CONTRACT AMENDMENT NO. 4

Original Contract Number 15-68387

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Colorado Access, 10065 East Harvard Avenue, Suite 600, Denver, CO, 80231, (hereinafter called "Contractor"), and the STATE OF COLORADO, acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called "Department" or "State.")

2. EFFECTIVE DATE AND ENFORCEABILITY

This Amendment shall not be effective or enforceable until it is approved and signed by the Colorado State Controller or designee (hereinafter called the "Effective Date.") The Department shall not be liable to pay or reimburse Contractor for any performance hereunder, including, but not limited to, costs or expenses incurred, or be bound by any provision hereof prior to the Effective Date.

3. FACTUAL RECITALS

The Parties entered into the Contract to administer the Community Behavioral Health Services Program (the Program) that provides comprehensive mental health and substance use disorder services to Medicaid clients in Colorado. The purpose of this Amendment is to renew the contract for an additional year, amend the statement of work, amend Exhibit B, amend Exhibit G, and delete Exhibit E.

4. CONSIDERATION

The Parties acknowledge that the mutual promises and covenants contained herein and other good and valuable consideration are sufficient and adequate to support this Amendment.

5. LIMITS OF EFFECT

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments thereto, if any, remain in full force and effect except as specifically modified herein.

6. MODIFICATIONS

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

A. Section 5, Term, is hereby deleted in its entirety and replaced with the following:

5. TERM

A. Initial Term

The Parties' respective performances under this Contract shall commence on the later of either the Effective Date or July 1, 2014. This Contract shall expire on June 30, 2016, unless sooner terminated or further extended as specified elsewhere herein.

B. Exhibit A, Statement of Work, Section 1.1.1.23., is hereby deleted in its entirety and replaced with the following:

1.1.1.23. Federally Qualified Health Center (FQHC) - a hospital-based or free standing center that meets the FQHC definition found in Section 1905(1)(2)(C) of the Social Security Act. Section 1905(1)(2)(C).

C. Exhibit A, Statement of Work, Section 1.1.1.2 is hereby deleted and replaced with the following:

1.1.1.2. Not Used

D. Exhibit A, Statement of Work, Section 1.1.2. is hereby added as follows:

1.1.2. The following Additional Acronyms, Abbreviations and Other Terminology are included to assist the reader in understanding terminology included in this document as part of the additions from Amendment 4 to the Contract.

1.1.2.1. FQHC Encounter Rate- The rate established by the Department to reimburse Federally Qualified Health Centers.

1.1.2.2. MAGI Adults - The expansion group under federal definitions. This includes parents >68% to 133% FPL and Childless adults 0% to 133% FPL, ages 19-64. Medicare clients are excluded from this group.

1.1.2.3. Modified Adjusted Gross Income (MAGI) - A category of Medical Assistance for adults who are at least age nineteen (19) but less than sixty-five (65) years without Medicaid eligible dependent children living in the client's household. SSI disability determination is not required for this population.

1.1.2.4. RHC Encounter Rate - The rate established by the Department to reimburse Rural Health Centers.

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

E. Exhibit A, Statement of Work, Section 2.1.5.9 is hereby deleted in its entirety and replaced with the following:

2.1.5.9. Individuals who are NGRI and who are in the community on temporary physical removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Behavioral Health Services Program while they are on TPR. TPR individuals remain under the control and care of the Colorado Mental Health Institute at Pueblo.

F. Exhibit A, Statement of Work, Sections 2.2.3.5 through 2.2.3.5.4.2.2, School-based Services, are hereby deleted in their entirety.

G. Exhibit A, Statement of Work, Sections 2.4.2.7.1.6.1 and 2.4.2.7.1.6.2 are hereby deleted in their entirety and replaced as follows:

2.4.2.7.1.6.1. DELIVERABLE: Program Improvement Advisory Committee Minutes.

2.4.2.7.1.6.2. DUE: Within ten (10) days of each meeting.

H. Exhibit A, Statement of Work, Section 2.5.2.3, Federally Qualified Health Centers (FQHC), is hereby deleted in its entirety and replaced with the following:

2.5.2.3. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

2.5.2.3.1. The Contractor shall offer contracts to all FQHCs and RHCs located in the Contract Service Area. The Contractor is not required to contract with every FQHC and RHC that provide behavioral health services in its geographic area.

2.5.2.3.2. FQHC and RHC Encounter Reimbursement

2.5.2.3.2.1. Payments from Contractor to FQHC and RHC Facilities

2.5.2.3.2.1.1. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505-10 8.7006C.

2.5.2.3.2.1.2. The Department shall notify the Contractor of the current FQHC and RHC rates on a no less than quarterly basis.

2.5.2.3.2.2. The Contractor shall reimburse the FQHC and RHC, at a minimum, an encounter rate in accordance with 10 CCR 2505-10 8.700.6 for each FQHC and RHC visit, for services identified in 10 CCR 2505-10 8.700.3 for allowable costs identified in 10 CCR 2505-10 8.700.5. The Department will conduct quarterly accuracy audits with RQHCs and RHCs and should the Department recognize any discrepancy in FQHC and RHC payments (less than the full encounter rate), then the Contractor shall be responsible for reimbursing the FQHC and RHC the difference of the encounter payment identified in 2.5.2.3.2.1.1 and the initial reimbursement amount.

2.5.2.3.2.3. An FQHC and RHC visit is defined in 10 CCR 2505-10 8.700.1.

2.5.2.3.2.4. If multiple services are provided by an FQHC and RHC within one visit, the Contractor will require a claims submission from the FQHC and RHC with multiple lines of services and the same claim number. The Contractor is required to pay the FQHC and RHC no less than the encounter rate minus any third party payments for each visit.

2.5.2.3.3. The Contractor will submit the encounter data for FQHC and RHC visits to the Department.

I. Exhibit A, Statement of Work, Sections 2.5.12.2.4.3 and 2.5.12.2.4.4 are hereby deleted in their entirety and replaced as follows:

2.5.12.2.4.3. DELIVERABLE: Annual Organizational Self-Assessment.

2.5.12.2.4.4. DUE: Annually by December 31st.

J. Exhibit A, Statement of Work, Section 2.9.3.1.1.6 is hereby added as follows:

2.9.3.1.1.6. Processes to comply with Section 2.9.7.4.4.

K. Exhibit A, Statement of Work, Section 2.9.7.4.3 is hereby deleted.

L. Exhibit A, Statement of Work, Sections 2.9.7.4.4.5 through 2.9.7.4.4.7 are hereby added as follows:

2.9.7.4.4.5. The Contractor shall assure that no Provider has been terminated by the Department.

2.9.7.4.4.6. The Contractor shall assure that no Provider is excluded by United States Department of Health and Human Services Office of Inspector General and appear on the List of Excluded Individuals and Entities (LEIE).

2.9.7.4.4.7. The Contractor shall assure that no Provider employs or contracts with an individual excluded by United States Department of Health and Human Services Office of Inspector General and appearing on the List of Excluded Individuals and Entities (LEIE).

M. Exhibit A, Statement of Work, Section 2.9.10.9 Screening of Employees and Contractors is hereby added as follows:

2.9.10.9. Screening of Employees and Contractors

2.9.10.9.1. The Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG).

2.9.10.9.2. The Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and contractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid.

2.9.10.9.3. If the Contractor determines that one of its employees or contractors has been excluded, then the Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery to the Department within five (5) business days of the date of discovery.

2.9.10.9.4. DELIVERABLE: Notification of discovery of excluded employee or contractor.

2.9.10.9.5. DUE: Within five (5) business days of the date of discovery.

N. Exhibit A, Statement of Work, Section 2.10.2 Business Transactions is hereby deleted in its entirety and replaced with the following:

2.10.2. Business Transaction Disclosures

2.10.2.1 The Contractor shall submit, within thirty-five (35) days of the date on a request by the Department or by the Secretary of the Department of Health and Human Services, full and complete information about:

2.10.2.1.1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the 12-month period ending on the date of the request; and

2.10.2.1.2. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

2.10.2.2. Significant business transaction means any business transaction or series of transactions that, during any one (1) fiscal year, exceed the lesser of twenty-five thousand dollars ($25,000.00) and five (5) percent of the Contractor's total operating expenses.

2.10.2.3. Wholly owned supplier means a supplier whose total ownership interest is held by the Contractor or by a person, persons, or other entity with an ownership or control interest in the Contractor.

2.10.2.3.1. DELIVERABLE: Business transaction disclosures.

2.10.2.3.2. DUE: Within thirty-five (35) calendar days of the date of a request by the Department or by the Secretary of the Department of Health and Human Services.

O. Exhibit A, Statement of Work, Section 2.10.5, Ownership or Control Disclosures is hereby deleted in its entirety and replaced with the following:

2.10.5. Ownership or Control Disclosures

2.10.5.1. The Contractor shall disclose to the Department, at the time of executing the Contract with the State, at Contract renewal or extension, within thirty-five (35) calendar days of a written request from the Department, and within thirty-five (35) calendar days after any change in ownership, the following information in a form to be provided by the Department:

2.10.5.1.1. The name and address of any individual or entity with an ownership or control interest in the Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

2.10.5.1.2. Date of birth and Social Security Number of any individual with an ownership or control interest in the Contractor.

2.10.5.1.3. Tax identification number of any corporation or partnership with an ownership or control interest in the Contractor, or in any subcontractor in which the Contractor has a five (5) percent or more interest.

2.10.5.1.4. Whether an individual with an ownership or control interest in the Contractor is related to another person with an ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which the Contractor has a five (5) percent or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling.

2.10.5.1.5. The name of any other Medicaid provider (other than an individual practitioner or group of practitioners), fiscal agent, or managed care entity in which an owner of the Contractor has an ownership or control interest.

2.10.5.1.6. The name, address, date of birth, and Social Security Number of any managing employee of the Contractor.

2.10.5.2. Definitions relating to Ownership or Control Disclosures

2.10.5.2.1. Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

2.10.5.2.2. Group of practitioners means two (2) or more health care practitioners who practice their profession at a common location, whether or not they share common facilities, common supporting staff, or common equipment.

2.10.5.2.3. Indirect ownership interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in another entity.

2.10.5.2.4. Ownership interest means the possession of equity in the capital, stock, or profits of an entity.

2.10.5.2.5. Individual or entity with an ownership or control interest means an individual or entity that: has an ownership interest totaling five (5) percent or more; has an indirect ownership interest equal to five (5) percent or more; has a combination of direct and indirect ownership interests equal to five (5) percent or more; owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five (5) percent of the value of the property or assets of the other entity; is an officer or director of an entity that is organized as a corporation; or is a partner in an entity that is organized as a partnership.

2.10.5.2.6. Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control, or who directly or indirectly conducts the day-to-day operation.

2.10.5.2.7. Subcontractor means an individual, agency, or organization to which an entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients.

2.10.5.2.7.1. DELIVERABLE: Ownership or Control Disclosures.

2.10.5.2.7.2. DUE: At the time of executing the Contract with the Department, at Contract renewal or extension, and within thirty-five (35) calendar days of either a change of ownership or a written request by the Department.

P. Exhibit A, Statement of Work, Sections 2.10.6 through 2.10.9 are hereby added; in addition, Sections 2.10.10 through 2.10.17 have been renumbered due to the added subsections as follows:

2.10.6. Disclosure of Information on Persons Convicted of Crimes

2.10.6.1. Upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date on a written request by the Department, the Contractor shall disclose the identity of any person who:

2.10.6.1.1. Has an ownership or control interest in the Contractor, or who is a managing employee of the Contractor; and

2.10.6.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program.

2.10.6.1.2.1. DELIVERABLE: Disclosure of Information on Persons Convicted of Crimes.

2.10.6.1.2.2. DUE: Upon execution of the Contract, upon renewal or extension of the Contract, and within thirty-five (35) calendar days of the date of a written request by the Department.

2.10.7. Network Provider Ownership or Control Disclosures

2.10.7.1. The Contractor shall require all Providers to disclose to the Contractor, upon submitting the provider application, upon executing the provider agreement, within 35 calendar days of a request by the Department, within thirty-five (35) calendar days of a request by the Contractor, and within thirty-five (35) days after any change in the Provider's ownership, the following information in writing:

2.10.7.1.1. The name and address of any individual or entity with an ownership or control interest in the Provider. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address;

2.10.7.1.2. Date of birth and Social Security Number of any individual with an ownership or control interest in the Provider;

2.10.7.1.3. Tax identification number of any corporation or partnership with an ownership or control interest in the Provider, or in any subcontractor in which the Provider has a five (5) percent or more interest;

2.10.7.1.4. Whether an individual with an ownership or control interest in the Provider is related to another person with an ownership or control interest in the Provider as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which the Provider has a 5 percent or more interest is related to another person with ownership or control interest in the Provider as a spouse, parent, child, or sibling;

2.10.7.1.5. The name of any other Medicaid provider (other than an individual practitioner or group of practitioners), fiscal agent, or managed care entity in which an owner of the Provider has an ownership or control interest; and

2.10.7.1.6. The name, address, date of birth, and Social Security Number of any managing employee of the Provider.

2.10.7.2. The definitions at Section 2.10.5.2 shall apply to these Network Provider Ownership or Control Disclosures.

2.10.7.3. The Contractor shall screen all individuals and entities disclosed under this section against the LEIE. If the Contractor discovers that an individual or entity disclosed under this section has been excluded and appears on the LEIE, then the Contractor shall take appropriate action in accordance with federal and state statutes and regulations, and shall report the discovery, in writing, to the Department within five (5) business days of the date of the discovery.

2.10.7.3.1. DELIVERABLE: Notification of Discovery of Excluded Network Provider

2.10.7.3.2. DUE: Within five (5) business days of discovering the exclusion of the Provider.

2.10.8. Network Provider Business Transaction Disclosures

2.10.8.1. The Contractor shall require all Providers to submit in writing, within thirty-five((35) days of the date of a request by the Contractor, by the Department, or the Secretary of the Department of Health and Human Services, to the requesting party, full and complete information about:

2.10.8.1.1. The ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2.10.8.1.2. Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request.

2.10.8.1.3. Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of the Provider's total operating expenses.

2.10.8.2. Wholly owned supplier means a supplier whose total ownership interest is held by the Provider, or by a person, persons, or other entity with an ownership or control interest in the Provider.

2.10.8.3. Upon receipt of any such Network Provider Business Transaction Disclosures, the Contractor shall take appropriate action in accordance with federal and state statutes and regulations.

2.10.9. Network Provider Disclosure of Information on Persons Convicted of Crimes

2.10.9.1. The Contractor shall require that, prior to entering into a Provider Agreement with the Contractor, prior to renewing a Provider Agreement with a Provider, within 35 calendar days of a request by the Contractor, and within 35 calendar days of a request by the Department, all Providers disclose the identity of any person who:

2.10.9.1.1. Has an ownership or control interest in the Provider, or who is a managing employee of the Provider; and

2.10.9.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program.

2.10.9.2. Upon receipt of any such disclosure, the Contractor shall take appropriate action in accordance with federal and state statutes and regulations.

2.10.10. Physician Incentive Plans

2.10.10.1. The Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

2.10.10.1.1. Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any Member.

2.10.11. Policies and Procedures

2.10.11.1. The Contractor shall disclose to the Department copies of any existing policies and procedures related to Section 2.10 of this Contract, upon request by the Department, within ten (10) Business Days.

2.10.11.1.1. DELIVERABLE: Notices and Disclosures Policies and Procedures.

2.10.11.1.2. DUE: Within ten (10) Business Days of the Department's request.

2.10.12. Practice Guidelines

2.10.12.1. The Contractor shall provide practice guidelines to the Department upon request within ten (10) Business Days, and at no cost to the Department.

2.10.12.1.1. DELIVERABLE: Practice Guidelines.

2.10.12.1.2. DUE: Within ten (10) Business Days of the Department's request.

2.10.13. Relationship to Community Mental Health Centers

2.10.13.1. The Contractor shall disclose to the Department at the at the time of contracting, at Contract renewal, and at any time there is a change, the nature and extent of its financial and organizational relationship with the Community Mental Health Centers in its service region.

2.10.14. Security Breaches and HIPAA violations

2.10.14.1. In the event of a breach of the security of sensitive data the Contractor shall immediately notify the Department to report all suspected loss or compromise of sensitive data within five (5) business days of the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

2.10.14.2. Contractor shall report all HIPAA violations as described in the HIPAA BUSINESS ASSOCIATE ADDENDUM.

2.10.14.2.1. DELIVERABLE: Security and HIPAA Violation Breach Notification.

2.10.14.2.2. DUE: Within five (5) business days of becoming aware of the breach.

2.10.15. Solvency

2.10.15.1. The Contractor shall notify the Department, within two (2) Business Days, of becoming aware of or having reason to believe that it does not, or may not, meet the solvency standards specified in this Contract.

2.10.15.1.1. DELIVERABLE: Solvency Notification.

2.10.15.1.2. DUE: Within two (2) Business Days, of becoming aware of a possible solvency issue.

2.10.16. Subcontracts and Contracts

2.10.16.1. The Contractor shall disclose to the Department, within five (5) business days of the Department's request, copies of any existing subcontracts and Contracts with Providers.

2.10.16.1.1. DELIVERABLE: Subcontracts and Provider Contracts.

2.10.16.1.2. DUE: Within five (5) Business Days of the Department's Request.

2.10.16.2. The Contractor shall notify the Department, in writing, of its decision to terminate any existing subcontractor at least sixty (60) calendar days prior to the services terminating, unless the basis for termination is for quality or performance issues, or credible allegation of fraud.

2.10.16.2.1. If the basis for termination is quality or performance issue, the Contractor shall notify the Department in writing within two (2) Business Days of its decision to terminate the subcontract. Contractor shall submit with the notice of termination, a narrative describing how it intends to provide or secure the services after termination.

2.10.16.2.1.1. DELIVERABLE: Notice of Subcontractor Termination.

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

2.10.17. Warranties and certifications

2.10.17.1. The Contractor shall, within five (5) Business Days, disclose to the Department if it is no longer able to provide the same warranties and certifications as required at the Effective Date of this Contract.

2.10.17.1.1. DELIVERABLE: Warranty and Certification Notification.

2.10.17.1.2. DUE: Within five (5) Business Days of becoming aware of its inability to offer the warranty and certifications.

Q. Exhibit A, Statement of Work, Section 2.11.1.2.2.1. is hereby deleted in its entirety and replaced with the following:

2.11.1.2.2.1. The Contractor shall submit a separate quarterly report in the same format to the Department and/or its designee detailing the previous quarter's expenditures for "Non-State Plan" services provided to MAGI Adults. In order to identify the population to be included in the report, the Department will submit a monthly file detailing the client ID and month of eligibility.

R. Exhibit A, Statement of Work, Section 2.11.1.19 is hereby added as follows:

2.11.1.19. Health Insurance Providers Fee Rate Settlement

2.11.1.19.1. The Contractor and the Department shall engage in Health Insurance Providers Fee Rate Settlements based upon the Health Insurance Providers Fee report provided by the Contractor to the Department each October. Each Health Insurance Providers Fee Rate Settlement process shall include the following:

2.11.1.19.1.1. During the rate-setting cycle, the Department will calculate a prospective rate to account for the health insurance provider fee. This rate will be withheld from the Contractor's payment.

2.11.1.19.1.2. Upon receipt of the Health Insurance Providers Fee Report, the Department will calculate the actual rate to account for the health insurance provider fee. The Department will issue a notification letter by January 31st with the amount to be remitted to the Contractor.

S. Exhibit A, Statement of Work, Section 2.11.2.1 Employments and Affiliations Report is hereby deleted in its entirety and the following subsections renumbered as follows:

2.11.2.1. Insurance Report

2.11.2.1.1. The Contractor shall submit documentation upon request by the Department establishing current and continuous insurance coverage.

2.11.2.1.2. The Department reserves the right to require complete, certified copies of all insurance policies required by this Agreement at any time.

2.11.2.1.2.1. DELIVERABLE: Insurance Report.

2.11.2.1.2.2. DUE: Within five (5) Business Days of request by the Department

2.11.2.2. Actuarial Solvency Report

2.11.2.2.1. Contractor shall submit an opinion by a qualified actuary that attests that Contractor's surplus level and outstanding claims liability meet the requirements of this Contract. Reports shall be completed in accordance with professional accounting standards and include supplementary schedules as specified by the Department.

2.11.2.2.1.1. DELIVERABLE: Actuarial Solvency Report.

2.11.2.2.1.2. DUE: Annually, no later than December 31st.

2.11.2.2.2. The Contractor shall submit to the Department financial reports for the previous fiscal year, produced in accordance with the Mental Health Accounting and Auditing Guidelines, and audited by an independent Certified Public Accountant.

2.11.2.2.2.1. DELIVERABLE: Financial Report.

2.11.2.2.2.2. DUE: Annually, no later than April 1st.

2.11.2.3. Personnel and Committee Report

2.11.2.3.1. The Contractor shall submit a report at the request of the Department identifying the following individuals:

2.11.2.3.1.1. Privacy Officer

2.11.2.3.1.2. Security Officer

2.11.2.3.1.3. Compliance Officer

2.11.2.3.1.4. QI Committee Members

2.11.2.3.1.5. Credentialing Committee Members

2.11.2.3.2. At the request of the Department the Contractor shall also submit the training, education and credentials of these individuals.

2.11.2.3.2.1. DELIVERABLE: Personnel and Committee Report.

2.11.2.3.2.2. DUE: Within five (5) days of request by the Department

2.11.2.4. Security Events Report

2.11.2.4.1. The Contractor shall submit, quarterly, a report focusing on the following four (4) primary potential risk areas:

2.11.2.4.1.1. Unauthorized systems access.

2.11.2.4.1.2. Compromised data.

2.11.2.4.1.3. Loss of data integrity.

2.11.2.4.1.4. Inability to transmit or process data.

2.11.2.4.2. Upon discovery, the Contractor shall disclose any and all incidents falling into the categories listed above, shall document its internal review of these incidents, and shall provide to the Department its corrective actions and other mitigating measures.

2.11.2.4.2.1. DELIVERABLE: Security Events Report

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

2.11.2.5. General

2.11.2.5.1. The Contractor shall inform the Department, within five (5) Business Days, of any significant event or change in circumstances that might beneficially or adversely affect Members, Providers, the Department or other stakeholders.

2.11.2.5.1.1. DUE: Significant Event/Circumstance Report.

2.11.2.5.1.2. DUE: Within five (5) Business Days of the event.

T. Exhibit A, Statement of Work, Section 2.12, Employee Education About False Claims is hereby added:

2.12. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

2.12.1. In accordance with 42 U.S.C. 1396a(a)(68), the Contractor shall establish written policies, for all employees (including management) and for any contractor or agent, that include detained information about the False Claims Act, 31 USC § 3729, et seq., administrative remedies for false claims and statements established under chapter 38 or title 31, United States Code, the Colorado Medicaid False Claims Act, C.R.S. § 25.5-4-304 et seq., detailed provisions regarding policies and procedures for detecting and preventing fraud, waste and abuse, whistleblower protections and the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs.

2.12.2. The Contractor shall provide upon request by the Department written assurances and submit its written policies and procedures. The written assurances are:

2.12.2.1. The Contractor has the policy and procedures required by 42 U.S.C. 1396a(a)(68).

2.12.2.2 The Contractor has incorporated language required by statute into the employee handbook, if one exists.

2.12.2.3 The policy and procedures have been disseminated to all employees including management and employees of any contractor or agent.

2.12.2.4 The Contractor understands that failure to comply within thirty (30) calendar days from the date of the request by the Department for assurances and submissions may result in suspension or termination.

2.12.2.4.1 DELIVERABLE: Written assurances, policies and procedures and employee handbook, if one exists.

2.12.2.4.2 DUE: Annually, within thirty (30) days of the date of written request by the Department's Program Integrity Section.

U. Exhibit A, Statement of Work, Section 5.3, Adult Without Dependent Children Rate Settlements, references in paragraphs 5.3.1 and 5.3.1.1 to "AWDC" shall be amended to refer to "MAGI Adults."

V. Exhibit A, Statement of Work, Section 5.3.1.2 is hereby deleted in its entirety and replaced as follows:

5.3.1.2 The Department will identify MAGI Adults by the capitation and eligibility files.

W. All references within the Exhibits to "Community Mental Health Services Program" shall be modified to "Community Behavioral Health Services Program."

X. Exhibit B2, Rates, is hereby deleted in its entirety and replaced with Exhibit B3, Rates, attached hereto and incorporated by reference into the Agreement. All references within the Agreement to Exhibit B2, shall be deemed to reference Exhibit B3.

Y. Code M0064 is hereby deleted in its entirety from Exhibit E, Covered Behavioral Health Procedure Codes.

Z. Exhibit G, Performance Measures, is hereby deleted in its entirety and replaced with Exhibit G1, Performance Measures, attached hereto and incorporated by reference into the Agreement. All references within the Agreement to Exhibit G, shall be deemed to reference Exhibit G1.

AA. Exhibit A, Statement of Work, Section 5.1, Compensation, is hereby deleted in its entirety and replaced with the following:

5.1. COMPENSATION

5.1.1. The Department shall remit to the Contractor, on behalf of each Member who is eligible for Covered Services, the appropriate Monthly Capitation Rate for each full month for which each Member is eligible for Covered Services, as specified by Exhibit B, on approximately the fifteenth (15th) Business Day of the month.

5.1.2. The Monthly Capitation Rate, as specified by Exhibit B, falls within the rate range that is certified by a qualified actuary.

5.1.3. The Department shall remit to the Contractor a prorated Monthly Capitation Rate for any Member whose enrollment begins after the first (1st) of the month, including Members retroactively enrolled, based on the Rates as specified in Exhibit B.

5.1.3.1. The prorated Monthly Capitation Rate is calculated by the MMIS. The MMIS converts the Monthly Capitation Rate into a per diem rate by dividing the Monthly Capitation Rate by the number of days in the month. The Contractor is reimbursed by the MMIS for the number of days that the Member is enrolled during the month.

5.1.3.2. To calculate the Monthly Capitation Rate and corresponding rate ranges, the Department converts the capitations paid to the Contractor into member months. The member months are calculated in the same manner described above to reflect the prorated capitation payments during the contract period.

5.1.3.3. The Department will remove the amount submitted in the annual Third Party Recovery Report, described in Section 2.11.1.14, from the calculation of the Monthly Capitation Rates.

5.1.4. Payment for retroactive eligibility months shall be made in the month following the date of the eligibility determination. The payment amount is calculated based on the capitation rates and the number of retroactive enrollment months, which is limited to three (3) months prior to the date that Medicaid eligibility is determined. When a material underpayment error in the amount of the Monthly Capitation Rate has been made due to an error by the Department, the Department shall remit to the Contractor the amount necessary to correct the error within ten (10) Business Days of notification of the error by the Contractor to the Department.

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

5.1.6. In addition to the Financial Reporting, outlined in Section 2.9.10.8, per 42 CFR 438.6(g) the Contractor shall allow the Department to inspect and audit the financial records of the Contractor and its Subcontractors related to this Contract.

Subcontractors related to this Contract.

BB. Exhibit A , Statement of Work, Section 5.3, Adult Without Dependent Children Rate Settlements, is hereby deleted in its entirety and replaced with the following:

5.3. EXPANSION POPULATION RATE SETTLEMENTS

5.3.1. The Contractor and the Department shall engage in Expansion Rate Settlements for future calendar years based upon the risk corridor presented in Exhibit B. Each Expansion Parent and MAGI Adult Rate Settlement process shall include the following:

5.3.1.1. The Contractor shall send Expansion encounter data, together with the monthly mental health encounter submissions, to the Department in a monthly flat-file format and in the ANSI ASC X12N 837 format, as outlined in Section 2.9.4.

5.3.1.2. The Department will identify Expansion Clients by the capitation file.

5.3.1.3. The Department will price the Expansion Clients encounter data and will calculate the actual Expansion Parent and MAGI Adult PMPMs. The actual PMPMs will be compared to the paid Behavioral Health Rate without administrative load.

5.3.1.3. The Department will calculate settlements according to the terms in the risk corridor presented in Exhibit B nine (9) months after the end date of the Expansion rates.

5.3.1.4. The Department will issue a demand letter with the settlement amount that shall be either remitted to the Contractor or recouped from the Contractor.

CC. Exhibit A, Statement of Work, Section 5.4, Medical Loss Ratio (MLR) Settlements, is hereby added as follows:

5.4. MEDICAL LOSS RATIO (MLR) SETTLEMENTS

5.4.1. The Contractor shall maintain a MLR in excess of seventy seven percent (77%) of total Medicaid capitations. MLRs of less than seventy seven percent (77%) shall result in a refund due the Department if the amount of the medical loss is less than the threshold.

5.4.1.2. The Department will calculate the MLR for the Contractor using the audited financial reports, as required in Section 2.11.2.3.2., three (3) months after the financial reports are due.

5.4.1.3. If the Contractor's MLR is less than seventy seven percent (77%) of the total Medicaid capitations, the Department will issue a demand letter with the settlement amount that the Contractor shall reimburse the Department.

DD. Exhibit A , Statement of Work, Section 5.5, Health Insurance Providers Fee Reporting, is hereby added as follows:

5.5. HEALTH INSURANCE PROVIDER FEE REPORTING

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

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

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

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

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

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

5.5.2.1. DELIVERABLE: Health Insurance Providers Fee Report.

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

7. START DATE

This Amendment shall take effect on the later of July 1, 2015 or the Effective Date.

8. ORDER OF PRECEDENCE

Except for the Special Provisions and the HIPAA Business Associates Addendum, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The most recent version of the Special Provisions incorporated into the Contract or any amendment shall always control other provisions in the Contract or any amendments.

9. AVAILABLE FUNDS

Financial obligations of the state payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, or otherwise made available to the Department by the federal government, state government and/or grantor.

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THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

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: Colorado Access	**STATE OF COLORADO:** John W. Hickenlooper, Governor
By: ____________________ Signature of Authorized Officer	By: ____________________ Susan E. Birch, MBA, BSN, RN Executive Director Department of Health Care Policy and Financing
Date: ____________________	Date: ____________________
____________________ Printed Name of Authorized Officer	**LEGAL REVIEW:** John W. Suthers, Attorney General
	By: ____________________
____________________ Printed Title of Authorized Officer	Date: ____________________

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:

Robert Jaros, CPA, MBA, JD

By: ______________________________

Department of Health Care Policy and Financing

Date: ______________________________

EXHIBIT B-3, RATES AND EXPANSION RISK CORRIDOR

Effective July 1, 2015 – December 31, 2015

RATES

The Contractor shall earn the following Rates shown in the following table:

	Behavioral Health Rate
Elderly	$9.13
Disabled	$90.09
Non-Expansion Parent	$20.79
Expansion Parent	$16.53
Children	$17.78
Foster Care	$142.44
MAGI Adult	$47.81

The Department shall withhold an amount from the Rates to account for the health insurance provider fee as shown in the following table:

	Behavioral Health Rate
Elderly	$0.00
Disabled	$0.00
Non-Expansion Parent	$0.00
Expansion Parent	$0.00
Children	$0.00
Foster Care	$0.00
MAGI Adult	$0.00

Once the Department has withheld the amount listed in the above table, the Contractor shall receive the amount shown in the following table:

	Behavioral Health Rate
Elderly	$9.13
Disabled	$90.09
Non-Expansion Parent	$20.79
Expansion Parent	$16.53
Children	$17.78
Foster Care	$142.44
MAGI Adult	$47.81

The Contractor and the Department shall engage in Health Insurance Providers Fee Rate Settlements based upon the Health Insurance Providers Fee report provided by the Contractor to the Department each October. Each Health Insurance Providers Fee Rate Settlement process shall include the following:

Upon receipt of the Health Insurance Providers Fee Report, the Department will calculate the actual rate to account for the health insurance provider fee. The Department will issue a notification letter by January 31st with the amount to be remitted to the Contractor.

The Department will pay the Contractor all amounts withheld during the year up to the actual rate calculated by the Department to account for the health insurance provider fee.

EXPANSION RISK CORRIDOR RATES

The Expansion Parent and MAGI Adult rates, shall also be subject to a risk corridor calculation as described below:

	Behavioral Health Rate	Medical Rate Component	Administrative Rate Component
Expansion Parent	$16.53	$14.38	$2.15
MAGI Adults	$47.81	$41.59	$6.22

Expansion Parent:

1. If the rate calculated by the Department is greater than or equal to $10.54 but less than $13.66 the Contractor shall pay the Department twenty-five percent (25%) of the difference between $14.38 and the rate calculated by the Department.
2. If the rate calculated by the Department is greater than or equal to $13.66 but less than $14.38 the Contractor shall pay the Department thirty percent (30%) of the difference between $14.38 and the rate calculated by the Department.
3. If the rate calculated by the Department is greater than or equal to $14.38 but less than $15.10 the Department shall pay the Contractor thirty percent (30%) of the difference between the rate calculated by the Department and $14.38.
4. If the rate calculated by the Department is greater than or equal to $15.10 but less than or equal to $18.22 the Department shall pay the Contractor twenty-five percent (25%) of the difference between the rate calculated by the Department and $14.38.

MAGI Adult

1. If the rate calculated by the Department is greater than or equal to $30.47 but less than $39.51 the Contractor shall pay the Department twenty-five percent (25%) of the difference between $41.59 and the rate calculated by the Department.
2. If the rate calculated by the Department is greater than or equal to $39.51 but less than $41.59 the Contractor shall pay the Department thirty percent (30%) of the difference between $41.59 and the rate calculated by the Department.
3. If the rate calculated by the Department is greater than or equal to $41.59 but less than $43.67 the Department shall pay the Contractor thirty percent (30%) of the difference between the rate calculated by the Department and $41.59.

4. If the rate calculated by the Department is greater than or equal to $43.67 but less than or equal to $52.71 the Department shall pay the Contractor twenty-five percent (25%) of the difference between the rate calculated by the Department and $41.59.

EXHIBIT G-1, PERFORMANCE MEASURES

#	Priority	Performance Measure	Source	Notes
1	C	Hospital Readmissions Department	BHO-HCPF Scope Document #1	This measure will be broken out by BHO and CMHC and it is expected to be calculated by the BHO. 180 days sub-measure to be added.
2	C	Percent of Members prescribed redundant or duplicated atypical antipsychotic medication	BHO-HCPF Scope Document #2	BHOs will calculate.
3	C	Psychotropic utilization in children Antipsychotic Utilization in children. Psychotropic utilization for children in child welfare	Drug Utilization Review (DUR)	The Department will calculate and work with UH.
4	C	Mental Health Engagement: Individuals accessing behavioral health services with 4 visits in 45 days	BHO-HCPF Scope Document #4	BHOs will calculate.
5	C	Adherence to antipsychotics for individuals with schizophrenia	HEDIS	The Department will calculate and work on including a BHO breakout.
6	C	ECHO Survey	AHRQ	The Department will calculate.
7	C	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	HEDIS	BHOs will calculate.
8	C	Penetration Rates (Behavioral Health Utilization by BHO)	BHO-HCPF Scope Document #8-#11	The Department will calculate.
9	C	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	HEDIS	The Department will calculate
10	C	Cardiovascular Monitoring for individuals diagnosed with Cardiovascular Disease and Schizophrenia	HEDIS	The Department will calculate
11	C	Diabetes monitoring for individuals diagnosed with schizophrenia or prescribed antipsychotic medications	HEDIS	The Department will calculate
12	C	Follow-up appointments within seven (7) and thirty (30) days	BHO Scope Document #13	This measure would be broken out by BHO

#	Priority	Performance Measure	Source	Notes
		after hospital discharge for mental health condition.		and CMHC and it is expected to be calculated by the BHO.
13	C	Clients with physical health well care visit	BHO-HCPF Scope Document #15	The Department will calculate.
14	C	BHO Inpatient Utilization (per 1000 Members)	BHO-HCPF Scope Document #16	BHOs will calculate.
15	C	Emergency Dept. Utilization (per 1000 members) for mental health condition	BHO-HCPF Scope Document #18	This measure would be broken out by BHO and CMHC and it is expected to be calculated by the BHO.
16	C	Antidepressant medication management – acute and continuation phases	HEDIS	BHOs will calculate.
17	SY	Appropriate utilization and follow up for children prescribed medication for ADHD	NCQA 0108 2009 CHIPRA Core Measure	Method of calculation to be determined by BHOs and HCPF.
18	SY	Number of children receiving intensive services in the community/home	None	Method of calculation to be determined by BHOs and HCPF.
19	SY	Depression Screening and Follow-up Care	HEDIS	Method of calculation to be determined by BHOs and HCPF.
20	SY	Care for Older Adults Advance care planning, medication review, functional status assessment and pain screening		Method of calculation to be determined by BHOs and HCPF.
21	SY	Adult Body Mass Index (BMI) assessment and follow-up	None	Possible sub-measure for #5. Method of calculation to be determined by BHOs and HCPF.

Performance Measures Key	
Measure Count Type	**Number**
CORE	16
Second Year	5
Total # of Measures	**21**
Priority Definitions	**Definition**

CORE (C)	Core measures that will be in place from the time the contract begins. Data submission will be either quarterly, semi-annually or annually, depending on the measure.
Second Year (SY)	Measures that are not yet defined, but expected to be worked by the Department and BHOs and reported in the second year of the Contract. The Department does not expect these measures to be reported if not fully defined by reporting due dates.