CONTRACT AMENDMENT NO. 12

Original Contract Number 3211-0171, CMS 30526
Amendment No. 12 CMS 97368

1. PARTIES

This Amendment to the above-referenced Original Contract (hereinafter called the "Contract") is entered into by and between Colorado Access, 11100 East Bethany Drive, Aurora, Colorado 80014-2630, (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 Care Collaborative Organization for the Department in Region 3, as that region is defined in Exhibit A-7. 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	Patrick Gillies Colorado Access 11100 East Bethany Drive, Aurora, Colorado 80014-2630 Patrick.Gillies@coaccess.com

B. HIPAA Business Associate Addendum, Section 15. Representative and Notice., Paragraph b. Notices., is hereby deleted in its entirety and replaced with the following:

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:	Susan Mathieu
Title:	ACC Program Manager
Department:	Department of Health Care Policy and Financing
Address:	1570 Grant Street Denver, Colorado 80203

Contractor / Business Associate Representative	
Name:	Legal Department
Company:	Colorado Access
Address:	11100 E. Bethany Drive Aurora, CO 80114

C. Exhibit A-7, Statement of Work, Section 1.0., TERMINOLOGY, Subsection 1.1., ACRONYMS, ABBREVIATIONS AND DEFINITIONS, is hereby deleted in its entirety and replaced with the following:

1.1. ACRONYMS, ABBREVIATIONS AND DEFINITIONS

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 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.

1.1.1.3. AwDC - Adults without Dependent Children as defined in CRS §25.5-4-402.3.

1.1.1.4. BHO - Behavioral Health Organization.

1.1.1.5. CCB - Community Centered Board.

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

1.1.1.7. CFR - Code of Federal Regulations.

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

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

1.1.1.10. 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.

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

1.1.1.12. 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.

1.1.1.13. Contractor's Region - The region in which the Contractor operates, in the case of this Contract, Region #3.

1.1.1.14. Covered Services - Medicaid benefits according to the Department's 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.

1.1.1.15. CJI - Criminal Justice Involved. State or county inmates who have been paroled or released from prison or jail.

1.1.1.16. CRS - Colorado Revised Statutes.

1.1.1.17. Enrollee - Any individual Client who is enrolled in the ACC Program with the Contractor or another RCCO.

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

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

1.1.1.20. 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).

1.1.1.21. Expansion Phase - The period of time from the end of the Initial Phase until termination of the Contract.

1.1.1.22. FBMME - Full Benefit Medicare-Medicaid Enrollee.

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

1.1.1.24. FFS - Fee For Service.

1.1.1.25. 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.

1.1.1.26. FQHC - Federally Qualified Health Center.

1.1.1.27. Go-Live Date - June 1, 2011, or the date, upon which the Department gives approval for the Contractor to begin the Initial Phase, whichever is later.

1.1.1.28. Guiding Care – A clinical tool created by Altruista Health, Inc.

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

1.1.1.30. Initial Phase - The period of time from the Go-Live Date until June 30, 2012 or until the Contractor is authorized by the Department to enter the Expansion Phase, whichever is later.

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. MAGI Adults - Adults who are eligible for the Colorado Medical Assistance Program as described in CRS 25.5-4-402.3(4)(b)(IV)(c).

1.1.1.34. Marketing - Any communication, from the Contractor, to a 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.

1.1.1.35. 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.

1.1.1.36. 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 B, Medical Home Model Principles.

1.1.1.37. Member - Any individual Client who is enrolled with the Contractor or another RCCO.

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

1.1.1.39. MMIS - the Colorado Medicaid Management Information System.

1.1.1.40. 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.

1.1.1.41. PCCM Entity - Primary Care Case Management Entity.

1.1.1.42. 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.

1.1.1.43. PCCM - Primary Care Case Manager.

1.1.1.44. 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.

1.1.1.45. PCMP - Primary Care Medical Provider.

1.1.1.46. 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.

1.1.1.47. PIP - Performance Improvement Plan.

1.1.1.48. PMPM - Per Member Per Month.

1.1.1.49. Potential Enrollee - A Client who is eligible for enrollment into the ACC Program with the Contractor or another RCCO, but is not yet enrolled in the ACC Program.

1.1.1.50. RCCO - Regional Care Collaborative Organization.

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

1.1.1.52. Region #3 - The geographical area encompassing Adams, Arapahoe and Douglas Counties.

1.1.1.53. 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.

1.1.1.54. RHC - Rural Health Clinic.

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

1.1.1.56. SDAC - Statewide Data Analytics Contractor.

1.1.1.57. SEP - Single Entry Point Agency.

1.1.1.58. Start-Up Phase - The period of time from the Contract's Effective Date until the Go-Live Date.

1.1.1.59. STD - Sexually Transmitted Disease.

1.1.1.60. TAP – Transition Access Program.

D. Exhibit A-7, 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 #3 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 #3 includes Adams, Arapahoe and Douglas Counties.

E. Exhibit A-7, Statement of Work, Section 4.0., NETWORK STRATEGY, Subsection 4.1., PCMP NETWORK AND NETWORK DEVELOPMENT, Paragraph 4.1.8., is hereby deleted in its entirety and replaced with the following:

4.1.8. The Contractor shall reasonably ensure that all providers and PCMPs in its network are aware of the Contractor's referral process as described in Section 6.1.

F. Exhibit A-7, Statement of Work, Section 6.0., MEDICAL MANAGEMENT AND CARE COORDINATION, Subsection 6.4., CARE COORDINATION, Paragraph 6.4.1., is hereby deleted in its entirety and replaced with the following:

6.4.1. The Contractor shall provide care coordination for its Members, necessary for the Members to achieve their desired health outcomes in an efficient and responsible manner. The Contractor may allow the PCMPs, other Subcontractors or other sources to perform some or all of the care coordination activities, but the Contractor shall be responsible for the ultimate delivery of care coordination services.

G. Exhibit A-7, Statement of Work, Section 7.0., ACCOUNTABILITY, Subsection 7.2., EXPANSION PHASE PERFORMANCE METRICS, is hereby deleted in its entirety and replaced with the following:

7.2. EXPANSION PHASE PERFORMANCE METRICS

7.2.1. Once the Contractor has entered the Expansion Phase, the Department shall begin enrolling additional Members into the Contractor's plan at the Department's discretion. The Department may enroll any eligible Client within the Contractor's Region into the Contractor's plan, and the Contractor shall accept all new Members enrolled by the Department.

7.2.2. The Department will use three performance targets to measure the Contractor during the first year of the Expansion Phase. The three performance targets will be Emergency Room Visits per 1,000 Full Time Enrollees (FTEs), Hospital Readmissions per 1,000 FTEs, and Outpatient Service Utilization of MRIs and CT Scans per 1,000 FTEs. The Department will use four performance targets to measure the Contractor during the second year of the Expansion Phase. The performance targets will be the three existing targets and Well Child Visits (EPSDT Screens) as defined by CMS 416 standards. After the second year of the Expansion Phase, the Department may adjust performance targets to align with goals of the program. The performance target measures and goals will be the same as those described in Section 11.2, Pay for Performance Program. The baseline for all performance targets listed in the table at Section 11.2.4., Key Performance Indicator Payment Table, shall be calculated based on the most recently available twelve (12) month period by the Department utilizing methodology that is fully disclosed to the Contractor in advance, with opportunity for consideration of comments submitted by the Contractor prior to finalization of the methodology by the Department.

7.2.3. The Department shall not include Members who are eligible for both Medicare and Medicaid in the incentive performance payment calculations, because the Department does not have completed Medicare data to calculate the measures. The incentive payments for Medicare and Medicaid clients not eligible for the Medicare-Medicaid Program (MMP) shall be paid out based on the Contractor's performance for all other FTEs. MMP clients are not included in the performance calculations or the incentive payment calculations, because the demonstration has its own incentive program as part of the demonstration.

7.2.4. During the second year of the Expansion phase and every subsequent year, the Department shall consult with the Contractor to determine the measurement areas and performance targets for the Contractor based on the Department's priorities, goals, objectives and initiatives. The Department shall amend this Contract to establish the new measurement areas and performance targets.

H. Exhibit A-7, Statement of Work, Section 7.0., ACCOUNTABILITY, Subsection 7.4., FEEDBACK AND INNOVATION, Paragraph 7.4.4., is hereby deleted in its entirety and replaced with the following:

7.4.4. The Department may request the Contractor provide a replacement representative, for any of the committees in this section, from the Contractor in the event that the Department determines, in its sole discretion, that the existing representative is unacceptable or if the representative shows a pattern of being disruptive during meetings, being tardy to regularly scheduled meetings or failing to attend regularly scheduled meetings. In the event that the Department requests a replacement representative, the Contractor shall provide the replacement representative by the next regularly scheduled meeting of that committee.

I. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.1., PMPM PAYMENTS FOR MEMBERS, is hereby renamed as follows:

11.1. PMPM PAYMENTS

J. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.1., PMPM PAYMENTS, Paragraph 11.1.1.1., is hereby deleted in its entirety and replaced with the following:

11.1.1.1. The PMPM shall be calculated as follows:

K. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.1., PMPM PAYMENTS, Paragraph 11.1.1.2. through 11.1.1.6., is hereby deleted in its entirety and replaced as follows:

11.1.1.2. The PMPM payments shall only be made during the Initial Phase and the Expansion Phase. The Contractor shall not receive any PMPM Payment before the beginning of the Initial Phase.

11.1.1.3. The number of active Members enrolled in the Contractor's plan shall be calculated based on the number of enrollments in the Colorado Medicaid Management Information System.

11.1.1.4. The Department shall remit all PMPM Payments to the Contractor within the month for which the PMPM Payment applies. In the event that the Contractor is not compensated for a Member in a month for which the Contractor should have been compensated, the Department shall compensate the Contractor for that Member.

11.1.1.5. The Contractor may attribute Members who had been enrolled in CHP+ to a PCMP. When making these attributions, the Contractor shall use the same attribution methodology the Department uses. The Department will process these attributions in MMIS within ninety (90) days of receiving the file.

11.1.1.5.1. DELIVERABLE: Documentation of methodology for attribution

11.1.1.5.2. DUE: Prior to implementing the attribution methodology

11.1.1.5.3. DELIVERABLE: Excel file with ACC clients identified by Medicaid client ID linked to Medicaid provider billing ID and a date for the last visit with that Provider

11.1.1.5.4. DUE: Upon completion of attribution.

L. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM FOR MEMBERS, is hereby renamed as follows:

11.2. PAY FOR PERFORMANCE PROGRAM

M. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM, Paragraph 11.2.1., is hereby deleted in its entirety and replaced with the following:

11.2.1. The Contractor may earn performance payments by meeting quality measures as established by the Department in the following areas:

11.2.1.1. Key performance indicators.

11.2.1.2. Additional performance target(s).

N. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM FOR MEMBERS, Paragraph 11.2.2., is hereby deleted in its entirety and replaced with the following:

11.2.2. For SFY2016 (July 01, 2015 through June 30, 2016) and SFY2017 (July 01, 2016 through June 30, 2017), the pay for performance program will be focused on one or more of the following measures or activities:

11.2.2.1. Emergency room visits.

11.2.2.2. Postpartum care.

11.2.2.3. Well child checks (ages 3 to 9).

11.2.2.4. Adolescent and adult depression screening (billed FFS).

11.2.2.5. Adolescent well care (ages 13 to 20).

11.2.2.6. Evaluation and management claim within thirty (30) days of hospitalization.

11.2.2.7. Cost of care.

11.2.2.8. Member satisfaction.

11.2.2.9. Increased practice transformation efforts that include, but are not limited to:

11.2.2.9.1. Alignment with the intent of the State Innovation Model (SIM).

11.2.2.9.2. Alignment with the intent of the Comprehensive Primary Care *Plus* (CPC+) initiative.

O. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM FOR MEMBERS, Paragraph 11.2.5., is hereby deleted in its entirety and replaced with the following:

11.2.5. The Department shall remit all Payments on Key Performance Indicators to the Contractor on a quarterly basis within 180 days from the last day of the quarter in which the Incentive Payments were earned. The Department will calculate the Incentive Payment as of the end of each quarter based off of performance from the prior 12 months.

P. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM FOR MEMBERS, Paragraph 11.2.6., is hereby deleted in its entirety and replaced with the following:

11.2.6. Program Savings (Shared Savings) Not Used.

Q. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM FOR MEMBERS, Paragraph 11.2.7.2., is hereby deleted in its entirety and replaced with the following:

11.2.7.2. The Department shall distribute the monies in the pay for performance pool to the Contractor based on the Contractor's performance in one or more of the following areas, as determined by the Department's calculation methodology: in increasing the number of Members with an evaluation and maintenance claim within thirty (30) days of hospitalization, decreasing the cost of care, increasing Member satisfaction, increasing depression screening rates, or another measure selected to support practice transformation efforts as stated in 11.2.2.9.

11.2.7.2.1. The Department will provide the Contractor with the documented calculation methodology prior to the distribution of funds. The Department shall release the calculation methodology as draft and shall provide a comment period of no less than two (2) weeks prior to releasing as final.

R. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM FOR MEMBERS, Paragraph 11.2.7.3., is hereby deleted in its entirety and replaced with the following:

11.2.7.3. The Department shall distribute money from the pay for performance pool quarterly by the end of the quarter. In the instance that the data is not available to make quarterly payments, the Department shall make payments within 180 days of receipt of the data.

S. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.2., PAY FOR PERFORMANCE PROGRAM FOR MEMBERS, Paragraph 11.2.8.1., is hereby deleted in its entirety and replaced with the following:

11.2.8.1. The Contractor shall assess and report to the Department the PCMPs that meet at least five (5) of the nine (9) criteria listed in Exhibit H. The Contractor shall be able to produce the documentation and shall provide said documentation to the Department upon Department request.

11.2.8.1.1. DELIVERABLE: List of providers meeting the criteria, all factors attained and the date by which the PCMP met the criteria.

11.2.8.1.2. DUE: Annually, by June 15th.

T. Exhibit A-7, Statement of Work, Section 11.0., COMPENSATION, Subsection 11.3., OPPORTUNITY LIAISON PAYMENT, Paragraph 11.3.1., is hereby deleted in its entirety and replaced with the following:

11.3.1. The Department shall provide $15,000 quarterly through June 30, 2017 to the Contractor to provide a Liaison, paid via quarterly invoice, at the end of each quarter. The Department shall only pay for a quarter if the Contractor can demonstrate, in a Department approved format, that either a full-time employee or multiple employees performing work equivalent to a full-time employee was in place to fulfill the duties of the Liaison during that quarter.

U. Exhibit A-7, Statement of Work, Section 14.0., GENERAL REQUIREMENT, Subsection 14.6., DEBARRED ENTITIES, Paragraph 14.6.3., is hereby deleted in its entirety and replaced with the following:

14.6.3. As stipulated in 42 CFR 438.610(c), if the Department finds that the Contractor is not in compliance with any provisions of Section 14.6. (Debarred Entities), the Department:

14.6.3.1. Must notify the Secretary of the U.S. Department of Health and Human Services (Secretary) of the noncompliance.

14.6.3.2. May continue an existing agreement with the Contractor, unless the Secretary directs otherwise.

14.6.3.3. May not renew or otherwise extend the duration of this contract, unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending this contract.

V. Exhibit A-7, Statement of Work, Section 15.0., Health IT Assessment, is hereby added as follows:

SECTION 15.0. HEALTH IT ASSESSMENT

15.1. HEALTH IT ASSESSMENT

15.1.1. The Contractor shall conduct an assessment of provider network EHR connections to the Colorado Health Information Exchange Organization and Quality Health Network (collectively, the Health Information Organizations or HIOs) and utilization of Health Information Exchange (HIE) services or modalities.

15.1.2. The Contractor shall draft a one (1) page Provider Network Survey Scope to determine the providers the Contractor intends to survey. The Contractor shall ensure that the Network Survey Scope includes all of the following:

15.1.2.1. Scope of providers the Contractor intends to survey.

15.1.2.2. Rational for determining scope of providers.

15.1.3. The Contractor shall deliver to the Department a copy of the Provider Network Survey Scope for review.

15.1.3.1. DELIVERABLE: Provider Network Survey Scope

15.1.3.2. DUE: Within seven (7) days after the Effective Date of amendment 12

15.2. EHR / HIE ASSESSMENT REPORT

15.2.1. The Contractor shall create and draft an EHR / HIE Assessment Report. The Contractor may collaborate with the Department and RCCOs to create a template for the EHR / HIE Assessment report. The Contractor shall consider survey data elements relevant to the needs of the State Innovation Model when drafting the EHR / HIE Assessment Report. The Contractor shall ensure that the Assessment Report includes the following sections:

15.2.1.1. EHR Assessment Report

15.2.1.1.1. The Contractor ensure that the EHR Assessment Report includes, but is not limited to, the following:

15.2.1.1.1.1. Name of the product.

15.2.1.1.1.2. The product's version number.

15.2.1.1.1.3. Name of the developer or vendor.

15.2.1.1.1.4. Certified Health IT Product List (CHPL) number.

15.2.1.1.1.5. The Contractor shall assess EHR interoperability capabilities.

15.2.1.1.1.6. Whether the EHR is certified by the Office of the National Coordinator (ONC) for Health Information Technology.

15.2.1.1.1.7. If EHR has the ability to generate and send electronic clinical quality measures (eCQMs) in a Quality Reporting Document Architecture (QRDA) or Consolidated Clinical Document Architecture (C-CDA) format to the HIE.

15.2.1.2. Health Information Exchange (HIE) Assessment Report

15.2.1.2.1. The Contractor shall ensure that the HIE Assessment Report includes, but is not limited to, all of the following:

15.2.1.2.1.1. Type of connection to the HIE and EHR capability to leverage, including but not limited to, the following:

15.2.1.2.1.1.1. DIRECT messaging, listing all that apply.

15.2.1.2.1.1.2. Alerting services.

15.2.1.2.1.1.3. CCD query and retrieve.

15.2.1.2.1.1.4. Other technical services and product lines offered by the Colorado HIEs.

15.2.1.2.1.1.5. Other HIE services utilized outside of Colorado HIOs.

15.2.1.2.1.2. To what extent are the above HIE capabilities accessible within the EHR workflow and do not require providers to log into a separate portal.

15.2.1.2.1.3. Provider readiness for HIE to include, but is not limited to, all of the following:

15.2.1.2.1.3.1. Adequate staffing and knowledge levels that include, but are not limited to, the following:

15.2.1.2.1.3.1.2. Managing EHR and HIE vendors, including testing of upgrades and new functionality rollouts

15.2.1.2.1.3.1.3. Managing system downtimes and data entry following downtimes

15.2.1.2.1.3.1.4. Conducting staff training for EHR use, including consistent data entry and security protocols

15.2.1.2.1.3.1.5. Conducting system audits; developing and fine-tuning reports

15.2.1.2.1.3.1.6. Managing quality reporting of eCQMs

15.2.1.2.1.4. Adequate local infrastructure such as the availability of broadband.

15.2.1.2.1.5. Does the practice have a workflow plan in place that is followed for each HIE service available?

15.2.1.2.2. As a component of the HIE Assessment Report, the Contractor shall determine whether Providers attend and participate in any Technical Assistance (TA) program, such as the Regional Extension Center program and the SIM CHITA program. The Contractor shall evaluate the providers on the following:

15.2.1.2.2.1. Length of time the practice participated in the TA program.

15.2.1.2.2.2. Which partner organization provided the TA services.

15.2.1.2.2.3. Which TA services were most useful and why.

15.2.1.2.2.4. Which TA services were not useful and why.

15.2.1.2.2.5 Participation in the Medicaid EHR Incentive Program.

15.2.1.2.2.6 Participation in the Value-Based Payment program.

15.2.2. The Contractor shall deliver to the Department a copy of the Electronic Health Records / Health Information Exchange Report.

15.2.2.1. DELIVERABLE: Electronic Health Records / Health Information Exchange Report

15.2.2.2. DUE: No later than May 31, 2017

15.2.3. The Contractor may work with the following entities to obtain the necessary information to draft the EHR / HIE Assessment Report:

15.2.3.1. The Department.

15.2.3.2. CORHIO.

15.2.3.3. QHN.

15.2.3.4. RCCOs.

15.2.3.5. Any other entity.

15.3. HEALTH IT ASSESSMENT AND STRATEGIC PLAN

15.3.1. The Contractor shall create and draft a Health IT Assessment and Strategic Plan.

15.3.1.1. The Contractor shall ensure that the Health IT Assessment and Strategic Plan includes, at the minimum, all of the following:

15.3.1.1.1. An Executive Summary.

15.3.1.1.2. The Current State of Health IT in the region to include any barriers.

15.3.1.1.3. Analysis to include any gaps in technology and opportunities such as the desire future state of region, statewide engagement.

15.3.1.2. The Contractor shall ensure that the Plan includes, but is not limited to, all of the following:

15.3.1.2.1. Most common EHR systems in the region.

15.3.1.2.2. Percentage of practices that use ONC-Certified Electronic Health Record Technology.

15.3.1.2.3. Most common HIE services utilized.

15.3.1.2.4. Increase of regional interoperability.

15.3.1.2.5. Increase in Certified EHR Technology connection to HIE and HIE services.

15.3.1.2.6. Rate of participation in TA programs and value-based payment reform programs.

15.3.1.2.7. Analysis of usefulness and challenges facing practices and providers participating in TA programs and value-based payment reform programs.

15.3.1.2.8. Alignment with ONC standards and the Seven Standards and Conditions.

15.3.1.2.9. Electronic Clinical Quality Measures (eCQM) generation with little effort.

15.3.1.2.10. Plan for region-wide RCCO-delivered TA.

15.3.2. The Contractor shall deliver to the Department a copy of the Health IT Assessment and Strategic Plan.

15.3.2.1. DELIVERABLE: Health IT Assessment and Strategic Plan.

15.3.2.2. DUE: No later than June 30, 2017

W. Exhibit H, Rates, is hereby attached hereto and incorporated herein by reference into the Contract.

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.

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

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: 2-20-17

Phil Reed
Printed Name of Authorized Officer

CFO
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

Date: 3/2/17

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: 3/17/17

EXHIBIT H, RATES

1.0 DELIVERABLES, TIMELINE AND COMPENSATION

1.1 The Contractor shall provide the stated deliverables in accordance with the dates stated in the table in Section 1.4.

1.2 The Contractor shall invoice the Department upon the completion of a deliverable and will be paid the fixed price amount stated in the table in Section 1.4 upon review and acceptance by the Department of each deliverable. All invoices must be submitted to the Department no later than June 30, 2017.

1.3 The total amount of funding for this fixed price purchase order for all work to be performed pursuant to this Statement of Work is two hundred thousand dollars ($200,000.00). This total amount of funding will be the sole compensation to the Contractor for the services and/or deliverables provided.

1.4 The due date and payment for each deliverable is detailed in the following table:

DELIVERABLES	DATE DUE TO THE DEPARTMENT	AMOUNT OF TOTAL AWARDED FIXED PRICE CONTRACTOR WILL BE PAID UPON ACCEPTANCE OF DELIVERABLE
EHR / HIE Assessment Report *	No later than 05/31/2017	$100,000.00
Health IT Assessment and Strategic Plan *	No later than 06/30/2017	$100,000.00
TOTAL		**$200,000.00**

* The Department will pay this deliverable using HITECH funds approved from Centers for Medicare & Medicaid Services (CMS).