

Agency or Department Name Health Care Policy & Financing Department or Agency Number UHA Contract Routing Number 3210-0101
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## CONTRACT

THIS CONTRACT, made this 1<sup>st</sup> day of July, 2009, by and between the State of Colorado, for the use and benefit of the Department of Health Care Policy and Financing, 1570 Grant St., Denver, CO 80203, hereinafter referred to as the Department, and Denver Health and Hospital Authority dba Denver Health Medicaid Choice, a body corporate and political subdivision of the State of Colorado, located at 777 Bannock Street, Denver, Colorado 80204, hereinafter referred to as the Contractor.

## FACTUAL RECITALS

WHEREAS, authority exists in the law and funds have been budgeted, appropriated and otherwise made available and a sufficient unencumbered balance thereof remains available for payment in the Colorado Financial Reporting Systems (COFRS) in Fund Number 100, Appropriation Code Number 275; and Encumbrance Number N/A; and,

WHEREAS, required approval, clearance and coordination has been accomplished from and with appropriate agencies; and,

WHEREAS, the Department is the single agency responsible for the administration of the Colorado Medical Assistance Program (Medicaid); and,

WHEREAS, the Contractor has been selected in accordance with the requirements of the Colorado Procurement Code; and

WHEREAS, these services were previously contracted under contract routing number 2106-0129 and its subsequent Amendments 1-9.

NOW THEREFORE, subject to the terms, conditions, provisions and limitations contained in this contract, the Department and the Contractor agree as follows:

### **I. DEFINITIONS**

The following terms as used in this Contract shall be construed and interpreted as follows unless the context otherwise expressly requires a different construction and interpretation:

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

2. "Care Coordination" means the process of identifying, screening and assessing Members' needs, identification of and Referral to appropriate services, and coordinating and monitoring 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.
3. "Client" means a recipient of the Medicaid program.
4. "Communication Disability" means an expressive or receptive impairment that creates a barrier to communication between a Member and a person not familiar with that Member.
5. "Contractor's Plan" means the Contractor's network or those Covered Services provided by the Contractor to eligible Clients in accordance with the terms and conditions of this Agreement.
6. "Covered Drugs" means those drugs currently covered by the Medicaid program and includes those products that require prior authorization by the Colorado Medicaid program. Covered Drugs shall be dispensed by a Participating Provider except for Emergency Services and shall be prescribed by Participating Providers or requested by an authorized prescriber as a result of authorized Referral, Emergency Services, dental care, or obtained under the Medicaid Mental Health Capitation Program.
7. "Covered Services" means those services described in Exhibit A, attached hereto and made part of this contract, which the Contractor is required to provide or arrange to be provided to a Member in return for the Monthly Payment Rate.
8. "Desk Audit" means the review of materials submitted upon request to the Department or its agents for quality assurance activities.
9. "Designated Client Representative" means the person as defined at 10 C.C.R. 2505-10, Section 8.209.2.
10. "Disability" or "Disabilities" means, 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.*
11. "Disenrollment" or "Disenroll" means the act of discontinuing a Member's Enrollment in the Contractor's Plan.
12. "Emergency Medical Condition" means a medical condition as defined at 42 C.F.R. Section 438.114(a).
13. "Emergency Services" means those services as set forth at 42 C.F.R. Section 438.114(a).

14. "Encounter Data" means an occurrence of examination or treatment of a patient by a medical practitioner or in a medical facility and includes pharmacy prescriptions. Mental health care is also included if provided under the auspices of this contract.
15. "Enrollment", "Enroll" or "Enrolled" means that a Client becomes a Member of the Contractor's Plan.
16. "EPSDT" means the Early, Periodic, Screening, Diagnosis and Treatment program that provides comprehensive health care to all Medicaid eligible children through periodic screenings, diagnostic and treatment services.
17. "EPSDT Extraordinary Home Health Services" means home health services that are not listed under Exhibit A but are federally required to be available to an EPSDT child. The services shall be Medically Necessary and the child shall need a) services that exceed the maximum allowable limit per day; b) services to be provided away from home; or c) a Certified Nursing Assistant providing unskilled personal care. These services are covered by Medicaid as a Wrap Around Benefit and therefore, are not Covered Services under this contract.
18. "Experimental or Investigational Services" means 1) any treatment, procedure, drug or device that has been reviewed and found by the Department to be experimental or investigational or 2) 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:
  - a. The treatment, procedure, drug or device shall have final approval from the Food and Drug Administration (FDA), if applicable;
  - b. The scientific evidence as published in peer-reviewed literature shall permit conclusions concerning the effect of the treatment, procedure, drug or device on health outcomes;
  - c. The treatment, procedure, drug or device must improve or maintain the net health outcome;
  - d. The treatment, procedure, drug or device must be as beneficial as any established alternative; and
  - e. The improvements in health outcomes must be attainable outside the investigational settings.
  - f. Additionally, the treatment, procedure, drug or device shall be Medically Necessary and not excluded by any other contract exclusion.

19. "Federally Qualified Health Center" (FQHC) means a Provider defined at 10 C.C.R. 2505-10, Section 8.700.1.
20. "Home Health Services" means those services described at 10 C.C.R. 2505-10, Section 8.520, *et seq.*
21. "Hospital Services" means 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.
22. "Hospital" means an institution which:
  - a. Is licensed by the state as a Hospital;
  - b. Has a Utilization Review program that meets Medicare conditions of participation;
  - c. 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,
  - d. Is certified by Medicare; or
  - e. 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.
23. "Independent Living" means 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.
24. "Marketing" means any communication from the Contractor to a Medicaid recipient who is not enrolled in the plan that can reasonably be interpreted as intended to influence the recipient to enroll in the Contractor's Plan, or either not to enroll in, or to disenroll from, another contractor's Medicaid plan.
25. "Marketing Materials" means materials that are produced in any medium by or on behalf of the Contractor and can be reasonably interpreted as intended to market to potential enrollees.
26. "Medical Record" means 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.

27. "Medical Screening Examination" means screening of sick, wounded or injured persons in the emergency room to determine whether the person has an Emergency Medical Condition.
28. "Medically Necessary" is defined in Exhibit A.
29. "Member" means any Client who is Enrolled in the Contractor's Plan.
30. "Monthly Payment Rate" means the capitated rate, as specified in Exhibit B, Public Policy Rates, attached and incorporated herein by reference, payable for each Member under this contract.
31. "Non-emergency" or "Non-emergent" means non-acute or chronic medical condition, wellness maintenance, and/or prescription refills that require medical intervention, when the Member's condition is stable.
32. "Nursing Facility" means an institution that can meet state and federal requirements for participation as a Nursing Facility.
33. "Open Enrollment Period" means the two (2) months immediately preceding the month in which a member's birthday occurs.
34. "Passive Enrollment" or "Passively Enrolled" means enrollment of eligible fee-for-service (FFS) Medicaid clients within a geographical service area into a Contractor's Plan, subject to the Member's election not to accept enrollment and to "opt-out."
35. "Participating Provider" means 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.
36. "Persons with Special Health Care Needs" or "Special Health Care Needs" means persons as defined in 10 C.C.R. 2505-10, Section 8.205.9.
37. "Physician" means any doctor licensed to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered.
38. "Primary Care Physician" or "Participating Primary Care Physician" means the Physician who has entered into a professional service agreement to serve the Contractor's Members.
39. "Provider" means a health care practitioner, institution, agency or supplier, which may or may not be a Participating Provider in the Contractor's Plan, but which furnishes or arranges for health care services with an expectation of receiving payment.

40. "Proprietary Information" means information relating to a Contractor's research, development, trade secrets, business affairs, internal operations and management procedures. It includes those of its customers, Members or affiliates, but does not include information (1) lawfully obtained from third parties or (2) that which is in the public domain.
41. "Psychiatric In Nature" means those occasions of service in which the Member has a diagnosis listed in Exhibit H, Covered Diagnoses and Procedures, attached and incorporated herein by reference, and receives services listed in Exhibit H.
42. "Qualified Interpreter" means an interpreter who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary.
43. "Referral" or "Written Referral" means 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 other than the Primary Care Physician.
44. Serious Reportable Events or Never Events are defined as hospital acquired conditions (HAC) that were not present on admission (POA) as an inpatient and that alter the condition or diagnosis of the recipient/Client receiving care.
45. "Service Area" means that area for which the Department and the Contractor have agreed that the Contractor shall provide Covered Services to Members. The Service Area shall be Adams, Arapahoe, Denver and Jefferson counties.
46. "Site Review" means the visit of Department staff or its designees to the site or the administrative office(s) of a Participating Provider and/or the Contractor and its Participating Providers.
47. "Subcontractor" means an individual or entity performing all or part of the services covered by this contract, under a separate contract with the Contractor. The terms Subcontractor and Subcontractors mean Subcontractor(s) in any tier.
48. "Triage" means the assessment of a Member's condition and direction of the Member to the most appropriate setting for Medically Necessary care.
49. "Urgently Needed Services" means Covered Services as defined at 42 C.F.R. Section 422.113(b)(1)(iii).
50. "Utilization Management" means 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.
51. "Utilization Review" means 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.

52. "Wrap Around Benefits" means those Medicaid services which: 1) exceed coverage limitations the Contractor is required by this contract to provide or, 2) the Contractor is not obligated to provide coverage for under this Contract. Wrap Around Benefits are services reimbursable under the Medicaid fee-for-service and shall be billed directly to the Department's fiscal agent by the Provider. Wrap Around Benefits include, but are not limited to, EPSDT Extraordinary Home Health Services, medical transportation, and private duty nursing.

## **II. SCOPE OF WORK**

### **A. LICENSES, PERMITS AND RESPONSIBILITIES**

1. The Contractor shall be licensed as a hospital pursuant to Colorado law, and shall maintain accreditation from the Joint Commission on Accreditation of Healthcare Organizations.
2. The Contractor shall notify the Department within two (2) business days, of any action on the part of the Colorado Department of Public Health and Environment or the Joint Commission on Accreditation of Healthcare Organizations of intent to suspend or revoke or modify licensure or full accreditation status. Any revocation, withdrawal or non-renewal of licensure or accreditation 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. In order to maintain the ability to pay outside providers, and in place of usual Department of Insurance reserves, the Contractor shall hold in reserve one twelfth (1/12) of monthly paid (non Denver Health and Hospital Authority) claims until such time as twelve (12) months of reserves have been accrued. Thereafter, on an ongoing basis, the reserve amount shall be a rolling balance based on the 12 most current months paid claims.
4. The Contractor shall provide the Department the opportunity to approve the contract manager assigned to manage this contract.

### **B. ENROLLMENT AND DISENROLLMENT**

1. Clients in the following aid categories are eligible for enrollment under this contract:
  - a. Aid to Families with Dependent Children – Adults (AFDC – A)
  - b. Aid to Families with Dependent Children – Children (AFDC – C)
  - c. Aid to the Needy Disabled/Aid to the Blind (AND/AB)
  - d. Baby Care/Kids Care – Adults (BCKC-A)

- e. Baby Care/Kids Care – Children (BCKC-C)
- f. Foster Care (FC)
- g. Old Age Pensioners – Age 65+ (OAP-A)
- h. Old Age Pensioners under Age 65 (OAP-B)
- i. Refugee Medical Assistance – Adults (RMA-A)
- j. Refugee Medical Assistance – Children (RMA-C)

2. Enrollment

- a. Enrollment in the Contractor's Plan shall be voluntary.
- b. Residents of Denver, Colorado, who are eligible for Medicaid but do not elect to enroll in Medicaid fee for service, shall be Passively Enrolled in Contractor's Plan.
- c. Members who are Passively Enrolled in Contractor's Plan may Disenroll from Contractor's Plan within ninety (90) days of the effective date of Passive Enrollment.
- d. Members who are Disenrolled from the Contractor's Plan solely because he/she loses Medicaid eligibility for a period of two (2) months or less, shall be reenrolled with the Contractor's Plan upon regaining eligibility within the two (2) month period.
- e. The Contractor shall not discriminate against Clients eligible to Enroll on the basis of race, color or national origin and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.
- f. The Contractor shall not discriminate against Clients eligible to Enroll on the basis of health status or need for health care services.
- g. Once Enrolled in the Contractor's Plan a member shall be Enrolled until the Member's next Open Enrollment Period, at which time the Member shall receive an open enrollment notice. Subsequent Enrollment shall be for twelve (12) months and may not Disenroll except as provided in the section on Disenrollment.
- h. All Enrollment notices, informational materials and instructional materials relating to Enrollment of Members shall be provided in a manner and format that may be easily understood and, wherever possible, at a sixth grade reading level.

- i. 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 statutes and regulations.

3. Effective Date of Enrollment

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

- a. If the Client has selected or been Passively Enrolled in the Contractor's Plan on or before the last day of the month, Enrollment shall be effective the first day of the next month.
- b. 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.
- c. Retroactive Enrollment of Members shall be limited to a period not to exceed ninety (90) calendar days from the date of Disenrollment of the Member from Contractor's Plan.

4. Enrollment of a Newborn

- a. The Contractor shall furnish Covered Services to newborns determined Medicaid eligible of Enrolled Members from the date of birth up to sixty (60) calendar days or until the last day of the first full month following birth, whichever is sooner. The Department shall Enroll newborns determined Medicaid eligible of Enrolled Members into Contractor's Plan upon receipt of the newborn's Medicaid identification number, unless the newborn's Mother or other designated representative requests Disenrollment on behalf of the newborn during the ninety (90) days following the Enrollment of the newborn, or ninety (90) days after the Department sends the notice of Enrollment, whichever is later.
- b. The Contractor shall ensure Covered Services for a newborn beyond sixty (60) days from the date of birth when the newborn is:
  - 1) A Hospital inpatient on the last day of the month Enrollment is scheduled to expire, or,
  - 2) Enrolled in the Contractor's Plan within sixty (60) days from the date of birth or before the last day of the second full month following the date of birth, whichever is sooner.
- c. The newborn's continued Enrollment in Contractor's Plan, after the initial term, shall be governed by Section II.C.2.

5. Enrollment Postponed Due to Inpatient Hospital Stay

- a. If a current Member of a Contractor's Plan or a Client, other than a newborn at birth, is an inpatient of a Hospital at 11:59 p.m. the day before his/her Enrollment into a new Contractor's Plan is scheduled to take effect, Enrollment shall be postponed. To postpone Enrollment of a current Member or Client, the new Contractor shall, within sixty (60) calendar days of the date the new Contractor discovers the Client's Hospital admission, request in writing to the Department that the Enrollment be delayed. The new Contractor's request shall include the name of the Hospital where the Client was inpatient and the date of admission. The Department shall respond to the Contractor in writing within five (5) business days of Contractor's request to postpone Enrollment or upon confirmation of the hospitalization, whichever is later.
- b. If the Client is discharged from the Hospital before the fifteenth (15th) day of the month, the new Enrollment date shall be the first day of the month following discharge. If the Client is discharged from the Hospital on or after the fifteenth (15th) day of the month, the new Enrollment date shall be the first day of the month after the month following discharge.
- c. If the Client was a Member of a Contractor's Plan at the time of admission to the Hospital and Enrollment into another Contractor's Plan, or the Medicaid Primary Care Physician Program, was postponed as set forth above, the Member shall not be Disenrolled from the Contractor's Plan of which he/she was a Member at the time of admission until after the Hospital discharge occurs.

6. Disenrollment

- a. A Member may request Disenrollment without cause during the ninety (90) days following the date of the Member's initial Enrollment with the Contractor.
- b. A Member may request Disenrollment without cause during the Open Enrollment Period. A Member may request Disenrollment upon automatic Reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity.
- c. The Contractor shall notify a Member of his or her ability to terminate or change Enrollment at least sixty (60) calendar days before the end of the Open Enrollment Period. The Contractor shall bear all expenses of providing the required notice.
- d. A newborn Member's mother or designated representative may request Disenrollment with cause of the newborn within ninety (90) days following Enrollment of the newborn. Said request must include mother's current address and a twenty-four (24) hour phone number both listed on

file with the county. The Department may conduct reviews of the requests to determine HIPAA compliance and/ or compliance with the contract.

- e. A Member may request Disenrollment when the Department imposes intermediate sanctions as set forth in this contract.
- f. A Member may request Disenrollment at any time for any of the following causes:
  - 1) The Member moves out of the Contractor's Service Area.
  - 2) The Contractor does not, because of moral or religious objections, cover the service the Member needs.
  - 3) The Member needs related services (for example, a caesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Member's Primary Care Physician or another Physician determines that receiving the services separately would subject the Member to unnecessary risk.
  - 4) Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error.
  - 5) Poor quality of care, as documented by the Department.
  - 6) Lack of access to Covered Services, as documented by the Department.
  - 7) Lack of access to Providers experienced in dealing with the Member's health care needs, as documented by the Department.
  - 8) The Member Enrolled in the Contractor's Plan with his/her Physician and the Physician leaves the Contractor.
  - 9) The Member is a resident of long-term institutional care (e.g. hospice or skilled nursing facility).
  - 10) The Member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than a Plan offered by the Contractor and Contractor cannot provide the Member with reasonable access to a Medicare approved Provider or, if the Member is enrolled in a Medicare managed care plan, Contractor cannot provide the Member with Providers participating in both Plans.
  - 11) The Member is a foster child.
  - 12) The Member is in long-term community based care (e.g. HCBS waiver programs).
  - 13) Other reasons satisfactory to the Department. When allowing Disenrollment under this subclause, the Department or its enrollment broker shall inform the Contractor of the rationale for

the decision. If a decision is based upon a policy or widely applicable practice, the Department will provide Contractor with the implementation criteria.

- g. The Contractor shall retrieve or download and review the Disenrollment reports from the MMIS web portal.

7. Effective Date of Disenrollment

- a. When a Member voluntarily Disenrolls from the Contractor's Plan, the effective date of the Disenrollment shall be no later than the first day of the second month following the month in which the Member requested the Disenrollment.
- b. If a decision regarding the Member's Disenrollment is not made by the Department, or its designee, by the first day of the second month following the month in which the Member requested the Disenrollment, the Disenrollment shall be considered approved.

8. Disenrollment Postponed Due to Inpatient Hospital Stay

- a. If a current Member of a Contractor's Plan is an inpatient of a Hospital at 11:59 p.m. the day before his/her Disenrollment from the Contractor's Plan is scheduled to take effect, Disenrollment shall be postponed until discharged from the Hospital.
- b. When the Member is discharged from the Hospital the new Disenrollment date shall be the last day of the month following discharge.
- c. The Department shall respond to the Contractor in writing within five (5) business days of Contractor's request to postpone Enrollment.

9. Member Moves Outside of Service Area

- a. When the Contractor determines a Member is no longer a permanent resident of its Service Area, the Contractor shall notify the Department.
- b. When the Department is notified and confirms that a Member is no longer a permanent resident in the Contractor's Service Area, the Member shall be Disenrolled from the Contractor's Plan effective the first day of the next month.

10. Verification of Medicaid Eligibility and Member Enrollment

The Contractor shall use the Medicaid Management Information System (MMIS) reports to verify Medicaid eligibility and Enrollment in the Contractor's Plan:

- a. Disenrollment Report (R0305) and (M0305);

- b. Prepaid Health Plan (PHP) Enrollment Change Report (R0310);
  - c. PHP Current Enrollment Report (R0315);
  - d. PHP New Enrollee Report (R0325 and M0325); and,
  - e. Capitation Summary Report (R0360);
  - f. When available, Benefit Enrollment and Maintenance Transaction report (ANSI X 12N 834); and
  - g. When available, Payroll Deducted and Other Group Premium Payment for Insurance Products Transactions report (ANSI X 12N 820) for capitation.
11. The Contractor may rely on the above-referenced reports for purposes of making coverage determinations.
12. The Contractor shall not be liable for any Covered Services incurred prior to a Member's effective date of coverage under this contract or after the date of termination of coverage.
13. Reporting
- The Contractor shall submit a quarterly Enrollment/Disenrollment report to the Department. The report shall provide a detailed summary and analysis of all Enrollment/Disenrollment activities, including overall trends and specific reasons for Disenrollment. The reports shall include voluntary Disenrollment, referrals to the Contractor's grievance process regarding requests for Disenrollment and involuntary Disenrollment information and trends. The report shall be submitted in a format specified by the Department and shall be submitted within thirty (30) calendar days following the end of the quarter being reported.
14. Contractor Requested Disenrollment
- a. The Contractor may request, and the Department may approve or initiate, Disenrollment for specific cases or persons where there is cause. The following are acceptable reasons for Disenrollment for cause:
    - 1) Admission to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institution.
    - 2) Receipt of Comprehensive Health Coverage other than Medicaid.
    - 3) A Member leaves the State of Colorado for ninety (90) consecutive days or more.
    - 4) Any other reason, as determined by the Department.

- 5) Enrollment in a Medicare MCO or capitated health plan other than such a plan offered by the Contractor.
- 6) Child welfare eligibility status or receipt of Medicare benefits.
- 7) Abuse or Intentional Misconduct

Behavior which is disruptive or abusive to the extent that the Contractor's ability to furnish services to either the Member or other Members is impaired; an ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet other Member responsibilities described in this contract; or, behavior that poses an immediate physical threat to the Provider, other staff, or Members.

The Contractor shall provide at least one oral warning regarding the activity in question. Where the misconduct continues, the Contractor shall send a written warning to the Member that continuation of his/her actions will result in termination of his/her Enrollment in the Contractor's Plan. The Contractor shall send a copy of the notification letter, along with a report of its investigation, to the Department thirty (30) calendar days prior to termination of the Member's Enrollment;

If the Member's actions or behaviors pose an imminent threat to the safety of Member(s) or Contractor, and the actions or behaviors do not result from causes specified in 14.b. below, the Contractor, after giving verbal warning, may request an expedited Disenrollment where a Member is Disenrolled promptly without an additional period to allow the actions or behaviors to be corrected.

- 8) Fraud or Knowingly Furnishing Incomplete/ Incorrect Information  
A Member knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to the Contractor incident to Enrollment under this contract.
- 9) A Member who is an inpatient refuses a medically appropriate transfer to facility in Contractor's Plan with a twenty-four (24) notice to the client/guardian. Client's refusal to accept the transfer requires a notice of action filing and/or a grievance.

- b. Disenrollment for cause shall not include adverse changes in a Member's health status, because of a change in the Member's utilization of medical services, because of diminished mental capacity, nor any behavior of the Member resulting from his or her special needs except those behaviors

that seriously impair the Contractor's ability to furnish services to either this Member or other Members.

## **C. COVERED SERVICES**

1. Health Coverage
  - a. The Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit A. 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.
  - b. 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-Member Medicaid recipients within the same area.
  - c. 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.
2. Coverage Limitations
  - a. The Contractor shall not be required to cover any service that does not meet the definition of Medically Necessary.
  - b. 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.
3. Covered Services through Participating Providers
  - a. Covered Services shall be made available in the Service Area only through Participating Providers, organizations or agencies that have contracts or affiliations with the Contractor to render said services, or non-Participating Providers authorized by the Contractor.
  - b. Except for Emergency Services and Urgently Needed Services, the Contractor shall have no liability or obligation due for any service or benefit sought or received by any Member from any non-Participating Provider unless: 1) special arrangements or Referrals are made by a Primary Care Physician or the Contractor, as specified in the Member handbook, or 2) the condition as set forth at Section II.E.4.d, e or f are met.
4. Coverage of Specific Services and Responsibilities

a. Emergency Services

- 1) The Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a 24 hour, seven day-a-week basis.
- 2) Members temporarily out of the Service Area may receive out-of-area Emergency Services and Urgently Needed Services, as specified in Exhibit A.
- 3) The Contractor shall not require prior authorization for Emergency Services or Urgently Needed Services.
- 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 enrollee to seek Emergency Services.
- 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.

b. Emergency Ambulance Transportation

The Contractor shall make reasonable efforts to ensure that Members within the Service Area shall have access to emergency ambulance transportation on a 24-hour, seven-day a week basis. This includes Members with medical/physical or psychiatric/behavioral emergencies.

c. Verification of Medical Necessity for Emergency Services

The Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services. The Contractor shall not deny benefits for conditions that a prudent layperson would perceive as Emergency Medical Conditions and shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

d. Poststabilization Care Services

The Contractor shall provide coverage for Poststabilization Care Services in compliance with 42 C.F.R. Section 438.114.

e. Coverage of New Services and Items

- 1) The Contractor shall not be responsible for providing any new

health care services or new technology that is authorized, approved or adopted as a covered benefit under Medicaid fee-for-service during the term of this Contract. New prescription drugs shall be a Covered Service subject to the Contractor's formulary.

- 2) The Contractor may submit a written request to the Department, requesting the Department to review the appropriateness of including a prescription drug as a Covered Service. The Department reserves the right to make the final decision.

f. Coverage of Prescription Drugs

- 1) Medicare Prescription Drug, Improvement, and Modernization Act (MMA)
  - a) The Contractor shall not provide Part D Drugs to dual-eligible individuals.
  - b) The Contractor shall comply with all federal and state statutes and regulations regarding Part D prescription drug benefits for dual-eligible individuals.
  - c) The Contractor shall cover excluded Part D drugs as defined in 42 U.S.C. Section 1395w-101, *et seq.* for dual-eligibles in the same manner and to the same extent as they cover excluded Part D drugs for all other eligible Medicaid clients.
- 2) The Contractor shall provide coverage for prescription drugs approved for use and reimbursed by the Medicaid Program, including those products that require prior authorization by the Medicaid Program. Such Covered Drugs shall be prescribed and dispensed within the Contractor's parameters for pharmaceuticals, and as follows:
  - a) The Contractor may establish a drug formulary, for all Medically Necessary Covered Drugs with its own prior authorization criteria provided the Contractor includes each therapeutic drug category in the Medicaid program.
  - b) The Contractor shall provide a Covered Drug if there is a Medical Necessity which is unmet by the Contractor's formulary product.
- 3) If a Member requests a brand name for a prescription that is included on the Contractor's drug formulary in generic form, the Member may pay the cost difference between the generic and brand name. The Contractor shall inform the Member that if the

Member requests a brand name for a prescription, the Member shall be responsible for paying any cost difference to the dispensing pharmacy unless the brand name drug is prescribed by the attending physician “dispense as written” or “no substitution”.

g. Financial Responsibility Regarding Psychiatric and Medical Diagnoses

1) Inpatient Hospital Services

a) The Contractor’s responsibility for inpatient Hospital Services is based on the primary diagnosis that is requiring inpatient level of care and is being actively managed within the treatment plan of the Member. The Contractor shall be financially responsible for the Hospital stay when the Client’s primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric procedures, exclusive of substance abuse rehabilitation.

b) The Contractor shall not be financially responsible for the inpatient services when the Client’s primary diagnosis is Psychiatric In Nature, even when the psychiatric hospitalization includes some medical conditions or procedures, to treat a secondary medical diagnosis exclusive of substance abuse rehabilitation.

2) Coverage for Emergency Services

a) The Contractor shall be financially 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.

b) The Contractor shall not be financially 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.

3) Coverage for Outpatient Hospital Services

The Contractor’s responsibility for the Covered Services of outpatient Hospital Services is based on the diagnosis and the billing procedures of the Hospital.

a) Procedures Billed in a UB-92/ANSI 837I, Health Care Claim Institutional (ANSI 837I) Format

The Contractor shall be financially responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

- (i) The procedure(s) is billed on a UB-92/ANSI 837I claim form; and,
  - (ii) The principal diagnosis is a medical diagnosis.
- b) Procedures Billed in a HCFA-1500/ANSI 837P, Health Care Claim Professional Format.

The Contractor shall be financially responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

- (i) The procedure(s) is billed on a HCFA-1500/ANSI 837P claim form; and,
- (ii) The Covered Services are not listed as a required Behavioral Health Organization (BHO) Covered Service as defined in 10 C.C.R. 2505-10, Section 8.212.4.A. Diagnoses and procedures covered by the BHOs are listed in Exhibit H, Covered Diagnoses and Procedures, attached and incorporated herein by reference.

h. Additional Benefits and Services

The Contractor may offer to Members additional benefits and services beyond Covered Services. These benefits and services shall be identified in the Member handbook and a written description provided to the Department in a format and on a schedule to be determined in consultation with the Contractor. The Contractor shall submit written notification to the Department at least thirty (30) calendar days prior to the targeted effective date for offering the additional benefits and services.

i. Wrap Around (Fee-for-Service) Benefits

- 1) The Contractor shall communicate to its Participating Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this contract but are available to Members under Medicaid fee-for service (FFS).
- 2) The Contractor shall instruct its Participating Providers on how to refer a Member for such services. The Contractor shall advise

Participating Providers of EPSDT support services that are available through local public health departments. The Contractor shall also advise post partum or breast-feeding or pregnant women of the special supplemental food program (Women, Infants, and Children), the state's special assistance program for substance abusing pregnant women, and enhanced prenatal care services.

- 3) The Contractor shall inform its Home Health Services Providers and Members that Home Health Services after 60 consecutive calendar days are not Covered Services but are available to Members under FFS and require prior authorization. If Home Health Services after 60 consecutive calendar days are anticipated, the Contractor shall ensure that, at least 30 days prior to the 60<sup>th</sup> day of Home Health Services, its Home Health Services Providers coordinate prior authorization with the Single Entry Point Agency for adult Members and with the Medicaid Fiscal Agent for children.

#### **D. SERVICE DELIVERY**

##### 1. Access

###### a. Access to Services

- 1) The Contractor shall comply with Section 10-16-704 C.R.S. access requirements. In establishing and maintaining the Provider network, the Contractor shall consider including both Essential Community Providers as designated at 10 C.C.R. 2505-10, Section 8.205.5.A and other Providers.
- 2) The Contractor shall maintain and monitor a network of appropriate Providers that is supported by written agreements with those Providers and is sufficient to provide adequate access to all Covered Services. The Contractor shall ensure a Provider to Member caseload ratio as follows:
  - a) 1:2000 Primary Care Physician to Member ratio. Primary Care Physician includes Physicians designated to practice Family Medicine and General Medicine.
  - b) 1:2000 Physician specialist to Member ratio. Physician specialist includes all specialist Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.
  - c) Physician specialists designated to practice Gerontology, Internal Medicine, OB/GYN and Pediatrics shall be

counted as either a Primary Care Physician or Physician specialist, but not both.

- 3) The Contractor shall consider the following when establishing and maintaining the Provider network:
  - a) The anticipated Medicaid Enrollment;
  - b) The expected utilization of Covered Services;
  - c) The numbers and types of Providers required to furnish the Covered Services;
  - d) The number of network Providers who are not accepting new Medicaid patients; and
  - e) 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.
- 4) 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 Primary Care Physician if that source is not a women's health specialist.
- 5) The Contractor shall provide for a second opinion from a qualified health care professional within the network or arrange for the Member to obtain one outside the network at no cost to the Member.
- 6) Access to Nurse and Midwife Practitioners
  - a) 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. Sections 440.165 and 440.166, as amended, and Section 25.5-5-102(1)(j), C.R.S., as amended, through either Provider agreements or Referrals.
  - b) This provision shall in no way be interpreted as requiring the Contractor to provide any services that are not Covered Services under this contract.

b. Out of Network Providers

- 1) If the Contractor is unable to provide Covered Services to a particular Member, the Contractor shall adequately and timely provide the Covered Services out of network at no cost to the Member.
- 2) The Contractor shall ensure that cost to the Member is not greater than it would be if the Covered Services were furnished within the Contractor's network. The Contractor shall coordinate with the out-of-network Provider with respect to payment.

c. Geographic Access

The Contractor shall establish and maintain adequate arrangements to ensure reasonable proximity of Participating Providers to the residence of Members so as not to result in unreasonable barriers to access and to promote continuity of care, taking into account the usual means of transportation ordinarily used by Members. The Contractor shall have Providers located throughout the Contractor's Service Area within thirty (30) miles or thirty (30) minutes travel time to the extent such services are available.

d. 24-Hour Availability of Services

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 this will be achieved. 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 the following requirements:

- 1) Emergency Services shall be available 24 hours per day, 7 days per week;
- 2) The Contractor shall have a comprehensive plan for Triage of requests for services on a 24 hour 7 day per week basis, including:
  - a) Immediate Medical Screening Exam by the Primary Care Physician or Hospital emergency room;
  - b) Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service; and,
  - c) Practitioner backs up covering all specialties.

e. Scheduling and Wait Times

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: routine physicals, diagnosis and treatment of acute pain or injury, and follow-up appointments for chronic conditions. The Contractor shall communicate its guidelines in writing to Participating Providers. The Contractor shall have an effective organizational process for monitoring, scheduling and wait times, identifying excessive practices, and taking appropriate corrective action. The Contractor shall ensure that the following minimum standards are met including:

- 1) Non-urgent health care, is scheduled within 2 weeks;
- 2) Adult, non-symptomatic well care physical examinations scheduled within 4 months; and,
- 3) Urgently Needed Services provided within 48 hours of notification of the Primary Care Physician or Contractor.

2. Service Area Standards

- a. The Department maintains the right to make any final determinations as to the Contractor's suitability for providing Covered Services to Members in a given Services Area(s).
- b. The 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:
  - 1) The name of the proposed county or counties in which the Contractor seeks to expand or the categories of populations to be served, and;
  - 2) An analysis by the Contractor concerning whether its Provider network is adequate to serve Clients 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 the contract.
- c. The Contractor shall provide to the Department an annual network adequacy strategic plan. The report is to be submitted not later than September 30, and is subject to the Department's approval. The plan shall reflect current and future network planning and include, at a minimum:
  - 1) Geographic access standards;

- 2) Provider network standards; and
  - 3) Population demographics.
- d. The Contractor shall, within thirty (30) business days following the close of each fiscal year quarter and as required by 42 C.F.R. Section 438.207(c), submit to the Department, a detailed written report regarding the Contractor's capacity and services. The report shall be in the format specified by the Department and shall demonstrate that the Contractor meets the following:
- 1) Provides an appropriate range of preventive care, primary care and specialty services that is adequate for the anticipated number of Members.
  - 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.
- e. The Contractor may discontinue providing Covered Services to Members within an entire county within the Contractor's Service Area, by providing no less than thirty (30) 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 thirty (30) calendar days notice period.
3. Selection and Assignment of Primary Care Providers
- a. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a Primary Care Physician.
  - b. If a Member does not select a Primary Care Physician, the Contractor shall assign the Member to a Primary Care Physician or a Primary Care Facility and notify the Member, by telephone or in writing, of his/her Facility's or Primary Care Physician's name, location, and office telephone number.
  - c. 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 his/her 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.

4. Coordination and Continuity of Care

- a. The Contractor shall have written policies and procedures to ensure timely coordination of the provision of Covered Services to its Members to promote and assure 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. Sections 160 and 164.
- b. The Contractor shall coordinate with the Member's mental health Providers to facilitate the delivery of mental health services, as appropriate.
- c. In addition to efforts made as part of the Contractor's internal quality assessment and improvement program, the Contractor shall have an effective Care Coordination system that includes but is not limited to:
  - 1) Procedures and the capacity to implement the provision of individual needs assessment after Enrollment and at any other necessary time, including the screening for Special Health Care Needs (e.g. mental health, high risk health problems, functional problems, language or comprehension barriers; and other complex health problems); the development of an individual treatment plan as necessary based on the needs assessment; the establishment of treatment objectives, treatment follow-up, the monitoring of outcomes, and a process to insure that treatment plans are revised as necessary. These procedures shall be designed to 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;
  - 2) Procedures designed to address those Members who may require services from multiple Providers, facilities and agencies and require complex coordination of benefits and services, and Members who require ancillary services, including social services and other community resources;
  - 3) 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;
  - 4) 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; and

- 5) Procedures to provide continuity of care for newly Enrolled Members to prevent disruption in the provision of Medically Necessary services that include but are not limited to: appropriate Care Coordination staff trained to evaluate and handle individual case transition and care planning, assessment for appropriate technology and equipment, procedures for evaluating adequacy of Participating Providers and clearly written criteria and procedures that are made available to all Participating Providers, staff and Members regarding how to initiate case planning.
  - d. The Contractor shall inform a new Member who is a Person with Special Health Care Needs as defined in 10 C.C.R. 2505-10, Section 8.205.9 that the Member may continue to receive Covered Services from his or her Provider for sixty (60) calendar days from the date of Enrollment in the Contractor's Plan, if the Member is in an ongoing course of treatment with the previous Provider and only if the previous Provider agrees as specified in Section 25.5-5-406(1)(g), C.R.S.
  - e. The Contractor shall inform a new Member with Special Health Care Needs that the Member may continue to receive Covered Services from ancillary Providers at the level of care received prior to Enrollment in the Contractor's Plan, for a period of seventy-five (75) calendar days, as specified in Section 25.5-5-406(1)(g), C.R.S.
  - f. The Contractor shall inform a new Member who is in her second or third trimester of pregnancy, that she may continue to see her Provider until the completion of post-partum care directly related to the delivery, as specified in Section 25.5-5-406(1)(g), C.R.S.
5. Persons with Special Health Care Needs
- a. The Contractor shall have sufficient experienced Providers with the ability to meet the unique needs of Persons with Special Health Care Needs. If necessary primary or specialty care cannot be provided within the network, the Contractor shall make arrangements for Members to access these Providers outside the network. The Contractor shall implement procedures to share with other Providers serving the Member with Special Health Care Needs, the results of its identification and assessment of that Member's needs to prevent duplication of those activities.
  - b. The Contractor shall implement mechanisms to assess each Medicaid Member identified as having Special Health Care Needs in order to identify any ongoing special conditions of the Member that require a

course of treatment or regular care monitoring. The assessment mechanism shall use appropriate health care professionals.

- c. 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 Primary Care Physicians (PCPs) or be allowed direct access/standing Referral to specialists for the needed care.
- d. The Contractor shall establish and maintain procedures and policies to coordinate health care services for children with Special Health Care Needs with other agencies (e.g., mental health and substance abuse, public health, transportation, home and community based care, Developmental Disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers and advocates).

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

a. Accessibility and Availability of Covered Services

The Contractor shall promote accessibility and availability of 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 shall be provided in such a manner that will promote Independent Living and Member participation in the community at large.

b. Independent Living Requirements

The Contractor shall:

- 1) Respond within twenty-four (24) hours, after written or oral notice to the Contractor by the Member, the Member's parents, guardian or Designated Client Representative, to any diminishment of the capacity of a Member with a Disability to live independently (e.g., a broken wheelchair), and,
- 2) Deliver Covered Services that will restore the Member's ability to live independently (e.g., an appropriate wheelchair) with the greatest possible expedience.

c. Cultural and Linguistic Competency Requirements

The Contractor shall facilitate culturally and linguistically appropriate care, by implementing the following requirements:

- 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;

- 2) Maintain policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation;
- 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;
- 4) Develop and/or provide cultural competency training programs, as needed, to the network Providers and Contractor staff regarding (a) health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services, and (b) the medical risks associated with the Client population's racial, ethical and socioeconomic conditions;
- 5) Make available written translation of Contractor materials, including Member handbook, correspondence and newsletters. 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. Prevalent populations shall consist of 500 or more Members speaking each language;
- 6) Develop policies and procedures, as needed, on how the Contractor shall 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: (a) conduct the appropriate assessment and treatment of non-English speaking Members (including Members with a Communication Disability) and (b) promote accessibility and availability of Covered Services, at no cost to Members;
- 7) Develop policies and procedures on how the Contractor shall respond to requests from Members for interpretive services by a Qualified Interpreter or publications in alternative formats;
- 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; and,

- 9) Provide access to interpretative services by a Qualified Interpreter for Members with a hearing impairment in such a way that it shall promote accessibility and availability of Covered Services.
  - a) 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;
  - b) 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;
  - c) 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; and
  - d) Make Member information available upon request for Members with visual impairments, including, but not limited to, braille, large print, or audiotapes. For Members who cannot read, member information shall be available on audiotape.

d. Preventive Health Services

- 1) The Contractor shall establish and maintain a comprehensive program of preventive health services for Members. The Contractor shall assure that Members with a Disability have the same access as other Members to preventive health services. 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 II.J. of this contract.
- 2) The Contractor's program of preventive health services shall include, but is not limited to:
  - a) Risk assessment by a Member's Primary Care Provider 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/high risk illnesses, a Disability, or the potential for such conditions;

- b) 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's responsibility shall also include the distribution of information to Members to encourage Member responsibility for following guidelines for preventive health;
- c) Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk Members;
- d) Procedures to identify priorities and develop guidelines for appropriate preventive services;
- e) Integration of preventive health programs into the Contractor's quality assurance program and describing specific preventive care priorities, services, accomplishments, and goals as part of required reporting in the Quality Improvement Plan, Program Impact Analysis and annual report; and,
- f) 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.

e. EPSDT Program Requirements

The Contractor shall comply with all requirements of EPSDT regulations at 42 C.F.R. Sections 441.50 through 441.62, as amended, to assure Members' access to EPSDT benefits.

- 1) The Contractor must inform all of its Members through age 20 that EPSDT services are available including such benefits which are not Covered Services pursuant to this contract.
- 2) The Contractor shall provide or arrange for the provision of all of the required screening, diagnostic and treatment components according to state and federal EPSDT standards and the periodicity schedule. The Contractor may offer additional preventive services beyond these required standards;
- 3) The Contractor shall complete and submit the annual EPSDT report, resulting from the preventive screenings, to the Department's EPSDT program administrator on the Form HCFA-416, no later than February 1st, for the October 1st through

September 30th period of the previous contract year.

f. Training on Department Policies and Member Populations

- 1) The Contractor shall ensure that appropriate staff participates in periodic training programs sponsored by the Department designed to provide technical assistance to the Contractor with policy interpretation and coordination of services to maximize compliance with requirements.
- 2) The Contractor shall be responsible for training Participating Providers and any Subcontractors.

**E. MEMBER ISSUES**

1. Member Services, Rights, Grievances and Appeals

a. Member Rights

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:

- 1) To be treated with respect and with due consideration for his/her dignity and privacy.
- 2) To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- 3) To participate in decisions regarding his/her health care, including the right to refuse treatment.
- 4) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- 5) To obtain family planning services directly from any Provider duly licensed or certified to provide such services without Referral.
- 6) To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45 C.F.R. Section 164.
- 7) To exercise his/her rights without any adverse effect on the way he/she is treated.
- 8) To receive, from the Provider and at the times specified in 42 C.F.R. Section 489.102, information concerning the

implementation of Advance Directives, including a clear and precise statement of limitation if the Provider can not implement an Advance Directive on the basis of conscience. The information shall include the Member's rights under this Contract, the Contractor's policies regarding the implementation of those rights and a statement regarding the fact that complaints 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) days after the effective date of the change.

b. Member Responsibilities

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. 2505-10, Section 8.205.2 and any amendments thereto.

c. Written Policies and Procedures

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 D, Member Handbook Requirements, attached hereto and incorporated herein.

d. Member Information

- 1) The Contractor shall provide to all Members, including new Members, a Member handbook that 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. Minimum requirements for information to be included in the Member handbook are listed in Exhibit D, and shall be available for review by the Department.
- 2) Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department, translated into other non-English languages prevalent in the Service Area, and provided in alternative formats as required in the contract. Members shall be informed that oral interpretation services are available for any

language that written information is available in prevalent languages and how to access interpretation services.

- 3) The Contractor shall include in its Member handbook and Marketing Materials a provision clearly stating that Enrollment in the Contractor's Plan is voluntary and shall also include information about how to request Disenrollment.
- 4) The Contractor may provide Members with similar information, in the form of newsletters, etc., as is provided to private/commercial enrollees, but shall also provide Members with additional information as appropriate to promote compliance with this contract.
- 5) The Contractor shall provide periodic updates to the Member handbook when needed to explain changes to the above policies. Prior to printing, the Contractor shall submit the updates to the Department for review and approval, at least thirty (30) calendar days prior to the targeted printing date.
- 6) 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.
- 7) 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.
- 8) The Contractor and its representatives shall not knowingly provide untrue or misleading information, as defined at Section 10-16-413 (1)(a)-(c), C.R.S., regarding the Contractor's Plan or Medicaid eligibility, to Clients or Members.
- 9) The Contractor shall notify all Members of their right to request and obtain the information listed in Exhibit D at least once a year. Members shall also be notified of any significant changes in the following information at least thirty (30) days prior to the effective date of the change:
  - a) The amount, duration and scope of Covered Services available in sufficient detail to ensure that Members understand the benefits to which they are entitled.
  - b) Procedures for obtaining Covered Services, including authorization requirements.

- c) The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers.
- d) The extent to which, and how, after-hours and Emergency Services are provided including:
  - (i) What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services.
  - (ii) The fact that prior authorization is not required for Emergency Services.
  - (iii) The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local equivalent.
  - (iv) 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.
  - (v) 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.
- e) Policy on Referrals for specialty care and for other benefits not furnished by the Member's Primary Care Physician.
- f) Cost sharing, if any.
- g) How and where to access Wrap Around Benefits, including any cost sharing and how transportation is provided. 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.

## 2. Appeal Process and Reporting

- a. The Contractor shall establish an internal appeal process under which a Member may challenge the denial of coverage of, or payment for, services in accordance with 42 C.F.R. Section 438.228, as amended.
- b. The Contractor shall comply with all requirements of the managed care appeal rules at 10 C.C.R. 2505-10, Section 8.209, set forth in Exhibit I, Medicaid Managed Care Grievance and Appeal Processes, attached and

incorporated herein by reference, and as required in this contract and shall support the Department by attending and responding to state fair hearings notices regarding its Members. Please see 10 C.C.R. 2505-10, Section 8.209, for the current version of the rules.

- c. The Contractor shall use the reporting format provided by the Department to document and maintain an organized system for recording, tracking, resolving, and assessing Members' appeals. The Contractor shall submit a completed data reporting form to the Department, on a quarterly basis, within thirty (30) calendar days following the end of the quarter being reported.
- d. The Contractor shall use the Department's reporting format to provide a written analysis of the appeal data. The Contractor shall submit the written report to the Department on a quarterly basis, within thirty (30) calendar days following of the end of the quarter being reported.
- e. The Contractor shall not be responsible for any grievance or appeal associated with a Wrap Around Benefit.

### 3. Patient Confidentiality

- a. 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. Except for purposes directly connected with the administration of the Medicaid 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 a minor's parent or guardian, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals. Contractor shall have written policies governing access to, duplication and dissemination of, all such information. Contractor shall advise its employees, agents, Participating Providers and Subcontractors, if any, that they are subject to these confidentiality requirements. 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.
- b. 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. The Medical Record shall accurately represent the full extent of care provided to the Member. 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. It may be reflected and noted in the record that an Advance Directive has been discussed with the Member, if one has

been executed. 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.

- c. The Contractor shall conform to the requirements of 45 C.F.R Section 205.50, as amended, Section 10-16-423, C.R.S., as amended, 45 C.F.R. Sections 160 and 164, as amended, and 42 C.F.R Sections 431.304 - 431.307, as amended, regarding confidentiality of health information about any Member for Covered Services hereunder.
- d. The Contractor agrees to abide by 42 C.F.R. Section 431.301, as amended, and Section 26-1-114, C.R.S., as amended, regarding the confidentiality of information concerning applicants for and Clients of medical assistance.

#### 4. Marketing

- a. The Contractor shall not distribute any Marketing Materials without first obtaining the Department's approval which shall include a review by a medical care advisory committee. The Department shall inform the Contractor of its decision on the materials, within three (3) business days of the medical care advisory committee's review. This includes materials that are produced in any medium, by or on behalf of the Contractor, which can reasonably be interpreted as intended to market to potential Members. All materials, including the Contractor's Member handbook, shall be submitted to the Department at least thirty (30) calendar days prior to the targeted release date.
- b. The Contractor shall assure the Department, in writing, upon submission of any written material for the Department's approval that any marketing plans and materials are accurate and do not mislead, confuse or defraud the Clients, Members or the Department.
- c. The Contractor's written materials or oral presentations shall not contain any assertion that the Client must Enroll in the Contractor's Plan or any other Managed Care Organization in order to obtain benefits or in order not to lose benefits.
- d. The Contractor's written materials or oral presentations shall not contain any assertion that the Contractor's Plan is endorsed by the Centers for Medicare and Medicaid Services, the federal or state government or similar entity.
- e. The Contractor shall not, directly or indirectly, engage in door-to-door, telephone, or cold-call marketing activities. Cold call marketing includes any unsolicited personal contact by the Contractor, its Subcontractors or Participating Providers with a potential Member for the purpose of marketing as defined at 42 C.F.R. Section 438.104(a).

- f. The Contractor shall not seek to influence Enrollment in conjunction with the sale or offering of any private insurance.
- g. Should the Contractor distribute Marketing Materials, it shall distribute the materials to its entire Service Area.
- h. Any final copy of written education materials developed by the Department, which describes the Contractor or the Contractor's Plan, shall be submitted to the Contractor at least ten (10) business days prior to the release.

## **F. PROVIDER ISSUES**

### **1. Licensure and Credentialing**

- a. The Contractor shall have written policies and procedures for the selection and retention of Providers.
- b. The Contractor shall verify that all Participating Providers meet licensing and certification requirements.
- c. 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.
- d. 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.
- e. 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.
- f. The Contractor's Provider selection policies and procedures shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

### **2. Provider Insurance**

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 the following:

- a. Physicians participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of \$0.5 million per incident and \$1.5 million in aggregate per year.
  - b. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of \$0.5 million per incident and \$3.0 million in aggregate per year.
  - c. Sections II.G.1 above and this II.G.2 shall not apply to Physicians and facilities in the Contractor's network which:
    - 1) Are public entities or employees pursuant to Section 24-10-103, C.R.S of the Colorado Governmental Immunity Act; or,
    - 2) Maintain any other security acceptable to the Colorado Commissioner of Insurance, which may include approved plan of self-insurance, pursuant to Section 13-64-301, C.R.S., as amended.
  - d. The Contractor shall, upon request, provide the Department with acceptable evidence that such insurance is in effect. In the event of cancellation of any such coverage, the Contractor shall, within two (2) business days, notify the Department of such cancellation.
3. Provider Incentive Plans
- a. No specific payment can be made directly or indirectly under a Provider incentive plan to a Provider as an inducement to reduce or limit Medically Necessary services furnished to a Member.
  - b. The Contractor shall disclose to the Department or any Member or Member's Designated Client Representative, at the Department's request, information on any Provider incentive plan.
  - c. The Contractor shall ensure that agreements containing Physician incentives comply with 42 C.F.R. Section 438.6, as described in Exhibit E, Requirements for Physician Incentive Plans, attached and incorporated herein by reference. Please see 42 C.F.R. Section 438.6 for the current version of the regulations.
4. Provider Quality of Care Issues
- a. For alleged quality of care concerns involving Physician Providers, the Contractor may use the process of its professional review committee, as

set forth in Sections 12-36.5-104 and 12-36.5-104.4, C.R.S., when a quality of care concern is brought to its attention.

- b. Notwithstanding any other provision in this contract, the Contractor is not required to disclose any information that is confidential by law.

5. Program Integrity

- a. The Contractor shall comply with the disclosure of ownership and control information set forth in 42 C.F.R. Section 455 Subpart B.
- b. The Contractor shall report to the National Practitioner Data Bank and to the appropriate state regulatory board 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.
- c. The Contractor shall establish and maintain a compliance program designed to prevent, detect investigate and report fraud, waste and abuse.
- d. Contractor shall create a compliance program plan documenting Contractor's written policies and procedures, standards and documentation of practices (Compliance Program Plan). The Compliance Program Plan shall be approved by Contractor's Chief Executive Officer and Compliance Officer. The Compliance Program Plan shall be submitted to the Department for review and approval and shall contain:
  - 1) Provisions for internal monitoring and auditing.
  - 2) Provisions for prompt response to detected offenses and for development of corrective action initiatives.
  - 3) Provisions for monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.
  - 4) Effective processes to screen all Provider claims, collectively and individually, for potential fraud, waste or abuse.
  - 5) Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste and abuse.
  - 6) 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.

- e. Contractor, its providers and subcontractors, are subject to the False Claims Act, §§ 3729 through 3733 of Title 31, United States Code.
- f. Contractor shall establish written policies for employees, within 30 days of the effective date of this contract, requiring all employees to be informed of and detailing compliance with:
  - 1) The False Claims Act, 31 USC §§ 3729, et seq.;
  - 2) Administrative remedies for false claims and statements;
  - 3) State laws relating to civil or criminal penalties for false claims and statements, if any; and
  - 4) Whistleblower protections under such laws.
- g. The Contractor shall establish a process for training existing and new employees on the compliance program and on the items in II.H.5.f.1 through II.H.5.f.4 above. All training shall be conducted in such a manner that it can be verified by the Department.
- h. Contractor shall designate a compliance officer and compliance committee that are accountable to senior management.
- i. Contractor shall have effective lines of communication between the compliance officer and the Contractor's employees for reporting violations.
- j. Contractor shall enforce its compliance program through well-publicized disciplinary guidelines.
- k. Contractor shall immediately report known confirmed intentional incidents of fraud and abuse to the Department's contract manager and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU).
- l. Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department's contract manager. Contractor shall investigate its suspicions and shall submit its written findings and concerns to the contract manager within three business days of the verbal report. If the investigation is not complete in three business days, Contractor shall continue to investigate. A final report shall be submitted within fifteen business days of the verbal report. The contract manager may approve an extension of time in which to complete the final report upon a showing of good cause.

m. The Contractor shall provide a list of excluded providers to the Department on a monthly basis.

6. Regarding Pharmacy Providers

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, Section 8.205.8. The Contractor may limit pharmacy Providers to its owned and operated pharmacies so long as the limitation does not adversely affect the delivery of pharmaceutical products in nursing facilities as required by 10 C.C.R. 2505-10, Section 8.205.8.A and B. All subcontracts with pharmacy Providers shall be subject to all standards set forth in this contract.

7. Advance Directives

- a. Advance Directives are defined in 42 C.F.R. Section 489.100, and Section 15-14-505(2), C.R.S.
- b. Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all adult individuals receiving medical care by or through the Contractor, as provided in 42 C.F.R. Section 489.
- c. Contractor must provide written information to those individuals with respect to the following:
  - 1) Their rights under the law of the state.
  - 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.
  - 3) Contractor shall inform individuals that complaints concerning noncompliance with the Advance Directive requirements may be filed with the Colorado Department of Public Health and Environment.

8. Prompt Payment of Claims

The Contractor shall promptly pay claims submitted by Providers, consistent with the claims payment procedures as required by Section 10-16-106.5, C.R.S., as amended.

9. Termination of Participating Provider Agreements

- a. 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 written notice shall be provided to the Department at least sixty (60) calendar days prior to termination of the services unless the termination is based upon quality or performance issues. 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.

- b. The Contractor shall make a reasonable effort to provide written notice of the termination of Participating Provider agreements to Members. This shall occur within fifteen (15) calendar days after receipt, issuance of, or notice of such termination to all Members receiving Covered Services on a regular basis from or through a Provider whose agreement is terminating with the Contractor, regardless of whether the termination is for cause or without cause. Where a termination involves a Primary Care Physician, all Members that receive Covered Services through that Primary Care Physician shall also be notified. Such notice shall describe how services provided by the Participating Provider will be replaced, and inform the Members of Disenrollment procedures. The Contractor shall allow Members to continue receiving care for sixty (60) calendar days from the date a Participating Provider is terminated without cause when proper notice as specified in this section has not been provided to the Members.

10. Incentives to Members

The Contractor and Participating Providers are prohibited 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.

11. Provider Applications

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.

This provision may not be construed to:

- a. Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees.
- b. Preclude the Contractor from using different reimbursement amounts for

different specialties or for different practitioners in the same specialty.

- c. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.
12. The Contractor shall monitor Covered Services rendered by subcontract 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.

#### **G. SUBCONTRACTS**

1. The Contractor shall be responsible for all work performed under this contract, but may enter into subcontracts for the performance of aspects of the scope of work required under this contract. Prior to entering into such subcontract, the Contractor shall evaluate the proposed Subcontractor's ability to perform the activities to be delegated. 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 required under this contract.
2. The Contractor shall have a written agreement with each Subcontractor. The agreement shall specify the activities and reporting responsibilities delegated to the Subcontractor. The agreement shall include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.
3. The Contractor shall develop and implement written procedures for monitoring Subcontractor performance on an ongoing basis. These procedures are subject to the approval of the Department.
4. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractors shall take corrective action.
5. The Contractor shall make available to the Department copies of any existing subcontracts and a full description of its procedures and policies in effect to accomplish the duties and responsibilities described herein, upon request by the Department.
6. The Contractor shall submit fully executed subcontracts to the Department, within five (5) business days of a written request from the Department.
7. Subcontracts shall meet the requirements of 42 C.F.R Section 434.6, as amended. All subcontracts shall provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, as specified in 45 C.F.R. Section 74, as amended.

8. The Contractor shall notify the Department, in writing, of its decision to terminate any existing subcontract. The written notice shall afford the Department at least sixty (60) calendar days prior to the services terminating unless the Contractor needs to terminate with less than sixty (60) calendar days notice based upon quality or performance issues. The Contractor shall define how the replacement of these services shall be performed in the termination notice.

## **H. COMPLIANCE AND MONITORING**

1. Utilization Management
  - a. The Contractor shall follow CMS regulations regarding Utilization Management at 42 C.F.R. Section 438.210(e).
  - b. The Contractor shall have a mechanism in effect to ensure consistent application of review criteria for authorization decision and consultation with the requesting Provider when appropriate. 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 need not be in writing.
  - c. At the time of Member Enrollment and at the time an agreement is executed with a Participating Provider, 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.
    - 1) Information for Providers shall include but is not limited to necessary information and guidelines to enable the Provider to understand and participate appropriately in the Utilization Management program.
    - 2) Information for Members shall include but is not limited to a brief explanation of the purpose of the Contractor's Utilization Management program and how the program works.
  - d. The Contractor shall maintain data systems sufficient to support Utilization 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 Medicaid eligibility.
  - e. The Contractor shall assure 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, shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

- f. Utilization Management shall be conducted under the auspices of a qualified clinician.

## 2. Compliance Reporting

- a. The Contractor shall be deemed out of compliance with reporting requirements under any of the following conditions:

- 1) Late or absent submission of report;
- 2) Report(s) does not contain all required elements as stated in Department format and/or
- 3) Report(s) contains inaccuracies or insufficient data.

- b. The Contractor shall provide, upon the Department's request, a corrective action plan to eliminate identified deficiencies.

- c. The Contractor shall comply with requirements and limitations regarding abortions, hysterectomies and surgical sterilizations and shall maintain certifications and documentation specified in 42 C.F.R. Section 441, Subparts E and F. The certifications and documentations, as well as any summary reports, shall be available to the Department within ten (10) business days of the Department's request.

- d. 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 Medicaid has ended as the Department is required to do under the Health Insurance Portability and Accountability Act (HIPAA), Pub.L. 104-191.

## 3. Other Monitoring Activities

- a. In consultation with the Department, the Contractor shall participate in and respond to other Department compliance monitoring activities, including but not limited to:

- 1) Encounter Data analysis; Encounter Data validation (the comparison of Encounter Data with Medical Records);
- 2) Appeals analysis to identify trends in the Medicaid program and among managed care organizations;

- 3) Risk-adjusted rate studies; and,
  - 4) Other reviews determined by the Department.
- b. The Department reserves the right to determine Contractor compliance with individual requirements under this contract based upon satisfactory review by recognized state agencies or private accreditation organizations.
4. Inspection, Monitoring and Site Reviews

a. Inspections and Acceptance

The Contractor shall permit duly authorized agents of the Department and of the state and federal government to access the Subcontractors', or Participating Providers' premises, during normal business hours. The purpose shall be to inspect, audit, monitor or otherwise evaluate the quality, appropriateness, timeliness or any other aspect of the performance of the Subcontractors' or Participating Providers' contractual services. Services as used in this clause include Covered Services performed or tangible material produced or delivered in the performance of Covered Services. If any of the Covered Services do not conform to the contract requirements, the Department may require the Contractor to perform the services again in order to conform to contract requirements, with no additional payment. When defects in the quality or quantity of Covered Services cannot be corrected by repeat performance, the Department may require the Contractor to take the necessary action to ensure that the future performance conforms to contract requirements. These remedies in no way limit the remedies available to the Department in the Termination and Remedies provisions of this contract, or remedies otherwise available by law.

b. Site Reviews

- 1) Site Reviews shall be conducted at least annually or more frequently if the Department, in its sole discretion, deems it necessary. Site Reviews shall be conducted by the Department 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, upon request, provide and make available staff to assist in the audit or inspection effort. They shall provide adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of the Subcontractor's or Participating Providers' provision of care.

- 2) 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 reserves the right to determine when an emergency review is required. 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. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to the Contractor at least sixty (60) 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 sixty (60) calendar days to submit the required materials for non-emergency reviews.
- 3) 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. Such internal procedures shall 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. 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 shall exist outside the Contractor's internal policies and procedures, generally in the form of direct Member correspondence or the Member handbook.
- 4) 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 cause the Contractor to be subject to remedial actions as specified in Section IV of 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.
- 5) A written report of the site visit shall be transmitted to the Contractor within thirty (30) calendar days of the Site Review. The Contractor shall be allowed thirty (30) days to review the preliminary report and respond to the findings. The final report

shall indicate areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response shall be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.

- 6) 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 and time frames. The corrective action plan is subject to approval by the Department. The Department review staff shall monitor progress on the corrective action plan until the Contractor is found to be in complete compliance. Department staff shall 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.
- 7) Where it is reasonable and advisable to do so, the Department may extend the time frame for corrective action. The Department may also reduce the time frame for corrective action if delivery of Covered Services for Members is adversely affected. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during corrective action periods.
- 8) Any data submitted by the Contractor to the Department or its agents after the last site visit day shall not be accepted towards compliance with the visit in the written report. This data shall apply toward the corrective action plan.
- 9) 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.
- 10) 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.

c. 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.

5. Audits and Maintenance of Records

a. Audits

The Contractor shall permit the Department, federal government, or any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and/or transcribe Contractor's records concerning its performance under this contract during the term of this contract. This right shall extend for a period of six (6) years following termination of this contract or final payment hereunder, whichever is later, to assure compliance with the terms hereof, or to evaluate the Contractor's performance hereunder. The Contractor shall also permit these same entities to monitor all activities conducted by the Contractor pursuant to the terms of this contract. As the monitoring agency may, in its sole discretion, deem necessary or appropriate, such monitoring may consist of internal evaluation procedures, examination of program data, special analyses, on-site check, formal audit examinations, or any other reasonable procedure. All such monitoring shall be performed in a manner that will not unduly interfere with contract work.

b. Maintenance of Records

- 1) The Contractor and all Subcontractors shall maintain a complete file of all records, documents, communications, and other materials which pertain to the operation of the program/project or the delivery of services under this contract sufficient to disclose fully the nature and extent of services/goods provided to each Member. These records shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records. Such files shall be sufficient to properly reflect all direct and indirect costs of labor, materials, equipment, supplies and services, and other costs of whatever nature for which contract payments was made and shall include but are not limited to:
  - a) All Medical Records, service reports, and orders prescribing treatment plans;
  - b) Records of goods, including such things as drugs and medical equipment and supplies, and copies of original invoices for such goods; and,
  - c) Records of all payments received for the provision of such services or goods.
- 2) The Contractor shall maintain records or shall have a system in place to retrieve information sufficient to identify the Physician who delivered services to the patient.
- 3) All such records, documents, communications, and other materials shall be maintained by the Contractor, for a period of six (6) years

from the date of any monthly payment under this contract, or for such further period as may be necessary to resolve any matters which may be pending, or until an audit has been completed with the following qualification: if an audit by or on behalf of the federal and/or state government has begun but is not completed at the end of the six (6) year period, or if audit findings have not been resolved after a six (6) year period, the materials shall be retained until the resolution of the audit finding.

6. Encounter Data Provisions

a. The Contractor shall certify all Encounter 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. The data shall be sent semi-annually based on the contract year (July 15 and January 15 for the previous six months of data submitted).

b. Encounter Data for Current Risk Adjustment and Quality Assurance

1) Paid Encounter Data Submissions

For purposes of risk adjustments and quality assurance, the Contractor shall submit paid Encounter Data to the Department. Paid encounters types shall include claims that were paid initially, adjusted claims and resubmissions, within the requested reporting periods.

2) Encounter Data Submission Schedule

The Contractor shall submit Encounter Data to the Department based on service dates from a twelve (12) month interval, on January 15th and July 15th, as follows:

a) January 15th submission reporting shall include encounters with service dates between July 1st and June 30th of the prior fiscal year; and,

b) July 15th submission reporting shall include encounters with service dates between January 1st and December 31st of the prior calendar year.

3) Encounter Data Submission Categories

Encounter Data submitted to the Department shall include the following categories: EPSDT; Hospital inpatient and outpatient;

medical group practices/clinics; Physicians, non-Physician practitioners; medical equipment; ambulatory surgical centers; family planning clinics; independent laboratories; optometrists; podiatrists; home health; dialysis centers; FQHCs; freestanding rehabilitation centers, pharmacies; and skilled nursing facilities.

4) Data Set Format Requirements

The Contractor shall submit Encounter Data in the format prescribed and approved by the Department following consultation with the managed care organizations. Data set format requirements are available from the Department.

5) Encounter Data Transmissions

The Contractor shall submit Encounter Data to the Department by compact disc (CD) or by encrypted email electronically.

6) Encounter Data Processing and Reporting

a) The Department will process all submissions for Encounter Data for risk adjustments and quality assurance.

b) The Department will send the Contractor a report within thirty (30) calendar days, providing the number of records received for the requested reporting period and the number of encounters that were unreadable.

c. Encounter Claims Data for MMIS Submissions

1) General Provisions

In addition to the direct submission of Encounter Data to the Department for purposes of risk adjustment and quality assurance, the Contractor shall submit encounter claims data directly to the Department's fiscal agent, via the Medicaid Management Information System (MMIS).

2) Encounter Claims Data Submission Schedule

The Contractor shall submit encounter claims data to the MMIS on a monthly basis.

3) Encounter Claims Submission Requirements

a) Hospital, Ambulatory Surgery Center and Home Health Encounter Claims

- (i) Hospital (both inpatient and outpatient) and home health encounter claims include paid and denied services provided by a Hospital, ambulatory surgery center or home health agency. These encounter claims shall contain revenue and procedure codes, as appropriate. One encounter claim shall be submitted for each hospitalization, outpatient visit or outpatient surgery. Multiple home health visits may be on one home health encounter claim. The encounter claim shall represent all services delivered to the Member during the billing episode billed.
  - (ii) Hospital, ambulatory surgery center and home health encounter claims are to be submitted electronically directly to MMIS, using the ANSI 837I, Health Care Claim Institutional format.
  - (iii.) 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 Provider.
- b) Pharmacy Encounter Claims
- (i) Pharmacy claims refer to all paid pharmaceutical prescriptions.
  - (ii) A pharmacy claim encounter is a single prescription. Example: A Member who goes to one Provider and has two prescriptions filled would have two encounters.
  - (iii) Pharmacy encounters are to be submitted electronically directly to the MMIS, using the National Council for Prescription Drug Program (NCPDP) version 5.1 format.
- c) Medical Encounters
- (i) Medical encounter claims include paid and denied services delivered by medical groups practices/clinics, Physicians, non-practitioners, medical equipment suppliers, family planning clinics, independent laboratories, optometrists, podiatrists, FQHCs, and freestanding rehabilitation

centers, and all other Providers not listed in sections a and b above.

- (ii) When a Member receives services from multiple Providers in the same day, submit separate encounter claims for each visit for each Provider.
- (iii) Medical encounters are to be submitted electronically directly to the MMIS, using the ANSI 837P, Health Care Claim professional format.

#### 4) Encounter Edits and Types

##### a) Encounter Data Edits

The MMIS will edit encounter claims for accuracy and reasonableness of data. The edits used will change as the volume and accuracy of data increases. The Contractor can obtain a current list of edits by contacting the Department.

##### b) Encounter Types

###### (i) Adjudicated Encounter Claims

Adjudicated encounter claims are encounters that have been accepted by the system edits as provisionally correct.

If the Department discovers errors with previously adjudicated claims resulting from a federal or state mandate or request that requires the completeness and accuracy of the Encounter Data, the Contractor shall be required to correct the error.

###### (ii) Rejected Encounter Claims

Rejected encounter claims are encounters that fail electronic claims capture (ECC) edits. These claims are not allowed into MMIS and will be reported to the Contractor upon failure of ECC.

###### (iii) Denied Encounter Claims

Level 1 denied encounter claims are encounters that have been denied by the Contractor. Encounter claims denied by the Contractor shall be submitted to the MMIS edits as described in section II.I.6.c.4.a. of this contract.

Level 2 denied encounter claims are encounter claims that fail to process correctly in the MMIS because of missing or erroneous data. These claims are not allowed into MMIS and will be reported to the Contractor on a routine basis.

5) Data Set Format Requirements

- a) The Contractor shall submit all Encounter Data for MMIS in a format to be specified by the Department.
  - (i) Detailed format information for the ASC 837 transaction is available at <http://www.wpc-edi.com>. HIPAA transaction data guides to prepare systems to work with the Colorado Medicaid program and detail acceptable Colorado Program values can be found at [www.chcpf.state.co.us](http://www.chcpf.state.co.us).
  - (ii) A detailed format for Pharmacy submissions has been emailed to the Contractor. Additional copies are available from the Department's Information Systems Section.
  - (iii) The Department reserves the right to change format requirements at any time, following consultation with the Contractor. The Department, however, retains the right to make the final decision regarding format submission requirements.
- b) The Contractor shall take necessary measures to ensure the:
  - (i) Accuracy of all required fields;
  - (ii) Completeness of encounter claims submitted;
  - (iii) Presence of Medical Record documentation and each encounter claim;
  - (iv) Submitted data include paid and denied claims identified in this section of the contract (paid only for Pharmacy encounter claims);
  - (v) Submitted data excludes interim, serial, duplicate and late billings or claims in appeal status; and,
  - (vi) Submitted data include the most current version of adjusted claims.

c) The Contractor shall review compliance with these criteria each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.

6) Encounter Provider Identification

a) Encounter claims for Covered Services provided by Medicaid Providers shall contain the Provider Medicaid identification number. The Contractor shall use the Department supplied pseudo-numbers to identify Participating Providers who are not Medicaid Participating Providers or whose Medicaid identification number is not known.

b) Encounter claims from Hospitals and FQHCs shall contain Medicaid Provider identification numbers. Pharmacy encounter claims shall contain the National Association of Boards of Pharmacies (NABP) number.

7) Encounter Data Transmissions

The Contractor shall submit all encounter claims data directly to the MMIS, via electronic transmission. Expanded privileges to submit encounter claims can be obtained through the Department's Information Systems Section.

8) Processing and Reporting

a) The Department will process all encounter claims received through the Medical Management Information System (MMIS).

b) The Department shall provide a weekly report to the Contractor of all encounter claims received via electronic transmission.

d. Clients Services

The Contractor is responsible to ensure that Providers supply services only to those eligible Colorado Medicaid Clients assigned as Members to the Contractor's Plan. It is the responsibility of the Provider to verify that the individual receiving medical services is Medicaid eligible 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.

e. Contract Termination and Encounter Data

Termination of the contract does not relieve the Contractor of its obligation to submit all required Encounter Data for dates of service during which time the contract was in effect, nor does it relieve the Contractor of the obligation to complete pay recovery costs.

7. The Contractor shall begin tracking and reporting quarterly Serious Reportable Events as described in Exhibit K, Serious Reportable Events or Never Events, attached and incorporated herein by reference, effective October 1, 2009 for all subcontracted facilities that provide inpatient services to Clients. The report shall contain any service with the Present on Admission (POA) indicator at the time of a hospital admission. The Department will provide a detailed report template. The Contractor or rendering provider cannot bill the Client or Medicaid for POA related services.

a. Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, Contractor shall not reimburse any provider for the additional costs resulting from the hospital acquired conditions and Serious Reportable Events per exhibit K.

b. Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, Contractor shall not reimburse the professional nor the hospital for the following occurrences of associated inpatient charges:

- 1) Surgery performed on the wrong body part;
- 2) Surgery performed on the wrong patient;
- 3) Wrong surgical procedure on a patient.

**I. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT**

1. The Contractor shall maintain an internal quality assessment and performance improvement program that complies with 42 C.F.R. Section 438.200 for all Covered Services.

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:

a. Practice Guidelines

1) The Contractor shall adopt practice guidelines for the following:

- a) Perinatal, prenatal and postpartum care for women;
- b) Conditions related to Persons with a Disability or Special Health Care Needs; and

- c) Well child care.
  - 2) The Contractor shall ensure that practice guidelines comply with the following requirements:
    - a) Based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.
    - b) Consider the needs of the Member.
    - c) Adopted in consultation with Participating Providers.
    - d) Review and updated annually.
  - 3) The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members and potential Members. The guidelines shall be available to the Department and Members at no cost. The guidelines shall be available to non-Members, including the public, at cost.
  - 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.
- b. Performance Improvement Projects
- 1) The Contractor shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.
  - 2) The Contractor shall conduct performance improvement projects on topics selected by the Centers for Medicare and Medicaid Services when the Department is directed to focus on a particular topic.
  - 3) The Contractor shall report the status and results of each performance improvement project in the annual quality report and when requested by the Department. The results of each performance improvement project shall be submitted in sufficient detail to allow the Department to validate the projects.
  - 4) The Contractor shall complete performance improvement projects 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.

c. Performance Measurement Data

1) Healthcare Effectiveness Data and Information Set (HEDIS)

- a) The Contractor shall calculate and submit specified HEDIS measures. The Department will collaborate with the Contractor's quality improvement committee to designate the required measures. The required measures shall be submitted to the Department, in a format defined by the Department, on June 30th of each contract year for the previous reporting year.
- b) The Contractor shall analyze and respond to results indicated in the HEDIS measures.
- c) The Contractor shall fund an external audit of the HEDIS measures according to HEDIS and EQRO protocols.
- d) A failed audit that nullifies more than three (3) required HEDIS measures is considered non-compliant with this standard and the Department may impose sanctions upon the Contractor pursuant to this contract.

2) Mandatory federal performance measurements

- a) The Contractor shall calculate additional performance measures when they are developed and required by the Centers for Medicare and Medicaid Services.

d. Enrollee Satisfaction

- 1) The Contractor shall monitor Member perceptions of accessibility and adequacy of services provided by the Contractor. Tools shall include the use of Member surveys, anecdotal information, grievance and appeals data and Enrollment and Disenrollment information. The monitoring results shall be included as part of the Contractor's Program Impact Analysis and Annual Report submission.
- 2) The Contractor shall fund an annual Member satisfaction survey, determined by the Department, and administered by a certified survey vendor, according to survey protocols. In lieu of a satisfaction survey conducted by an external entity, the Department, at the Department's discretion, may conduct the survey. In addition, the Contractor shall report to the Department results of internal satisfaction surveys of Members designed to

identify areas of satisfaction and dissatisfaction by June 30<sup>th</sup> of each fiscal year.

- 3) The Contractor shall develop a corrective action plan when Members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.
- 4) The Contractor shall implement and maintain a mechanism to assess the quality and appropriateness of care for Persons with Special Health Care Needs.

e. Mechanisms to Detect Over and Under Utilization

The Contractor shall implement and maintain a mechanism to detect over and under utilization of services.

f. Quality of Care Concerns

- 1) The Contractor shall investigate any alleged quality of care concerns.
- 2) In response to a request from the Department, 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. The outcome 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(s) involved. The letter shall not include the names of the persons conducting the investigation or participating in a peer review process, as the case may be.

The complete letter shall be sent to the Department within fourteen (14) 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 the referral.

- 3) Notwithstanding any other provision of this contract, the Contractor is not required to disclose any information that is confidential by law. After the letter is received by the Department, if there is a request for public disclosure pursuant to the Colorado Open Records Act at Section 24-72-203, C.R.S., the Department will assert any applicable exemptions and, if none apply, will petition the court pursuant to Section 24-72-204(6)(a), C.R.S. to prohibit disclosure.

g. Quality Improvement Committee

The Contractor shall participate in the Department's Quality Improvement Committee (QuIC) 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.

h. Program Impact Analysis and Annual Report

- 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.
- 2) The Contractor shall submit an annual report to the Department, detailing the findings of the program impact analysis. The report shall describe techniques used by the Contractor to improve performance, the outcome of each performance improvement project and the overall impact and effectiveness of the quality assessment and improvement program. The report shall be submitted by the last business day of September for the preceding year's quality activity or at a time the contract has been terminated.
- 3) The Program Impact Analysis and Annual Report shall provide sufficient detail for Department staff to validate the Contractor's performance improvement projects according to 42 C.F.R. Section 438.240, External Quality Review of Medicaid Managed Care Organizations.
- 4) Upon request, this information shall be made available to Providers and Members at no cost.

i. Quality Improvement Plan

The Contractor shall provide a quality improvement plan to the Department by the last business day in September. The plan shall delineate current and future quality assessment and performance improvement activities. The plan shall integrate finding and opportunities for improvement identified in focused studies, HEDIS measurements, Enrollee satisfaction surveys and other monitoring and quality activities. The plan is subject to the Department's approval.

j. External Review

- 1) The Contractor shall participate in the annual external independent review of quality outcomes, timeliness of, and access to the services covered under this contract. The external review may include but not be limited to all or any of the following: Medical

Record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, administrative data analyses and review of individual cases.

- 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.
- 3) The Contractor shall participate in the development and design of any external independent review studies to assess and assure quality of care. Final study specifications shall be at the discretion of the Department.

k. Health Information System

- 1) The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, encounters and Disenrollment.
- 2) The Contractor shall collect data on Member and Provider characteristics and on services furnished to Members.
- 3) The Contractor shall make all collected data available to the Department and to Centers for Medicare and Medicaid Services upon request.

**J. DISCLOSURES**

1. The Contractor shall disclose the following information in a form similar to that set forth in Exhibit J, Contractor Disclosures, attached and incorporated herein by reference:
  - a. The name and address of each person with an ownership or control interest in Contractor or in any subcontractor in which the Contractor has direct or indirect ownership of 5 percent or more;
  - b. Whether any of the persons named, in compliance with paragraph a. of this section, is related to another as spouse, parent, child, or sibling.
  - c. The name of any other disclosing entity in which a person with an ownership or control interest in the Contractor also has an ownership or control interest. This requirement applies to the extent that the Contractor can obtain this information by requesting it in writing from the person.
2. Any Contractor that is subject to periodic survey and certification of its compliance with Medicaid standards shall supply the information specified in

paragraph 1 above to the Department or its survey agency at the time it is surveyed. The Department or its survey agency shall promptly furnish the information to the Secretary of Health and Human Services and the Department.

3. Any Contractor that is not subject to periodic survey and certification and has not supplied the information specified in paragraph 1 above to the Secretary of Health and Human Services within the prior 12-month period, shall submit the information to the Department before entering into a contract or agreement with the Department. The Department shall promptly furnish the information to the Secretary of Health and Human Services.
4. Updated information shall be furnished to the Secretary of Health and Human Services, the Department or its survey agency at intervals between contract renewals, within 35 days of a written request.
5. Before the Department enters into or renews an agreement, or at any time upon written request by the Department, Contractor shall disclose to the Department the identity of any person who:
  - a. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor; and/or
  - b. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
6. The Contractor shall disclose to the Department certain business transactions to include:
  - a. Any sale, exchange or lease of any property between the Contractor and a party in interest.
  - b. Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.
  - c. Any lending of money or other extension of credit between the Contractor and a party in interest.
  - d. Parties of interest include:
    - 1) Any director, officer, partner, or employee responsible for management or administration of Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the

Contractor; or, in the case of a Contractor organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

- 2) Any organization in which a person described in subsection 1 is a director, officer or partner; has a direct or indirect beneficial interest of more than five percent (5%) in the equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the Contractor;
- 3) Any person directly or indirectly controlling, controlled by, or under common control with a Contractor; or
- 4) Any spouse, child, or parent of an individual described in subsections 1, 2, or 3.

### **III. REIMBURSEMENT**

#### **A. PAYMENT OF MONTHLY PAYMENT RATE**

1. For each Member Enrolled with the Contractor, the Department shall pay the Contractor the Monthly Payment Rate specified in Exhibit B.
2. The Department shall remit payment of the Monthly Payment Rate to the Contractor, on or before the twentieth (20th) business day of each month.
3. The Department shall remit to the Contractor a prorated Monthly Payment Rate for any Enrollment that begins after the first of the month, including Members retroactively Enrolled and Newborns, based on the Monthly Payment Rate as specified in Exhibit B.
4. The Department shall remit payment through an electronic transfer of funds to the bank account designated by the Contractor. The Department shall provide the Contractor with a monthly payment report through the Medicaid Management Information System (MMIS).
5. The Contractor shall be responsible for the accuracy of direct deposit information provided to the Department and for updating such information as needed.
6. The Monthly Payment Rate shall be considered payment in full for all Covered Services set forth in Exhibit A.
7. In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Exhibit B and any other provision of the contract, Exhibit B shall prevail over other provisions of this contract, pages 1 to 89 and Exhibits A and C through M (see Section IV.A, Order of Precedence).

## **B. CALCULATION OF MONTHLY PAYMENT RATE**

1. The Monthly Payment Rates set forth in Exhibit B are based on the costs of providing the Covered Services set forth in Exhibit A which shall not exceed one hundred percent (100%) of the direct health care cost of providing these same services to an actuarially equivalent Colorado Medicaid population group consisting of unassigned recipients and recipients in the Primary Care Physician Program. Calculation of the Monthly Payment Rate includes, for selected categories of aid, a risk adjustment for health status. Rates will be set in accordance with all applicable state statutes, federal regulations and actuarial standards of practice. The actuarial basis for calculation of the Monthly Payment Rate is set forth in the actuarial certification which is part of and incorporated herein as Exhibit B.
2. 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.

## **C. RECOUPMENTS**

1. The Department shall recoup Monthly Payment Rate amounts paid to the Contractor in error. Error may be either human or machine error on the part of the Department, the Contractor or otherwise. Error includes, but is not limited to, lack of eligibility, computer error, move by the Member outside the Contractor's Service Area, or situations where the Member cannot use the Contractor's facilities.
2. The Department shall recoup, from the Contractor, all claims for Covered Services paid by the Department, on behalf of Members who are retroactively Enrolled in the Contractor's Plan.
3. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) calendar days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) calendar days, the Department shall deduct the overpayments from the next payment to the Contractor.
4. The Contractor's obligation to refund all overpayments continues subsequent to the termination of the contract. If the contract has terminated, the Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within ninety (90) calendar days of termination.
5. Payments made by the Department to the Contractor due to the Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

6. Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any Monthly Payment Rate amounts paid in error.

**D. THIRD PARTY PAYER LIABILITY**

1. All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition for participation in the Medicaid program. The Contractor shall have the same rights that the Department has under Section 25.5-4-301, C.R.S. for all months that the Client is a Member of the Contractor's Plan.
2. 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.
  - a. Potential liable third parties shall include any of the sources identified in 42 C.F.R. Section 433.138 relating to identifying liable third parties. The Contractor shall coordinate 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.
  - b. The Contractor shall, on a monthly basis, notify the Department's fiscal agent, by telephone or in writing, of any third party payers, excluding Medicare, identified by the Contractor. If the third party payer is Medicare, the Contractor shall notify the Department and provide the Member's name and Medicaid identification along with the Medicare identification number. If the Member has health insurance coverage other than Medicare, the Contractor shall submit the following information:
    - 1) Medicaid identification number;
    - 2) Member's social security number;
    - 3) Member's relationship to policyholder;
    - 4) Name, complete address, and telephone number of health insurer;
    - 5) Policy Member identification and group numbers;
    - 6) Policy Member's social security number;
    - 7) Policy Member's full name, complete address and telephone number; and,
    - 8) Daytime telephone number where Member can be reached.

- c. The Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor.
- d. The Contractor shall provide a quarterly report of all third party recovery efforts and amounts recovered by Medicaid client ID, category of assistance and date of service to the Department. The report shall be provided on compact disc (CD) or by encrypted email, no later than thirty (30) calendar days following the end of each quarter.
- e. The Contractor may retain as income all amounts recovered from third party resources, up to the amount of Contractor's usual full billed charges, as long as recoveries are obtained in compliance with this contract and state and federal laws.
- f. The Contractor shall not restrict access to Covered Services due to the existence of possible or actual third party liability.
- g. 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 network, 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.
- h. 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.
- i. With the exception of Section III.D.2.j and except as otherwise specified in contracts between the Contractor and Participating Providers, the Contractor shall pay all applicable co-payments, coinsurance and deductibles for approved Covered Services for the Member from the third party resource using the lower-of pricing methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service:
  - 1) The sum of reported third party coinsurance and/or deductible or
  - 2) The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

- j. The Contractor shall pay, except as otherwise specified in contracts between the Contractor and Participating Providers, all applicable co-payment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service.
- k. 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.
- l. 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 Section 25.5-4-301, C.R.S.
- m. Benefits for Members shall be coordinated with third party auto insurance.

**E. DISPROPORTIONATE SHARE HOSPITAL**

The Contractor shall submit data according to the specifications in Exhibit C, Disproportionate Share and Graduate Medical Education Hospital Reporting, attached and incorporated herein by reference. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

**F. FQHC WRAP-AROUND ENCOUNTER REIMBURSEMENT**

- 1. The Contractor shall pay FQHCs within its Provider network one hundred percent (100%) of reasonable cost for Covered Services minus any third party payments. This payment shall be referred to as the Contractor's FQHC Payment Obligation. One hundred percent (100%) of reasonable cost is the Medicaid rate in effect on the date of service.
- 2. The Department shall pay the Contractor for the portion of the Contractor's FQHC Payment Obligation that is not covered in the Monthly Payment Rate. The Department's payment shall be referred to as the FQHC Wrap Around Payment.
- 3. The FQHC Wrap Around Payment shall be the percentage of the FQHC Medicaid rate, as set forth in Exhibit B, which is not included in the Monthly Payment Rate.

The Department shall pay a FQHC Wrap Around Payment only for those FQHC services that are Covered Services set forth in Exhibit A and that are available FQHC encounters under state and federal requirements.

4. Where the Member has third party coverage applicable to the Covered Service, the Department and the Contractor shall agree on a process for reimbursement.
5. The Contractor shall maintain records of all third party FQHC payments and denials and shall provide those records to the Department upon request.
6. The Contractor shall bill the Department for the FQHC Wrap Around Payment within one hundred fifty (150) days of the FQHC date of service unless the Member has third party coverage in which case then Contractor shall bill the Department within sixty (60) days of the date of the explanation of benefits. The Contractor shall furnish the Department with any FQHC utilization data necessary for the Department to calculate the FQHC Wrap Around Payment.
7. In order for the Contractor to receive the FQHC Wrap Around Payment for payments the Contractor has made to the FQHCs, the Contractor shall submit to the Department, by the fifteenth (15th) of each month, a compact disc (CD), or equivalent data media, containing encounter activities for all FQHCs that billed the Contractor in the prior month. Each encounter claim identified on the compact disc shall contain the following information:
  - a) Date report sent to Department;
  - b) Provider number (Contractor ID number);
  - c) Member Medicaid number (Member ID);
  - d) Encounter date of service;
  - e) Eligibility category of Member (category of aid);
  - f) Amount billed by FQHC;
  - g) Third party payor (required for Members with third party coverage);
  - h) Third party payment amount (required for Members with third party coverage);
  - i) Third party payment or denial date (required for Members with third party coverage);
  - j) Member name (last name, first name);
  - k) Name of FQHC service location;
  - l) FQHC Medicaid Provider number;

- m) Principal diagnosis; and
  - n) Billing Code (appropriate revenue or procedure code).
8. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.
  9. The Department shall adjudicate the Contractor's request for FQHC Wrap Around Payment within thirty-five (35) days of receipt of all information necessary to calculate the payment.
  10. In January of every year the Department shall perform a complete audit of the FQHC wrap around bills for the previous fiscal year. A settlement and agreement process shall conclude this review.

**G. DELIVERIES REIMBURSEMENT**

1. The Contractor shall receive payment for delivery services provided to Members through a supplemental payment. The payment, which is set forth in Exhibit B, includes facility and professional service costs related to the delivery and post-partum care. One payment shall be made for each delivery regardless of the number of births associated with that delivery.
2. In order to receive payment for deliveries, the Contractor shall submit, to the Department, a cover letter and an electronic Excel spreadsheet in the format designated by the Department. Documentation of the delivery, e.g., a claim record of delivery, must accompany the request for payment. The request for payment shall be submitted to the Department no later than one hundred and fifty (150) days following the delivery.
3. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.
4. The Department shall adjudicate the Contractor's request for payment within thirty-five (35) days of receipt of all documentation of the delivery.

**H. [NOT USED]**

**I. [NOT USED]**

#### **IV. REMEDIAL ACTIONS AND SANCTIONS**

- A. The Contractor shall comply with all provisions of this contract and its amendments, if any, and shall act in good faith in the performance of the provisions of said contract. The Contractor agrees that failure to comply with the Contract provisions may result in the application of remedial actions and/or termination of this contract.
- B. In addition to any other remedies available under this contract, and without limiting its remedies otherwise available at law, the Department may exercise the other remedial actions and intermediate sanctions, described in this section, if the Contractor substantially fails to:
1. Provide medically necessary services that the Contractor is required to provide, under law or this contract, to a Member.
  2. Provide Medical Records and other requested documents for Non-emergency review within thirty (30) calendar days of the date of the written request as stated in Section IV.E.
  3. Satisfy the scope of work found in this contract, as determined by the results of monitoring activities or audits.
  4. Comply with the requirements for physician incentive plans, as stated in Exhibit E.
- C. In addition to any other remedies available under this contract, and without limiting its remedies otherwise available under law, the Department may exercise the other remedial actions and intermediate sanctions, described in this section, if the Contractor:
1. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
  2. Discriminates among Members on the basis of their health status or need for health care services including termination of Enrollment or refusal to reenroll a recipient, except as permitted under the Medicaid program or any other practice that would reasonably be expected to discourage Enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.
  3. Misrepresents or falsifies information furnished to the Department or the Centers for Medicare and Medicaid Services.
  4. Misrepresents or falsifies information furnished to Members, potential Members, or Providers.
  5. Distributes directly or indirectly, through any agent or independent contractor, any Marketing Materials that have not been approved by the Department or that contain false or materially misleading information.

6. Violates any applicable requirements of sections 1903(m) or 1932 of the Social Security Act and its implementing regulations.
  7. Prohibits or otherwise restricts a health care professional acting within the scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the following:
    - a. The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    - b. Any information the Enrollee needs in order to decide among all relevant treatment options.
    - c. The risks, benefits, and consequences of treatment or nontreatment.
    - d. The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- D. The Department may choose to impose any of the following intermediate sanctions:
1. Civil monetary penalties to a limit of \$25,000 for each determination of failure to adhere to contract requirements as stated in Sections IV.B.1, IV.B.4, IV.C.4, and IV.C.5.
  2. Civil monetary penalties to a limit of \$100,000 for each determination of a failure to adhere to contract requirements as stated in Sections IV.C.2 and IV.C.3.
  3. Civil monetary penalties to a limit of \$15,000 for each Client the State determines was not Enrolled because of a discriminatory practice under Section IV.C.2, up to a limit of \$100,000.
  4. Civil monetary penalties to a limit of \$25,000, or double the amount of excess charges, whichever is greater, for excess charges under Section IV.C.1.
  5. Imposition of temporary management, if the Contractor has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act. Temporary management will continue until it has been determined that the Contractor can ensure that the sanctioned behavior will not recur. Enrollees will be granted the right to terminate Enrollment without cause and notify the affected Enrollees of their right to terminate Enrollment.
  6. Allow Members the right to terminate Enrollment without cause with notification to the Members of their right to terminate Enrollment, for each failure to adhere to contract requirements as stated in Section IV.C.6.
  7. Suspension of all new Enrollments, after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section IV.C.6. until

the necessary services or corrections in performance are satisfactorily completed as determined by the Department.

8. Suspension of payment for Enrollments after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section IV.C.6. until the necessary services or corrections in performance are satisfactorily completed as determined by the Department

Only the sanctions specified in D.6, D.7, and D.8, of this section may be imposed for failure to meet any of the requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

- E. The Contractor shall be subject to the requirements and sanctions of 42 C.F.R. Section 438.730. Payment provided under this contract for new Members will be denied when and for so long as payment for these same Members is denied by the Centers for Medicare and Medicaid pursuant to 42 C.F.R. Section 438.730(e).

F. Liquidated Damages

1. Time is of the essence in the performance of this contract. The parties agree that the damages from breach of this contract are difficult to prove or estimate, and the amount of liquidated damages specified herein represents a reasonable estimation of damages that will be suffered by the Department from late performance, including costs of additional inspection and oversight, and lost opportunity for additional efficiencies that would have attended on-time completion of performance. Assessment of liquidated damages shall not be exclusive of or in any way limit remedies available to the Department at law or equity for Contractor's breach of contract.
2. If the Contractor fails to satisfactorily perform the services required under this contract, the Contractor shall, in place of actual damages, pay the Department liquidated damages as follows:
  - a. For each calendar day beyond the date: 1) specified in a corrective action plan approved by the Department by which Contractor compliance is to be achieved; or 2) the date that a corrective action plan is due but not submitted to the Department, the amount of three hundred dollars (\$300) per calendar day until the compliance is achieved or an acceptable correction action plan is submitted. If the Contractor notifies the Department that it will not be able to achieve compliance by the date specified in the corrective action plan, and explains in writing its reasonable efforts to achieve compliance, the Department may grant in writing an extension of the deadline for Contractor compliance. No more than fifteen thousand dollars (\$15,000) in such damages for failure to comply with corrective action plans shall be assessed during any contract year.

- b. For each calendar day beyond the date that all requested documents, including but not limited to policies, procedures, reports, manuals and handbooks are required to be produced either by the contract or specified in a written request of the Department, the amount of three hundred dollars (\$300.00) per calendar day until the documents are produced. A written request of the Department will allow the Contractor a minimum of thirty (30) calendar days to produce documents. No more than fifteen thousand dollars (\$15,000) in such damages shall be assessed during any contract year. If the Contractor notifies the Department that it will not be able to produce the documents within the specified timeframe and explains its reasonable efforts to produce the documents, if the Department determines, in its sole discretion, that an emergency or unannounced visit is necessary, the said documents shall be produced immediately, or on a schedule determined by the Department. Failure to produce the said documents may result in the assessment of liquidated damages as set forth herein.
  - c. For failure to issue and report notice of action when required by Colorado Code of Regulations (CCR) Section 2505-10, Section 8.209, and federal regulations at 42 CFR § 438.400 and §438.404, a fine of five hundred dollars (\$500.00) for each occurrence shall be assessed.
  - d. For failure to process and report grievances when required by C.C.R. 2505-10, Section 8.209 and federal regulations at 42 CFR § 438.400, a fine of one hundred dollars (\$100.00) for each occurrence shall be assessed.
  - e. For failure to comply with the Department's request for information, response to site visit requests or other reports by the defined timelines specified in the written request, the Department will assess five hundred dollars (\$500.00) for each calendar day for which the request is late.
3. All Medical Records shall be produced by the date specified in the Department's (or its designee's) written request, which shall allow a minimum of thirty (30) calendar days for the Contractor to produce the records for Non-emergency reviews. For each record specified in the Department's written request that is not produced within the timeframe specified in the Department's written request or any extensions granted, liquidated damages of three hundred dollars (\$300.00 per calendar day) may be assessed against the Contractor. No more than fifteen thousand dollars (\$15,000) in such damages for failure to produce Medical Records shall be assessed during any contract year.
4. If the Contractor notifies the Department (or designee) that it will not be able to meet the due date for the production of Medical Records, and explains in writing its reasonable efforts to produce the records, the Department may grant an extension of time for production of records in writing. If the Contractor notifies

the Department that it cannot produce Medical Records due to the inability or unwillingness of a Participating Provider to produce the records, the Department may require exclusion of that Participating Provider from the Contractor's Medicaid network. If the Department determines, in its sole discretion, that an emergency review is required, the Contractor shall have five (5) business days from the date of the request to produce the Medical Records to the Department. In the case of a Provider site visit, the Contractor shall submit the Medical Records to the Department within two (2) business days of the site visit, or on a schedule determined by the Department. Failure to produce the said Medical Records may result in the assessment of liquidated damages as set forth herein.

5. Notwithstanding any other provision of this Section, if the Contractor is provided notice of termination for breach of contractual obligations pursuant to Section V, Termination, and the Contractor fails to cure the alleged breach in the time specified, in addition to any other damages that are applicable as the result of the termination, the Contractor shall be liable for \$300.00 per calendar day from the date set for cure until either the purchasing agency reasonably obtains similar supplies or services. If the Contractor is not terminated for default, liquidated damages shall not be due to the Department. The Contractor will not be required to pay liquidated damages when the delay in performance is beyond the control and without the fault or negligence of the Contractor.
6. If liquidated damages are imposed under this contract, the department may reduce the amount of any payments otherwise due to the Contractor by withholding the amount of such damages. Exercise of any of the remedial actions set forth in this section shall not relieve the Contractor from performance of any of its duties and obligations under this contract.
7. The Contractor will not be required to pay liquidated damages when the delay in performance is beyond the control and without the fault or negligence of the Contractor.
8. The remedies available to the Department set forth above are in addition to all other remedies available to the Department by law or equity, are joint and several and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any remaining remedies. The Department's exercise of any of the remedies set forth in this section shall not excuse the Contractor from performance of its obligations and duties under this Contract.

## **V. TERMINATION**

This contract may be terminated, by either party or upon mutual agreement, by proper notice, as described below:

1. Either party may terminate this contract without cause by providing written notice of termination to the other party at least ninety (90) calendar days before termination. The effective date of termination shall be the last day of the month at least ninety (90) calendar days from the date of the termination notice.

The Contractor shall be financially responsible for all costs associated with notifying clients that the Contractor will no longer serve as the client's managed care organization.

The Contractor shall notify each participating provider in writing that Contractor has terminated its contract with the Department. The written notice shall include the effective date of the termination and shall explain to the participating provider how the provider can continue participating in the Medicaid program.

Sixty (60) calendar days prior to the effective date of the contract termination, the Contractor shall provide the following information in a format prescribed and approved by the Department:

- a. A list of each participating provider, including providers who are not contracted with the Department.
  - b. A list of clients with special health care needs and clients who are receiving case management.
  - c. A list of all services requiring Contractor prior authorization.
  - d. A list of all clients receiving prior authorized services that extends beyond the contract termination date.
2. With respect to termination by either party for breach of contractual obligations, effective notice shall be given by providing the notice at least forty-five (45) calendar days before date of termination. The notice shall state the reason(s) for termination and may state a reasonable period, not less than thirty (30) calendar days, in which the alleged breach(es) may be cured.
  3. In the event of fraud, Medicaid program abuse, failure to have any necessary licenses or certificates required by Section II.A.1 of this contract, or to notify the Department as required by this contract, failure to meet the solvency standards set forth in Section 10-16-411, C.R.S. or failure to notify the Department as required by this contract or jeopardy to the health and safety of any Member, the Department may terminate this contract immediately.
  4. In the event funding from state, federal or other sources is withdrawn, reduced or limited in any way after the effective date of the contract and prior to the anticipated contract expiration date, the Department may terminate the contract upon written notice thirty (30) calendar days before the effective date of termination. If the effective date of funding withdrawal, reduction or limitation

does not allow for a full thirty (30) notice, a shorter notice period shall be effective.

5. Where this Contract is terminated for any reason other than unilateral termination by the Department without cause, the Contractor shall be responsible for all expenses related to Member notification regarding the termination.

#### **IV. GENERAL PROVISIONS**

##### **A. ORDER OF PRECEDENCE**

The provisions of this contract shall govern the relationship of the Department and the Contractor. In the event of conflicts or inconsistencies between this contract and its exhibits or attachments, such conflicts or inconsistencies shall be resolved by reference to the document in the following order of priority:

1. Colorado Special Provisions, pages 90 and 91.
2. HIPAA Business Associate Addendum.
3. Exhibit B.
4. Contract, Pages 1 to 89.
5. Exhibits A, C, D, E, F, G, H, I, J, K, L and M.

##### **B. PERFORMANCE PERIOD**

The contract shall be effective upon approval by the State Controller, or designee, or on July 1, 2009, whichever is later. The contract performance contemplated herein shall commence as soon as practicable after the effective date of this contract and shall be undertaken and performed in the sequence and manner set forth in the scope of work and extend through June 30, 2010. The Contractor understands and agrees that the Department shall not be liable for payment of work or services or for costs or expenses incurred by this Contractor prior to the proper execution and State Controller approval of this contract.

The contract may be renewed for up to four additional one-year periods, at the sole discretion of the Department, contingent upon funds being appropriated, budgeted and otherwise made available, and other contractual requirement, if applicable, being satisfied. Such extension shall be made by contract amendment. If the Department extends this contract, the extended contract shall be considered to include this renewal provision. The total duration of this contract, including all the renewal periods, shall not exceed five years. Financial obligations of the State of Colorado payable after any current fiscal year are contingent upon the availability of funds for that purpose.

**C. HOLDOVER PROVISION**

In the event that the Department desires to continue the services and a replacement contract has not been fully executed by the ending term date of this contract, the Department, upon written notice to the Contractor, may unilaterally extend this contract for a period of up to two (2) months. The contract shall be extended under the same terms and conditions as the original contract, including, but not limited to prices, rates and service delivery requirements. However, this extension shall terminate at the end of the two month period or when the replacement contract is signed by the State Controller or an authorized delegate.

**D. FEDERAL FUNDING**

This contract is subject to and contingent upon the continuing availability of federal funds for the purposes hereof. The parties hereto expressly recognize that the Contractor is to be paid, reimbursed, or otherwise compensated with funds provided to the Department for the purpose of contracting for the services provided herein; therefore, the Contractor expressly understands and agrees that all its rights, demands and claims to compensation arising under this Contract are contingent upon receipt of such funds by the Department. In the event that the Department does not receive such funds or any part thereof, the Department may immediately terminate this contract without liability, including liability for termination cost.

**E. HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (“HIPAA”)**

Federal law and regulations governing the privacy of certain health information requires a “Business Associate Contract” between the State and the Contractor. 45 C.F.R. Section 164.504(e). Attached and incorporated herein by reference and agreed to by the parties is a HIPAA Business Associate Addendum for HIPAA compliance. Terms of the Addendum shall be considered binding upon execution of this contract and shall remain in effect during the term of the contract including any extensions.

**F. LEGAL AUTHORITY**

The Contractor warrants that it possesses the legal authority to enter into this contract and that it has taken all actions required by its procedures, by-laws, and/or applicable laws to exercise that authority, and to lawfully authorize its undersigned signatory to execute this contract and to bind the Contractor to its terms. The person(s) executing this contract on behalf of the Contractor warrant(s) that such person(s) have full authorization to execute this contract.

**G. PROPRIETARY INFORMATION**

Unless otherwise provided for in this contract, neither party shall use or disclose directly nor indirectly without prior written authorization, any identified Proprietary Information concerning the other party obtained as a result of this contract.

## **H. INSPECTION AND ACCEPTANCE**

The Department reserves the right to inspect services provided under this contract at all reasonable times and places during the term of the contract. "Services" as used in this clause include services performed or tangible material produced or delivered in the performance of services. If any of the services do not conform with contract requirements, the Department may require the Contractor to perform the services again in conformity with contract requirements, with no additional payment. When defects in the quality or quantity of service cannot be corrected by reperformance, the Department may (1) require the Contractor to take necessary action to ensure that the future performance conforms to contract requirements and (2) equitably reduce the payment due the Contractor to reflect the reduced value of the services performed. These remedies in no way limit the remedies available to the Department in the termination provisions of this contract, or remedies otherwise available at law.

## **I. REMEDIES**

In addition to any other remedies provided for in this contract, and without limiting its remedies otherwise available at 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 shall be defined to mean significant insufficient, incorrect or improper performance, activities, or inaction by the Contractor. These remedial actions are as follows:

1. Suspend Contractor's performance pending necessary corrective action as specified by the Department without Contractor's entitlement to adjustment in price/cost or schedule; and/or
2. Withhold payment to Contractor until the necessary services or corrections in performance are satisfactorily completed; and/or
3. 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 whose continued employment on the contract the Department deems to be contrary to the public interest or not in the best interest of the Department; and/or
4. Deny payment for those services or obligations which have not been performed and which, due to circumstances caused by 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.
5. Terminate the contract for default.

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

## J. INSURANCE

1. The Contractor shall obtain, and maintain at all times during the term of this agreement, insurance in the following kinds and amounts:
  - a. Workers' Compensation Insurance as required by state statute, and Employer's Liability Insurance covering all of contractor's employees acting within the course and scope of their employment.
  - b. Commercial General Liability Insurance written on ISO occurrence form CG 00 01 10/93 or equivalent, covering premises operations, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows:
    - 1) \$1,000,000 each occurrence;
    - 2) \$1,000,000 general aggregate;
    - 3) \$1,000,000 products and completed operations aggregate; and
    - 4) \$50,000 any one fire.

If any aggregate limit is reduced below \$1,000,000 because of claims made or paid, the Contractor shall immediately obtain additional insurance to restore the full aggregate limit and furnish to the State a certificate or other document satisfactory to the State showing compliance with this provision.
  - c.
  - d. Automobile Liability Insurance covering any auto (including owned, hired and non-owned autos) with a minimum limit as follows: \$1,000,000 each accident combined single limit.
2. The State of Colorado shall be named as additional insured on the Commercial General Liability and Automobile Liability Insurance policies (leases and construction contracts will require the additional insured coverage for completed operations on endorsements CG 2010 11/85, CG 2037, or equivalent). Coverage required of the contract will be primary over any insurance or self-insurance program carried by the State of Colorado.
3. The Insurance shall include provisions preventing cancellation or non-renewal without at least 45 days prior notice to the State by certified mail.
4. The Contractor will require all insurance policies in any way related to the contract and secured and maintained by the Contractor to include clauses stating that each carrier will waive all rights of recovery, under subrogation or otherwise,

against the State of Colorado, its agencies, institutions, organizations, officers, agents, employees and volunteers.

5. All policies evidencing the insurance coverages required hereunder shall be issued by insurance companies satisfactory to the State.
6. The Contractor shall provide certificates showing insurance coverage required by this contract to the State within 7 business days of the effective date of the contract, but in no event later than the commencement of the services or delivery of the goods under the contract. No later than 15 days prior to the expiration date of any such coverage, the Contractor shall deliver the State certificates of insurance evidencing renewals thereof. At any time during the term of this contract, the State may request in writing, and the Contractor shall thereupon within 10 days supply to the State, evidence satisfactory to the State of compliance with the provisions of this section.
7. Notwithstanding subsection A of this section, if the Contractor is a “public entity” within the meaning of the Colorado Governmental Immunity Act C.R.S. Section 24-10-101, *et seq.*, as amended (“Act”), the Contractor shall at all times during the term of this contract maintain only such liability insurance, by commercial policy or self-insurance, as is necessary to meet its liabilities under the Act. Upon request by the State, the Contractor shall show proof of such insurance satisfactory to the State.

**K. REPRESENTATIVES AND NOTICE**

1. Representatives. For the purpose of this contract, the individuals identified below are hereby designated representatives of the respective parties. Either party may from time to time designate in writing new or substitute representatives:

For the Department:

<u>Bernadette Marra</u>	<u>Contract Manager</u>
Name	Title

For the Contractor:

<u>LeAnn Donovan</u>	<u></u>
Name	Title

2. Authority. With respect to the representative of the Department, such individual shall have the authority to monitor performance, inspect and reject services, approve invoices for payment, and act otherwise for the Department, except with respect to the execution of formal amendments to or termination of this agreement.
3. Notices. All notices required to be given by the parties hereunder shall be hand delivered or given by certified or registered mail to the individuals at the

addresses set forth below. Either party may from time to time designate in writing substitute addresses or persons to whom such notices shall be sent.

For the Department:

Individuals Name: Bernadette Marra, Contract Manager  
Department and Division: Medical Assistance Office  
Department of Health Care Policy and  
Financing  
Address: 1570 Grant Street, 3rd Floor  
Denver, Colorado 80203

For the Contractor:

Individuals Name: LeAnn Donovan  
Company Name: Denver Health and Hospital Authority  
Address: 777 Bannock Street Mail Code 0278  
Denver, Colorado 80204

#### **L. ASSIGNMENT AND SUCCESSORS**

The Contractor agrees not to assign rights or delegate duties under this contract or subcontract any part of the performance required under the contract without the express, written consent of the Department which shall not be unreasonably withheld. Except as herein otherwise provided, this agreement shall inure to the benefit of, and be binding upon, the parties hereto and their respective successors and assigns. This provision shall not be construed to prohibit assignments of the right to payment to the extent permitted by Section 4-9-318, CRS, provided that written notice of assignment adequate to identify the rights assigned is received by the controller for the agency, department, or institution executing this contract. Such assignment shall not be deemed valid until receipt by such controller -- as distinguished from the State Controller -- and the Contractor assumes the risk that such written notice of assignment is received by the controller for the agency, department, or institution involved.

#### **M. FORCE MAJEURE**

Neither the Contractor nor the Department shall be liable to the other for any delay in, or failure of performance of, any covenant or promise contained in this contract, nor shall any delay or failure constitute default or give rise to any liability for damages if, and only to the extent that, such delay or failure is caused by "force majeure." As used in this contract "force majeure" means acts of God; acts of the public enemy; acts of the state and any governmental entity in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather.

**N. THIRD PARTY BENEFICIARIES**

It is expressly understood and agreed that the enforcement of the terms and conditions of this contract and all rights of action relating to such enforcement, shall be strictly reserved to the State and the named Contractor. Nothing contained in this agreement shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Department and the Contractor that any such person or entity, other than the Department or the Contractor, receiving services or benefits under this agreement shall be deemed an incidental beneficiary only.

**O. GOVERNMENTAL IMMUNITY**

Notwithstanding any other provision of this contract to the contrary, no term or condition of this contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of the Colorado Governmental Immunity Act, Section 24-10-101, *et seq.*, C.R.S., as now or hereafter amended. The parties understand and agree that liability for claims for injuries to persons or property arising out of negligence of the State of Colorado, its departments, institutions, agencies, boards, officials and employees is controlled and limited by the provisions of Section 24-10-101, *et seq.*, C.R.S., as now or hereafter amended and the risk management statutes, Section 24-30-1501, *et seq.*, C.R.S., as now or hereafter amended. Any liability of the Department created under any other provision of this contract, whether or not incorporated herein by reference, shall be controlled by, limited to, and otherwise modified so as to conform with, the above cited laws.

**P. SEVERABILITY**

To the extent that this contract may be executed and performance of the obligations of the parties may be accomplished within the intent of the contract, the terms of this contract are severable, and should any term or provision hereof be declared invalid or become inoperative for any reason, such invalidity or failure shall not affect the validity of any other term or provision hereof.

**Q. WAIVER**

The waiver of any breach of a term, provision, or requirement of this contract shall not be construed or deemed as waiver of any subsequent breach of such term, provision, or requirement, or of any other term, provision, or requirement.

**R. ENTIRE UNDERSTANDING**

This contract is intended as the complete integration of all understandings between the parties. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever, unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a writing executed and approved pursuant to the State Fiscal Rules.

**S. SURVIVAL OF CERTAIN CONTRACT TERMS**

Notwithstanding anything herein to the contrary, the parties understand and agree that all terms and conditions of this contract and the exhibits and attachments hereto which may require continued performance, compliance, or effect beyond the termination date of the contract shall survive such termination date and shall be enforceable by the Department as provided herein in the event of such failure to perform or comply by the Contractor.

**T. MODIFICATION AND AMENDMENT**

This contract is subject to such modifications as may be required by changes in federal or state law, or their implementing regulations. Any such required modification shall automatically be incorporated into and be part of this contract on the effective date of such change as if fully set forth herein. Except as provided above, no modification of this contract shall be effective unless agreed to in writing by both parties in an amendment to this contract that is properly executed and approved in accordance with applicable law.

**U. REPORTING**

Unless otherwise provided, in service contracts having a performance term longer than three (3) months, the Contractor shall submit, on a quarterly basis, a written program report specifying progress made for each activity identified in the Contractor's duties and obligations, regarding the performance of the contract. Such written analysis shall be in accordance with the procedures developed and prescribed by the Department. The preparation of reports in a timely manner shall be the responsibility of the Contractor and failure to comply may result in delay of payment of funds and/or termination of the contract. Required reports shall be submitted to the Department not later than the end of each calendar quarter, or at such time as otherwise specified.

**V. CONFIDENTIALITY OF RECORDS**

The Contractor shall protect the confidentiality of all records and other materials containing personally identifying information that are maintained in accordance with the contract. Except as provided by law, no information in possession of the Contractor about any individual constituent shall be disclosed in a form including identifying information without the prior written consent of the person in interest, a minor's parent, or guardian. The Contractor shall have written policies governing access to, duplication and dissemination of, all such information. The Contractor shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. The Contractor shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted. No confidentiality requirements contained in this contract shall negate or supercede the provisions of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**W. COMPLIANCE WITH APPLICABLE LAW**

The Contractor shall at all times during the execution of this contract strictly adhere to, and comply with, all applicable federal and state laws, and their implementing regulations, as they currently exist and may hereafter be amended, which are incorporated herein by this reference as terms and conditions of this contract. The Contractor shall also require compliance with these statutes and regulations in subcontracts and subgrants permitted under this contract. The Federal laws and regulations include:

Age Discrimination Act of 1975	42 U.S.C. Sections 6101, <i>et seq.</i>
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, <i>et seq.</i>
Equal Pay Act of 1963	29 U.S.C. 206(d)
Immigration Reform and Control Act of 1986	8 U.S.C. 1324b
Section 504 of the Rehabilitation Act of 1973	29 U.S.C. 794
Title VI of the Civil Rights Act of 1964	42 U.S.C. 2000d
Title VII of the Civil Rights Act of 1964	42 U.S.C. 2000e
Title IX of the Education Amendment of 1972	20 U.S.C. 1681, <i>et seq.</i>
E.O. 11246, Equal Employment Opportunity, as amended by E.O. 11375, Amending Executive Order 11246 Relating to Equal Employment Opportunity and as supplemented by 41 CFR part 60	
Clean Air Act	42 U.S.C. 7401 <i>et seq.</i>
Federal Water Pollution Control Act, as amended	33 U.S.C. 1251 <i>et seq.</i>

Section 24-34-302, *et seq.*, Colorado Revised Statutes 1997, as amended

The Contractor also shall comply with any and all laws and regulations prohibiting discrimination in the specific program(s) which is/are the subject of this contract. In consideration of and for the purpose of obtaining any and all federal and/or state financial assistance, the Contractor makes the following assurances, upon which the Department relies.

1. The Contractor will not discriminate against any person on the basis of race, color, national origin, age, sex, religion and handicap, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions, in performance of work under this contract.
2. At all times during the performance of this contract, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or denied benefits of the service, programs, or activities performed by the Contractor, or be subjected to any discrimination by the Contractor.

The Contractor shall take all necessary affirmative steps, as required by 45 CFR 92.36(e) and (Colorado Executive Order, Procurement Rules), to assure that small and minority businesses and women's business enterprises are used, when possible, as sources of supplies, equipment, construction, and services purchased under this contract.

**X. LICENSES, PERMITS, AND RESPONSIBILITIES**

Contractor certifies that, at the time of entering into this contract, it has currently in effect all necessary licenses, certifications, approvals, insurance, permits, etc. required to properly perform the services and/or deliver the supplies covered by this contract. The Contractor warrants that it will maintain all necessary licenses, certifications, approvals, insurance, permits, etc. required to properly perform this contract, without reimbursement by the Department or other adjustment in contract price. Additionally, all employees of the Contractor performing services under this contract shall hold the required licenses or certification, if any, to perform their responsibilities. The Contractor further certifies that, if it is a foreign corporation or other entity, it currently has obtained and shall maintain any applicable certificate of authority to do business in the State of Colorado and has designated a registered agent in Colorado to accept service of process. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, insurance, permits, etc. required for the Contractor to properly perform this contract, shall be grounds for termination of this contract by the Department for default.

**Y. LITIGATION REPORTING**

Unless otherwise provided, the Contractor shall promptly notify the Department in the event that the Contractor learns of any actual litigation in which it is a party defendant. The Contractor, within ten (10) days after being served with a summons, complaint, or other pleading in a case which involves services provided under this contract and which has been filed in any federal or state court or administrative agency, shall deliver copies of such document to the representative designated in this contract, or in absence of such designation, to the chief executive officer of the department, agency, or institution executing this contract on behalf of the Department.

**Z. VENUE**

The parties agree that venue for any action related to performance of this contract shall be in the City and County of Denver, Colorado.

**AA. FEDERAL AUDIT PROVISIONS**

The Office of Management and Budget (OMB) Circular No. A-133 Audits of States, Local Governments, and Non-Profit Organizations defines audit requirements under the Single Audit Act of 1996 (Public Law 104-156). All state and local governments and non-profit organizations expending \$500,000 or more from all sources (direct or from pass-through entities) are required to comply with the provisions of Circular No. A-133. The Circular also requires pass-through entities to monitor the activities of subrecipients and ensure that subrecipients meet the audit requirements. To identify its pass-through responsibilities, the State of Colorado requires all subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed \$500,000.

**BB. FEDERAL CERTIFICATIONS**

1. Certification Regarding Lobbying

The Contractor certifies, to the best of his or her knowledge and belief, that:

- a. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- b. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- c. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.
- d. This certification is a material representation of fact upon which reliance was placed when the transaction was made or entered into. Submission of the certification is a requisite for making or entering into transaction

imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

2. Debarment and Suspension

- a. If this is a covered transaction or the contract amount exceeds \$100,000, the Contractor certifies to the best of its knowledge and belief that it and its principals and subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency.
- b. This certification is a material representation of fact upon which reliance was placed when the Department determined to enter into this transaction. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available at law or by contract, the Department may terminate this Contract for default.
- c. The Contractor shall provide immediate written notice to the Department if it has been debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any Federal department or agency.
- d. The terms “covered transaction,” “debarment,” “suspension,” “ineligible,” “lower tier covered transaction,” “principal,” and “voluntarily excluded,” as used in this paragraph have the meanings set out in 2 CFR Part 180 and 376.
- e. The Contractor agrees that it will include this certification in all lower tier covered transactions and subcontracts that exceed \$100,000.

**CC. CONFLICT OF INTEREST**

1. During the term of this contract, the Contractor shall not engage in any business or personal activities or practices or maintain any relationships which conflict in any way with the Contractor fully performing his/her obligations under this contract.
2. Additionally, the Contractor acknowledges that, in governmental contracting, even the appearance of a conflict of interest is harmful to the interests of the Department. Thus, the Contractor agrees to refrain from any practices, activities or relationships which could reasonably be considered to be in conflict with the Contractor’s fully performing his/her obligations to the Department under the terms of this contract, without the prior written approval of the Department.
3. In the event that the Contractor is uncertain whether the appearance of a conflict of interest may reasonably exist, the Contractor shall submit to the Department a full disclosure statement setting forth the relevant details for the Department’s

consideration and direction. Failure to promptly submit a disclosure statement or to follow the Department's direction in regard to the apparent conflict shall be grounds for termination of the contract.

4. The Contractor (and subcontractors or subgrantees permitted under the terms of this contract) shall maintain a written code of standards governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Contractor, subcontractor, or subgrantee shall participate in the selection, or in the award or administration of a contract or subcontract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:
  - a. The employee, officer or agent;
  - b. Any member of the employee's immediate family;
  - c. The employee's partner; or
  - d. An organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The Contractor's, subcontractor's, or subgrantee's officers, employees, or agents will neither solicit nor accept gratuities, favors, or anything of monetary value from Contractors, potential Contractors, or parties to sub-agreements.
5. The term "conflict of interest" applies to the relationship of a Contractor with the Department when the Contractor also maintains a relationship with a third party and the two relationships are in opposition. In order to create the appearance of a conflict of interest, it is not necessary for the Contractor to gain from knowledge of these opposing interests. It is only necessary that the Contractor know that the two relationships are in opposition.
6. During the performance period of this contract, the Contractor shall not enter into any third party relationship that gives the appearance of a conflict of interest. Upon learning of an existing appearance of a conflict of interest situation, the Contractor shall submit to the Department a full disclosure statement setting forth the details that create the appearance of a conflict of interest. Failure to promptly submit a disclosure statement required by this paragraph shall constitute grounds for the Department's termination, for cause, of its Contractor with the Contractor.

#### **DD. MEDICAID PAYMENT IN FULL**

1. The Contractor agrees that in no event, including but not limited to non-payment by the Contractor, insolvency of the Contractor or breach of this contract, shall the Contractor its Subcontractors or Participating Providers bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have

any recourse against a Member or persons (other than the Contractor) acting on their behalf for services provided pursuant to this contract.

2. The Contractor agrees that this provision shall survive the termination of this contract, for authorized services rendered prior to the termination of this contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Contractor's Members. This provision is not intended to apply to Covered Services provided after this contract has been terminated.

## **EE. OTHER REMEDIES**

1. Enrollment retention is the percentage of all members (originally voluntarily or passively enrolled) who choose to reenroll in Contractor's Plan during open enrollment. Enrollment retention shall be calculated as follows:
  - a. The numerator is the total enrollment for the calculated period. The denominator shall include all clients who had been enrolled in Contractor's Plan for 120 days or more prior to a birthday between April 1<sup>st</sup> through March 30<sup>th</sup>.
  - b. The numerator shall include all clients who disenrolled from Contractor's Plan within sixty (60) days of a birthday between April 1<sup>st</sup> through March 30<sup>th</sup> with one of the disenrollment reason codes bolded in series 200 listed in Exhibit M, Enrollment Retention Rate Disenrollment Codes, attached and incorporated herein by reference.
2. Enrollment retention of less than eighty-five percent (85%) by end of third quarter of fiscal year 2010 shall result in a ten percent (10%) reduction in passive enrollment for the next fiscal year
3. Enrollment retention of less than ninety percent (90%) by end of third quarter of fiscal year 2011 shall result in a fifty percent (50%) reduction in passive enrollment for the next fiscal year.
4. The Contractor will forfeit the option of passive enrollment in future years beginning in FY 2113 until the ninety (90%) percentile of retention is achieved. Involuntary disenrollment secondary to failure to report financial status or ineligibility is exempt.

## SPECIAL PROVISIONS

(The Special Provisions apply to all contracts except where noted in *italics*.)

1. **CONTROLLER'S APPROVAL. CRS §24-30-202(1).** This contract shall not be valid until it has been approved by the Colorado State Controller or designee.
2. **FUND AVAILABILITY. CRS §24-30-202(5.5).** Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.
3. **GOVERNMENTAL IMMUNITY.** No term or condition of this contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, of the Colorado Governmental Immunity Act, CRS §24-10-101 et seq., or the Federal Tort Claims Act, 28 U.S.C. §§1346(b) and 2671 et seq., as applicable now or hereafter amended.
4. **INDEPENDENT CONTRACTOR.** Contractor shall perform its duties hereunder as an independent contractor and not as an employee. Neither Contractor nor any agent or employee of Contractor shall be deemed to be an agent or employee of the State. Contractor and its employees and agents are not entitled to unemployment insurance or workers compensation benefits through the State and the State shall not pay for or otherwise provide such coverage for Contractor or any of its agents or employees. Unemployment insurance benefits will be available to Contractor and its employees and agents only if such coverage is made available by Contractor or a third party. Contractor shall pay when due all applicable employment taxes and income taxes and local head taxes incurred pursuant to this contract. Contractor shall not have authorization, express or implied, to bind the State to any agreement, liability or understanding, except as expressly set forth herein. Contractor shall (a) provide and keep in force workers' compensation and unemployment compensation insurance in the amounts required by law, (b) provide proof thereof when requested by the State, and (c) be solely responsible for its acts and those of its employees and agents.
5. **COMPLIANCE WITH LAW.** Contractor shall strictly comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.
6. **CHOICE OF LAW.** Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this contract. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. Any provision incorporated herein by reference which purports to negate this or any other Special Provision in whole or in part shall not be valid or enforceable or available in any action at law, whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision shall not invalidate the remainder of this contract, to the extent capable of execution.
7. **BINDING ARBITRATION PROHIBITED.** The State of Colorado does not agree to binding arbitration by any extra-judicial body or person. Any provision to the contrary in this contract or incorporated herein by reference shall be null and void.
8. **SOFTWARE PIRACY PROHIBITION. Governor's Executive Order D 002 00.** State or other public funds payable under this contract shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Contractor hereby certifies and warrants that, during the term of this contract and any extensions, Contractor has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Contractor is in violation of this provision, the State may exercise any remedy available at law or in equity or under this contract, including, without limitation, immediate termination of this contract and any remedy consistent with federal copyright laws or applicable licensing restrictions.
9. **EMPLOYEE FINANCIAL INTEREST/CONFLICT OF INTEREST. CRS §§24-18-201 and 24-50-507.** The signatories aver that to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this contract. Contractor has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Contractor's services and Contractor shall not employ any person having such known interests.
10. **VENDOR OFFSET. CRS §§24-30-202 (1) and 24-30-202.4. [Not Applicable to intergovernmental agreements]** Subject to CRS §24-30-202.4 (3.5), the State Controller may withhold payment under the State's vendor offset intercept system for debts owed to State agencies for: (a) unpaid child support debts or child support arrearages; (b) unpaid balances of tax, accrued interest, or other charges specified in CRS §39-21-101, et seq.; (c) unpaid loans due to the Student Loan Division of the Department of Higher Education; (d) amounts required to be paid to the Unemployment Compensation Fund; and (e) other unpaid debts owing to the State as a result of final agency determination or judicial action.

# SPECIAL PROVISIONS

**(The Special Provisions apply to all contracts except where noted in *italics*.)**

- 11. PUBLIC CONTRACTS FOR SERVICES. CRS §8-17.5-101.** [*Not Applicable to agreements relating to the offer, issuance, or sale of securities, investment advisory services or fund management services, sponsored projects, intergovernmental agreements, or information technology services or products and services*] Contractor certifies, warrants, and agrees that it does not knowingly employ or contract with an illegal alien who will perform work under this contract and will confirm the employment eligibility of all employees who are newly hired for employment in the United States to perform work under this contract, through participation in the E-Verify Program or the Department program established pursuant to CRS §8-17.5-102(5)(c), Contractor shall not knowingly employ or contract with an illegal alien to perform work under this contract or enter into a contract with a subcontractor that fails to certify to Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this contract. Contractor **(a)** shall not use E-Verify Program or Department program procedures to undertake pre-employment screening of job applicants while this contract is being performed, **(b)** shall notify the subcontractor and the contracting State agency within three days if Contractor has actual knowledge that a subcontractor is employing or contracting with an illegal alien for work under this contract, **(c)** shall terminate the subcontract if a subcontractor does not stop employing or contracting with the illegal alien within three days of receiving the notice, and **(d)** shall comply with reasonable requests made in the course of an investigation, undertaken pursuant to CRS §8-17.5-102(5), by the Colorado Department of Labor and Employment. If Contractor participates in the Department program, Contractor shall deliver to the contracting State agency, Institution of Higher Education or political subdivision a written, notarized affirmation, affirming that Contractor has examined the legal work status of such employee, and shall comply with all of the other requirements of the Department program. If Contractor fails to comply with any requirement of this provision or CRS §8-17.5-101 et seq., the contracting State agency, institution of higher education or political subdivision may terminate this contract for breach and, if so terminated, Contractor shall be liable for damages.
- 12. PUBLIC CONTRACTS WITH NATURAL PERSONS. CRS §24-76.5-101.** Contractor, if a natural person eighteen (18) years of age or older, hereby swears and affirms under penalty of perjury that he or she **(a)** is a citizen or otherwise lawfully present in the United States pursuant to federal law, **(b)** shall comply with the provisions of CRS §24-76.5-101 et seq., and **(c)** has produced one form of identification required by CRS §24-76.5-103 prior to the effective date of this contract.

**CONTRACT SIGNATURE PAGE**

THE PARTIES HERETO HAVE EXECUTED THIS CONTRACT

Persons signing for Contractor hereby swear and affirm that they are authorized to act on Contractor's behalf and acknowledge that the State is relying on their representations to that effect.

**CONTRACTOR:**

Denver Health and Hospital  
Authority dba Denver Health  
Medicaid Choice

**STATE OF COLORADO:**

Bill Ritter, Jr., Governor

By: \_\_\_\_\_  
Signature of Authorized Officer

By: \_\_\_\_\_  
Joan Henneberry, Executive  
Director  
Department of Health Care Policy  
and Financing

Date: \_\_\_\_\_  
\_\_\_\_\_  
Printed Name of Authorized Officer

Date: \_\_\_\_\_  
**LEGAL REVIEW:**  
John W. Suthers, Attorney  
General

\_\_\_\_\_  
Printed Title of Authorized Officer

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contractor for such performance or for any goods and/or services provided hereunder.

STATE CONTROLLER:  
David J. McDermott, CPA

By: \_\_\_\_\_  
Date: \_\_\_\_\_

## **HIPAA BUSINESS ASSOCIATE ADDENDUM**

This Business Associate Addendum (“Addendum”) is part of the Contract dated July 1, 2009 between the State of Colorado, Department of Health Care Policy and Financing, and Denver Health and Hospital Authority dba Denver Health Medicaid Choice, contract number 3210-0101. For purposes of this Addendum, the State is referred to as “Department”, “Covered Entity” or “CE” and the Contractor is referred to as “Associate”. Unless the context clearly requires a distinction between the Contract document and this Addendum, all references herein to “the Contract” or “this Contract” include this Addendum.

### **RECITALS**

- A. CE wishes to disclose certain information to Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information (“PHI”) (defined below).
- B. CE and Associate intend to protect the privacy and provide for the security of PHI disclosed to Associate pursuant to this Contract in compliance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d – 1320d-8 (“HIPAA”) and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160 and 164 (the “Privacy Rule”) and other applicable laws, as amended.
- C. As part of the HIPAA regulations, the Privacy Rule requires CE to enter into a contract containing specific requirements with Associate prior to disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 160.103, 164.502(e) and 164.504(e) of the Code of Federal Regulations (“C.F.R.”) and contained in this Addendum.

The parties agree as follows:

#### 1. Definitions.

a. Except as otherwise defined herein, capitalized terms in this Addendum shall have the definitions set forth in the HIPAA Privacy Rule at 45 C.F.R. Parts 160 and 164, as amended. In the event of any conflict between the mandatory provisions of the Privacy Rule and the provisions of this Contract, the Privacy Rule shall control. Where the provisions of this Contract differ from those mandated by the Privacy Rule, but are nonetheless permitted by the Privacy Rule, the provisions of this Contract shall control.

b. “Protected Health Information” or “PHI” means 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, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

c. “Protected Information” shall mean PHI provided by CE to Associate or created or received by Associate on CE’s behalf. To the extent Associate is a covered entity under HIPAA and creates or obtains its own PHI for treatment, payment and health care operations, Protected Information under this Contract does not include any PHI created or obtained by Associate as a covered entity and Associate shall follow its own policies and procedures for accounting, access and amendment of Associate’s PHI.

2. Obligations of Associate.

a. Permitted Uses. Associate shall not use Protected Information except for the purpose of performing Associate’s obligations under this Contract and as permitted under this Addendum. Further, Associate shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule if so used by CE, except that Associate may use Protected Information: (i) for the proper management and administration of Associate; (ii) to carry out the legal responsibilities of Associate; or (iii) for Data Aggregation purposes for the Health Care Operations of CE. Additional provisions, if any, governing permitted uses of Protected Information are set forth in Attachment A to this Addendum.

b. Permitted Disclosures. Associate shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule if disclosed by CE, except that Associate may disclose Protected Information: (i) in a manner permitted pursuant to this Contract; (ii) for the proper management and administration of Associate; (iii) as required by law; (iv) for Data Aggregation purposes for the Health Care Operations of CE; or (v) to report violations of law to appropriate federal or state authorities, consistent with 45 C.F.R. Section 164.502(j)(1). To the extent that Associate discloses Protected Information to a third party, Associate must obtain, prior to making any such disclosure: (i) reasonable assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party; and (ii) an agreement from such third party to notify Associate within two business days of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such breach. Additional provisions, if any, governing permitted disclosures of Protected Information are set forth in Attachment A.

c. Appropriate Safeguards. Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information other than as permitted by this Contract. Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate’s operations and the nature and scope of its activities.

d. Reporting of Improper Use or Disclosure. Associate shall report to CE in writing any use or disclosure of Protected Information other than as provided for by this Contract within five (5) business days of becoming aware of such use or disclosure.

e. Associate’s Agents. If Associate uses one or more subcontractors or agents to provide services under the Contract, and such subcontractors or agents receive or have access to Protected Information, each subcontractor or agent shall sign an agreement with Associate containing substantially the same provisions as this Addendum and further identifying CE as a

third party beneficiary with rights of enforcement and indemnification from such subcontractors or agents in the event of any violation of such subcontractor or agent agreement. Associate shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions shall mitigate the effects of any such violation.

f. Access to Protected Information. Associate shall make Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) business days of a request by CE to enable CE to fulfill its obligations to permit individual access to PHI under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524.

g. Amendment of PHI. Within ten (10) business days of receipt of a request from CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment to enable CE to fulfill its obligations with respect to requests by individuals to amend their PHI under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.526. If any individual requests an amendment of Protected Information directly from Associate or its agents or subcontractors, Associate must notify CE in writing within five (5) business days of receipt of the request. Any denial of amendment of Protected Information maintained by Associate or its agents or subcontractors shall be the responsibility of CE.

h. Accounting Rights. Within ten (10) business days of notice by CE of a request for an accounting of disclosures of Protected Information, Associate and its agents or subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528. As set forth in, and as limited by, 45 C.F.R. Section 164.528, Associate shall not provide an accounting to CE of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 C.F.R. Section 164.506; (ii) to individuals of Protected Information about them as set forth in 45 C.F.R. Section 164.502; (iii) pursuant to an authorization as provided in 45 C.F.R. Section 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 C.F.R. Section 164.510; (v) for national security or intelligence purposes as set forth in 45 C.F.R. Section 164.512(k)(2); (vi) to correctional institutions or law enforcement officials as set forth in 45 C.F.R. Section 164.512(k)(5); (vii) incident to a use or disclosure otherwise permitted by the Privacy Rule; (viii) as part of a limited data set under 45 C.F.R. Section 164.514(e); or (ix) disclosures prior to April 14, 2003. Associate agrees to implement a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years prior to the request, but not before the compliance date of the Privacy Rule. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to Associate or its agents or subcontractors, Associate shall within five (5) business days of the receipt of the request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested.

Associate shall not disclose any Protected Information except as set forth in Section 2(b) of this Addendum.

i. Governmental Access to Records. Associate shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to the Secretary of the U.S. Department of Health and Human Services (the “Secretary”), in a time and manner designated by the Secretary, for purposes of determining CE’s compliance with the Privacy Rule. Associate shall provide to CE a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary.

j. Minimum Necessary. Associate (and its agents or subcontractors) shall only request, use and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure, in accordance with the Minimum Necessary requirements of the Privacy Rule including, but not limited to, 45 C.F.R. Sections 164.502(b) and 164.514(d).

k. Data Ownership. Associate acknowledges that Associate has no ownership rights with respect to the Protected Information.

l. Retention of Protected Information. Except upon termination of the Contract as provided in Section 4(d) of this Addendum, Associate and its agents or subcontractors shall retain all Protected Information throughout the term of this Contract and shall continue to maintain the information required under Section 2(h) of this Addendum for a period of six (6) years.

m. Associate’s Insurance. Associate shall maintain casualty and liability insurance to cover loss of PHI data and claims based upon alleged violations of privacy rights through improper use or disclosure of PHI. All such policies shall meet or exceed the minimum insurance requirements of the Contract (e.g., occurrence basis, combined single dollar limits, annual aggregate dollar limits, additional insured status and notice of cancellation).

n. Notification of Breach. During the term of this Contract, Associate shall notify CE within two (2) business days of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

o. Audits, Inspections and Enforcement. Within ten (10) business days of a written request by CE, Associate and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection; and (iii) CE shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested

by Associate. The fact that CE inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Contract.

p. Safeguards During Transmission. Associate shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of Protected Information transmitted to CE pursuant to the Contract, in accordance with the standards and requirements of the Privacy Rule, until such Protected Information is received by CE, and in accordance with any specifications set forth in Attachment A.

q. Restrictions and Confidential Communications. Within ten (10) business days of notice by CE of a restriction upon uses or disclosures or request for confidential communications pursuant to 45 C.F.R. Section 164.522, Associate will restrict the use or disclosure of an individual's Protected Information, provided Associate has agreed to such a restriction. Associate will not respond directly to an individual's requests to restrict the use or disclosure of Protected Information or to send all communication of Protected Information to an alternate address. Associate will refer such requests to the CE so that the CE can coordinate and prepare a timely response to the requesting individual and provide direction to Associate.

### 3. Obligations of CE.

a. Safeguards During Transmission. CE shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Associate pursuant to this Contract, in accordance with the standards and requirements of the Privacy Rule, until such PHI is received by Associate, and in accordance with any specifications set forth in Attachment A.

b. Notice of Changes. CE shall provide Associate with a copy of its notice of privacy practices produced in accordance with 45 C.F.R. Section 164.520, as well as any subsequent changes or limitation(s) to such notice, to the extent such changes or limitation(s) may effect Associate's use or disclosure of Protected Information. CE shall provide Associate with any changes in, or revocation of, permission to use or disclose Protected Information, to the extent it may affect Associate's permitted use or disclosure of PHI, CE shall notify Associate of any restriction on the use or disclosure of Protected Information that CE has agreed to in accordance with 45 C.F.R. Section 164.522. CE may effectuate any and all such notices of non-private information via posting on CE's web site. Associate shall review CE's designated web site for notice of changes to CE's HIPAA privacy policies and practices on the last day of each calendar quarter.

### 4. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by Associate of any provision of this Addendum, as determined by CE, shall constitute a material breach of this Contract and shall provide grounds for immediate termination of this

Contract by CE pursuant to the provisions of the Contract covering termination for cause, if any. If the Contract contains no express provisions regarding termination for cause, the following terms and conditions shall apply:

(1) Default. If Associate refuses or fails to timely perform any of the provisions of this Contract, CE may notify Associate in writing of the non-performance, and if not promptly corrected within the time specified, CE may terminate this Contract. Associate shall continue performance of this Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services elsewhere.

(2) Associate's Duties. Notwithstanding termination of this Contract, and subject to any directions from CE, Associate shall take timely, reasonable and necessary action to protect and preserve property in the possession of Associate in which CE has an interest.

(3) Compensation. Payment for completed supplies delivered and accepted by CE shall be at the Contract price. In the event of a material breach under paragraph 4(a), CE may withhold amounts due Associate as CE deems necessary to protect CE against loss from third party claims of improper use or disclosure and to reimburse CE for the excess costs incurred in procuring similar goods and services elsewhere.

(4) Erroneous Termination for Default. If after such termination it is determined, for any reason, that Associate was not in default, or that Associate's action/inaction was excusable, such termination shall be treated as a termination for convenience, and the rights and obligations of the parties shall be the same as if this Contract had been terminated for convenience, as described in this Contract.

b. Reasonable Steps to Cure Breach. If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum or another arrangement and does not terminate this Contract pursuant to Section 4(a), then CE shall take reasonable steps to cure such breach or end such violation, as applicable. If CE's efforts to cure such breach or end such violation are unsuccessful, CE shall either (i) terminate the Contract, if feasible or (ii) if termination of this Contract is not feasible, CE shall report Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. Judicial or Administrative Proceedings. Either party may terminate the Contract, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

d. Effect of Termination.

(1) Except as provided in paragraph (2) of this subsection, upon termination of this Contract, for any reason, Associate shall return or destroy all Protected Information that Associate or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information that Associate or its agents or subcontractors still maintain in any

form, and shall retain no copies of such Protected information. If Associate elects to destroy the PHI, Associate shall certify in writing to CE that such PHI has been destroyed.

(2) If Associate believes that returning or destroying the Protected Information is not feasible, Associate shall promptly provide CE notice of the conditions making return or destruction infeasible. Upon mutual agreement of CE and Associate that return or destruction of Protected Information is infeasible, Associate shall continue to extend the protections of Sections 2(a), 2(b), 2(c), 2(d) and 2(e) of this Addendum to such information, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

5. Injunctive Relief. CE shall have the right to injunctive and other equitable and legal relief against Associate or any of its agents or subcontractors in the event of any use or disclosure of Protected Information in violation of this Contract or applicable law.

6. No Waiver of Immunity. No term or condition of this Contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of the Colorado Governmental Immunity Act, CRS 24-10-100 *et seq.* or the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq.* as applicable, as now in effect or hereafter amended.

7. Limitation of Liability. Any limitation of Associate's liability in the Contract shall be inapplicable to the terms and conditions of this Addendum.

8. Disclaimer. CE makes no warranty or representation that compliance by Associate with this Contract, HIPAA or HIPAA Regulations will be adequate or satisfactory for Associate's own purposes. Associate is solely responsible for all decisions made by Associate regarding the safeguarding of PHI.

9. Certification. To the extent that CE determines an examination is necessary in order to comply with CE's legal obligations pursuant to HIPAA relating to certification of its security practices, CE or its authorized agents or contractors may, at CE's expense, examine Associate's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to CE the extent to which Associate's security safeguards comply with HIPAA, the HIPAA Regulations or this Addendum.

10. Amendment.

a. Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the Privacy Rule, the Final HIPAA Security Regulations at 68 Fed. Reg. 8334 (Feb 20, 2003), 45 C.F.R. § 164.314 and other applicable laws relating to the security or privacy of PHI. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written

assurances consistent with the standards and requirements of HIPAA, the Privacy Rule or other applicable laws. CE may terminate this Contract upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Contract when requested by CE pursuant to this Section or (ii) Associate does not enter into an amendment to this Contract providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the Privacy Rule.

b. Amendment of Attachment A. Attachment A may be modified or amended by mutual agreement of the parties in writing from time to time without formal amendment of this Addendum.

11. Assistance in Litigation or Administrative Proceedings. Associate shall make itself, and any subcontractors, employees or agents assisting Associate in the performance of its obligations under the Contract, available to CE, at no cost to CE, up to a maximum of thirty (30) hours, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of HIPAA, the Privacy Rule or other laws relating to security and privacy or PHI, except where Associate or its subcontractor, employee or agent is a named adverse party.

12. No Third Party Beneficiaries. Nothing express or implied in this Contract is intended to confer, nor shall anything herein confer, upon any person other than CE, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

13. Interpretation and Order of Precedence. The provisions of this Addendum shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. Together, the Contract and This Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA and the Privacy Rule. The parties agree that any ambiguity in this Contract shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the Privacy Rule. This Contract supersedes and replaces any previous separately executed HIPAA addendum between the parties.

14. Survival of Certain Contract Terms. Notwithstanding anything herein to the contrary, Associate's obligation under Section 4(d) ("Effect of Termination") and Section 12 ("No Third Party Beneficiaries") shall survive termination of this Contract and shall be enforceable by CE as provided herein in the event of such failure to perform or comply by the Associate. This Addendum shall remain in effect during the term of the Contract including any extensions.

15. Representatives and Notice.

a. Representatives. For the purpose of the Contract, the individuals identified elsewhere in this Contract shall be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are hereby designated as the parties' respective representatives for purposes of this Contract. Either party may from time to time designate in writing new or substitute representatives.

b. Notices. All required notices shall be in writing and shall be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

**State/Covered Entity Representative:**

Name: **Bernadette Marra**  
Title: **Health Plan Contract Manager**  
Department: **Department of Health Care Policy and Financing**  
Address: **1570 Grant Street, Denver, Colorado**

**Contractor/Business Associate Representative:**

Name: **LeAnn Donovan**  
Title: **Executive Director of Managed Care Programs**  
Company: **Denver Health and Hospital Authority**  
Address: **777 Bannock Street, Denver, Colorado**

## ATTACHMENT A

This Attachment sets forth additional terms to the HIPAA Business Associate Addendum, which is part of the Contract dated July 1, 2009, between the State of Colorado, Department of Health Care Policy and Financing, and Denver Health and Hospital Authority dba Denver Health Medicaid Choice, contract number 3210-0101 (“Contract”) and is effective as of July 1, 2009 (the “Attachment Effective Date”). This Attachment may be amended from time to time as provided in Section 10(b) of the Addendum.

1. Additional Permitted Uses. In addition to those purposes set forth in Section 2(a) of the Addendum, Associate may use Protected Information as follows:  
No additional permitted uses.
2. Additional Permitted Disclosures. In addition to those purposes set forth in Section 2(b) of the Addendum, Associate may disclose Protected Information as follows:  
No additional permitted disclosures.
3. Subcontractor(s). The parties acknowledge that the following subcontractors or agents of Associate shall receive Protected Information in the course of assisting Associate in the performance of its obligations under this Contract:  
None.
4. Receipt. Associate’s receipt of Protected Information pursuant to this Contract shall be deemed to occur as follows and Associate’s obligations under the Addendum shall commence with respect to such PHI upon such receipt:  
Upon receipt of PHI from the Department.
5. Additional Restrictions on Use of Data. CE is a Business Associate of certain other Covered Entities and, pursuant to such obligations of CE, Associate shall comply with the following restrictions on the use and disclosure of Protected Information:  
No additional restrictions on Use of Data.
6. Additional Terms  
No additional terms.

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