliance with this Contract.

14.1.3.13. The Contractor shall provide periodic updates to the Member handbook when needed to explain changes to the above policies. The Contractor shall submit the updates to the Department for review and approval.

14.1.3.13.1. The Member handbook shall be approved or disapproved by the Department in writing within forty-five (45) calendar days of receipt by Department. If the Member handbook is disapproved by the Department, the Department shall specify the reason(s) for disapproval in the written notice to Contractor.

14.1.3.13.2. The Contractor shall provide a copy of the policies on Members' rights and responsibilities to all Participating Providers and ensure that Participating Providers are aware of information being provided to Members.

14.1.3.13.3. The Contractor and its representatives shall not knowingly provide untrue or misleading information, as defined at §10-16-413 (1)(a)-(c), C.R.S., regarding the Contractor's Plan or Medical Assistance eligibility, to Clients or Members.

14.1.3.14. Notices of Changes, Information and Actions

14.1.3.14.1. The Contractor shall notify all Members of their right to request and obtain the information listed in Section 14.1.3.1. at least once per year.

14.1.3.14.2. If the Contractor chooses to provide required information electronically, it must observe the following requirements:

14.1.3.14.2.1. It must be in a format that is readily accessible.

14.1.3.14.2.2. The information shall be placed in a location on the Contractor's website that is prominent and readily accessible.

14.1.3.14.2.3. The information shall be provided in an electronic form which can be electronically retained and printed.

14.1.3.14.2.4. The information is consistent with content and language requirements.

14.1.3.14.2.5. The Contractor shall notify the enrollee that the information is available in paper form without charge upon request

14.1.3.14.2.6. The Contractor shall provide, upon request, information in paper form within five (5) business days.

14.1.3.14.3. The Contractor shall also notify Members of any significant changes in the following information at least thirty (30) calendar days prior to the effective date of the change. Significant changes include, but are not limited to:

14.1.3.14.3.1. The amount, duration and scope of Covered Services available in sufficient detail to ensure that Members understand the benefits to which they are entitled.

14.1.3.14.3.2. Procedures for obtaining Covered Services, including authorization requirements.

14.1.3.14.3.3. The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers.

14.1.3.14.3.4. The extent to which, and how, after-hours and Emergency Services are provided including:

14.1.3.14.3.4.1. What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services.

14.1.3.14.3.4.2. The fact that prior authorization is not required for Emergency Services.

14.1.3.14.3.4.3. The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local equivalent.

14.1.3.14.3.4.4. The locations of any emergency settings and other locations at which Providers and Hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the contract.

14.1.3.14.3.4.5. The fact that, subject to the provisions of this section, the Member has the right to use any Hospital or other setting for Emergency Services.

14.1.3.14.3.5. Policy on Referrals for specialty care and for other benefits not furnished by the Member's Primary Care Physician.

14.1.3.14.3.6. Any changes of cost sharing or co-payments that the Member is responsible for in relation to the receipt of a Covered service.

14.1.3.14.3.6.1. 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.

14.1.3.14.3.6.2. The Contractor shall not charge a deductible, cost sharing or copayment charge upon the following categorically or medically needy individuals:

14.1.3.14.3.6.2.1. Pregnant women

14.1.3.14.3.6.2.2. American Indians

14.1.3.14.3.6.2.3. Native Alaskans

14.1.3.14.3.7. 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.

14.1.3.15. Notice of Adverse Benefit Determination

14.1.3.15.1. If the Contractor denies coverage of or payment for a Covered Service to a Member, the Contractor shall send the Member a notice of adverse benefit determination approved by the Department that meets the following requirements:

14.1.3.15.1.1. Is in writing.

14.1.3.15.1.2. Is available in the state-established prevalent non-English languages in its region.

14.1.3.15.1.3. Is available in alternative formats for persons with special needs.

14.1.3.15.1.4. Is in an easily understood language and format.

14.1.3.15.1.5. Explains the adverse benefit determination the Contractor or its subcontractor has taken or intends to take.

14.1.3.15.1.6. Explains the reasons for the adverse benefit determination, including the right of the Member to be provided with reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination upon request and free of charge.

14.1.3.15.1.7. 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.

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

14.1.3.15.1.9. Describes the procedures for the Member to exercise their Appeal or Grievance rights.

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

14.1.3.15.1.11. Explains the Member's right to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of continued services.

14.1.3.15.1.12. A member's right to the appeals process available under the Child Mental Health Treatment Act (CMHTA), when applicable.

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

14.1.3.15.2.1. 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.

14.1.3.15.2.2. As few as five (5) days prior to the date of adverse benefit determination if the Contractor has verified information indicating probable beneficiary fraud.

14.1.3.15.2.3. By the date of adverse benefit determination when any of the following occur:

14.1.3.15.2.3.1. The recipient has died.

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

14.1.3.15.2.3.3. 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.

14.1.3.15.2.3.4. The Member has been admitted to an institution in which the Member is ineligible for Medical Assistance services.

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

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

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

14.1.3.15.2.3.8. The notice involves an adverse determination with regard to preadmission screening requirements.

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

14.1.3.15.2.4. On the date of adverse benefit determination when the adverse benefit determination is a denial of payment.

14.1.3.15.2.5. As expeditiously as the Member's health condition requires, within ten (10) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

14.1.3.15.2.5.1. 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.

14.1.3.15.2.5.2. 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 he/she disagrees with the decision.

14.1.3.15.2.6. 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.

14.1.3.15.2.7. 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 Member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

14.1.3.15.2.7.1. The Contractor may extend the seventy-two (72) hour 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.

14.1.3.15.2.8. If the Contractor does not notify a Member of a service authorization decision within the timeframes in this section, the Contractor shall be deemed to have denied the service authorization and that Member shall have any rights relating to the service authorization that the Member would have if the Contractor had denied it.

14.1.4. Appeal Process

14.1.4.1. A Member's request for a review of any adverse benefit determination, taken by the Contractor in relation to that Member, shall be considered an appeal.

14.1.4.1.1. The Contractor shall allow Members, Providers acting on behalf of a member and with the Member's written consent, or a Designated Client Representative, to file an appeal within sixty (60) days from the date of the Contractor's notice of adverse benefit determination.

14.1.4.1.2. A Member or a Provider shall be allowed to file an appeal either orally or in writing. If the Member or Provider files the appeal orally, the Contractor shall ensure that the Member or Provider is aware that they must file a signed, written appeal following the filing of oral appeal, unless an expedited appeal is requested.

14.1.4.1.3. Within two (2) business days of Contractor receipt of the Member's or Provider's request for appeal, the Contractor shall 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 wither in writing or in person to the Contractor.

14.1.4.1.4. The Contractor shall resolve each Appeal and provide notice as expeditiously as the Member's health condition requests, and not to exceed ten (10) working days from the day the Contractor receives the appeal.

14.1.4.1.4.1. 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 that there is a need for additional information and that the delay is in the Member's best interest, upon state request.

14.1.4.1.4.2. The Contractor shall provide the Member with written notice within two (2) calendar days of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member.

14.1.4.1.5. When conducting an appeal, the Contractor shall:

14.1.4.1.5.1. Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the Member or the Provider requests expedited resolution

14.1.4.1.5.2. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.

14.1.4.1.5.3. Allow the Member and the Member's representative opportunity, before and during the appeals process, to examine the Member's case file, including medical records, and any other documents and records.

14.1.4.1.5.4. Consider the Member, the Member's representative or the estate representative of a deceased Member as parties to the appeal.

14.1.4.1.6. The Contractor shall ensure that decision makers on appeals were not involved in previous levels of review or decision-making.

14.1.4.1.6.1. 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:

14.1.4.1.6.1.1. A denial appeal based on lack of medical necessity.

14.1.4.1.6.1.2. Any appeal involving clinical issues.

14.1.4.1.7. The Contractor shall provide written notice of the disposition of the appeal and shall make reasonable efforts to provide the Member oral notice of this disposition. The notice shall include:

14.1.4.1.7.1. The results and date of the Appeal resolution.

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

14.1.4.1.7.2.1. Right to request a State Review,

14.1.4.1.7.2.2. How to request a State Review,

14.1.4.1.7.2.3. The right to continue to receive benefits pending a hearing,

14.1.4.1.7.2.4. How to request the continuation of benefits, and

14.1.4.1.7.2.5. Notice that the Member may be liable for the cost of any continued benefits if the Contractor's adverse benefit determination is upheld in the hearing.

14.1.4.1.8. Expedited Appeals Process

14.1.4.1.8.1. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines - for a request from the Member - or when the 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.

14.1.4.1.8.2. The Contractor shall accept a request for an expedited appeal either orally or in writing. The Member shall not be required to follow up any request for an expedited appeal.

14.1.4.1.8.3. When the Contractor receives a Member's request for an expedited appeal, the Contractor shall notify that Member of the limited time available for the Member to present evidence and allegations of fact or law, in person or in writing.

14.1.4.1.8.4. If an appeal meets the conditions for the expedited appeal process, the Contractor shall inform the Member that the Member is entitled to an expedited State Review, in accordance with C.R.S. 25.5-5-406(1)(b).

14.1.4.1.8.4.1. If the Contractor denies a request for expedited resolution of an appeal, it 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 of receiving the request for expedited resolution.

14.1.4.1.8.4.2. The Contractor shall resolve each expedited Appeal and provide notice as expeditiously as the Member's health condition requires, within seventy-two (72) hours after the Contractor receives the expedited Appeal request.

14.1.4.1.8.4.3. The Contractor may extend 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.

14.1.4.1.8.4.4. The Contractor shall provide the Member with written notice within two (2) calendar days of the reason for any extension to the timeframe for processing an expedited Appeal that is not requested by the Member.

14.1.4.1.8.4.5. The Contractor shall provide written notice, and make reasonable efforts to provide prompt oral notice, of the resolution of an expedited Appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

14.1.4.1.8.5. The Contractor shall not take any punitive action against a Member, or a Provider, or a Provider supporting a Member's request, in response to the Member or Provider requesting an expedited appeal.

14.1.4.1.9. Continuation of Benefits and Services During an Appeal

14.1.4.1.9.1. The Contractor shall continue the Member's benefits while an appeal is in the process if all of the following are met:

14.1.4.1.9.1.1. The Member files the request for an appeal within sixty (60) calendar days following the date on the adverse benefit determination notice.

14.1.4.1.9.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

14.1.4.1.9.1.3. The Member's services were ordered by an authorized Provider;

14.1.4.1.9.1.4. The authorization period has not expired; and

14.1.4.1.9.1.5. The Member requests continuation of benefits:

14.1.4.1.9.1.5.1. Within ten (10) calendar days of the Contractor sending the notice of adverse benefit determination, or

14.1.4.1.9.1.6. On or before the intended effective date of the Contractor's proposed adverse benefit determination.

14.1.4.1.9.2. If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits shall be continued until one of the following occurs:

14.1.4.1.9.2.1. The Member withdraws the request for the appeal or state review.

14.1.4.1.9.2.2. The Member does not request a State Review with continuation of benefits within ten (10) days from the date the Contractor mails an adverse Appeal decision.

14.1.4.1.9.2.3. A State Review decision adverse to the Member is made.

14.1.4.1.9.2.4. The service authorization expires or the authorization limits are met.

14.1.4.1.9.3. The Contractor may recover the cost of the continued services furnished to the Member while the appeal was pending if the final resolution of the appeal upholds the Contractor's adverse benefit determination.

14.1.4.1.9.4. If the Contractor or State Review Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, 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 notice reversing the determination.

14.1.4.1.9.5. If the Contractor or State Review Officer reverses a decision to deny authorization of the services, the Contractor shall pay for disputed services received by the Member while the appeal was pending, unless State policy and regulations provide for the State to cover the cost of such services.

14.1.4.1.9.6. 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.

14.1.4.1.10. State Review

14.1.4.1.10.1. The Contractor shall allow a Member to request a State Review. The Member must exhaust the Contractor Appeal process before requesting a State Review. The Member has one hundred twenty (120) calendar days from the date of a notice of an adverse Appeal resolution to request a State Review. The parties to the State Review include the Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.

14.1.4.1.10.2. 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.

14.1.4.1.10.3. The parties to the State Review include the Contractor as well as the Member and his or her representative or the representative of a deceased Member's estate.

14.1.4.1.10.4. The State's standard timeframe for reaching its decision on a state review request is within ninety (90) days of the date the Member filed the appeal with the Contractor if the Member filed initially 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.

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

14.1.4.1.11. Expedited State Review

14.1.4.1.11.1. When the appeal was heard first through the Contractor's appeal process, the Office of Appeals shall issue a Final Agency Decision for an expedited State Review decisions as expeditiously as the Member's health condition requires, but no later than three (3) calendar days from the Department's receipt of a hearing request for a denial of service that:

14.1.4.1.11.1.1. Meets the criteria for an expedited appeal process but was not resolved with the Contractor's expedited appeal timeframes; or

14.1.4.1.11.1.2. Was resolved wholly or partially adversely to the enrollee using the Contractor's expedited appeal timeframes.

14.1.4.1.12. Recordkeeping Process for Grievances and Appeals

14.1.4.1.12.1. 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.

14.1.4.1.12.2. The record of each grievance or appeal must contain, at a minimum, all of the following information:

14.1.4.1.12.2.1. A general description of the reason for the appeal or grievance.

14.1.4.1.12.2.2. The date received.

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

14.1.4.1.12.2.4. Resolution at each level of the appeal or grievance, if applicable.

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

14.1.4.1.12.2.6. Name of covered person for whom the appeal or grievance was filed.

14.1.4.1.12.3. The Contractor must accurately maintain the record in a manner accessible to the Department and available upon request to CMS.

14.1.5. Grievance Process

14.1.5.1. The Contractor shall establish and maintain a grievance process through which Members, or a Provider acting on behalf of a Member, may file a complaint they have that is not the result of an Adverse Benefit Determination subject to an appeal.

14.1.5.2. The Contractor shall ensure that information about the grievance process, including how to file a grievance, is available to all Members

14.1.5.3. 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.

14.1.5.4. In accordance with 42 C.F.R. §438.402(b)(2) and 10 C.C.R. 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.

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

14.1.5.6. The Contractor shall accept grievances orally or in writing.

14.1.5.7. The Contractor shall make a decision regarding the grievance and provide notice to the Member of this decision within fifteen (15) business days of when the Member files the grievance.

14.1.5.8. The Contractor shall ensure that individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the Member's condition or disease if deciding a grievance that involves clinical issues.

14.1.5.9. This notice shall be made in a form and format approved by the Department.

14.1.5.10. The Contractor may extend timeframes for the disposition of Grievance by up to fourteen (14) calendar days if:

14.1.5.10.1. The Member requests the extension; or

14.1.5.10.2. The Contractor shows that there is a need for additional information and that the delay is in the Member's best interest. The Contractor shall give the Member prior written notice of the reason for the delay if the timeframe is extended.

14.1.5.11. The Contractor shall notify the Member in writing of the disposition of a Grievance.

14.1.5.11.1. The notice shall include the results of the disposition / resolution process and the date it was completed.

14.1.6. Patient Confidentiality

14.1.6.1. Contractor shall protect the confidentiality of all Member records and other materials, in any form, including electronic, that are maintained in accordance with this Contract.

14.1.6.2. Except for purposes directly connected with the administration of the CHP+ Program, no information about or obtained from any Member in possession of Contractor shall be disclosed in a form identifiable with the Member without the prior written consent of the Member or the parent or guardian of the Member if the Member is a minor, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals.

14.1.6.3. Contractor shall have written policies governing access to, duplication and dissemination of, all such information.

14.1.6.4. Contractor shall advise its employees, agents, Participating Providers and Subcontractors, if any, that they are subject to these confidentiality requirements.

14.1.6.5. Contractor shall provide its employees, agents, Participating Providers and Subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

14.1.6.6. The Contractor shall maintain or make provisions for the maintenance of a Medical Record for each Member according to state and federal laws and regulations.

14.1.6.6.1. The Medical Record shall accurately represent the full extent of care provided to the Member.

14.1.6.6.2. The record shall include, at a minimum, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed under this Contract.

14.1.6.6.3. It may be reflected and noted in the record that an Advance Directive has been discussed with the Member, if one has been executed.

14.1.6.6.4. Each Member's record must be legible and maintained in detail consistent with good medical and professional practices that facilitate effective internal and external peer review, medical audit and adequate follow-up treatment.

14.1.6.7. The Contractor shall conform to the requirements of 45 C.F.R §205.50, as amended, C.R.S. §10-16-423, as amended, 45 C.F.R. §§160 and 164, as amended, and 42 C.F.R 431.304 - 431.307, as amended, regarding confidentiality of health information about any Member for Covered Services hereunder.

14.1.6.8. The Contractor shall comply with 3 C.C.R. 702-4-2-35, as amended, and shall take reasonable steps to ensure that the protected health information (PHI) of any adult child or adult dependent who is covered under the policy is protected.

14.1.6.8.1. This protection includes ensuring that any communications between the carrier and covered adult child remain confidential and private, as required under the Health Insurance Portability and Accountability Act (HIPAA).

14.1.6.8.2. This protection of health information would include, but is not limited to developing a means of communicating exclusively with the covered adult child or adult dependent such that PHI would not be sent to the policyholder without prior consent of the covered adult child or dependent.

14.1.6.8.3. The Contractor shall abide by 42 C.F.R. §431.301, as amended, and C.R.S. §25.5-1-116, as amended, regarding the confidentiality of information concerning Applicants, Clients, and Members of medical assistance.

14.1.7. Marketing

14.1.7.1. The Contractor shall not distribute any Marketing Materials without the Department's approval.

14.1.7.2. The Contractor agrees to supply the Department with information and materials sufficient to communicate benefits and services available through the Contractor's Plan upon request from the Department.

14.1.7.3. The Contractor agrees that its Marketing Materials will use culturally and gender sensitive language and images, and be available in English and Spanish.

14.1.7.4. In accordance with 42 C.F.R. §438.10 Contractor's materials provided to Members shall be written, in a manner and format that may be easily understood, unless otherwise directed by the Department.

14.1.7.5. Marketing Materials shall be translated into other non-English languages prevalent in the Service Area, and provided in alternative formats as required in this Contract.

14.1.7.6. The Contractor shall inform Members that oral interpretation services are available free of charge to the Member or Potential Member for any language, that written information is available in prevalent languages and how the Member may access interpretation services.

14.1.7.7. The Contractor shall submit all materials relating to Marketing Activities to the Department's designee, and allow the Department to review any materials the Contractor proposes to use in relation to its Marketing Activities before distributing any such materials.

14.1.7.7.1. Based on this review, the Department may require changes to any materials before the Contractor may distribute those materials, or may disallow the use of any specific materials in its sole discretion.

14.1.7.8. The Contractor shall specify methods of assuring the Department that Marketing, including plans and materials, are accurate and do not mislead, confuse, defraud, misrepresent the Department, Members or the Program.

14.1.7.9. The Contractor shall distribute all materials to the entire Service Area.

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

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

14.1.7.12. Marketing Materials shall not 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.

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

14.1.7.14. Marketing Materials shall 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.

14.1.7.15. The Contractor shall not make any statements, claims, or promises, whether written or expressed orally, that conflict with, materially alter, or erroneously expand upon the information contained in the Contractor's Marketing Materials.

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

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

14.1.8. Member notification of Provider Termination

14.1.8.1. Upon termination of a Provider's agreement or participation with the Contractor, for any reason, the Contractor shall notify any Member who has selected that Provider to be their PCP, of that Provider's termination, as required in 42 C.F.R. §438.10(f)(5).

14.1.8.2. The Contractor shall provide the Department with a copy of the notification that is provided to the Members.

14.1.8.2.1. DELIVERABLE: Notice to Members of Provider Termination

14.1.8.2.2. DUE: Fifteen (15) Business Days from the notice of termination

14.1.9. Advance Directives

14.1.9.1. Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all Members, as provided in 42 C.F.R. §422.128. The Contractor shall provide all of the following information to those Members:

14.1.9.1.1. The Member's rights under the law of the State.

14.1.9.1.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

14.1.9.2. Contractor shall inform individuals that Grievances concerning noncompliance with the Advance Directive requirements may be filed with the Colorado Department of Public Health and Environment.

14.1.10. Incentives to Members

14.1.10.1. The Contractor shall not provide material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider.

14.1.10.2. The Contractor shall also ensure that any agreements it has with its Participating Providers prohibit those Providers from providing material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider.

14.2. Provider issues

14.2.1. Licensure and Credentialing

14.2.1.1. The Contractor shall have written policies and procedures for the selection and retention of Providers.

14.2.1.1.1. 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.

14.2.1.1.1.1.1. The Contractor may use mechanisms such as telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds.

14.2.1.1.2. The Contractor shall document and post on its public website policies and procedures for the selection and retention of Providers.

14.2.1.1.2.1. 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.

14.2.1.1.2.2. 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.

14.2.1.1.2.3. The Contractor shall comply with any additional provider selection requirements established by the Department.

14.2.1.1.2.4. If the Contractor declines to include individual or groups of Providers in its provider network, the Contractor shall give the affected Providers written notice of the reason for its decision in accordance with 42 C.F.R. § 438.12.

14.2.1.1.3. 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.

14.2.1.1.3.1. 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.

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

14.2.1.1.5. The Contractor shall not be required to contract with more provider than necessary to meet the needs of its Members.

14.2.1.2. The Contractor shall verify that all Participating Providers meet licensing and certification requirements.

14.2.1.3. The Contractor's credentialing program shall comply with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of Participating Providers. The Contractor may use information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to assist in meeting NCQA credentialing standards.

14.2.1.4. The Contractor's credentialing program shall include policies and procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.

14.2.1.5. The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. Those laboratories with Certificates of Waiver will provide only the nine (9) types of tests permitted under the terms of the Waiver. Laboratories with Certificates of Registration may perform a full range of laboratory tests.

14.2.1.6. Section moved.

14.2.1.7. The Contractor shall not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

14.2.1.8. The Contractor shall comply with any additional requirements established by the State.

14.2.2. Provider Insurance

14.2.2.1. The Contractor shall ensure that Participating 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:

14.2.2.2. Physicians participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000) per incident and one million five-hundred thousand dollars ($1,500,000) in aggregate per year.

14.2.2.3. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000) per incident and three million dollars ($3,000,000) in aggregate per year.

14.2.2.4. Sections 14.2.3.2 and 14.2.3.3 shall not apply to Physicians and facilities in the Contractor's Plan which meet any of the following requirements:

14.2.2.4.1. The Physician or facility is a public entity or employee pursuant to C.R.S. §24-10-103, of the Colorado Governmental Immunity Act, as amended.

14.2.2.4.2. 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 C.R.S. §13-64-301, as amended.

14.2.2.5. 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.

14.2.3. Provider Quality of Care Issues

14.2.3.1. For alleged quality of care concerns involving Physician Providers, the Contractor may use the process of its professional review committee, as set forth in C.R.S. §§ 12-36.5-104 and 12-36.5-104.4, when a quality of care concern is brought to its attention. This provision shall not be construed to require the Contractor to disclose any information that is confidential by law.

14.2.4. Program Integrity

14.2.4.1. The Contractor shall report all adverse licensure or professional review actions it has taken against any Participating 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 and to the Department.

14.2.4.2. The Contractor shall establish and maintain a compliance program designed to prevent, detect investigate and report fraud, waste and abuse.

14.2.4.3. The Contractor shall create a Compliance Program Plan documenting Contractor's written policies and procedures, standards and documentation of practices. The Compliance Program Plan shall be approved by Contractor's Chief Executive Officer and Compliance Officer.

14.2.4.4. The Compliance Program Plan shall contain, at a minimum:

14.2.4.4.1. Provisions for internal monitoring and auditing.

14.2.4.4.2. Provisions for prompt response to detected offenses and for development of corrective action initiatives.

14.2.4.4.3. Provisions for monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care, or card-sharing.

14.2.4.4.4. Effective processes to screen all Provider claims, collectively and individually, for potential fraud, waste or abuse.

14.2.4.4.5. Effective mechanisms to identify and report suspected instances of CHP+ fraud, waste and abuse.

14.2.4.4.6. Effective methods to verify whether reimbursed services were actually furnished to Members.

14.2.4.4.7. Identification of the kinds of misdemeanor and felony convictions that will disqualify an individual or entity from becoming a Participating Provider, or which will result in terminating an existing Participating Provider.

14.2.4.4.8. Effective mechanisms to identify and report suspected instances of up-coding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided.

14.2.4.4.9. The Contractor shall establish and maintain a Regulatory Compliance Committee on the Board of Directors and at the senior accountable to the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this contract.

14.2.4.5. The Contractor shall deliver the Compliance Program Plan to the Department for review and approval.

14.2.4.5.1. DELIVERABLE: Compliance Program Plan

14.2.4.5.2. DUE: July 30, 2017

14.2.4.6. The Contractor shall review at least annually, and update as necessary the Compliance Program Plan.

14.2.4.7. Upon completion of its review, the Contractor shall notify the Department and deliver the updated plan to the Department for review and approval.

14.2.4.8. Upon approval by the Department, The Contractor shall execute and implement the approved Compliance Program Plan.

14.2.4.8.1. DELIVERABLE: Review and submit current Compliance Program Plan.

14.2.4.8.2. DUE: Annually, no later than July 30th.

14.2.5. Suspension of Payments

14.2.5.1. At the Department's request, the contractor shall suspend payments to any Participating Provider against whom there is a credible allegation of fraud.

14.2.5.2. The Contractor may, on its own initiative, suspend payment to any Participating Provider against whom there is a credible allegation of fraud, but only after consultation with the Department and the Medicaid Fraud Control Unit. 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.

14.2.5.3. The Contractor shall suspend payments to any Participating Provider that is actively under investigation for a credible allegation of fraud.

14.2.5.4. If, after notification, the Contractor has not suspended payments in accordance with 14.2.5.3., the Department may suspend managed care Capitation Payments, depending on the allegations at issue.

14.2.5.5. The Department may suspend managed care capitation payments to Contractor, in whole or in part, when the Contractor and/or any party with an ownership or control interest in the Contractor is under investigation for a credible allegation of fraud. Suspension of capitation payments to the Contractor may be initiated by the Department when the Contractor appears complicit in the alleged fraud, or should have, by reasonable standards, been aware of and/or reported it to the Department.

14.2.5.6. The Department may suspend Capitation Payments to the Contractor should the Contractor be actively under investigation for a credible allegation of fraud. If the Department fails to suspend payments to such an entity for which there is a pending investigation of a credible allegation of fraud, without good cause, Federal Financial Participation (FFP) may be disallowed with regard to such payments to the Contractor.

14.2.5.7. The Department will not pay for any services rendered by Providers that are excluded by Medicare, Medicaid or SCHIP unless such services are emergency services provided pursuant to 42 C.F.R. 431.55(h) and 42 C.F.R. 438.808.

14.2.6. Compliance Requirements

14.2.6.1. The Contractor shall establish written policies for employees requiring all employees to be informed of and detailing compliance with all of the following laws, rules and regulations:

14.2.6.1.1. The False Claims Act, 31 U.S.C. §§ 3729, et seq.

14.2.6.1.2. Administrative remedies for false claims and statements.

14.2.6.1.3. State laws relating to civil or criminal penalties for false claims and statements, if any.

14.2.6.1.4. Whistleblower protections under such laws.

14.2.6.2. The Contractor shall create and maintain a training program for new and existing employees on the compliance program described in the Compliance Program Plan and the policies regarding false claims described in section 14.2.6.1. This training shall be conducted in a manner that allows the Department to verify that the training has occurred.

14.2.6.3. Contractor shall designate a compliance officer and compliance committee that is accountable to the Contractor's senior management.

14.2.6.4. Contractor shall have effective lines of communication between the compliance officer and the Contractor's employees for reporting violations.

14.2.6.5. Contractor shall enforce its compliance program through well-publicized disciplinary guidelines.

14.2.6.6. Contractor shall immediately report known confirmed intentional incidents of fraud and abuse to the Department and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU).

14.2.6.7. The Contractor shall cooperate fully with the Colorado Medicaid Fraud Control Unit and the Attorney General on cases of suspected Provider fraud, and False Claims actions.

14.2.6.8. Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department.

14.2.6.8.1. Contractor shall investigate its suspicions and shall submit its preliminary fraud report containing its findings and concerns to the Department.

14.2.6.8.1.1. DELIVERABLE: Preliminary Fraud Report

14.2.6.8.1.2. DUE: Within three (3) Business Days of the initial verbal fraud report

14.2.6.8.2. The Contractor shall continue its investigation and shall provide a final fraud report to the Department detailing the results of the investigation.

14.2.6.8.3. The Department may approve an extension of time in which to complete the final fraud report upon a showing of good cause.

14.2.6.9. Contractor must report the following to the Department for each case that warrant investigation

14.2.6.9.1. Member/Provider name and Identification number.

14.2.6.9.2. Source of the Case.

14.2.6.9.3. Nature of the Case.

14.2.6.9.4. Approximate dollars involved.

14.2.6.9.5. Legal and administrative disposition of the case.

14.2.6.9.6. Type of Provider (if applicable).

14.2.6.10. The Contractor shall deliver the Final Fraud Report to the Department for review and approval.

14.2.6.10.1. DELIVERABLES: Final Fraud Report.

14.2.6.10.2. DUE: Within fifteen (15) Business Days of the initial verbal fraud report.

14.2.6.11. The Contractor shall have a way to verify the services actually provided.

14.2.6.12. The Contractor shall require Provider attestations on claims forms, check endorsements, or both, as specified in 42 C.F.R. §§455.18 and 455.19.

14.2.7. Pharmacy Providers

14.2.7.1. The Contractor shall provide or enter into subcontracts with qualified pharmacy Providers for the provision of Covered Drugs as required, and in the manner specified, by Department regulations at 10 C.C.R. 2505-10, §8.205.8 and 42 C.F.R §483.60. All subcontracts with pharmacy Providers shall be subject to all standards set forth in this Contract 10 C.C.R. 2505-10, §8.205.8 and 42 C.F.R. §483.60.

14.2.8. Prompt Payment of Claims

14.2.8.1. 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.

14.2.8.2. Payments to FQHCs

14.2.8.2.1. Each FQHC has an encounter rate calculated in accordance with 10 C.C.R. 2505-10 8.700.6C

14.2.8.2.2. The Department will notify the Contractor of the FQHC rates.

14.2.8.2.3. The FQHC rate changes are effective 120 days after the end of the FQHC's fiscal year, retroactive back to the beginning of the fiscal year.

14.2.8.2.4. This 120 day timeframe may cause the Contractor to make retro payments or retro take backs to the FQHC.

14.2.8.2.5. Should implementation of new rates be delayed for any reason, the Department will notify Contractor as soon as possible of the delay, and provide an estimated date for implementation of the new rate.

14.2.8.2.6. If rate implementation is delayed, Contractor will continue to make payment at the current rate, until the new rate is implemented.

14.2.8.2.7. The Contractor shall reimburse the FQHC the encounter rate in accordance with 10 C.C.R. 2505-10 8.700.6 for each FQHC visit, for services identified in 10 C.C.R. 2505-10 8.700.3 for allowable cost identified in 10 C.C.R. 2505-10 8.700.5.

14.2.8.3. In addition to those services listed in 10 C.C.R. 2505-10 8.700.5B, immunization costs will be an unallowable cost.

14.2.8.4. 10 C.C.R. 2505-10 8.700.6.B.2. will not apply to CHP+ members.

14.2.8.5. FQHC visit shall be as defined in 10 C.C.R. 2505-10 8.700.1.

14.2.8.6. If multiple services are provided by an FQHC within one visit, the Contractor shall require a claims submission from the FQHC with multiple lines of service and the same claim number.

14.2.8.7. The Contractor shall pay the FQHC at least the encounter rate for each visit minus any third party payments, including Member co-payments as identified in the Covered Services Exhibit of this Contract regardless of whether or not the Contractor imposes or collects the co-payments on Members for each visit.

14.2.8.8. The Contractor shall offer contracts to all FQHCs located in the Contract Service Area. The Contractor is not required to contract with every FQHC that provide health services in its geographic area.

14.2.8.9. The Department will conduct quarterly accuracy audits, as detailed in 14.2.10. with FQHCs and should the Department recognize any discrepancy in FQHC payments (less than the full encounter rate), then the Contractor shall be responsible for reimbursing the FQHC the difference of the encounter payment and the initial reimbursement amount.

14.2.8.10. The Contractor shall submit the encounter data for FQHC visits to the Department.

14.2.9. Payments to RHCs

14.2.9.1. Each RHC has an encounter rate calculated in accordance with 10 C.C.R. 2505-10 8.740.7.B.

14.2.9.2. The Department will notify the Contractor of the RHC rates.

14.2.9.3. The Contractor shall reimburse the RHC the encounter rate in accordance with 10 C.C.R. 2505-10 8.740.7 for each visit, for services identified in 10 C.C.R. 2505-10 8.740.4 for allowable cost identified in 8.740.6.

14.2.9.4. RHC visit shall be as defined in 10 C.C.R. 2505-10 8.740.

14.2.9.5. If multiple services are provided by an RHC within one visit, the Contractor will require a claims submission from the RHC with multiple lines of service and the same claim number.

14.2.9.6. The Contractor shall pay the RHC at least the encounter rate for each visit minus any third party payments, including Member co-payments as identified in the Covered Services Exhibit of this Contract, regardless of whether or not the Contractor imposes or collects the co-payments on Members for each visit.

14.2.10. FQHC Accuracy Audit

14.2.10.1. The Contractor shall review and comply with the MCAAR MCE Instructions found at Colorado.gov/hcpf > For our Providers > Provider Services > Forms > Federally Qualified Health Center Forms.

14.2.10.2. The Contractor shall complete and submit the MCAAR MCE Data Section as specified in the MCAAR MCE Instructions found at Colorado.gov/hcpf > For our Providers > Provider Services > Forms > Federally Qualified Health Center Forms.

14.2.10.3. The Contractor shall review, complete, comply and return the MCAAR MCE Attestation Statement found at Colorado.gov/hcpf > For our Providers > Provider Services > Forms > Federally Qualified Health Center Forms.

14.2.11. The Department is implementing an outpatient prospective payment system (OPPS) to reimburse for Medicaid and CHP+ hospital services in CY 2017. The Department's goals with this change include:

14.2.11.1. More accurately classify the full range of outpatient service episodes.

14.2.11.2. More accurately account for the intensity of services provided.

14.2.11.3. Motivate outpatient service providers to increase efficiency and effectiveness.

14.2.12. The Department believes that the implementation of the Enhanced Ambulatory Patient Grouping (EAPG) System is the best option for the Department, Contractor, Colorado hospitals, and Colorado Medical Assistance beneficiaries. The Department supports the Contractor if the Contractor decides to implement the EAPG methodology.

14.3. Termination of Provider Agreements

14.3.1. The Contractor shall notify the Department, in writing, of its decision to terminate any existing Participating Provider agreement where such termination will cause the delivery of Covered Services to be inadequate in a given area. The notice to the Department shall include a description of how the Contractor will replace the provision of Covered Services at issue. In the event that the Contractor is unable to adequately replace the affected services to the extent that accessibility will be inadequate in a given area, the Department may impose limitations on Enrollment in the area or eliminate the area from the Contractor's Service Area.

14.3.1.1. DELIVERABLE: Notification of Provider agreement termination.

14.3.1.2. DUE: at least sixty (60) calendar days prior to the effective date of the termination unless the termination is based upon quality or performance issues.

14.4. Provider Applications

14.4.1. The Contractor shall not discriminate with regards to the participation, reimbursement or Indemnification of any Provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification. 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 no event shall this provision be construed to:

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

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

14.4.1.3. 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.

14.5. The Contractor shall monitor Covered Services rendered by Participating Providers for quality, appropriateness and patient outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting, and other applicable provisions of this Contract.

15. REPORTING

15.1. General Reporting Requirements

15.1.1. For all reports described in this Contract, the Contractor shall meet the following requirements:

15.1.1.1. Unless otherwise stated, the deadline for all quarterly reports will be according to the following schedule:

Quarter	Months being reported	Due
Q1	July, August, September	December 31st
Q2	October, November, December	March 31th
Q3	January, February, March	June 30th
Q4	April, May, June	September 30st

15.1.1.2. The Contractor shall meet all deliverables in this contract and deliver all reports to the Department and ensure that those reports are delivered in a timely manner.

15.1.1.3. The Contractor shall ensure that all reports are complete, contain all required elements and are presented in a Department-approved format.

15.1.1.4. The reports shall not contain any inaccuracies or present insufficient data.

15.1.2. Any report that does not meet the requirements of this section shall be considered improperly submitted.

15.1.3. For any improperly submitted report, the Contractor shall provide a corrective action plan to remedy any identified deficiencies in a report, as directed by the Department, within five (5) Business Days of notification by the Department of the improper submission of that report.

15.1.3.1. The Contractor shall remedy all identified deficiencies within five (5) Business Days of its submission of it corrective action plan to the Department unless the Department agrees to a longer period in writing.

15.2. Disenrollment Reporting

15.2.1. The Contractor shall submit a quarterly Disenrollment report to the Department. The report shall provide, at a minimum, all of the following:

15.2.1.1. Overall trends relating to Disenrollment and specific reasons for Disenrollment including, but not limited to:

15.2.1.1.1. Referrals to the Contractor's Grievance/Appeals process regarding requests for Disenrollment.

15.2.1.1.2. Involuntary Disenrollment information and trends.

15.2.1.2. The Disenrollment Report shall be submitted in a format approved by the Department for review and approval.

15.2.1.2.1. DELIVERABLE: Disenrollment Report.

15.2.1.2.2. DUE: Quarterly, according to the schedule in 15.1.1.1.

15.3. Provider Network Reporting

15.3.1. The Contractor shall provide an annual Provider Network Strategic Plan to the Department. This Provider Network Strategic Plan shall contain, at a minimum, all of the following:

15.3.1.1. The Contractor's current and future strategic planning relating to its Provider Network.

15.3.1.1.1. The Contractor must demonstrate how they meet the Safe Harbor Standards.

15.3.1.2. The Contractor's approach to meeting all access standards described in section 10.1.

15.3.1.3. All applicable metrics relating to the Provider Network including, but not limited to:

15.3.1.3.1. PCP to Member Ratio.

15.3.1.3.2. Physician Specialist to Member Ratio.

15.3.1.3.3. ECP to Member Ratio.

15.3.1.3.4. Number of Members who are more than thirty (30) miles or thirty (30) minutes travel time, whichever area is larger, from a Provider in the Contractor's Plan.

15.3.1.3.5. Number of Urban County, Suburban County, and Rural County Members who have a travel time of more than thirty (30) miles or thirty (30) minutes, forty five (45) miles or forty five (45) minutes, ninety (90) miles or ninety (90) minutes respectively from an Essential Community Provider in the Contractor's Plan.

15.3.1.3.6. Population demographics, as determined by the Department, of the Contractor's Providers and Members.

15.3.1.3.7. The organizational process that was created as identified in 10.2.1.22 and 10.2.1.23 of this SOW, for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and taking appropriate corrective action.

15.3.1.4. The Provider Network Strategic Plan shall be submitted in a format approved by the Department for review and approval.

15.3.1.4.1. DELIVERABLE: Provider Network Strategic Plan.

15.3.1.4.2. DUE: Annually, no later than September 30th of each year.

15.3.2. The Contractor shall provide a quarterly Provider Network Capacity and Services Report to the Department regarding the Contractor's capacity and services. This Provider Network Capacity and Services report shall contain support showing that the Contractor meets, at a minimum, all of the following requirements:

15.3.2.1. The Contractor provides an appropriate range of preventive care, Primary Care and specialty services that is adequate for the anticipated number of Members.

15.3.2.2. The Contractor maintains a network of Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the Service Area.

15.3.2.3. The Contractor shall, submit to the Department, a detailed written report regarding the Contractor's capacity and services as required by 42 C.F.R. Section 438.207(c). The report shall be in the format specified by the Department and shall demonstrate that the Contractor meets the following:

15.3.2.3.1. Provides an appropriate range of preventive care, primary care and specialty services that is adequate for the anticipated number of Members.

15.3.2.3.2. Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the Service Area.

15.3.3. The Contractor shall submit the Provider Network Capacity and Services Report to the Department for review and approval

15.3.3.1. DELIVERABLE: Network Capacity and Services Report.

15.3.3.2. DUE: Quarterly, according to the schedule in 15.1.1.1

15.4. Appeal Reporting

15.4.1. The Contractor shall provide a quarterly Appeal Report to the Department. This report shall meet the following requirements:

15.4.1.1. The Appeal Report shall follow the format approved by the Department and contain any Appeal information requested by the Department.

15.4.1.2. The report shall document Member's Appeals and show how those Appeals were tracked, resolved and assessed.

15.4.1.3. The report shall contain a written summary analysis and a categorical analysis of the Appeal data documented in the report. Based on this report, the Department may request a detailed report on any or all of the Appeals shown on that report.

15.4.2. The Appeal Report shall be delivered to the Department for review and approval.

15.4.2.1. DELIVERABLE: Appeal Report.

15.4.2.2. DUE: Quarterly, according to the schedule in 15.1.1.1.

15.5. Grievance Reporting

15.5.1. The Contractor shall provide a quarterly Grievance Report to the Department. This report shall meet the following requirements:

15.5.1.1. The Grievance Report shall follow the format approved by the Department and contain any Grievance information requested by the Department.

15.5.1.2. The report shall document Member's Grievances and show how those Grievances were tracked, resolved and assessed.

15.5.1.3. The report shall contain a written summary analysis and a categorical analysis of the Grievance data documented in the report. Based on this report, the Department may request a detailed report on any or all of the Grievances shown on that report.

15.5.2. The Grievance Report shall be delivered to the Department for review and approval.

15.5.2.1. DELIVERABLE: Grievance Report.

15.5.2.2. DUE: Quarterly, according to the schedule in 15.1.1.1.

15.6. Customer Service reporting

15.6.1. Eighty percent (80%) of CHP+ Calls answered within 30 seconds or less.

15.6.2. Reporting Requirements - The following measures must be reported electronically to the Department on a quarterly basis.

15.6.2.1.1. The percentage of CHP+ calls answered within 30 seconds or less.

15.6.2.1.2. If 15.6.1 is not met, Contractor will submit a work plan detailing steps taken to improve the percentage.

15.6.3. The Customer Service Report shall be delivered to the

15.6.3.1. DELIVERABLE: Customer Service Report.

15.6.3.2. DUE: Quarterly, according to the table in 15.1.1.1.

15.7. Clinical Reporting

15.7.1. HEDIS Report

15.7.1.1. The Contractor shall provide an annual HEDIS Report to the Department. This report shall meet the following requirements:

15.7.1.1.1. The HEDIS Report shall contain all HEDIS measures determined by the Department under section 12.4.1. for that year.

15.7.1.1.2. The HEDIS Report shall follow the format approved by the Department and be delivered for review and approval

15.7.1.1.2.1. DELIVERABLE: HEDIS Report.

15.7.1.1.2.2. DUE: Annually, by June 30th for the report covering the state fiscal year that ends on that day.

15.7.2. Quality Assessment and Performance Improvement Project Reporting

15.7.2.1. The Contractor shall provide an annual Quality Assessment and Performance Improvement Project Report to the Department. This report shall contain, at a minimum, all of the following:

15.7.2.1.1. A description of the Contractor's quality assurance program that describes the specific preventative care priorities, services covered in and goals of the program over the prior twelve (12) month period.

15.7.2.1.2. The status and results of each PIP started, continuing or completed during the prior twelve (12) month period. The results shall be described in sufficient detail to allow the Department to validate those results for each project.

15.7.2.1.3. The results of any Member satisfaction surveys completed during the prior twelve (12) month period.

15.7.2.1.4. A detailed description of the findings of the program impact analysis that includes the techniques used by the Contractor to improve performance and the overall impact and effectiveness of the quality assessment and improvement program during the prior twelve (12) month period.

15.7.2.2. The Quality Assessment and PIP Report shall provide sufficient detail for Department to validate the Contractor's PIPs according to 42 C.F.R. §§433 and 438, External Quality Review of Medicaid Managed Care Organizations.

15.7.2.3. The Contractor shall deliver The Quality Assessment and Performance Improvement Project Report to the Department for review and approval.

15.7.2.3.1. DELIVERABLE: Quality Assessment and Performance Improvement Project Report.

15.7.2.3.2. DUE: Annually by September 30

15.7.3. Serious Reportable and Never Events Reporting

15.7.3.1. The Contractor shall provide a quarterly Serious Reportable and Never Events Report in a format approved by the Department. This report shall contain all events described in Exhibit H, Serious Reportable Events or Never Events, attached and incorporated herein by reference for the Contractor and all Subcontracted facilities that provide inpatient services to Members. The report shall also contain any service with the Present on Admission (POA) indicator at the time of a Hospital admission.

15.7.3.2. Members may not be billed for the balance of claims for the portion denied by CHP+.

15.7.3.3. The Contractor shall deliver the Serious Reportable and Never Events Report to the Department for review and approval.

15.7.3.3.1. DELIVERABLE: Serious Reportable and Never Events Report.

15.7.3.3.2. DUE: Quarterly, according to the schedule in 15.1.1.1.

15.7.4. Department Focused Goals Reporting

15.7.4.1. The Department will provide dental utilization results by plan using data submitted to the Department or its designee by the Contractor.

15.7.4.2. Contractor shall create an Oral Health Improvement Plan. Contractor may use the data described in 15.7.4.1.. for the Oral Health Improvement Plan, or Contractor may choose to provide the Department with baseline data for the chosen Oral Health Improvement.

15.7.4.3. The Contractor shall deliver the Oral Health Improvement Plan to the Department for review and approval.

15.7.4.3.1. DELVERABLE: Oral Health Improvement Plan.

15.7.4.3.2. DUE: Annually, in the Quality Assessment and Performance Improvement Project Report.

15.7.4.4. The Contractor shall also provide a quarterly report identifying the following:

15.7.4.4.1. The number of quality of care issues for CHP+ Members for each month in any given quarter.

15.7.4.4.2. The Quarterly Quality of Care Report shall be delivered to the Department for review and approval.

15.7.4.4.3. DELIVERABLE: Quarterly Quality of Care Report

15.7.4.4.4. DUE: Quarterly, according to the schedule in 15.1.1.1.

15.7.4.5. The Contractor shall report Usual Source of Care for each month. Usual Source of Care is one well care or two sick care visits with one practice in the preceding 12 months. If the Contractor is part of an open network, this means that their contracted physicians see patients from more than one (1) MCO.

15.7.4.5.1. The Contractor shall deliver the Usual Source of Care Report to the Department for review and approval.

15.7.4.5.1.1. DELIVERABLE: Usual Source of Care Reporting.

15.7.4.5.1.2. DUE: Annually by the last Business Day in September.

15.7.4.6. Other Health Reporting

15.7.4.6.1. Reporting Requirements- The following measures must be reported electronically to the Department on a quarterly basis, broken down monthly and as otherwise indicated.

15.7.4.6.1.1. The number of Emergency Room visits, and the number of Emergency Room visits per thousand members per year (on a rolling 12-month basis).

15.7.4.6.1.2. The number and percent of members who had at least one well child visit (on a rolling 12-month basis).

15.7.4.6.1.3. The total cost of care per member (on a rolling 12-month basis).

15.7.4.6.1.3.1. DELIVERABLE: Other Health Report.

15.7.4.6.1.3.2. DUE: Quarterly, according to the schedule in 15.1.1.1.

15.7.4.7. Behavioral Health and SUD Reporting

15.7.4.7.1. Reporting Requirements - The following measures must be reported electronically to the Department on a quarterly basis.

15.7.4.7.2. Total unique CHP+ members that had a medical mental health visit

15.7.4.7.3. Total unique CHP+ members that had a facility mental health visit

15.7.4.7.4. Total CHP+ members that had medical and facility mental health visits

15.7.4.7.5. Total number of CHP+ visits related to substance use

15.7.4.7.6. Total unique CHP+ members who had an inpatient hospital visit for a primary mental health diagnosis.

15.7.4.7.7. Total unique CHP+ members who had a visit for a primary mental health diagnosis.

15.7.4.7.8. Total unique CHP+ members who had an outpatient or community-based visit for a primary substance use disorder diagnosis.

15.7.4.7.9. Total unique CHP+ members who had an inpatient hospital visit for a primary substance use disorder diagnosis.

15.7.4.7.10. Total unique CHP+ members who had visits for a primary substance use disorder diagnosis.

15.7.4.8. DELIVERABLE: Behavioral Health and SUD Report

15.7.4.9. DUE: Quarterly, according to the table in 15.1.1.1.

16. REIMBURSEMENT

16.1. Inspection and auditing of financial records

16.1.1. The Contractor shall allow the Department to inspect and audit the financial records of the Contractor and its Subcontractors related to this Contract in accordance with 42 C.F.R.§§438.3(h) and 438.3(m).

16.2. Payment Terms

16.2.1. Payments provided for under this Contract will 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 C.F.R. §438.730.

16.2.2. Monthly Payment Cycle: The Department shall, in accordance with the Monthly Premium Payment rate schedule established in Exhibit C, issue concurrent payment to the Contractor for every Member identified on the electronic Enrollment reports specified in Section 6.5 on the Friday after the second Saturday of the month for which coverage under the Contractor's Plan shall be effective.

16.2.3. Monthly Reconciliation Cycle: The Department shall, in accordance with the Monthly Premium Payment rate schedule established in Exhibit C, issue retrospective payment to the Contractor for every Member that was identified on the electronic Enrollment reports and received coverage under the Contractor's Plan in the previous month, but for whom Monthly Premium Payment was not made by the Department.

16.2.3.1. In the event that there are fewer Members identified for coverage on the monthly electronic Enrollment reports than for the previous month, or if there is a different age and income mix of Members on the electronic Enrollment reports that results in a lower net amount of Monthly Premium Payment owed to the Contractor than originally calculated pursuant to the electronic Enrollment reports for the previous month, the Department shall, in accordance with the Monthly Premium Payment rate schedule established in Exhibit C, reduce the amount of payment made to the Contractor to reflect the difference in Membership and recover the overpayment.

16.2.4. Payment Summary Statement: All monthly payments and payment adjustments made by the Department to reflect differences between the electronic Enrollment reports and any other adjustments made hereunder (e.g., for recovery of overpayments or to reflect late or retroactive Disenrollments) shall be separately recorded on a monthly Payment Summary Statement that shall accompany payment to the Contractor. The monthly Payment Summary Statement shall contain, at a minimum, the following elements:

16.2.4.1. The amount of payment made or adjusted on behalf of all Members or Disenrollees.

16.2.4.2. The month or months for which payment is made or adjusted.

16.2.5. In the event the Contract is terminated for any reason, any payments advanced to the Contractor for Covered Services to Members for periods after the date of termination shall be returned to the Department within thirty (30) calendar days of notification by the Department of such incorrect payment, unless otherwise authorized by the Department in writing.

16.2.6. The Contractor agrees that reimbursement received for a Member shall be adjusted for a change in age category on the first day of the month following the month in which the Member's birthday occurred, when applicable.

16.2.7. If the Contractor receives payment in excess of that which is authorized hereunder, whether as a result of the Department's error, the Contractor's error, or otherwise, the Department shall recover such overpayment by making appropriate reductions from subsequent Monthly Premium Payments to the Contractor in compliance with section 7 (b) (v) of the Contract. In the event that excess payment cannot be recovered by adjustment to subsequent Monthly Premium Payments, The Contractor shall promptly repay, in full, any overpayment directly to the Department within thirty (30) calendar days after notification by the Department in writing, unless otherwise authorized by the Department in writing.

16.2.8. The Contractor agrees that the Monthly Premium Payment rate schedule established in Exhibit C is for the Contract Year listed on the Exhibit. The Department will evaluate the Monthly Premium Payment rate schedule each fiscal year. Financial obligations of the State of Colorado payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.

16.2.8.1. The Department retains the discretion to select a payment rate within the actuarially sound rate range based on performance and timeliness of deliverables in this Contract.

16.2.9. The Contractor shall utilize best efforts to implement the Colorado Medical Home Standards set forth in Exhibit G, Children's Basic Health Plan Medical Home Standards. The Contractor shall ensure that all children in the Contractor's plan have access to a Medical Home.

16.2.10. The Contractor shall reimburse an additional $21.00 incentive for the provision of the Covered Services identified in Exhibit I, including the applicable occurrence and age limits. Monthly capitation rates include an increase to provide the funding for Medical Home incentives, unless otherwise approved by the Department. The Contractor is not required to provide incentive amounts in excess of those received in the monthly capitation.

16.2.11. The Contractor shall submit to the Department a quarterly report as specified in Exhibit G, detailing what has been paid in incentives for the CPT codes.

16.3. Financial Reconciliations

16.3.1. The Department will perform a financial reconciliation, at the Department's discretion or at the direction of CMS. The Department may perform this reconciliation for any year in which the Contractor has provided services under this Contract or in a prior contract for the provision substantially similar services.

16.3.2. The Contractor shall provide all necessary information and take all necessary steps to ensure that no act or omission of the Contractor delays any reconciliation or otherwise results in the reconciliation being incomplete by any deadline imposed by the Department or CMS.

16.3.3. Certification of data - When State payments to the Contractor are based on data submitted by the Contractor, the State must require certification of the data as provided in 42 C.F.R. §438.606 and 42 C.F.R §457.950.

16.3.3.1. The Contractor shall ensure that either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer shall certify the submission of the following data, documentation or information:

16.3.3.1.1. Encounter data submission, as described in Section 18.2. of this Agreement.

16.3.3.1.2. Data on which the Department certifies the actuarial soundness of the capitation rates.

16.3.3.1.3. Data on which the Department determines the Contractor's compliance with the medical loss ratio requirement described in 42 C.F.R. §438.8.

16.3.3.1.4. Data on which the Department determines that the Contractor has made adequate provision against the risk of insolvency.

16.3.3.1.5. Data on which the Department bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network.

16.3.3.1.6. The annual report of overpayment recoveries in 42 C.F.R. §438.608(d)(3).

16.3.3.1.7. Information on ownership and control, as described in Section 19.4. of this Agreement.

16.3.3.2. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.

16.3.3.3. The Contractor must submit the certification concurrently with the certified data and documents.

16.3.3.4. The Contractor shall provide access for the State, CMS, and the HHS Office of the Inspector General to Member health claims data and payment data, in conformance with the appropriate privacy protections in the State.

16.3.3.5. The Contractor shall provide a guarantee that the Contractor will not avoid costs for services covered in this Contract by referring Members to publicly support health care resources.

16.4. Liability for Payment

16.4.1. The Contractor agrees that:

16.4.1.1. Members are not held liable for the MCO's debts, in the event the MCO becomes insolvent.

16.4.1.2. Members are not held liable for covered services provided to the enrollee, for which the state does not pay the MCO, or for which the state or MCO does not pay the provider that furnished the service under a contractual, referral, or other arrangement.

16.4.1.3. Members are not held liable for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the enrollee would owe if the MCO covered the services directly.

16.4.2. The Contractor shall provide assurances satisfactory to the state that its provision against the risk of insolvency is adequate to ensure that Medical Assistance enrollees will not be liable for the MCO's debt if the MCO becomes insolvent.

16.4.3. Item deleted.

16.4.4. Excess payments - Each Contractor must provide that Members are not held liable for payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.

16.4.5. Timely Filing - 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 must file all claims for reimbursement of payments to the Contractor with CMS within 2 years after the calendar quarter in which the Department made the expenditure. Therefore, if the Department is unable to file the Contractor's claims or capitation payments within 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.

16.4.6. The Monthly Payment Rate may be adjusted during the performance period of this contract pursuant to an executed amendment, upon approval of the State Controller or his/her designee.

16.4.6.1. The Department retains the discretion to select a payment rate within the actuarially sound rate range based on performance and timeliness of deliverables in this Contract.

16.5. Medical Loss Ratio (MLR)

16.5.1. MLR Calculation

16.5.1.1. The MLR will be calculated according to the instructions provided on the MLR template and the guidance provided in 42 C.F.R. §438.8(a).

16.5.1.2. All data provided by the Contractor for the purposes of MLR calculation shall use actual costs.

16.5.1.2.1. The first annual measurement period began upon execution of the FY 16-17 Contract and ended on June 30, 2017.

16.5.1.2.2. Subsequent annual measurement periods will align with the state fiscal year; beginning on July 1, and ending on June 30 of the subsequent calendar year.

16.5.1.2.3. The Contractor will 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.

16.5.1.2.4. The Contractor must submit the calculated internally certified MLR template along with supporting data and documentation, including, but not limited to, all encounters, financial information and reporting, and flat files for the measurement period, before the Department can validate the submitted MLR for the Contractor. The submission date is annually on March 1. See Encounter Claims Data Provisions and the Medical Loss Ratio (MLR) Calculation Template, as provided by the Department.

16.5.1.2.4.1. The Contractor must submit the externally certified financial template to the Department annually by May 1, based on the requirements provided by the Department.

16.5.1.2.4.2. The MLR reporting process shall comply with the CMS' two-year timely filing requirement in 45 C.F.R. 95.7. If the Department does not receive the above listed deliverables in Section 16.5.1.1.2.4within one and a half years after the calendar quarter in which the underlying claims for the deliverables were incurred, the Department shall thereafter process the reporting on a quarterly basis.

16.5.1.2.5. The Contractor's Medical Spend and audited supplemental data provided in the Contractor's annual financial reporting will be verified using encounter data submitted through flat file submissions on a secure server, until such time that the Department deems it appropriate for such encounter data submissions to be sent through the State's Colorado interChange.

16.5.1.2.6. MLR Target: The Contractor shall have a Medical Loss Ratio (MLR) of eighty-five percent (85%). The Contractor will calculate a cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department.

16.5.1.2.7. The MLR is rounded 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%.

16.5.1.2.8. If the Contractor's MLR does not meet or exceed the Adjusted MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:

16.5.1.2.8.1. Reimbursement amount shall equal the total amount of capitations payments received by the Contractor multiplied by the difference between the Contractor's MLR and the Adjusted MLR Target.

16.5.1.2.8.2. The Contractor shall reimburse the Department within thirty (30) days of the Department finalizing the MLR validation. The Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to the Contractor of the amount due, pursuant to 10 C.C.R. 2505-10, Section 8.050.3 A-C Provider Appeals, as well as Section 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

16.5.1.3. The MLR will be calculated as the ratio of the numerator (as defined below) to the denominator (as defined below).

16.5.1.3.1. 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 prevention activities.

16.5.1.3.1.1. Incurred claims must include the following:

16.5.1.3.1.1.1. Direct claims that Contractor paid to external providers and the cost of internal staff for services or supplies covered under the contract and services meeting the requirements of 42 C.F.R. 438.3(e) provided to enrollees.

16.5.1.3.1.1.2. Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

16.5.1.3.1.1.3. Withholds from payments made to network providers.

16.5.1.3.1.1.4. Claims that are recoverable for anticipated coordination of benefits.

16.5.1.3.1.1.5. Claims payments recoveries received as a result of subrogation.

16.5.1.3.1.1.6. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

16.5.1.3.1.1.7. Changes in other claims-related reserves.

16.5.1.3.1.1.8. Reserves for contingent benefits and the medical claims portion of lawsuits.

16.5.1.3.1.2. Amounts that must be deducted from incurred claims include the following:

16.5.1.3.1.2.1. Overpayment recoveries received from network providers.

16.5.1.3.1.2.2. Prescription drug rebates received and accrued.

16.5.1.3.1.3. Expenditures that must be included in incurred claims include the following:

16.5.1.3.1.3.1. The amount of incentive and bonus payments made, or expected to be made, to network providers.

16.5.1.3.1.3.2. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses.

16.5.1.3.1.4. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

16.5.1.3.1.5. Amounts that must be excluded from incurred claims:

16.5.1.3.1.5.1. Non-claims costs. Those expenses for administrative services that are not: Incurred claims as defined in section 16.5.1.3.1.1, expenditures on activities that improve health care quality, as defined in section 16.5.1.3.1.5.6, or licensing and regulatory fees, or Federal and State taxes, as defined in section 16.5.1.4.3.

16.5.1.3.1.5.2. Non-claims costs include the following:

16.5.1.3.1.5.2.1. Amounts paid to third party vendors for secondary network savings.

16.5.1.3.1.5.2.2. Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

16.5.1.3.1.5.2.3. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 C.F.R. 438.3(e) and provided to an enrollee.

16.5.1.3.1.5.2.4. Fines and penalties assessed by regulatory authorities.

16.5.1.3.1.5.3. Amounts paid to the Department as remittance under section 42 C.F.R. 438.8(j).

16.5.1.3.1.5.4. Amounts paid to network providers under 42 C.F.R. 438.6(d).

16.5.1.3.1.5.5. Incurred claims paid by the Contractor that are later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the Contractor.

16.5.1.3.1.5.6. Activities that improves health care quality must be in one of the following categories:

16.5.1.3.1.5.6.1. Activities that meet the requirements of 45 C.F.R. 158.150(b), and are not excluded under 45 C.F.R. 158.150(c)

16.5.1.3.1.5.6.2. Activities related to any EQR-related activity as described in C.F.R. 438.358(b) and (c).

16.5.1.3.1.5.6.3. Any expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. 158.151, and is not considered incurred claims, as defined in section 12.4.10.

16.5.1.3.1.5.7. Expenditures on activities related to fraud prevention as adopted for the private market at 45 C.F.R. part 158. Expenditures under this paragraph must not include expenses for fraud prevention efforts in section 16.5.1.1.3.1.

16.5.1.4. Denominator

16.5.1.4.1. The denominator of the Contractor's MLR for an MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the Contractor's premium revenue (as defined below) minus the Contractor's Federal, State, and local taxes and licensing and regulatory fees (as defined below) and is aggregated in accordance with 42 C.F.R. 438.8(i).

16.5.1.4.2. Premium revenue includes the following for the MLR reporting year:

16.5.1.4.2.1. State capitation payments, developed in accordance with 42 C.F.R. 438.4, to the Contractor for all enrollees under a risk contract approved under 42 C.F.R. 438.3(a), excluding payments made under to 42 C.F.R. 428.6(d).

16.5.1.4.2.2. State-developed one time payments, for specific life events of enrollees.

16.5.1.4.2.3. Other payments to the Contractor approved under 42 C.F.R. 438.6(b)(3).

16.5.1.4.2.4. Unpaid cost-sharing amounts that the Contractor could have collected from enrollees under the contract, except those amounts the Contractor can show it made a reasonable, but unsuccessful, effort to collect.

16.5.1.4.2.5. All Changes to unearned premium reserves.

16.5.1.4.2.6. Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 C.F.R. 438.5 or 438.6

16.5.1.4.3. Federal, State, and local taxes and licensing and regulatory fees for the MLR reporting year include:

16.5.1.4.3.1. Statutory assessments to defray the operating expenses of any State or Federal department.

16.5.1.4.3.2. Examination fees in lieu of premium taxes as specified by State law.

16.5.1.4.3.3. Federal taxes and assessments allocated to the Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

16.5.1.4.4. State and local taxes and assessments including:

16.5.1.4.4.1. Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

16.5.1.4.4.2. Guaranty fund assessments.

16.5.1.4.4.3. Assessments of State or locality industrial boards or other boards for operating expense or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

16.5.1.4.4.4. State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

16.5.1.4.4.5. State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

16.5.1.4.5. Payment made by the Contractor that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 C.F.R. 158.162(c), limited to the highest of either:

16.5.1.4.5.1. Three percent of earned premium; or

16.5.1.4.5.2. The highest premium tax rate in the State for which the report is being submitted, multiplied by the Contractor's earned premium in the State

16.5.1.5. The total amount of the denominator for the Contractor, which is later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year and no amount under this section for that year may be reported by the ceding entity.

16.5.1.6. The Department will recoup payment from the Contractor for missing the MLR target using the MLR calculation methodology as expressed above.

16.5.1.7. Allocation of Expense

16.5.1.7.1. General

16.5.1.7.1.1. The Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition or, 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.

16.5.1.7.1.2. The Contractor shall report expenditures that benefit multiple contracts or populations, or contracts other than those being reported, on a pro rata basis.

16.5.1.7.2. Expenditures

16.5.1.7.2.1. The Contractor shall ensure that expense allocations are based on a generally accepted accounting method that is expected to yield the most accurate results.

16.5.1.7.2.2. 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.

16.5.1.7.2.3. 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.

16.5.1.7.3. Credibility Adjustment

16.5.1.7.3.1. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances.

16.5.1.7.3.2. The Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

16.5.1.7.3.3. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

16.5.1.7.4. Aggregation of Data

16.5.1.7.4.1. The Contractor will aggregate data for all Medical Assistance eligibility groups covered under this Contract.

16.5.1.7.5. Reporting Requirements

16.5.1.7.5.1. The Contractor shall submit an MLR report to for each MLR reporting year, that includes:

16.5.1.7.5.1.1. Total incurred claims.

16.5.1.7.5.1.2. Expenditures on quality improving activities.

16.5.1.7.5.1.3. Expenditures related to activities compliant with program integrity requirements.

16.5.1.7.5.1.4. Non-claims costs.

16.5.1.7.5.1.5. Premium revenue.

16.5.1.7.5.1.6. Taxes.

16.5.1.7.5.1.7. Licensing fees.

16.5.1.7.5.1.8. Regulatory fees.

16.5.1.7.5.1.9. Methodology(ies) for allocation of expenditures.

16.5.1.7.5.1.10. Any credibility adjustment applied.

16.5.1.7.5.1.11. The calculated MLR.

16.5.1.7.5.1.12. Any remittance owed to the Department, if applicable.

16.5.1.7.5.1.13. A comparison of the information reported with the audited financial report.

16.5.1.7.5.1.14. A description of the aggregation method used to calculate total incurred claims.

16.5.1.7.5.1.15. The number of member months.

16.5.1.7.5.2. The Contractor shall require any subcontractors providing claims 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.

16.5.1.7.6. Recalculation of MLR

16.5.1.7.6.1. In any instance where the Department makes a retroactive change to the capitation payments for an MLR reporting year where the report has already been submitted to the Department, the Contractor shall:

16.5.1.7.6.1.1. Re-calculate the MLR for all MLR reporting years affected by the change.

16.5.1.7.6.1.2. Submit a new MLR report meeting the requirements in 42 C.F.R. 438.8(k).

17. TERMINATION

17.1. Termination for Convenience

17.1.1. Convenience

17.1.1.1. The Contractor may, when the interests of the Contractor so require, terminate this Contract for the convenience of the Contractor. The Contractor shall give written notice to the Department of termination for convenience at least ninety (90) calendar days before termination. Termination shall become effective on the first day of the month following the expiration of the ninety (90) calendar day notice period.

17.1.1.2. The Department may, when the interests of the Department so require, terminate this Contract for the convenience of the Department. The Department shall give written notice to the Contractor of termination for convenience at least ninety (90) calendar days before termination. Termination shall become effective on the first day of the month following the expiration of the ninety (90) calendar day notice period.

17.1.1.3. In the event of fraud, CHP+ program abuse, or jeopardy to the health and safety of any Member, the Department may terminate this Contract immediately.

17.1.2. Contractor's Obligations

17.1.2.1. The Contractor shall incur no further obligations after the effective date of termination of this Contract. The Department may direct the Contractor to assign the Contractor's right, title and interest under terminated orders or subcontracts to the Department, to the extent permitted under the Contractor's Provider agreements.

17.1.2.2. The Contractor must still complete and deliver to the Department the work not terminated by the effective date of termination and may incur obligations as are necessary to do so.

17.1.3. Compensation

17.1.3.1. In the event that the Contract is terminated for convenience:

17.1.3.1.1. The Department shall be responsible for notifying all Members of the date of termination and process by which the Members will continue to receive Covered Services;

17.1.3.1.2. The terminating party shall be responsible for all expenses relating to said notification; and;

17.1.3.1.3. The Department's obligation to pay the Contractor shall end on the first day of the month following the expiration of the ninety (90) calendar day notice period, except if the Contractor receives payment in an amount in excess or less than authorized by this Contract, whether as a result of the Contractor's error or the Department's error, or otherwise, the Department shall adjust payments as specified elsewhere in this Contract within ninety (90) calendar days of termination.

17.2. Termination for Default

17.2.1. Default

17.2.1.1. If the Contractor refuses or fails to timely perform any of the provisions of this Contract, with such diligence as will ensure its completion within the time specified in this Contract, the Department shall notify the Contractor in writing of the non-performance, and if not promptly corrected within thirty (30) calendar days from the date of notification, the Department may terminate the Contractor's right to proceed with the Contract. Termination shall become effective on the first day of the month following the date in which the Department gives notice to the Contractor that the Department shall terminate the Contract for default.

17.2.1.2. The Contractor shall not be in default by reason of any failure in performance of this Contract in accordance with its terms if such failure arises out of acts of God, acts of the public enemy, acts of the Department or any governmental entity in its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, explosions, strikes or other labor disputes, freight embargoes, interruption of transportation, rationing, court action, illegality, unusually severe weather, or any other cause beyond the control of the party affected and which, by the exercise of reasonable diligence, could not have been prevented by the party affected. Upon request of the Contractor, the Department shall ascertain the facts and extent of such failure, and, if the department determines that any failure to perform was occasioned by anyone or more of the excusable causes, and that, but for the excusable cause, the Contractor's progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the Department.

17.2.1.3. If, after notice of termination of the Contractor's right to proceed under the provisions of this clause, it is determined for any reason that the Contractor was not in default under the provisions of this clause, or that the delay was excusable, the rights and obligations of the parties shall be the same as if the notice of termination had not been issued.

17.2.2. Contractor's Obligations

17.2.2.1. The Contractor shall incur no further obligations on or after the effective date of termination. The Department may direct the Contractor to assign the Contractor's right, title and interest under terminated orders or subcontracts to the Department, to the extent permitted under Provider agreements.

17.2.2.2. The Contractor must still complete and deliver to the Department the work not terminated by the effective date of termination and may incur obligations as are necessary to do so.

17.2.3. Compensation

17.2.4. In the event that the Contract is terminated for default:

17.2.4.1. The Department shall be responsible for notifying all Members of the date of termination and process by which the Members will continue to receive Covered Services.

17.2.4.2. The Contractor shall be responsible for all expenses related to said notification.

17.2.4.3. The Department's obligation to pay the Contractor shall end on the first day of the month following the expiration of the thirty (30) calendar day notice period, except if the Contractor receives payment in an amount in excess or less than authorized by this Contract, whether as a result of the Contractor's error or the Department's error, or otherwise, the Department shall adjust payments as specified elsewhere in this Contract within ninety (90) calendar days of termination.

17.2.4.4. In addition to any other remedies set forth in this Contract, the Department may use any other remedy allowed by law.

18. DATA ELEMENTS AND DEPARTMENT REQUESTS FOR INFORMATION

18.1. Claims Data

18.1.1. The Contractor agrees to produce claims data for Members in the format specified in Exhibit F, at the times, and for the periods, requested by the Department. All such requests shall be made at least sixty (60) calendar days in advance. The Department will use the claims data reported by the Contractor for rate development analyses, quality improvement activities and/or other purposes noted in writing at the time the data are requested. The Contractor shall provide reasonable assistance to the Department, and/or its designees, when validation of the accuracy and integrity of reported claims data is necessary for the purposes described above. Upon request, the Department shall provide the Contractor with a written description of any procedures conducted by the Department or its designee(s) to validate the accuracy of reported claims data, or make necessary adjustments to ensure that the data are useful for the purposes noted in writing at the time the data were requested.

18.1.2. Contractor Review of Study or Audit Results - The Department shall submit to the Contractor, for a ten (10) business day review and comment period, any studies or audits prior to the release to the public.

18.1.3. The Department will not require the Contractor to submit any reports or information that may be obtained from another State or Federal agency, provided such information is sufficient to meet stated program and/or operational objectives, and may be obtained in a timely manner.

18.1.4. The Department, in consultation with the Contractor, may modify, eliminate, or add to specific data and reporting requirements specified in this Contract.

18.2. Claims Data Submission

18.2.1. Upon interChange implementation, the Contractor shall submit all Encounter Claims Data electronically, 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 C.C.R. 2505-10). Contractor shall submit Encounter Claims Data in the

interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837 format encounter claims, reflecting paid, adjusted and/or denied by the Contractor shall be submitted via a regular batch process. Contractor shall submit all encounter claims in accordance with the following:

18.2.1.1. Applicable HIPAA transaction guides posted available at: colorado.gov/hcpf

18.2.1.2. Provider Billing Manual Guidelines available at: colorado.gov/hcpf.

18.2.1.3. 837 X12N Companion Guide Specifications available at: colorado.gov/hcpf.

18.2.2. The Contractor shall either have or acquire knowledge and experience with the interChange X12N 837 formatted encounter data for these submittals. Data submission shall comply with the federal confidentiality requirements of 42 C.F.R. Part 2, and may require the development of a Qualified Service Organization (QSO) Agreement.

18.2.3. The Department reserves the right to change format requirements at any time, following consultation with the Contractor and retains the right to make the final decision regarding format submission requirements.

18.2.4. Encounter Claims Data Provisions. The Contractor shall submit all Encounter Claims Data electronically, 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 C.C.R. 2505-10).

18.2.5. The Contractor shall certify all Encounter Claims 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.

18.2.6. Contractor shall submit Encounter Claims Data in the current ANSI ASC X12N 837 version directly to the Department's fiscal agent using the Department's data transfer protocol.

18.2.7. Contractor shall follow the guidelines for data submission set forth in the Companion Guides provided by the Department available at: colorado.gov/hcpf/

18.2.8. 837-format encounter claims, reflecting all medical, facility and supplier claims paid, adjusted or denied by the Contractor, shall be submitted via a regular weekly or monthly batch process to the MMIS as follows:

18.2.8.1. All encounter claims shall be submitted in accordance with applicable HIPAA transaction guides posted at Colorado.gov/hcpf.

18.2.8.2. For Hospital, Ambulatory Surgery Center and Home Health Encounter Claims:

18.2.8.3. Both Inpatient and outpatient Hospital and home health encounter claims include paid and denied services provided by a Hospital, ambulatory surgery center or home health agency.

18.2.8.3.1. These encounter claims shall contain revenue and procedure codes, as appropriate.

18.2.8.3.1.1. One encounter claim must be submitted for each hospitalization, outpatient visit or outpatient surgery.

18.2.8.3.1.2. Multiple home health visits may be on one home health encounter claim.

18.2.8.3.1.3. The encounter claim must represent all services delivered to the Member during the billing episode billed.

18.2.8.4. Hospital, ambulatory surgery center and home health encounter claims shall be submitted using the ANSI 837I, Health Care Claim Institutional format.

18.2.8.5. Certain services, such as an infusion during home health, may be billed on an ANSI 837P, Health Care Claim Professional format rather than an ANSI 837I, Health Care Claim Institutional format. Such services may be submitted in the format received by the Contractor from the Provider.

18.2.8.6. For Pharmacy Encounter Claims:

18.2.8.6.1. Pharmacy encounter claims refer to all paid and denied pharmaceuticals prescriptions.

18.2.8.6.2. A pharmacy encounter Claim is a single prescription. If a single Member has multiple prescriptions filled from a single Provider there would still be a Pharmacy Encounter Claim for each prescription.

18.2.8.6.3. All pharmacy encounters claims shall be submitted using the HIPAA compliant format approved by National Council for Prescription Drug Program (NCPDP) version 5.1 format.

18.2.8.7. For Medical Encounter Claims:

18.2.8.7.1. Medical encounter claims include paid and denied services delivered by any Provider. These claims may include, but are not limited to services delivered by medical groups, practices, clinics, Physicians, mid-level practitioners, medical equipment suppliers, family planning clinics, independent laboratories, optometrists, podiatrists, FQHCs, freestanding rehabilitation centers, or any other Providers.

18.2.8.7.2. When a Member receives services from multiple Providers in the same day, Contractor shall submit separate encounter claims for each visit for each Provider.

18.2.8.7.3. Medical encounters shall be submitted using the ANSI 837P, Health Care Claim professional format.

18.2.8.8. For 837-format submissions, Contractor shall submit actual claim paid amounts.

18.2.8.9. A description of Encounter Claims data edits and types can be found at colorado.gov/hcpf/.

18.2.9. Payment methodology for services, supplies, equipment and drugs

18.2.9.1. Automated Encounter Claims Payment Process

18.2.9.1.1. For all pharmacy encounters, the Contractor shall submit the encounters to Magellan Rx electronically. The Contractor shall only submit the following type of electronic transactions for any encounter:

18.2.10. National Council for Prescription Drug Programs (NCPDP) (pharmacy claim)

18.2.10.1. For all other encounters, the Contractor shall submit the encounters to the MMIS electronically, following the Department's standard fee-for-service claims transaction process. The Contractor shall only submit one of the following types of electronic transactions for any encounter:

18.2.11. X12N 837 Professional (practitioner claim)

18.2.12. X12N 837 Institutional (institutional claim)

18.2.13. X12N 837D Dental Services

19. ADDITIONAL FEDERAL REQUIREMENTS

19.1. Federal Debarred Entities

19.1.1. In addition to the Debarment and Suspension provisions in §21(B) of this Contract, the Contractor shall not knowingly have a relationship with any of the following entities:

19.1.1.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.

19.1.1.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in the prior paragraph.

19.1.2. For the purposes of this section, a relationship is described as:

19.1.2.1. A director, officer or partner of the Contractor.

19.1.2.2. A person or entity with more than five percent (5%) beneficial ownership of the Contractor.

19.1.2.3. A Person with an employment, consulting or other arrangement with the Contractor that is responsible for any of the Contractor's obligations under this Contract.

19.2. Federal Intermediate Sanctions

19.2.1. The Department may implement any intermediate sanctions, as described in 42 C.F.R. §438.702, if the Department makes the determination to impose sanctions under 42 C.F.R. §438.700.

19.2.2. Before imposing any intermediate sanctions, the Department shall give the Contractor timely written notice that explains:

19.2.2.1. The basis and nature of the sanction.

19.3. Termination under Federal Regulations

19.3.1. The Department may terminate this Contract for cause and enroll any Member enrolled with the Contractor in other Plan, or provide their CHP+ benefits through other options included in the State plan, if the Department determines that the Contractor has failed to:

19.3.1.1. Carry out the substantive terms of its contracts.

19.3.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

19.3.2. Before terminating the Contractor's Contract as described in this section, the Department shall:

19.3.2.1. Provide the Contractor a cure notice that includes, at a minimum, all of the following:

19.3.2.1.1. The Department's intent to terminate.

19.3.2.1.2. The reason for the termination.

19.3.2.1.3. The time and place for the pre-termination hearing

19.3.2.2. Conduct a pre-termination hearing.

19.3.2.3. Give the Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

19.3.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department shall send a written termination notice to the Contractor that contains the effective date of the termination.

19.3.2.4.1. Upon receipt of the termination notice, the Contractor shall give Members enrolled with the Contractor notice of the termination and information, consistent with 42 C.F.R. §438.10, on their options for receiving Medical assistance services following the effective date of termination.

19.3.3. Once the Department has notified the Contractor of its intent to terminate under this section, the Department may:

19.3.3.1. Give the Members enrolled with the Contractor written notice of the Department's intent to terminate the Contract.

19.3.3.2. Allow Members enrolled with the Contractor to disenroll immediately, without cause.

19.4. Federal Disclosures of Information on Ownership and Control

19.4.1. The Contractor shall provide all disclosures required by 42 C.F.R. §455.104, as amended or hereinafter amended, in a form substantially similar to Exhibit L, Contractor Disclosure Template. These disclosures are:

19.4.1.1. The name and address of any person, either an individual or a corporation, with an ownership or control interest in the Contractor. For a corporate entity, the address shall include the primary business address, the address of each business location if there is more than one location and any applicable P.O. Box address.

19.4.1.1.1. The date of birth and social security number for any individual with an ownership or control interest in the Contractor.

19.4.1.1.2. The tax identification number of any corporate entity with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five percent (5%) or greater interest.

19.4.1.2. Whether any person, either an individual or a corporation, with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

19.4.1.3. Whether any person, either an individual or a corporation, with an ownership or control interest in the any subcontractor in which the Contractor has a five percent (5%) or greater interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling.

19.4.1.4. The name of any other entity required to disclose under 42 C.F.R. §455.104 in which any owner of the Contractor has an ownership or control interest.

19.4.1.5. The name, address, date of birth and Social Security Number of any managing employee of the Contractor.

19.4.2. "Ownership interest" and "person with an ownership or control interest" shall have the meaning specified in 42 C.F.R. §455.101, as amended or hereinafter amended. "Subcontractor", for purposes of this subsection regarding Federal Disclosures of Information on Ownership and Control only, shall have the meaning specified in 42 C.F.R. §455.101, as amended or hereinafter amended.

19.4.3. The Contractor shall complete these disclosures upon execution of the contract. The Contractor shall deliver new disclosures to the Department within thirty-five (35) calendar days of the any change in ownership of the Contractor.

19.4.4. The Contractor shall provide written disclosure to the Department within sixty (60) calendar days of identification of any prohibited affiliation ownership or control, or capitation payments or other payments more than amounts specified in the Contract.

20. DATA SHARING

20.1. The purpose of sharing Data under this agreement is to complete the services required by this contract.

20.2. Contractor shall utilize data provided by the Department which is classified as PHI .

20.3. The Contractor shall safeguard all provided State Confidential Information pursuant to this agreement and all applicable privacy laws.

20.4. The Contractor shall not have any ownership rights to the State Confidential Information they may receive from the State, unless specifically granted in this agreement.

20.5. The Contractor shall use the provided State Confidential Information only for the purposes expressly stated in this agreement.

20.6. The Contractor shall minimize the number of individuals who have access to the State Confidential Information.

20.6.1. The Contractor shall only use State Confidential Information if it is critical to the Work, and otherwise shall seek to use non State Confidential Information.

20.6.2. The specific positions and/or persons authorized to view and manipulate the State Confidential Information shall be listed in the Appendix corresponding with the project for which the data is being shared.

20.7. The Contractor shall destroy, or otherwise sequester, all original State Confidential Information when it is no longer necessary to complete the Work, as required by governing rule or statute.

20.7.1. If there is no required date by which the State Confidential Information must be destroyed, then the Contractor shall destroy the State Confidential Information within thirty (30) days after the completion of the Work for which the State Confidential Information is used.

20.8. The Contractor shall revoke permissions for an Authorized User to access the State Confidential Information when the individual is no longer necessary to complete the Work.

20.9. The Contractor shall be responsible for any Incident or breach that occurs after transmission of the Data from the Department and shall work with the Department to limit and remedy any Incident.

20.10. The Contractor shall work with the Department to ensure that the Data is securely transferred.

20.11. Data Governance and Security

20.11.1. The Contractor shall provide the Department with their Data Governance and Security Plan.

20.11.2. The Data Governance and Security Plan shall describe how the Contractor stores, transfers, and keeps all State Confidential Information secure and only accessible by Authorized Users.

20.11.3. The Data Governance and Security Plan shall, at minimum, describe their policies and procedures which control the following:

20.11.3.1. Data Storage

20.11.3.2. Data Retention

20.11.3.3. Data Security

20.11.3.4. Data Transfer

20.11.3.5. Authorization of Authorized Users

20.11.4. The Data Governance and Security Plans shall, at minimum, conform with the terms of this agreement, as well as all applicable state and federal laws, rules, and regulations.

20.11.5. The Data Governance and Security Plan shall be delivered to the State for review and approval.

20.11.5.1. DELIVERABLE: Data Governance and Security Plans

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

20.11.6. Contractor shall ensure that the Data Governance and Security Plan stays up-to-date with current rules, regulations, laws, and best practices.

20.11.7. The Contractor shall create a data governance policy that describes the circumstances when the Contractor will allow other entities, including providers and Community organizations, full access to Member level data, including how behavioral health data will be shared.

20.11.7.1. DELIVERABLE: Updated Data Governance and Security Plan

20.11.7.2. DUE: The Contractor shall update the data governance policy annually by September 30.

20.11.8. If during the State's review of the Data Governance plan a vulnerability is identified, and Contractor is notified and does not correct it, then the State retains the right to withhold data until the vulnerability is corrected as determined by the State.

20.12. Data Reporting

20.12.1. The Contractor shall, upon successful receipt of Data, notify the Department in writing of the receipt of the Data within twenty-four (24) hours of receipt.

20.12.1.1. DELIVERABLE: Data Receipt Notification

20.12.1.2. DUE: Within twenty-four (24) hours of successful data transfer

20.12.2. The Contractor shall notify the Department in writing upon destruction or sequestration of State Confidential Information that Contractor is no longer using.

20.12.3. The Contractor shall ensure that the Notification includes a specific description of the Data that was destroyed or sequestered.

20.12.3.1. DELIVERABLE: Data Destruction Notification

20.12.3.2. DUE: Within twenty-four (24) hours of destruction of State Confidential Information

21. CLOSEOUT PERIOD

21.1. This Contract shall have a Closeout Period.

21.2. Closeout Period

21.2.1. During the Closeout Period, Contractor shall complete all of the following:

21.2.1.1. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by the State, 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.

21.2.1.2. Provide to the State, 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.

21.2.1.3. 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.

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

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

21.2.1.5.1. DELIVERABLE: Provider and Member Notifications

21.2.1.5.2. DUE: 30 days prior to termination of the Contract

21.2.1.6. Continue meeting each requirement of the Contract as described in the Department-approved and updated Closeout Plan, or until the Department determines that 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 Contractor of this determination for that requirement.

21.2.2. The Closeout Period may extend past the termination of the Contract. The Department will perform a closeout review to ensure that Contractor has completed all requirements of the Closeout Period. If 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.

21.3. Closeout Planning

21.3.1. Closeout Plan

21.3.1.1. 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.

21.3.1.1.1. DELIVERABLE: Closeout Plan

21.3.1.1.2. DUE: 30 days following the Effective Date

21.3.1.2. 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.

21.3.1.2.1. DELIVERABLE: Closeout Plan Update

21.3.1.2.2. DUE: Annually, by June 30th of each year

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EXHIBIT C-1, RATES
STATE FISCAL YEAR 2018-19

CAPITATION RATES

State Fiscal Year 2018-19 rates will be effective on the later of the Effective Date or July 1, 2018.

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

Age	Under 101% FPL	101% to 156% FPL	157% to 200% FPL	201% to 260% FPL
Ages less than 2	$253.35	$253.03	$253.14	$254.66
Ages 2 through 5	$137.53	$137.53	$137.55	$137.56
Ages 6 through 18	$162.37	$162.53	$162.46	$162.56

WITHHOLD AMOUNT

The Department shall withhold an amount from the capitation rate payments each month to account for the health insurance provider fee as shown in the following table:

Age	Under 101% FPL	101% to 156% FPL	157% to 200% FPL	201% to 260% FPL
Ages less than 2	$1.27	$1.27	$1.27	$1.28
Ages 2 through 5	$0.69	$0.69	$0.69	$0.69
Ages 6 through 18	$0.82	$0.82	$0.82	$0.82

MONTHLY PAYMENT AMOUNT

Once the Department has withheld the amount listed in the above Withhold Amount table, the Contractor shall receive the amount shown in the following table each month for each client based on age and poverty of that client's family.

Age	Under 101% FPL	101% to 156% FPL	157% to 200% FPL	201% to 260% FPL
Ages less than 2	$252.07	$251.76	$251.87	$253.38
Ages 2 through 5	$136.84	$136.84	$136.85	$136.86
Ages 6 through 18	$161.55	$161.71	$161.64	$161.74

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

Note: For children with family income up to and including 100% of the Federal Poverty Level there is no cost-sharing.

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%- 260% FPL D0, D1, D2
1. ANNUAL DEDUCTIBLE Individual Family	Not applicable.	 None. None.	 None. None.	 None. None.	 None. None.
2. OUT-OF-POCKET LIMIT Individual Family	Maximum amount Member has to pay out of pocket in any one year for covered benefits.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.	5% of annual family income adjusted for family size.
3. EMERGENCY CARE	Covered.	$3	$3	$30	$50
4. URGENT/AFTER HOURS CARE		$1	$1	$20	$30
5. EMERGENCY TRANSPORT/AMBULANCE SERVICES	Covered.	$0	$2	$15	$25
6. HOSPITAL/OTHER FACILITY SERVICES	Covered.				
A. INPATIENT		$0	$2	$20	$50
B. PHYSICIAN		$0	$2	$5	$10
C. OUTPATIENT/ AMBULATORY		$0	$2	$5	$10
7. ROUTINE MEDICAL OFFICE VISIT [1]	Covered.	$0	$2	$5	$10
8. FLUORIDE VARNISH APPLICATION	Covered. As detailed in Exhibit J.	$0	$0	$0	$0
9. LABORATORY AND X-RAY	Covered.	$0	$0	$5	$10
10. PREVENTIVE, ROUTINE, AND FAMILY PLANNING SERVICES	Covered. Same Benefits as mandated under Essential Health Benefits as defined in section 10-16-102(22) C.R.S., and Colorado Division of Insurance Regulation 3 C.C.R.702-4 (4-2-42).	$0	$0	$0	$0

[1] Routine medical office visits include physician, mid-level practitioner and specialist visits, including outpatient mental health visits.

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%- 260% FPL D0, D1, D2
11. MATERNITY CARE Prenatal	Covered.	$0	$0	$0	$0
Delivery & inpatient well baby care[2]	Covered. State law requires infant to be covered for first 31 days.	$0	$0	$0	$0

[2] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening.

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%- 260% FPL D0, D1, D2
12. MENTAL ILLNESS CARE					
A. NEUROBIOLOGICALLY-BASED MENTAL ILLNESSES[3]	Covered.				
B. MENTAL DISORDERS	Effective January 1, 2008 this new category of illness (listed below) is to be treated the same as any other health condition (e.g., there are no limits on the number of hospital days covered).	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10/office visit $50/admission
	Post-traumatic stress disorder, drug and alcohol disorders, Dysthymia, Cyclothymia, social phobia, Agoraphobia with panic disorder, general anxiety, Anorexia Nervosa exclusive of residential treatment, Bulimia exclusive of residential treatment	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10/office visit; $50/admission
C. ALL OTHER[4]	The Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance disorder benefits, within the scope of benefits stipulated in the Contract.				
1. INPATIENT[5]		$0	$2	$20	$50
2. OUTPATIENT		$0	$2	$5	$10
	No limits apply if medically necessary.				
	No limits apply if medically necessary.				

[3] Requires the following to be treated as any other illness or condition: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive compulsive disorder, and panic disorder. Applies to all group health benefit plans.
[4] All other mental health benefits include coverage for all mental health conditions recognized in the DSM-IV manual.
[5] The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%-260% FPL D0, D1, D2
13. ALCOHOL AND SUBSTANCE ABUSE	Covered. Same Benefits as mandated under Essential Health Benefits as defined in section 10-16-102(22) C.R.S., and Colorado Division of Insurance Regulation 3 C.C.R.702-4 (4-2-42).	$0	$2	$5	$10
14. PHYSICAL THERAPY, SPEECH THERAPY, AND OCCUPATIONAL THERAPY	For outpatient physical rehabilitation (physical, occupational, and/or speech therapy) the standard CHP+ coverage is limited to 30 visits per calendar year. For children ages 0-3, the benefit of physical, occupational, and speech therapy is unlimited through Early Intervention Program.	$0	$2	$5	$10
15. DURABLE MEDICAL EQUIPMENT (DME)[6]	Limited coverage. Maximum $2,000/year paid by plan. Coverage for lesser of purchase price or rental price for medically necessary durable medical equipment, including home administered oxygen.	$0	$0	$0	$0

[6] DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devises applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the member is not covered.

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%- 260% FPL D0, D1, D2
16. TRANSPLANTS	Limited coverage. Will include those same transplant benefits as mandated under Essential Health Benefits as defined in section 10-16-102(22) C.R.S., and Colorado Division of Insurance Regulation 3 C.C.R.702-4 (4-2-42), including liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants. Transplants will be covered only if they are Medically Necessary and the facility meets clinical standards for the procedure. Coverage is no less extensive than the coverage for any other physical illness. Coverage for all covered organ transplants and all transplant-related services, including travel, lodging, and donor expenses or organ procurement is limited to a maximum lifetime benefit for major organ transplants of $1,000,000 per member.	$0	$0	$0	$0
17. HOME HEALTH CARE	Covered.	$0	$0	$0	$0
18. HOSPICE CARE[7]	Covered.	$0	$0	$0	$0
19. PRESCRIPTION DRUGS	Covered. (includes expendable medical supplies for the treatment of diabetes)	$0	$1 – generic or brand name	$3 – generic. $10 – brand name[8].	$5-generic $15-brand name

[7] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Division of Insurance Regulation 4-2-8 as amended.

[8] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%- 260% FPL D0, D1, D2
20. KIDNEY DIALYSIS	Covered, only when Member is not eligible for Medicare.	$0	$0	$0	$0
21. SKILLED NURSING FACILITY CARE	Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.	$0	$0	$0	$0
22. VISION SERVICES	Limited coverage. Vision screenings are covered as age appropriate preventive care. $50 annual benefit for eyeglasses.	$0	$2 for referral and refraction benefits only	$5 for referral and refraction benefits only	$10 for referral and refraction benefits only
23. AUDIOLOGY SERVICES	Limited coverage. Hearing screenings are covered as age appropriate preventive care. Hearing aids covered as medically necessary, not subject to DME.	$0	$0	$0	$0
24. INTRACTABLE PAIN	Covered. Included as a benefit with the medical office visit copay.	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10 office visit $50 admission
25. AUTISM COVERAGE	Covered. Included as a benefit with the medical office visit copay.	$0	$2/office visit; $2/admission	$5/office visit; $20/admission	$10 office visit $50 admission
26. CASE MANAGEMENT	Covered, when Medically Necessary.	$0	$0	$0	$0
27. DIETARY COUNSELING /NUTRITIONAL SERVICES	Limited coverage. Formula for metabolic disorders, total parenteral nutrition, enteral and nutrition products, and formulas for gastrostomy tubes are covered for people with documented medical need. Documentation includes prior authorization which lists medical condition including gastrointestinal disorders, malabsorption syndromes or a condition that affects normal growth patterns or the normal absorption of nutrition.	$0	$0	$0	$0
28. LIFETIME MAXIMUM	The CHP+ program does not have a lifetime maximum benefit except for organ transplants.	None.	None.	None.	None.

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%-260% FPL D0, D1, D2
29. DENTAL ANESTHESIA	In accordance with C.R.S. 10-16-104(12) Hospitalization and general anesthesia for dental procedures for dependent children will be covered by the medical MCO. General anesthesia when provided in a hospital, outpatient surgical facility or other facility. The associated hospital or facility charges for dental care. In order for dental anesthesia services to be covered by medical HMO, member must: • have a physical, mental or medically compromising condition; • have dental needs for which local anesthesia is not effective due to acute infection, anatomic variation or allergy; • be considered extremely uncooperative, unmanageable, uncommunicative, or anxious by Member provider and Member dental needs must be deemed sufficiently important that dental care cannot be deferred; or • have sustained extensive orofacial and dental trauma.	$0	$0	$0	$0

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	**101-156% FPL B0, B1, B2, B3, B4**	**157-200% FPL C0, C1, C2, C3**	**201%- 260% FPL D0, D1, D2**
30. DENTAL RELATED	Medical coverage in connection with treatment of the teeth or periodontium is excluded unless such treatment: is performed by a physician or legally licensed dentist, is begun within 72 hours after an accidental injury to sound natural teeth. Also not excluded (state mandate) is orthodontic and prosthodontic treatment for cleft lip or cleft palate for newborns.	None.	None.	None.	None.
31. PRE-EXISTING CONDITION LIMITATIONS	No pre-existing condition limitations.	Not applicable.	Not applicable.	Not applicable.	Not applicable.
32. THERAPIES: CHEMOTHERAPY AND RADIATION	Covered. When received during a covered admission and billed as part of the facility service, therapy charges will be paid in the same manner as room expenses and other ancillary services. This provision shall not be interpreted as an exclusion of Chemotherapy and Radiation therapy when delivered in an outpatient setting.	$0	$0	$0	$0

Exhibit E-1
Children's Basic Health Plan
Covered Services & Copayments

	DESCRIPTION OF BENEFIT	COPAY			
		<101% FPL A0, A1, A2, A3	101-156% FPL B0, B1, B2, B3, B4	157-200% FPL C0, C1, C2, C3	201%- 260% FPL D0, D1, D2
33. EXCLUSIONS	Benefits covered by a no-fault auto policy or employers liability laws; care that is not medically necessary; cosmetic surgery; custodial care; educational training programs; experimental and investigational procedures; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under this plan; TMJ with no medical basis; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[9]; transplants except for those listed above; and war. Any service not identified as a Covered Service under this Contract may be interpreted by the Contractor as an exclusion. The Contractor may, in accordance with this provision and all other the terms of this Contract, further describe and/or enumerate exclusions in member materials it develops for the Program.				
34. ADDITIONAL POLICY ISSUES	For definitions of terms used in this Attachment , see section 1.0 of the Statement of Work.				

[9] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries.

EXHIBIT F-1
DATA SPECIFICATIONS

All Data supplied to the actuary hired by the Department for rate development is held confidentially by the actuary. This data will be used to create a cost-based rate for the CHP+ Program, determine the cost for benefits that may be added to the program, and for quality metrics.

Data Requested in General

1. All claims involving any type of health care rendered, including dental, medical, mental health, and pharmacy claims
2. All claim lines, including paid claims, denied claims, and adjusted claim lines.
3. Data updates shall be made quarterly, with each quarter's processed data due to the Department's actuary within three months after the quarter-end. For example, data from the quarter spanning July 1through September 30would be due by January 1.
4. The specifications on the field names or field characters, such as length or data type (numeric / text) will be determined by the Department and the Department's actuary.
5. Claims information shall be supplied electronically. Possible types include test, Access, or Excel. Transference of the data can be via CD, diskette, FTP site, or e-mail with password protection.

Other Cost Information

Following are other types of cost information that is requested, but not required, of CHP+ participating HMOs.

1. Administrative expenses.
2. Stop loss contract or summary thereof, including attachment point, reimbursement percentages and premium paid to stop loss carrier.

EXHIBIT K-1
MEMBER HANDBOOK REQUIREMENTS
CHILDREN'S BASIC HEALTH PLAN

SECTION 1.0 MEMBER HANDBOOK REQUIREMENTS

1.1. To inform members of their rights and responsibilities, the contractor shall publish and distribute to all members a member handbook that shall include but is not limited to the following information:

1.1.1. 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 will issue to the Member. Contractor must notify Members annually of the online location and the Members right to request and receive a hard copy

1.1.2. A complete statement of Member rights and responsibilities as specified in 10 C.C.R. 2505-10.8.205.3 in accordance with 42 C.F.R. §438.100;

1.1.3. Cost sharing, if any.

1.1.4. Covered Services and any additional benefits and services offered by the Contractor;

1.1.4.1. The amount, duration and scope of Covered Services available.

1.1.4.2. Procedures for obtaining Covered Services, including authorization requirements.

1.1.4.3. The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers.

1.1.5. Excluded or non-covered services;

1.1.6. Information about the Contractor's standards for the availability and accessibility of services including points of access for primary care, specialty, Hospital, and other services and how to request accommodations for Special Needs, including materials in alternative formats;

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

1.1.8. Hours of service;

1.1.9. Location of facilities/offices;

1.1.10. Appropriate use of and procedures for obtaining after hours care and Emergency Care within the service area;

EXHIBIT K-1
MEMBER HANDBOOK REQUIREMENTS
CHILDREN'S BASIC HEALTH PLAN

1.1.10.1. The extent to which, and how, after-hours and Emergency Services are provided including:

1.1.10.1.1. That which constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services as set forth in 42 C.F.R. §422.113 in its entirety and 2.6.6.4 of the SOW.

1.1.10.2. The fact that prior authorization is not required for Emergency Services.

1.1.10.3. The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local equivalent.

1.1.10.4. The locations of any emergency settings and other locations at which Providers and Hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract.

1.1.10.5. The fact that, subject to the provisions of this section, the Member has the right to use any Hospital or other setting for Emergency Services.

1.1.11. Appropriate use of and procedures for obtaining after hours care and Emergency Care when out of the service area;

1.1.12. Instructions about accessing urgently needed services;

1.1.13. The phone number that can be used for assistance in obtaining Emergency Care, including the 9-1-1 number if that number is operable within the service area;

1.1.14. Enrollment procedures of the Contractor, including how to change Primary Care Providers, and disenrollment information as required in Section 2.5.8 of the Statement of Work, to ensure that Disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so and members are informed about how to access the Department concerning disenrollment;

1.1.14.1. Pursuant to section 1932(a)(4)(B) of the Social Security Act and 42 C.F.R. §438.10(f)(1), the Department shall notify members of their disenrollment rights at least sixty (60) calendar days before each annual enrollment opportunity.

1.1.15. Complaint form;

1.1.16. Maximum number of days between appointment request and actual visit with appropriate Provider, as follows:

1.1.16.1. Urgently Needed Services shall be provided within twenty-four (24) hours of notification of the Member's need for those services to the Member's PCP or the Contractor.

1.1.16.2. Outpatient Follow-up Appointments – within seven (7) days after discharge from a hospitalization.

EXHIBIT K-1
MEMBER HANDBOOK REQUIREMENTS
CHILDREN'S BASIC HEALTH PLAN

1.1.16.3. Non-emergent, non-urgent medical problem shall be provided within thirty (30) calendar days. This thirty (30) calendar day standard does not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) calendar days.

1.1.16.4. Non-urgent, symptomatic care shall be scheduled within seven (7) calendar days of the Member's request for services.

1.1.16.5. Non-symptomatic well care physical examinations shall be scheduled within thirty (30) calendar days, unless an appointment is required sooner to ensure the recommended screenings in accordance with the American Academy of Pediatrics (AAP) accepted Bright Futures schedule.

1.1.16.6. 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.

1.1.16.7. Non-urgent, Symptomatic Behavioral Health Services – within seven (7) days after a Member's request.

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

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

1.1.17. Policies on referrals for specialty care and for other benefits not furnished by the Member's PCP.

1.1.18. Informal and formal procedures and timeframes to voice a complaint, file a grievance 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 process and the Department's or the State's external process(es) to include:

1.1.18.1. The requirements and timeframes for filing a grievance or appeal.

1.1.18.1.1. The availability of assistance in the filing process.

1.1.18.1.2. The toll-free numbers that the Member can use to file a grievance or an appeal by phone.

1.1.18.1.3. The fact that, when requested by the Member, benefits will continue if the Member files an appeal or a request for State review within the timeframes specified for filing; and the fact that the Member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the Member.

1.1.18.1.4. Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

EXHIBIT K-1
MEMBER HANDBOOK REQUIREMENTS
CHILDREN'S BASIC HEALTH PLAN

1.1.18.1.5. Informing the Member that a provider may act on behalf of a Members through such grievance process.

1.1.18.2. For State review in accordance with 42 C.F.R. Part 431 subpart E:

1.1.18.2.1. The right to hearing;

1.1.18.2.2. The method for obtaining a hearing; and

1.1.18.2.3. The rules that govern representation at the hearing.

1.1.18.3. Additional information that is available upon request, including the following:

1.1.18.3.1. Information on the structure and operation of the MCO.

1.1.19. Information about the Contractor's Utilization Management program and how it is used to determine Medical Necessity of services. Information shall include: appropriate points of contact with the Utilization Management program; contact persons or phone numbers for information or questions; and information about how to initiate appeals related to utilization management decisions;

1.1.20. Family planning policies;

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

1.1.22. Circumstances under which Members may have to pay for care;

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

1.1.24. Information regarding the Member's right to formulate Advanced Directives, according to applicable statutes and regulations and the Contractor's policies respecting the implementation of such rights;

1.1.25. How to request information about the Contractor's Quality Assessment and Performance program as described in Section 2.9 of the Statement of Work;

1.1.26. How to obtain information regarding the Contractor's Participating Providers who serve members. The information shall include the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Member's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals;

1.1.27. Information regarding Member participation on the Contractor's consumer advisory committee, and notification of right to attend meetings of the committee. Such information shall include telephone contact number;

1.1.28. Information concerning a Member's responsibility for providing the Contractor with written notice to the Contractor after filing a claim or action against a third party responsible for illness or injury to the Member;

EXHIBIT K-1
MEMBER HANDBOOK REQUIREMENTS
CHILDREN'S BASIC HEALTH PLAN

1.1.29. Information concerning a member's responsibility for following any protocols of a liable third party payor prior to receiving non-emergency services; and

1.1.30. Information on restrictions, if any, on the Member's freedom of choice among network providers.

EXHIBIT M-1
ADMINISTRATIVE AND MEDICAL SERVICES
CHILDREN'S BASIC HEALTH PLAN

SECTION 1.0 ADMINISTRATIVE AND MEDICAL SERVICES

1.1. Administrative services covered: the contractor shall provide or shall arrange to have provided all services specified in Exhibit E, covered services). The contractor shall provide care coordination, utilization management and disease management and pharmacy medical management for members to promote the appropriate and cost effective utilization of covered services. The contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished as follows:

1.1.1. Utilization Management / Quality Improvement:

1.1.1.1. Designed to monitor and oversee the quality, appropriateness and delivery of health care services provided by contracted providers for the Contractor's Members. Core concepts of the program are to improve health care outcomes; determine patterns of over and under utilization of tests, procedures and services; monitor issues and data associated with adverse benefit determinations; and implement improvements to the health care services and delivery.

1.1.1.2. Utilization Management involves:

1.1.1.3. Prospective, concurrent, and retrospective review

1.1.1.4. Preauthorization system

1.1.1.5. Medical Management Team oversight

1.1.1.6. Transplant coordination

1.1.1.7. Onsite reviews

1.1.1.8. Discharge planning

1.1.1.9. Case management

1.1.1.10. Appeals and Grievances

1.1.2. Disease Management Programs:

1.1.2.1. Designed to improve the health status of the entire identified disease/condition population. These programs include Diabetes, Asthma, High Risk OB, and Depression.

1.1.2.1.1. Accomplished by:

1.1.2.1.1.1. Identification and tracking (internal and external operations)

1.1.2.1.2. Stratification by:

1.1.2.1.2.1. Population Management and one-to-one case management

1.1.2.1.2.2. Initiated by imported lab values, patient assessment results and physician input.

1.1.2.1.3. Measurement and Reporting by:

1.1.2.1.3.1. Utilization, process improvement and clinical outcome

EXHIBIT N-1
ENCOUNTER SUBMISSION AND SYSTEM PROCESSING

ELECTRONIC TRANSACTIONS

1.0.1. Contractor submits all encounters into the MMIS electronically. Contractor is required to follow the same electronic transaction process as fee-for-service claims. The MMIS accepts these types of electronic transactions for encounters:

1.0.1.1. X12N 837 Professional (practitioner claim).

1.0.1.2. X12N 837 Institutional (institutional claim).

1.0.1.3. X12N 837D (dental claim).

1.0.2. Contractor submits all pharmacy encounters to Magellan Rx electronically. Contractor is required to follow the same electronic transaction process as fee-for-service claims.

1.0.3. National Council for Prescription Drug Programs (NCPDP) (pharmacy claim).

1.0.4. Encounter Data Specifications are described in detail in the Companion Guides for submission of these transactions.

1.1. MMIS Processing

1.1.1. All encounter claims from Contractor are edited and reviewed prior to submission for payment by the Department of Health Care Policy and Financing (the State or HCPF). Pre-submission edits and reviews are applied in five (5) key domains of accuracy to ensure that payments in excess of allowed Medical Assistance reimbursement do not occur. These are:

1.1.1.1. Eligibility

1.1.1.2. Benefits

1.1.1.3. Pricing

1.1.1.4. Continuation Of Benefits (COB) & Third Party Liability (TPL) Adjustments

1.1.1.5. Duplicates

1.1.1.6. Set forth below is a high-level summary of how these edits and reviews are applied in current payment and reporting processes.

EXHIBIT N-1
ENCOUNTER SUBMISSION AND SYSTEM PROCESSING

1.2. ELIGIBILITY

1.2.1. The MMIS produces daily and monthly eligibility/enrollment records electronically for Contractor. These records are stored on the Department's MMIS and are available for Contractor through the provider web portal. The records are produced for the Department and Contractor concurrently so that MMIS and Contractor have the same eligibility information. Encounters for ineligible clients will be denied and priced at zero, which is why the Department supplies Contractor daily eligibility records. Also, client's eligibility span must correspond with the date of service from the transaction.

1.2.2. Eligibility edits that deny encounters are listed on Health Care Policy and Financing webpage, on the Provider site under Billing Manuals.

1.3. COVERED SERVICES

1.3.1. The MMIS applies the same benefit coverage logic for encounters as the fee-for-service program. Encounters including a procedure or revenue code that is not covered by CHP+ fee-for-service program will be denied and the service will be priced at zero. Procedure and revenue code coverage information is retained in the MMIS reference subsystem.

1.4. ENCOUNTER PRICING

1.4.1. MMIS does not price an encounter differently than a fee-for-service claim.

1.5. COORDINATION OF BENEFITS (COB) AND THIRD PARTY LIABILITY (TPL) ADJUSTMENTS

1.5.1. The MMIS edits and adds TPL adjustments for all encounters similarly to fee-for-service claims. MMIS relies on the Colorado Benefit Management System (CBMS) and other sources to supply valid TPL information for appropriate encounter processing. TPL information is retained in the MMIS. The TPL information is used to edit encounters and will adjust the encounter price based on the information submitted on the transaction. MMIS will deny encounters if Contractor does not supply TPL information for clients who have other insurance coverage. For encounters that contain TPL information, the price of the encounter will be adjusted. The amount paid by another carrier will be deducted from the final price of the encounter.

1.6. PHARMACY ENCOUNTERS

1.6.1. Contractor submits pharmacy encounters into the Magellan Rx. Magellan Rx adjudicates the encounters on the basis of the CHP+ fee-for-service payment schedule and pushes the adjudicated encounter to MMIS.

EXHIBIT N-1
ENCOUNTER SUBMISSION AND SYSTEM PROCESSING

1.7. DUPLICATE CLAIMS/SERVICES

1.7.1. The MMIS denies all duplicate encounters. Any duplicate encounters submitted will deny and price at zero.

1.8. LIST OF MMIS EDITS APPLIED TO ENCOUNTERS

1.8.1. The interChange Error Codes will be included on Health Care Policy and Financing webpage, on the Provider site under Billing Manuals