CONTRACT AMENDMENT NO. 03

Original Contract Number 2016ACCMMP02

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, Colorado 80231-5963, (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 act as a Regional Collaborative Care Organization for the Department, for the Accountable Care Collaborative: Medicare-Medicaid Program (ACC: MMP), in the Contractor's Region, as defined in Exhibit A-1, Statement of Work. The purpose of this Amendment is to update language in the Statement of Work and Contract.

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 16., NOTICES AND REPRESENTATIVES, is hereby deleted in its entirety and replaced with the following:

16. NOTICES AND REPRESENTATIVES

Each individual identified below is the principal representative of the designating Party. All notices required to be given hereunder shall be hand delivered with receipt required or sent by certified or registered mail to such Party's principal representative at the address set forth below. In addition to, but not in lieu of, a hard-copy notice, notice also may be sent by e-mail to the e-mail addresses, if any, set forth below. Either Party may from time to time designate by written notice substitute addresses or persons to

whom such notices shall be sent. Unless otherwise provided herein, all notices shall be effective upon receipt.

For the State	Susan Mathieu Department of Health Care Policy & Financing 1570 Grant St Denver, Colorado 80203 Susan.Mathieu@state.co.us

For the Contractor	Attn: Legal Department Colorado Access 11100 E. Bethany Drive Aurora, CO 80111 legal@coaccess.com

B. Exhibit A., Statement of Work, Section 1.0., TERMINOLOGY, Subsection 1.1., ACRONYMS, ABBREVIATIONS AND DEFINITIONS, Paragraph 1.1.1., is hereby deleted in its entirety and replaced with the following:

1.1.1. Acronyms and abbreviations are defined at their first occurrence in this Statement of Work. The following list of acronyms, abbreviations and definitions is provided to assist the reader in understanding acronyms, abbreviations and terminology used throughout this document.

1.1.1.1. ACC - Accountable Care Collaborative.

1.1.1.2. ACC Base Contract - Contract number 3211-0171 between the Department and Colorado Access.

1.1.1.3. ACC: MMP - Accountable Care Collaborative: Medicare-Medicaid Program – the Department's demonstration to integrate care for full benefit Medicare-Medicaid enrollees.

1.1.1.4. ACC Program - The Department program designed to affordably optimize Client health, functioning and self-sufficiency with the primary goals to improve Medicaid Client health outcomes and control costs.

1.1.1.5. BHO - Behavioral Health Organization.

1.1.1.6. CCB - Community Centered Board.

1.1.1.7. C.C.R. - Colorado Code of Regulations.

1.1.1.8. CFR - Code of Federal Regulations.

1.1.1.9. Chief Medical Officer - The position within the Contractor's organization responsible for the implementation of all clinical and/or medical programs.

1.1.1.10. Client - An individual eligible for and enrolled in the Colorado Medicaid Program.

1.1.1.11. Cold Call Marketing - Any unsolicited personal contact by the Contractor with a Potential Enrollee for the purpose of marketing as defined in 42 CFR 438.104(a). See Marketing.

1.1.1.12. CME - Continuing Medical Education.

1.1.1.13. Contract Manager - The position within the Contractor's organization that acts as the primary point of contact between the Contractor and the Department.

1.1.1.14. Contractor's PCMP Network - All of the providers who have contracted with the Contractor to provide primary care medical home services within the Contractor's Region or to provide primary care medical home services to Members enrolled with the Contractor.

1.1.1.15. Contractor's Region - The region in which the Contractor operates, in the case of this Contract, Region #2.

1.1.1.16. Covered Services - Medicaid benefits according to the Department' State Plan, as filed with the federal Centers for Medicare and Medicaid Services, which are provided through the Department's Promulgated Rules, Benefit Coverage Standards, Billing Manuals and Provider Bulletins.

1.1.1.17. C.R.S. - Colorado Revised Statutes.

1.1.1.18. DCC Tool - Disability-Competent Care Tool.

1.1.1.19. DOC - Colorado Department of Corrections.

1.1.1.20. Enrollee - Any individual Client who is enrolled in the ACC: MMP with the Contractor or another RCCO.

1.1.1.21. EPSDT - Early Periodic Screening, Diagnosis and Treatment.

1.1.1.22. Essential Community Provider - A provider defined under CRS §25.5-5-403.

1.1.1.23. Expansion Adults - Adults who are newly eligible for and enrolled in Medicaid due to expanded Medicaid eligibility limits allowed by the Affordable Care Act (ACA).

1.1.1.24. FBMME - Full Benefit Medicare-Medicaid Enrollee, dually eligible for both Medicare and Medicaid.

1.1.1.25. Federally Qualified Health Center - A provider defined under 10 C.C.R. 2505-10 §8.700.1.

1.1.1.26. FFS - Fee For Service.

1.1.1.27. Financial Manager - The position within the Contractor's organization that is responsible for the implementation and oversight of all of the Contractor's financial operations.

1.1.1.28. FQHC - Federally Qualified Health Center.

1.1.1.29. Frail Elderly - Individuals who meet the following criteria: 1) greater than or equal to 65 years of age with 2 or more chronic conditions, 2) greater than eighty (80) years of age, 3) Sixty-five to seventy-nine (65-79) years of age with two (2) or more cognitive impairments listed in the ULTC (100.2), 4) Sixty-five to seventy-

nine (65-79) years of age with two (2) or more Activities of Daily Living (ADL) deficits in the ULTC (100.2).

1.1.1.30. Informal Network - The non-contractual or contractual relationships with Providers, other than PCMPs, designed to meet Member's needs.

1.1.1.31. Key Personnel - The individuals fulfilling the positions of Contract Manager, Financial Manager or Chief Medical Officer.

1.1.1.32. LTSS - Long-term Services and Supports.

1.1.1.33. Marketing - Any communication, from the Contractor, to a Medicaid Client who is not enrolled with the Contractor, that can reasonably be interpreted as intended to influence the Client to enroll in the Contractor's Medicaid product, or either to not enroll in, or to disenroll from, another Contractor's Medicaid product.

1.1.1.34. Marketing Materials - Materials that are produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended to market to Potential Enrollees.

1.1.1.35. Medical Home - An approach to providing comprehensive primary-care that facilitates partnerships between individual patients, their providers, and, where appropriate, the patient's family, that meets the requirements described in Exhibit C, Medical Home Model Principles.

1.1.1.36. Member - Any individual Client who is enrolled in the ACC: MMP with the Contractor or another RCCO.

1.1.1.37. Member Dismissal - Termination of a Member's primary care relationship with a contracted Primary Care Medical Provider.

1.1.1.38. MMIS - the Colorado Medicaid Management Information System.

1.1.1.39. Primary Care Case Management - A system under which a primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Members, or a PCCM Entity that contracts with the State to provide a defined set of functions as defined in 42 CFR§438.2.

1.1.1.40. PCCM Entity - Primary Care Case Management Entity.

1.1.1.41. Primary Care Case Management Entity - An organization that provides any of the following functions, in addition to PCCM services, for the State: provision of intensive telephonic or face-to-face case management; development of enrollee care plans; execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program; provision of payments to FFS providers on behalf of the State; provision of enrollee outreach and education activities; operation of a customer service call center; review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; coordination with behavioral health systems/providers; coordination with long-term services and supports systems/providers as defined in 42 CFR §438.2.

1.1.1.42. PCCM - Primary Care Case Manager.

1.1.1.43. Primary Care Case Manager - A physician, a physician group practice, a physician assistant, nurse practitioner, certified nurse-midwife as defined in 42 CFR §438.2.

1.1.1.44. PCMP - Primary Care Medical Provider.

1.1.1.45. Primary Care Medical Provider - A primary care provider who serves as a Medical Home for Members. A PCMP may be a FQHC, RHC, clinic or other group practice that provides the majority of a Member's comprehensive primary, preventive and sick care. A PCMP may also be individual or pods of PCMPs that are physicians, advanced practice nurses or physician assistants with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

1.1.1.46. PIP - Performance Improvement Plan.

1.1.1.47. PMPM - Per Member Per Month.

1.1.1.48. Potential Enrollee - A Medicaid Client who is eligible for enrollment into the ACC: MMP with the Contractor or another RCCO.

1.1.1.49. RCCO - Regional Care Collaborative Organization.

1.1.1.50. Region - A geographical area containing specific counties, within the State of Colorado, that is served by a RCCO.

1.1.1.51. Region #2 - The geographical area encompassing Weld, Morgan, Logan, Sedgwick, Phillips, Yuma, Kit Carson, Washington, Cheyenne, and Lincoln Counties.

1.1.1.52. Regional Care Collaborative Organization - One of seven (7) regional entities contracted with the Department to support the ACC Program by improving the health outcomes for Members and controlling the cost of care.

1.1.1.53. RHC - Rural Health Clinic.

1.1.1.54. Rural Health Clinic - A provider or practice as defined in 10 C.C.R. 2505-10 §8.740.

1.1.1.55. SCP - Service Coordination Plan. The SCP will serve as the care plan for ACC: MMP Members as required by this Contract.

1.1.1.56. SDAC - Statewide Data Analytics Contractor.

1.1.1.57. SEP - Single Entry Point Agency.

1.1.1.58. STD - Sexually Transmitted Disease.

1.1.1.59. ULTC - Uniform Long-Term Care (ULTC) Instrument. The Functional Needs Assessment and professional medical information used to determine Functional Eligibility for Long-Term Care.

C. Exhibit A., Statement of Work, Section 2.0., REGION AND PERSONNEL, Subsection 2.1., REGION, Paragraph 2.1.1., is hereby deleted in its entirety and replaced with the following:

2.1.1. The Contractor shall be the RCCO for Region #2 and shall be a Primary Care Case Management Entity (PCCM Entity), as defined in 42 CFR §438.2, for Members enrolled with the Contractor.

2.1.1.1. Region #2 includes Weld, Morgan, Logan, Sedgwick, Phillips, Yuma, Kit Carson, Washington, Cheyenne, and Lincoln Counties.

D. Exhibit A., Statement of Work, Section 6.0., MEDICAL MANAGEMENT AND CARE COORDINATION, Subsection 6.4., CARE COORDINATION, Paragraph 6.4.3.2., is hereby deleted in its entirety and replaced with the following:

6.4.3.2. The Contractor shall complete the initial Service Coordination Plan (SCP) for all Members within ninety (90) days of the Member's first effective enrollment in the ACC: MMP. In alignment with Centers for Medicare and Medicaid requirements, the ninety (90) day time-frame is equivalent to three (3) full calendar months, including the month of enrollment, where the last day of the third (3rd) month is the target date for completing the SCP. The Contractor shall meet in person with all Members who are determined by the Department and the Contractor to be high risk to complete the SCP. The Contractor shall offer all other Members the option to meet in-person or by other telecommunication methods and shall complete the initial SCP according to the Members' choice. If the Contractor uses their own paper or electronic version of a SCP, it shall include all of the elements prescribed by the Department. The Service Coordination Plan shall serve as the care plan for the member. When the Contractor can confirm that a Member has an existing care plan through a SEP, CCB, BHO, or other Medicaid provider, the Service Coordination Plan is meant to complement the existing care plan.

6.4.3.2.1. The Contractor shall ensure that the SCP is reviewed and updated as necessary with the Member, the Member's PCMP, and the Member's other service providers as appropriate. This review shall occur no less frequently than every six (6) months from when the initial SCP was completed or a more recently updated SCP was completed and after a critical incident (as specified by the SCP Guidelines).

E. Exhibit A., Statement of Work, Section 8.0., PROGRAM REPORTING, Subsection 8.2., PERFORMANCE REPORTS, Paragraph 8.2.4.1.1.1.5., is hereby deleted in its entirety and replaced with the following:

8.2.4.1.1.1.5. The number and percentage of Clients discharged from a hospital, nursing facility, or other institutional setting who were contacted for care coordination within 0-7 days following discharge.

F. Exhibit A., Statement of Work, Section 8.0., PROGRAM REPORTING, Subsection 8.2., PERFORMANCE REPORTS, Paragraph 8.2.4.1.2.1.6., is hereby deleted in its entirety and replaced with the following:

8.2.4.1.2.1.6. The number and percentage of Clients discharged from a hospital, nursing facility, or other institutional setting who were contacted for care coordination by the delegated entities within 0-7 days following discharge.

G. Exhibit A., Statement of Work, Section 8.0., PROGRAM REPORTING, Subsection 8.2., PERFORMANCE REPORTS, Paragraph 8.2.4.4., is hereby added as follows:

8.2.4.4. Starting in January 2017, quarterly ACC: MMP Reports due by the 30th day of the month following the end of the calendar quarter the report covers

H. Exhibit E., DELIVERABLES, is hereby deleted in its entirety and replaced with Exhibit E-1, attached hereto and incorporated by reference into the Agreement. All references within the Agreement to Exhibit E shall be deemed to reference Exhibit E-1.

7. START DATE

This Amendment shall take effect on the later of its Effective Date or January 01, 2017.

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

By: _____
Signature of Authorized Officer

Date: 12/19/16

Marshall Thomas MD
Printed Name of Authorized Officer

President & CEO
Printed Title of Authorized Officer

STATE OF COLORADO:
John W. Hickenlooper, Governor

By: _____
Susan E. Birch, MBA, BSN, RN
Executive Director
Department of Health Care Policy and Financing

FOR SUSAN BIRCH

Date: 12/22/16

LEGAL REVIEW:
Cynthia H. Coffman, Attorney General

By: n/a

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: 12/27/16

EXHIBIT E-1, DELIVERABLES

DUE DATE AND TIMELINES

- All due dates, deadlines and timelines in the contract Statement of Work are measured in calendar days unless specifically stated otherwise. Additionally, all due dates, deadlines and timelines in this Contract, based on quarters, refer to state fiscal year calendar quarters, with the first quarter beginning on July 1st of each year. In the event that any due date or deadline falls on a weekend, a Department holiday or other day the Department is closed, the due date or deadline shall be automatically extended to the next business day the Department is open.
- The Department may, in its sole discretion, extend the due date, deadline or timeline of any activity, deliverable or requirement under this Statement of Work. Any such extension shall only be valid if it is delivered to the Contractor in writing, in either a hard copy or electronic format.
- All Contract deliverables shall be submitted electronically to acc@state.co.us, the Department's contract manager, and other Department staff as directed by the Department.

CONTRACT DELIVERABLES

2.2.7.1. DELIVERABLE: **Organizational Chart.**
2.2.7.2. DUE: Thirty (30) days from the Contract's Effective Date.

2.2.8.1. DELIVERABLE: **Updated Organizational Chart.**
2.2.8.2. DUE: Five (5) days from any change in Key Personnel of from the Department's request for an updated Organizational Chart.

3.2.1.3.1. DELIVERABLE: All **ACC: MMP client materials.**
3.2.1.3.2. DUE: Ten (10) Business Days prior to the Contractor printing or disseminating materials to any Member or Client, unless the Department approves a shorter submission deadline.

3.2.1.3.3. DELIVERABLE: **Updated client materials** including changes required by the Department.
3.2.1.3.4. DUE: Thirty (30) days from the request by the Department to make a change.

3.2.4.1.1. DELIVERABLES: **ACC: MMP Member Handbook** – updated section specific to the Contractor's Region, when significant changes occur.
3.2.4.1.2. DUE: Thirty (30) days from the effective date of the changes.

3.2.4.2.1. DELIVERABLES: **PCMP Directory.**
3.2.4.2.2. DUE: Monthly by the first day of the month, unless extension is allowed by the Department.

4.3.1.3.1. DELIVERABLE: **Updated Communication Plan**

4.3.1.3.2. DUE: Thirty (30) days prior to the date of any significant change to the Communication Plan

5.1.1.3.1 DELIVERABLE: All **provider support documents** and direct provider contact plans.

5.1.1.3.2 DUE: Ten (10) Business Days from the date the documents or plans are requested by the Department; and ten (10) Business Days from the request by the Department to make a change for updated documents.

6.1.1.2.1. DELIVERABLE: **Updated Clinical Referral** Protocol including all changes directed by the Department.

6.1.1.2.2. DUE: Within three (3) Business Days from the Department's request for a change, unless more time is granted by the Department.

6.4.1.1.3.1. DELIVERABLE: **Care Coordination Agreements and/or Description**

6.4.1.1.3.2. DUE: Thirty (30) days from the Department's request.

6.4.12.1. DELIVERABLE: **Updated documentation of formal system of care coordination.**

6.4.12.2. DUE: Sixty (60) days from the change or from the Department's request.

6.4.14.3. DELIVERABLE: **Care Coordination Report**

6.4.14.4. DUE: Semi-annually on November 1, reporting for the period of April 1 through September 30; and May 1, reporting for the period of October 1 through March 30.

7.2.2.1. DELIVERABLE: **Initial Quality Report and Quality Improvement Plan; Annual Quality Report and Quality Improvement Plan Update.**

7.2.2.2. DUE: The Initial Quality Report and Quality Improvement Plan is due by October 1, 2015; the Quality Report and Quality Improvement Plan Update is due annually, by October 1st of the year.

8.1.2.3.1. DELIVERABLE: **Network Report.**

8.1.2.3.2. DUE: Semi-annually, by January 31st and July 31st of each year.

8.1.2.4.1. DELIVERABLE: **Interim Network Report.**

8.1.2.4.2. DUE: within ten (10) Business Days after the Department's request for the interim Network Report.

8.1.3.3.1. DELIVERABLE: **Program Integrity Report.**

8.1.3.3.2. DUE: Ten (10) Business Days from the initial report of the fraud or abuse.

8.1.3.4.1. DELIVERABLE: **Member Fraud Report.**

8.1.3.4.2. DUE: Ten (10) Business Days from the initial report of the fraud or abuse.

8.2.1.1.3. DELIVERABLE: **Integrated Care Report.**

8.2.2.1.4. DUE: Semi-annually, by January 31st and July 31st of each year.

8.2.2.3.1. DELIVERABLE: **Member Outreach and Stakeholder Feedback Report.**
8.2.2.3.2. DUE: Thirty (30) days from the end of the quarter that the report covers

8.2.3.2. DELIVERABLE: **RCCO Quarterly Financial Report**
8.2.3.3. DUE: No later than forty-five (45) days from the end of the state fiscal quarter that the report covers.

8.2.4.2. DELIVERABLE: **ACC: MMP Report**
8.2.4.3. DUE: Quarterly, by the 10th day of the month following the end of the calendar quarter the report covers starting in July 2015
8.2.4.4. DUE: Starting in January 2017, quarterly ACC: MMP Reports due by the 30th day of the month following the end of the calendar quarter the report covers

8.3.2.1. DELIVERABLE: **Update reports.**
8.3.2.2. DUE: Ten (10) Business Days from the Department's request for an updated or corrected report.

10.1.1.1. DELIVERABLE: **Transition Plan**
10.1.1.2. DUE: Annually by the last business day in September and one hundred twenty (120) days prior to the termination date