Contract Routing Number 2016MEDMCO001

STATE OF COLORADO
Department of Health Care Policy and Financing
Intergovernmental Agreement with
Denver Health and Hospital Authority
for
Managed Care Services

TABLE OF CONTENTS

1. PARTIES 2
2. EFFECTIVE DATE AND NOTICE OF NONLIABILITY 2
3. RECITALS 2
4. DEFINITIONS 2
5. TERM 4
6. STATEMENT OF WORK 4
7. PAYMENTS TO CONTRACTOR 5
8. REPORTING NOTIFICATION 6
9. CONTRACTOR RECORDS 6
10. CONFIDENTIAL INFORMATION 7
11. CONFLICTS OF INTEREST 9
12. REPRESENTATIONS AND WARRANTIES 9
13. INSURANCE 10
14. BREACH 13
15. REMEDIES 13
16. NOTICES AND REPRESENTATIVES 16
17. RIGHTS IN DATA, DOCUMENTS, AND COMPUTER SOFTWARE 16
18. GOVERNMENTAL IMMUNITY 17
19. GENERAL PROVISIONS 17
20. ADDITIONAL GENERAL PROVISIONS 19
21. COLORADO SPECIAL PROVISIONS 24

HIPAA BUSINESS ASSOCIATE ADDENDUM
EXHIBIT A, STATEMENT OF WORK
EXHIBIT B, RATES
EXHIBIT C, SAMPLE OPTION LETTER
EXHIBIT D, COVERED SERVICES
EXHIBIT E, DISPROPORTIONATE SHARE AND GRADUATE MEDICAL EDUCATION HOSPITAL REPORTING BY CALENDAR YEAR QUARTER
EXHIBIT F, MEMBER HANDBOOK REQUIREMENTS
EXHIBIT G, REQUIREMENTS FOR PHYSICIAN INCENTIVE PLANS
EXHIBIT H, CONTRACTOR DISCLOSURE TEMPLATE
EXHIBIT I, COVERED BEHAVIORAL HEALTH PROCEDURE CODES
EXHIBIT J, MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESS
EXHIBIT K, SERIOUS REPORTABLE EVENTS OR NEVER EVENTS

EXHIBIT L, ENROLLMENT TETENTION RATE DISENROLLMENT CODES
EXHIBIT M, COVERED 1202 PROCEDURE CODES

1. PARTIES

This Contract (hereinafter called "Contract") is entered into by and between Denver Health and Hospital Authority dba Denver Health Medicaid Choice, a body corporate and political subdivision of the State of Colorado, located at 777 Bannock Street, Denver, Colorado 80204 (hereinafter 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 the "State" or "Department"). Contractor and the State hereby agree to the following terms and conditions.

2. EFFECTIVE DATE AND NOTICE OF NONLIABILITY

This Contract shall not be effective or enforceable until the later of July 1, 2015 or when it is approved and signed by the Colorado State Controller or designee (hereinafter called the "Effective Date"). The State 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. RECITALS

A. Authority, Appropriation, and Approval

Authority to enter into this Contract exists in Section 25.5-4-104, et seq. C.R.S. and Title XIX of the Social Security Act and funds have been budgeted, appropriated and otherwise made available and a sufficient unencumbered balance thereof remains available for payment. Required approvals, clearance and coordination have been accomplished from and with appropriate agencies.

B. 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 Contract.

C. Purpose

The purpose of this Contract is for the Contractor to perform as a Managed Care Entity .

D. References

All references in this Contract to sections (whether spelled out or using the §symbol), subsections, exhibits or other attachments, are references to sections, subsections, exhibits or other attachments contained herein or incorporated as a part hereof, unless otherwise noted.

4. DEFINITIONS

The following terms as used herein shall be construed and interpreted as follows:

A. “Closeout Period” means the period of time defined in Exhibit A, Statement of Work.

B. “Contract” means this Contract, its terms and conditions, attached addenda, exhibits, documents incorporated by reference under the terms of this Contract, and any future modifying agreements, exhibits, attachments or references incorporated herein pursuant to Colorado State law, Fiscal Rules, and State Controller Policies.

C. Exhibits and other Attachments. The following documents are attached hereto and incorporated by reference herein:

HIPAA Business Associate Addendum
Exhibit A, Statement of Work
Exhibit B, Rates
Exhibit C, Sample Option Letter
Exhibit D, Covered Services
Exhibit E, Disproportionate Share and Graduate Medicaid Education Hospital Reporting by Calendar Year Quarter
Exhibit F, Member Handbook Requirements
Exhibit G, Requirements for Physician Incentive Plans
Exhibit H, Contractor Disclosure Template
Exhibit I, Covered Behavioral Health Procedure Codes
Exhibit J, Medicaid Managed Care Grievance and Appeal Processes
Exhibit K, Serious Reportable Events or Never Events
Exhibit L, Enrollment Retention Rate Disenrollment Codes
Exhibit M, Covered 1202 Procedure Codes

D. “Goods” means tangible material acquired, produced, or delivered by Contractor either separately or in conjunction with the Services Contractor renders hereunder.

E. “Party” means the State or Contractor and Parties means both the State and Contractor.

F. “Review” means examining Contractor’s Work to ensure that it is adequate, accurate, correct, and in accordance with the standards described in this Contract.

G. “Services” means the required services to be performed by Contractor pursuant to this Contract.

H. “State Fiscal Year” or “SFY” means the twelve (12) month period beginning on July 1st of a year and ending on June 30th of the following year.

I. “Subcontractor” means third-parties, if any, engaged by Contractor to aid in performance of its obligations.

J. “Work” means the tasks and activities Contractor is required to perform to fulfill its obligations under this Contract, including the performance of the Services and delivery of the Goods.

K. “Work Product” means the tangible or intangible results of Contractor’s Work, including, but not limited to, software, research, reports, studies, data, photographs, negatives or other finished or unfinished documents, drawings, models, surveys, maps, materials, or work product of any type, including drafts.

Any terms used herein which are defined in Exhibit A, Statement of Work shall be construed and interpreted as defined therein.

5. TERM

E. Initial Term

The Parties' respective performances under this Contract shall commence on July 1, 2015. This Contract shall expire June 30, 2016, unless sooner terminated or further extended as specified elsewhere herein.

F. Two Month Extension

The State, at its sole discretion, upon written notice to Contractor as provided in **§16**, may unilaterally extend the term of this Contract for a period not to exceed two months if the Parties desire to continue the services and a replacement Contract has not been fully executed by the expiration of any initial term or renewal term. The provisions of this Contract in effect when such notice is given, including, but not limited to, prices, rates and delivery requirements, shall remain in effect during the two month extension. The two (2) month extension shall immediately terminate when and if a replacement contract is approved and signed by the Colorado State Controller or an authorized designee, or at the end of two (2) months, whichever is earlier.

G. Option to Extend

The State may require continued performance for a period of one (1) year or less at the same rates and same terms specified in the Contract. If the State exercises this option, it shall provide written notice to Contractor at least thirty (30) days prior to the end of the current Contract term in form substantially equivalent to **Exhibit C**. If exercised, the provisions of the Option Letter shall become part of and be incorporated into this Contract.

6. STATEMENT OF WORK

A. Completion

Contractor shall complete the Work and its other obligations as described in this Contract on or before the end of the term of this Contract. The State shall not be liable to compensate Contractor for any Work performed prior to the Effective Date or after the expiration or termination of this Contract.

B. Goods and Services

Contractor shall procure Goods and Services necessary to complete the Work. Such procurement shall not increase the maximum amount payable hereunder by the State.

C. Independent Contractor

All persons employed by Contractor or Subcontractors to perform Work under this Contract shall be Contractor's or Subcontractors' employee(s) for all purposes

hereunder and shall not be employees of the State for any purpose as a result of this Contract.

7. PAYMENTS TO CONTRACTOR

The State shall, in accordance with the provisions of this **§7** and Exhibit A, Statement of Work, pay Contractor in the amounts and using the methods set forth below:

A. Maximum Payment

In no circumstance shall any payment under this Contract exceed the upper limit of payment for Non-risk Contracts, as described in 42 CFR §447.362.

B. Payment

Payment pursuant to this Contract will be made as earned.

C. Interest

The State shall not pay interest on any amounts due to Contractor hereunder.

D. Available Funds-Contingency-Termination

The State is prohibited by law from making commitments beyond the term of the State's current fiscal year. Therefore, Contractor's compensation beyond the State's current fiscal year is contingent upon the continuing availability of State appropriations as provided in the Colorado Special Provisions, set forth below. If federal funds are used to fund this Contract, in whole or in part, the State's performance hereunder is contingent upon the continuing availability of such funds. Payments pursuant to this Contract shall be made only from available funds and the State's liability for such payments shall be limited to the amount remaining of such available funds. If State or federal funds are not appropriated, or otherwise become unavailable to fund this Contract, the State may terminate this Contract immediately, in whole or in part, without further liability notwithstanding any notice and cure period in **§14.B**.

E. Erroneous Payments

At the State's sole discretion, payments made to Contractor in error for any reason, including, but not limited to, overpayments or improper payments, may be recovered from Contractor by deduction from subsequent payments under this Contract or other contracts, grants or agreements between the State and Contractor or by other appropriate methods and collected as a debt due to the State. Such funds shall not be paid to any party other than the State.

F. Closeout Payments

Notwithstanding anything to the contrary in this Contract, all payments for the final month of the Contract shall be paid to the Contractor no sooner than ten (10) days after the Department has determined that the Contractor has completed all of the requirements of the Closeout Period.

G. Option to Increase or Decrease Statewide Quantity of Service

The Department may increase or decrease the statewide quantity of services described in the Contract based upon the rates established in the Contract. If the Department exercises the option, it will provide written notice to Contractor in a form substantially equivalent to **Exhibit C**. Delivery/performance of services shall continue at the same rates and terms. If exercised, the provisions of the Option Letter shall become part of and be incorporated into the original Contract.

8. REPORTING NOTIFICATION

Reports required under this Contract shall be in accordance with the procedures and in such form as prescribed by the State and as described in **Exhibit A**.

A. Litigation Reporting

Within ten (10) days after being served with any pleading in a legal action filed with a court or administrative agency, related to this Contract or which may affect Contractor's ability to perform its obligations hereunder, Contractor shall notify the State of such action and deliver copies of such pleadings to the State's principal representative as identified herein. If the State's principal representative is not then serving, such notice and copies shall be delivered to the Executive Director of the Department.

B. Noncompliance

Contractor's failure to provide reports and notify the State in a timely manner in accordance with this **§8** may result in the delay of payment of funds and/or termination as provided under this Contract.

9. CONTRACTOR RECORDS

A. Maintenance

Contractor shall make, keep, maintain, and allow inspection and monitoring by the State of a complete file of all records, documents, communications, notes, and other written materials, electronic media files and electronic communications, pertaining in any manner to the Work or the delivery of Services or Goods hereunder. Contractor shall maintain such records until the last to occur of: **(i)** a period of six (6) years after the date this Contract expires or is sooner terminated, or **(ii)** a period of six (6) years after final payment is made hereunder, or **(iii)** a period of six (6) years after the resolution of any pending Contract matters, or **(iv)** if an audit is occurring, or Contractor has received notice that an audit is pending, until such audit has been completed and its findings have been resolved (collectively, the "Record Retention Period"). All such records, documents, communications and other materials shall be the property of the State, and shall be maintained by the Contractor in a central location and the Contractor shall be custodian on behalf of the State.

B. Inspection

Contractor shall permit the State, the federal government and any other duly authorized agent of a governmental agency to audit, inspect, examine, excerpt, copy and/or transcribe Contractor's records related to this Contract during the Record Retention Period, to assure compliance with the terms hereof or to evaluate performance hereunder. The State reserves the right to inspect the Work at all reasonable times and places during the term of this Contract, including any extensions or renewals. If the Work fails to conform with the requirements of this Contract, the State may require Contractor promptly to bring the Work into conformity with Contract requirements, at Contractor's sole expense. If the Work cannot be brought into conformance by re-performance or other corrective measures, the State may require Contractor to take necessary action to ensure that future performance conforms to Contract requirements and exercise the remedies available under this Contract, at law or in equity, in lieu of or in conjunction with such corrective measures.

C. Monitoring

Contractor shall permit the State, the federal government and any other duly authorized agent of a government agency, in their sole discretion, to monitor all activities conducted by Contractor pursuant to the terms of this Contract using any reasonable procedure, including, but not limited to: internal evaluation procedures, examination of program data, special analyses, on-site checking, formal audit examinations, or any other procedure. All monitoring controlled by the State shall be performed in a manner that shall not unduly interfere with Contractor's performance hereunder.

D. Final Audit Report

If an audit is performed on Contractor's records for any fiscal year covering a portion of the term of this Contract, Contractor shall submit a copy of the final audit report to the State or its principal representative at the address specified herein.

10. CONFIDENTIAL INFORMATION

Contractor shall comply with the provisions of this **§10** if it becomes privy to confidential information in connection with its performance hereunder. Confidential information includes, but is not necessarily limited to, any state records, personnel records, and information concerning individuals. Such information shall not include information required to be disclosed pursuant to the Colorado Open Records Act, CRS §24-72-101, et seq.

A. Confidentiality

Contractor shall keep all State records and information confidential at all times and comply with all laws and regulations concerning confidentiality of information. Any request or demand by a third party for State records and information in the possession of Contractor shall be immediately forwarded to the State's principal representative.

B. Health Insurance Portability & Accountability Act of 1996 (“HIPAA”)

i. Federal Law and Regulations

Pursuant to federal law and regulations governing the privacy of certain health information, the Contractor, to the extent applicable, shall comply with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d – 1320d-8 (“HIPAA”) and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160 and 164 (the “Privacy Rule”) and other applicable laws, as amended.

ii. Business Associate Contract

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

iii. Confidentiality of Records

Whether or not an Addendum is attached to this Contract, the Contractor shall protect the confidentiality of all records and other materials containing personally identifying information that are maintained in accordance with the Contract and comply with HIPAA rules and regulations. Except as provided by law, no information in possession of the Contractor about any individual constituent shall be disclosed in a form including identifying information without the prior written consent of the person in interest, a minor’s parent, or guardian. The Contractor shall have written policies governing access to, duplication and dissemination of, all such information. The Contractor shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. The Contractor shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the federal Health Insurance Portability and Accountability Act of 1996.

C. Notification

Contractor shall notify its agents, employees, Subcontractors and assigns who may come into contact with State records or other confidential information that each is subject to the confidentiality requirements set forth herein, and shall provide each with a written explanation of such requirements before permitting them to access such records and information.

D. Use, Security, and Retention

Confidential information of any kind shall not be distributed or sold to any third party or used by Contractor or its agents in any way, except as authorized by this Contract or approved in writing by the State. Contractor shall provide and maintain a secure environment that ensures confidentiality of all State records and other confidential information wherever located. Confidential information shall not be retained in any files or otherwise by Contractor or its agents, except as permitted in this Contract or approved in writing by the State.

11. CONFLICTS OF INTEREST

A. Contractor shall not engage in any business or personal activities or practices or maintain any relationships which conflict in any way with the full performance of Contractor's obligations hereunder. Contractor acknowledges that with respect to this Contract, even the appearance of a conflict of interest is harmful to the State's interests. Absent the State's prior written approval, Contractor shall refrain from any practices, activities or relationships that reasonably appear to be in conflict with the full performance of Contractor's obligations to the State hereunder. If a conflict or appearance exists, or if Contractor is uncertain whether a conflict or the appearance of a conflict of interest exists, Contractor shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the apparent conflict constitutes a breach of this Contract.

B. The Contractor (and Subcontractors or subgrantees permitted under the terms of this Contract) shall maintain a written code of standards governing the performance of its employees engaged in the award and administration of contracts. No employee, officer or agent of the Contractor, Subcontractor, or subgrantee shall participate in the selection, or in the award or administration of a contract or subcontract supported by federal funds if a conflict of interest, real or apparent, would be involved. Such a conflict would arise when:

i. The employee, officer or agent;
ii. Any member of the employee's immediate family;
iii. The employee's partner; or
iv. An organization which employs, or is about to employ, any of the above, has a financial or other interest in the firm selected for award. The Contractor's, Subcontractor's, or subgrantee's officers, employees, or agents will neither solicit nor accept gratuities, favors, or anything of monetary value from Contractors, potential Contractors, or parties to subagreements.

12. REPRESENTATIONS AND WARRANTIES

Contractor makes the following specific representations and warranties, each of which was relied on by the State in entering into this Contract.

A. Standard and Manner of Performance

Contractor shall perform its obligations hereunder in accordance with the highest standards of care, skill and diligence in Contractor's industry, trade, or profession and in the sequence and manner set forth in this Contract.

B. Legal Authority – Contractor Signatory

Contractor warrants that it possesses the legal authority to enter into this Contract and that it has taken all actions required by its procedures and/or applicable laws to exercise that authority, and to lawfully authorize its undersigned signatory to execute this Contract, or any part thereof, and to bind Contractor to its terms. If requested by the State, Contractor shall provide the State with proof of Contractor's authority to enter into this Contract within five (5) days of receiving such request.

C. Licenses, Permits, Etc.

Contractor represents and warrants that as of the Effective Date it has, and that at all times during the term hereof it shall have and maintain, at its sole expense, all licenses, certifications, approvals, insurance, permits and other authorizations required by law to perform its obligations hereunder. Contractor warrants that it shall maintain all necessary licenses, certifications, approvals, insurance, permits, and other authorizations required to properly perform this Contract, without reimbursement by the State or other adjustment in the Contract. Additionally, all employees, agents, and Subcontractors of Contractor performing Services under this Contract shall hold all required licenses or certifications, if any, to perform their responsibilities. Contractor, if a foreign corporation or other foreign entity transacting business in the State of Colorado, further warrants that it currently has obtained and shall maintain any applicable certificate of authority to transact business in the State of Colorado and has designated a registered agent in Colorado to accept service of process. Any revocation, withdrawal or non-renewal of licenses, certifications, approvals, insurance, permits or any such similar requirements necessary for Contractor to properly perform the terms of this Contract is a material breach by Contractor and constitutes grounds for termination of this Contract.

13. INSURANCE

Contractor and its Subcontractors shall obtain and maintain insurance as specified in this section at all times during the term of this Contract. All policies evidencing the insurance coverage required hereunder shall be issued by insurance companies satisfactory to Contractor and the State.

A. Contractor

i. Public Entities

The Contractor is a "public entity" within the meaning of the Colorado Governmental Immunity Act, CRS §24-10-101, et seq., as amended (the "GIA"), and shall maintain at all times during the term of this Contract such liability insurance, by commercial policy or self-insurance, as is necessary to meet its liabilities under the GIA. Contractor shall show proof of such

insurance satisfactory to the State, if requested by the State. Contractor shall require each contract with a Subcontractor that is a public entity, to include the insurance requirements necessary to meet such Subcontractor's liabilities under the GIA.

B. Subcontractors

Contractor shall require each contract with Subcontractors other than those that are public entities, providing Goods or Services in connection with this Contract, to include insurance requirements substantially similar to the following:

i. Worker's Compensation

Worker's Compensation Insurance as required by State statute, and Employer's Liability Insurance covering all of Contractor's or Subcontractor's employees acting within the course and scope of their employment.

ii. General Liability

Commercial General Liability Insurance written on ISO occurrence form CG 00 01 10/93 or equivalent, covering premises operations, fire damage, independent contractors, products and completed operations, blanket contractual liability, personal injury, and advertising liability with minimum limits as follows:

a. $1,000,000 each occurrence;
b. $1,000,000 general aggregate;
c. $1,000,000 products and completed operations aggregate; and
d. $50,000 any one fire.

If any aggregate limit is reduced below $1,000,000 because of claims made or paid, Subcontractor shall immediately obtain additional insurance to restore the full aggregate limit and furnish to Contractor a certificate or other document satisfactory to Contractor showing compliance with this provision.

iii. Protected Health Information Insurance

Liability insurance covering all loss of Protected Health Information data and claims based upon alleged violations of privacy rights through improper use or disclosure of Protected Health Information with minimum limits as follows:

a. $1,000,000 each occurrence; and
b. $2,000,000 general aggregate.

iv. Automobile Liability

Automobile Liability Insurance covering any auto (including owned, hired and non-owned autos) with a minimum limit of $1,000,000 each accident combined single limit.

v. Professional Liability Insurance

Professional Liability Insurance covering any damages caused by an error, omission or any negligent acts with minimum limits as follows:
a. $1,000,000 each occurrence; and
b. $1,000,000 general aggregate.

vi. Crime Insurance

Crime Insurance including Employee Dishonesty coverage with minimum limits as follows:
a. $1,000,000 each occurrence; and
b. $1,000,000 general aggregate.

vii. Additional Insured

The State shall be named as additional insured on all Commercial General Liability and protected health information insurance policies (leases and construction contracts require additional insured coverage for completed operations on endorsements CG 2010 11/85, CG 2037, or equivalent) required of Contractor and any Subcontractors hereunder.

viii. Primacy of Coverage

Coverage required of Contractor and Subcontractor shall be primary over any insurance or self-insurance program carried by Contractor or the State.

ix. Cancellation

The above insurance policies shall include provisions preventing cancellation or non-renewal without at least 30 days prior notice to Contractor and Contractor shall forward such notice to the State in accordance with **§16** (Notices and Representatives) within seven days of Contractor's receipt of such notice.

x. Subrogation Waiver

All insurance policies in any way related to this Contract and secured and maintained by Contractor or its Subcontractors as required herein shall include clauses stating that each carrier shall waive all rights of recovery, under subrogation or otherwise, against Contractor or the State, its agencies, institutions, organizations, officers, agents, employees, and volunteers.

C. Certificates

Contractor and all Subcontractors shall provide certificates or other documentation showing insurance coverage required hereunder to the State within seven (7) Business Days of the Effective Date of this Contract. No later than fifteen (15) days prior to the expiration date of any such coverage, Contractor and each Subcontractor shall deliver to the State or Contractor certificates or other documentation of insurance evidencing renewals thereof. In addition, upon request by the State at any other time during the term of this Contract or any subcontract, Contractor and each Subcontractor shall, within ten (10) days of such request,

supply to the State evidence satisfactory to the State of compliance with the provisions of this **§13**.

14. BREACH

A. Defined

In addition to any breaches specified in other sections of this Contract, the failure of the Contractor to perform any of its material obligations hereunder in whole or in part or in a timely or satisfactory manner, constitutes a breach. The institution of proceedings under any bankruptcy, insolvency, reorganization or similar law, by or against Contractor, or the appointment of a receiver or similar officer for Contractor or any of its property, which is not vacated or fully stayed within twenty (20) days after the institution or occurrence thereof, shall also constitute a breach.

B. Notice and Cure Period

In the event of a breach, the State shall notify the Contractor of such in writing in the manner provided in **§16**. If such breach is not cured within ten (10) days of receipt of written notice, the State may exercise any of the remedies set forth in **§15**. Notwithstanding anything to the contrary herein, the State, in its sole discretion, need not provide advance notice or a cure period and may immediately terminate this Contract in whole or in part if reasonably necessary to preserve public safety or to prevent immediate public crisis.

15. REMEDIES

A. Termination for Cause and/or Breach

If Contractor is in breach under any provision of this Contract, the State shall have all of the remedies listed in this **§15** in addition to all other remedies set forth in other sections of this Contract, and without limiting its remedies otherwise available at law or equity, following the notice and cure period set forth in **§14.B**. Remedies are cumulative and the State may exercise any or all of the remedies available to it, in its sole discretion, concurrently or consecutively. The State may terminate this entire Contract or any part of this Contract. Exercise by the State of this right shall not be a breach of its obligations hereunder.

i. Obligations and Rights

To the extent specified in any termination notice, Contractor shall not incur further obligations or render further performance hereunder past the effective date of such notice, and shall terminate outstanding orders and subcontracts with third parties. However, Contractor shall complete and deliver to the State all Work, Services and Goods not cancelled by the termination notice. Contractor shall continue performance of this Contract up to the effective date of the termination. To the extent the Contract is not terminated, if any, Contractor shall continue performance until the expiration of this Contract. At the sole discretion of the State, Contractor shall assign to the State all of Contractor's right, title, and interest under such terminated orders or subcontracts. Upon termination, Contractor shall

take timely, reasonable and necessary action to protect and preserve property in the possession of Contractor in which the State has an interest. All materials owned by the State in the possession of Contractor shall be immediately returned to the State. All Work Product, at the option of the State, shall be delivered by Contractor to the State and shall become the State’s property. The Contractor shall be obligated to return any payment advanced under the provisions of this Contract.

ii. Payments

The State shall reimburse Contractor only for accepted performance up to the effective date of the termination. If, after termination by the State, it is determined that Contractor was not in breach or that Contractor's action or inaction was excusable, such termination shall be treated as a Early Termination Without Cause and the rights and obligations of the Parties shall be the same as if this Contract had been terminated Early Termination Without Cause, as described herein.

iii. Damages and Withholding

Notwithstanding any other remedial action by the State, Contractor shall remain liable to the State for any damages sustained by the State by virtue of any breach under this Contract by Contractor and the State may withhold any payment to Contractor for the purpose of mitigating the State’s damages, until such time as the exact amount of damages due to the State from Contractor is determined. The State may withhold any amount that may be due Contractor as the State deems necessary to protect the State against loss, including loss as a result of outstanding liens, claims of former lien holders, or for the excess costs incurred in procuring similar goods or services. Contractor shall be liable for excess costs incurred by the State in procuring from third parties replacement Work, Services or substitute Goods as cover.

B. Early Termination Without Cause

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

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

iii. The Contractor shall notify each participating provider in writing that Contractor has terminated its contract with the Department. The written notice shall include the effective date of the termination and shall explain

to the participating provider how the provider can continue participating in the Medicaid program.

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

a. A list of each participating provider, including providers who are not contracted with the Department.

b. A list of Clients with special health care needs and Clients who are receiving case management.

c. A list of all services requiring Contractor prior authorization.

d. A list of all Clients receiving prior authorized services that extends beyond the contract termination date.

C. Additional Remedies

The State, in its sole discretion, may exercise one or more of the following remedies in addition to other remedies available to it:

i. Suspend Performance

Suspend Contractor's performance with respect to all or any portion of this Contract pending necessary corrective action as specified by the State without entitling Contractor to an adjustment in price/cost or performance schedule. Contractor shall promptly cease performance of such portions of the contract.

ii. Withhold Payment

Withhold payment to Contractor until Contractor's performance or corrections in Contractor's performance are satisfactorily made and completed.

iii. Deny/Reduce Payment

Deny payment for those obligations not performed in conformance with Contract requirements, that due to Contractor's actions or inactions, cannot be performed or, if performed, would be of no value to the State; provided, that any denial or reduction of payment shall be reasonably related to the value to the State of the obligations not performed.

iv. Removal

Notwithstanding any other provision herein, the State may demand immediate removal of any of Contractor's employees, agents, or Subcontractors from work on the Contract whom the State deems incompetent, careless, insubordinate, unsuitable, or otherwise unacceptable, or whose continued relation to this Contract is deemed to be contrary to the public interest or the State's best interest.

v. Intellectual Property

If Contractor infringes on a patent, copyright, trademark, trade secret or other intellectual property right while performing its obligations under this Contract, Contractor shall, at the State's option:

a. Obtain for the State or Contractor the right to use such products and services;

b. Replace any Goods, Services, or other product involved with non-infringing products or modify them so that they become non-infringing; or,

c. If neither of the foregoing alternatives are reasonably available, remove any infringing Goods, Services, or products and refund the price paid therefore to the State.

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:
Jeremy Sax
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203
jeremy.sax@state.co.us

For the Contractor:
LeAnn Donovan
Denver Health and Hospital Authority
990 Bannock St.
Mailcode 6000
Denver, CO 80204
leann.donovan@dhha.org

17. RIGHTS IN DATA, DOCUMENTS, AND COMPUTER SOFTWARE

Any software, research, reports, studies, data, photographs, negatives or other documents, drawings, models, materials, or Work Product of any type, including drafts, prepared by Contractor in the performance of its obligations under this Contract shall be the exclusive property of the State, and all Work Product shall be delivered to the State by Contractor upon completion or termination hereof. The State's exclusive rights in such Work Product shall include, but not be limited to, the right to copy, publish, display, transfer, and prepare derivative works. Contractor shall not use, willingly allow, cause or permit such Work Product to be used for any purpose other than the performance of Contractor's obligations hereunder without the prior written consent of the State.

18. GOVERNMENTAL IMMUNITY

Liability for claims for injuries to persons or property arising from the negligence of the Parties, their departments, institutions, agencies, boards, officials, and employees is controlled and limited by the provisions of the Colorado Governmental Immunity Act, CRS §24-10-101, *et seq.*, and the risk management statutes, CRS §24-30-1501, *et seq.*, as now or hereafter amended.

19. GENERAL PROVISIONS

A. Assignment and Subcontracts

Contractor's rights and obligations hereunder are personal and may not be transferred, assigned or subcontracted without the prior, written consent of the State. Any attempt at assignment, transfer or subcontracting without such consent shall be void. All assignments, subcontracts, or Subcontractors approved by the Contractor or the State are subject to all of the provisions hereof. Contractor shall be solely responsible for all of the Work performed under this Contract, regardless of whether Subcontractors are used and for all aspects of subcontracting arrangements and performance. Copies of any and all subcontracts entered into by Contractor to perform its obligations hereunder shall be in writing and submitted to the State upon request. Any and all subcontracts entered into by Contractor related to its performance hereunder shall require the Subcontractor to perform in accordance with the terms and conditions of this Contract and to comply with all applicable federal and state laws. Any and all subcontracts shall include a provision that such subcontracts are governed by the laws of the State of Colorado.

B. Binding Effect

Except as otherwise provided in **§19.A**, all provisions herein contained, including the benefits and burdens, shall extend to and be binding upon the Parties' respective heirs, legal representatives, successors, and assigns.

C. Captions

The captions and headings in this Contract are for convenience of reference only, and shall not be used to interpret, define, or limit its provisions.

D. Counterparts

This Contract may be executed in multiple identical original counterparts, all of which shall constitute one agreement.

E. Entire Understanding

This Contract represents the complete integration of all understandings between the Parties regarding the Work and all prior representations and understandings, oral or written, related to the Work are merged herein. Prior or contemporaneous additions, deletions, or other changes hereto shall not have any force or effect whatsoever, unless embodied herein.

F. Jurisdiction and Venue

All suits or actions related to this Contract shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver.

G. Modification

i. By the Parties

Except as specifically provided in this Contract, modifications of this Contract shall not be effective unless agreed to in writing by the Parties in an amendment to this Contract, properly executed and approved in accordance with applicable Colorado State law and State Fiscal Rules. Modifications permitted under this Contract, other than contract amendments, shall conform to the policies of the Office of the State Controller, including, but not limited to, the policy entitled MODIFICATIONS OF CONTRACTS - TOOLS AND FORMS.

ii. By Operation of Law

This Contract is subject to such modifications as may be required by changes in Federal or Colorado State law, or their implementing regulations. Any such required modification automatically shall be incorporated into and be part of this Contract on the effective date of such change, as if fully set forth herein.

H. Order of Precedence

The provisions of this Contract shall govern the relationship of the State and Contractor. In the event of conflicts or inconsistencies between this Contract and its exhibits and attachments, including, but not limited to, those provided by Contractor, such conflicts or inconsistencies shall be resolved by reference to the documents in the following order of priority:

i. Colorado Special Provisions
ii. HIPAA Business Associate Addendum
iii. The provisions of the main body of this Contract
iv. Exhibit A, Statement of Work
v. Exhibit B, Rates
vi. Exhibit C, Sample Option Letter
vii. Exhibit D, Covered Services
viii. Exhibit E, Disproportionate Share and Graduate Medicaid Education Hospital Reporting by Calendar Year Quarter
ix. Exhibit F, Member Handbook Requirements
x. Exhibit G, Requirements for Physician Incentive Plans
xi. Exhibit H, Contractor Disclosure Template
xii. Exhibit I, Covered Behavioral Health Procedure Codes
xiii. Exhibit J, Medicaid Managed Care Grievance and Appeal Processes
xiv. Exhibit K, Serious Reportable Events or Never Events
xv. Exhibit L, Enrollment Retention Rate Disenrollment Codes
xvi. Exhibit M, Covered 1202 Procedure Codes

I. Severability

Provided this Contract can be executed and performance of the obligations of the Parties accomplished within its intent, the provisions hereof are severable and any provision that is declared invalid or becomes inoperable for any reason shall not affect the validity of any other provision hereof.

J. Survival of Certain Contract Terms

Notwithstanding anything herein to the contrary, provisions of this Contract requiring continued performance, compliance, or effect after termination hereof, shall survive such termination and shall be enforceable by the State if Contractor fails to perform or comply as required.

K. Taxes

The State is exempt from all federal excise taxes under IRC Chapter 32 (No. 84-730123K) and from all State and local government sales and use taxes under CRS §§39-26-101 and 201, *et seq*. Such exemptions apply when materials are purchased or services are rendered to benefit the State; provided, however, that certain political subdivisions may require payment of sales or use taxes even though the product or service is provided to the State. Contractor shall be solely liable for paying such taxes as the State is prohibited from paying or reimbursing Contractor for such taxes.

L. Third Party Beneficiaries

Enforcement of this Contract and all rights and obligations hereunder are reserved solely to the Parties. Any services or benefits which third parties receive as a result of this Contract are incidental to the Contract, and do not create any rights for such third parties.

M. Waiver

Waiver of any breach under a term, provision, or requirement of this Contract, or any right or remedy hereunder, whether explicitly or by lack of enforcement, shall not be construed or deemed as a waiver of any subsequent breach of such term, provision or requirement, or of any other term, provision, or requirement.

N. CORA Disclosure

To the extent not prohibited by federal law, this Contract and the performance measures and standards under CRS §24-103.5-101, if any, are subject to public release through the Colorado Open Records Act, CRS §24-72-101, et seq.

20. ADDITIONAL GENERAL PROVISIONS

A. Compliance with Applicable Law

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

subcontracts and subgrants permitted under this contract. The federal laws and regulations include:

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

State laws include:

Civil Rights Division	Section 24-34-301, CRS, *et seq.*

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

i. The Contractor will not discriminate against any person on the basis of race, color, national origin, age, sex, religion or handicap, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions, in performance of Work under this Contract.

ii. At all times during the performance of this Contract, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or denied benefits of the service, programs, or activities performed by the Contractor, or be subjected to any discrimination by the Contractor.

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

B. Federal Audit Provisions

Office of Management and Budget (OMB) Circular No. A-133, Audits of States, Local Governments, and Non-Profit Organizations, defines audit requirements under the Single Audit Act of 1996 (Public Law 104-156). All state and local governments and non-profit organizations expending $500,000.00 or more from all sources (direct or from pass-through entities) are required to comply with the provisions of Circular No. A-133. The Circular also requires pass-through entities to monitor the activities of subrecipients and ensure that subrecipients meet the audit requirements. To identify its pass-through responsibilities, the State of Colorado requires all subrecipients to notify the State when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.00.

C. Debarment and Suspension

i. If this is a covered transaction or the Contract amount exceeds $100,000.00, the Contractor certifies to the best of its knowledge and belief that it and its principals and Subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency.

ii. This certification is a material representation of fact upon which reliance was placed when the State determined to enter into this transaction. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available at law or by contract, the State may terminate this Contract for default.

iii. The Contractor shall provide immediate written notice to the State if it has been debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any Federal department or agency.

iv. The terms "covered transaction," "debarment," "suspension," "ineligible," "lower tier covered transaction," "principal," and "voluntarily excluded," as used in this paragraph, have the meanings set out in 2 C.F.R. Parts 180 and 376.

v. The Contractor agrees that it will include this certification in all lower tier covered transactions and subcontracts that exceed $100,000.00.

D. Force Majeure

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

E. Disputes

Except as herein specifically provided otherwise, disputes concerning the performance of this Contract which cannot be resolved by the designated Contract representatives shall be referred in writing to a senior departmental management staff designated by the State and a senior manager designated by the Contractor. Failing resolution at that level, disputes shall be presented in writing to the Executive Director of the State and the Contractor’s appropriate senior official for resolution. This process is not intended to supersede any other process for the resolution of controversies provided by law.

F. Lobbying

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

i. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative Contract, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative Contract.

ii. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative Contract, the undersigned shall complete and submit Standard Form-LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions.

iii. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative Contracts) and that all subrecipients shall certify and disclose accordingly.

iv. This certification is a material representation of fact upon which reliance was placed when the transaction was made or entered into. Submission of the certification is a requisite for making or entering into transaction

imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

21. COLORADO SPECIAL PROVISIONS

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

A. **CONTROLLER'S APPROVAL**. **CRS §24-30-202(1)**. This contract shall not be valid until it has been approved by the Colorado State Controller or designee.

B. **FUND AVAILABILITY**. **CRS §24-30-202(5.5)**. Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.

C. **INDEPENDENT CONTRACTOR**. Contractor shall perform its duties hereunder as an independent contractor and not as an employee. Neither Contractor nor any agent or employee of Contractor shall be deemed to be an agent or employee of the State. Contractor and its employees and agents are not entitled to unemployment insurance or workers compensation benefits through the State and the State shall not pay for or otherwise provide such coverage for Contractor or any of its agents or employees. Unemployment insurance benefits will be available to Contractor and its employees and agents only if such coverage is made available by Contractor or a third party. Contractor shall pay when due all applicable employment taxes and income taxes and local head taxes incurred pursuant to this contract. Contractor shall not have authorization, express or implied, to bind the State to any agreement, liability or understanding, except as expressly set forth herein. Contractor shall **(a)** provide and keep in force workers' compensation and unemployment compensation insurance in the amounts required by law, **(b)** provide proof thereof when requested by the State, and **(c)** be solely responsible for its acts and those of its employees and agents.

D. **COMPLIANCE WITH LAW**. Contractor shall strictly comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.

E. **CHOICE OF LAW**. Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this contract. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. Any provision incorporated herein by reference which purports to negate this or any other Special Provision in whole or in part shall not be valid or enforceable or available in any action at law, whether by way of complaint, defense, or otherwise. Any provision rendered null and void by the operation of this provision shall not invalidate the remainder of this contract, to the extent capable of execution.

F. **SOFTWARE PIRACY PROHIBITION. Governor's Executive Order D 002 00**. State or other public funds payable under this contract shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Contractor hereby certifies and warrants that, during the term of this contract and any extensions, Contractor has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Contractor is in violation

of this provision, the State may exercise any remedy available at law or in equity or under this contract, including, without limitation, immediate termination of this contract and any remedy consistent with federal copyright **laws** or applicable licensing restrictions.

G. **EMPLOYEE FINANCIAL INTEREST/CONFLICT OF INTEREST**. **CRS §§24-18-201 and 24-50-507**. The signatories aver that to their knowledge, no employee of the State has any personal or beneficial interest whatsoever in the service or property described in this contract. Contractor has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Contractor's services and Contractor shall not employ any person having such known interests.

SIGNATURE PAGE

THE PARTIES HERETO HAVE EXECUTED THIS CONTRACT

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

CONTRACTOR
Denver Health and Hospital Authority

____
***Signature**

Date:_______________________

By:_______________________________________
Name of Authorized Individual

Title:______________________________________
Official Title of Authorized Individual

STATE OF COLORADO
John W. Hickenlooper, Governor
Department of Health Care Policy and Financing

____
Susan E. Birch, MBA, BSN, RN
Executive Director

Signatory avers to the State Controller or delegate that Contractor has not begun performance or that a Statutory Violation waiver has been requested under Fiscal Rules

Date:_______________________

LEGAL REVIEW
Cynthia H. Coffman, Attorney General

By:____
Signature - Assistant Attorney General

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:___________________

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum ("Addendum") is part of the Contract between the State of Colorado, Department of Health Care Policy and Financing and the Contractor. For purposes of this Addendum, the State is referred to as "Department", "Covered Entity" or "CE" and the Contractor is referred to as "Associate". Unless the context clearly requires a distinction between the Contract document and this Addendum, all references herein to "the Contract" or "this Contract" include this Addendum.

RECITALS

A. CE wishes to disclose certain information to Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information ("PHI") (defined below).

B. CE and Associate intend to protect the privacy and provide for the security of PHI disclosed to Associate pursuant to this Contract in compliance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §1320d – 1320d-8 ("HIPAA") as amended by the American Recovery and Reinvestment Act of 2009 ("ARRA")/HITECH Act (P.L. 111-005), and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160, 162 and 164 (the "HIPAA Rules") and other applicable laws, as amended.

C. As part of the HIPAA Rules, the CE is required to enter into a contract containing specific requirements with Associate prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 160.103, 164.502(e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this Addendum.

The parties agree as follows:

1. Definitions.

a. Except as otherwise defined herein, capitalized terms in this Addendum shall have the definitions set forth in the HIPAA Rules at 45 C.F.R. Parts 160, 162 and 164, as amended. In the event of any conflict between the mandatory provisions of the HIPAA Rules and the provisions of this Contract, the HIPAA Rules shall control. Where the provisions of this Contract differ from those mandated by the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Contract shall control.

b. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the HIPAA Rules, including, but not limited to, 45 C.F.R. Section 164.501.

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

d. "Subcontractor" shall mean a third party to whom Associate delegates a function, activity, or service that involves CE's Protected Information, in order to carry out the responsibilities of this Agreement.

2. Obligations of Associate.

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

b. Permitted Disclosures. Associate shall not disclose Protected Information in any manner that would constitute a violation of the HIPAA Rules if disclosed by CE, except that Associate may disclose Protected Information: (i) in a manner permitted pursuant to this Contract; (ii) for the proper management and administration of Associate; (iii) as required by law; (iv) for Data Aggregation purposes for the Health Care Operations of CE; or (v) to report violations of law to appropriate federal or state authorities, consistent with 45 C.F.R. Section 164.502(j)(1). To the extent that Associate discloses Protected Information to a third party Subcontractor, Associate must obtain, prior to making any such disclosure: (i) reasonable assurances through execution of a written agreement with such third party that such Protected Information will be held confidential as provided pursuant to this Addendum and only disclosed as required by law or for the purposes for which it was disclosed to such third party; and that such third party will notify Associate within five (5) business days of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of such breach. Additional provisions, if any, governing permitted disclosures of Protected Information are set forth in Attachment A.

c. Appropriate Safeguards. Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information other than as permitted by this Contract. Associate shall comply with the requirements of the HIPAA Security Rule, at 45 C.F.R. Sections 164.308, 164.310, 164.312, and 164.316. Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate's operations and the nature and scope of its activities. Associate shall review, modify, and update documentation of its safeguards as needed to ensure continued provision of reasonable and appropriate protection of Protected Information.

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

e. Associate's Agents. If Associate uses one or more Subcontractors or agents to provide services under the Contract, and such Subcontractors or agents receive or have access to Protected Information, each Subcontractor or agent shall sign an agreement with Associate containing substantially the same provisions as this Addendum and further identifying CE as a third party beneficiary with rights of enforcement and indemnification from such Subcontractors or agents in the event of any violation of such Subcontractor or agent agreement. The agreement between the Associate and Subcontractor or agent shall ensure that the Subcontractor or agent agrees to at least the same restrictions and conditions that apply to Associate with respect to such Protected Information. Associate shall implement and maintain sanctions against agents and Subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation.

f. Access to Protected Information. If Associate maintains Protected Information contained within CE's Designated Record Set, Associate shall make Protected Information maintained by Associate or its agents or Subcontractors in such Designated Record Sets available to CE for inspection and copying within ten (10) business days of a request by CE to enable CE to fulfill its obligations to permit individual access to PHI under the HIPAA Rules, including, but not limited to, 45 C.F.R. Section 164.524. If such Protected Information is maintained by Associate in an electronic form or format, Associate must make such Protected Information available to CE in a mutually agreed upon electronic form or format.

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

h. Accounting Rights. Associate and its agents or Subcontractors shall make available to CE, within ten (10) business days of notice by CE, the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the HIPAA Rules, including, but not limited to, 45 C.F.R. Section 164.528. In the event that the request for an accounting is delivered directly to Associate or its agents or Subcontractors, Associate shall within five (5) business days of the receipt of the request, forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. Associate shall not disclose any Protected Information except as set forth in Section 2(b) of this Addendum.

i. Governmental Access to Records. Associate shall keep records and make its internal practices, books and records relating to the use and disclosure of Protected Information available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), in a time and manner designated by the Secretary, for purposes of determining CE's or Associate's compliance with the HIPAA Rules. Associate shall provide to CE a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary when the Secretary is investigating CE. Associate shall cooperate with the Secretary if the Secretary undertakes an investigation or compliance review of Associate's policies, procedures or practices to determine whether Associate is complying with the HIPAA Rules, and permit access by the Secretary during normal business hours to its facilities, books, records, accounts, and other sources of information, including Protected Information, that are pertinent to ascertaining compliance.

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

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

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

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

n. Notification of Breach. During the term of this Contract, Associate shall notify CE within five (5) business days of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of Protected Information and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Associate shall not initiate notification to affected individuals per the HIPAA Rules without prior notification and approval of CE. Information provided to CE shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired or disclosed during the breach. Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

o. Audits, Inspection and Enforcement. Within ten (10) business days of a written request by CE, Associate and its agents or Subcontractors shall allow CE to conduct a reasonable

inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; and (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection. The fact that CE inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Contract.

p. Safeguards During Transmission. Associate shall be responsible for using appropriate safeguards, including encryption of PHI, to maintain and ensure the confidentiality, integrity and security of Protected Information transmitted to CE pursuant to the Contract, in accordance with the standards and requirements of the HIPAA Rules.

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

3. Obligations of CE.

a. Safeguards During Transmission. CE shall be responsible for using appropriate safeguards, including encryption of PHI, to maintain and ensure the confidentiality, integrity and security of Protected Information transmitted pursuant to this Contract, in accordance with the standards and requirements of the HIPAA Rules.

b. Notice of Changes. CE maintains a copy of its Notice of Privacy Practices on its website. CE shall provide Associate with any changes in, or revocation of, permission to use or disclose Protected Information, to the extent that it may affect Associate's permitted or required uses or disclosures. To the extent that it may affect Associate's permitted use or disclosure of PHI, CE shall notify Associate of any restriction on the use or disclosure of Protected Information that CE has agreed to in accordance with 45 C.F.R. Section 164.522.

4. Termination.

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

if any. If the Contract contains no express provisions regarding termination for cause, the following terms and conditions shall apply:

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

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

b. Reasonable Steps to Cure Breach. If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum or another arrangement, then CE shall take reasonable steps to cure such breach or end such violation. If CE's efforts to cure such breach or end such violation are unsuccessful, CE shall terminate the Contract, if feasible. If Associate knows of a pattern of activity or practice of a Subcontractor or agent that constitutes a material breach or violation of the Subcontractor's or agent's obligations under the written agreement between Associate and the Subcontractor or agent, Associate shall take reasonable steps to cure such breach or end such violation, if feasible.

c. Effect of Termination.

(1) Except as provided in paragraph (2) of this subsection, upon termination of this Contract, for any reason, Associate shall return or destroy all Protected Information that Associate or its agents or Subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If Associate elects to destroy the Protected Information, Associate shall certify in writing to CE that such Protected Information has been destroyed.

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

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

6. No Waiver of Immunity. No term or condition of this Contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of the Colorado Governmental Immunity Act, CRS 24-10-101 *et seq*. or the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq*. as applicable, as now in effect or hereafter amended.

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

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

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

10. Amendment.

a. Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of the HIPAA Rules and other applicable laws relating to the confidentiality, integrity, availability and security of PHI. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all Protected Information and that it is Associate's responsibility to receive satisfactory written assurances from Associate's Subcontractors and agents. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of the HIPAA Rules or other applicable laws. CE may terminate this Contract upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Contract when requested by CE pursuant to this Section, or (ii) Associate does not enter into an amendment to this Contract providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of the HIPAA Rules.

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

11. Assistance in Litigation or Administrative Proceedings. Associate shall make itself, and any Subcontractors, employees or agents assisting Associate in the performance of its obligations under the Contract, available to CE, at no cost to CE, up to a maximum of thirty (30) hours, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of the HIPAA Rules or other laws relating to security and privacy or PHI, in which the actions of

Associate are at issue, except where Associate or its Subcontractor, employee or agent is a named adverse party.

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

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

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

ATTACHMENT A

This Attachment sets forth additional terms to the HIPAA Business Associate Addendum, which is part of the Contract between the State of Colorado, Department of Health Care Policy and Financing and the Contractor and is effective as of the date of the Contract (the "Attachment Effective Date"). This Attachment may be amended from time to time as provided in Section 10(b) of the Addendum.

1. Additional Permitted Uses. In addition to those purposes set forth in Section 2(a) of the Addendum, Associate may use Protected Information as follows:

No Additional Permitted Uses.

2. Additional Permitted Disclosures. In addition to those purposes set forth in Section 2(b) of the Addendum, Associate may disclose Protected Information as follows:

No additional permitted disclosures.

3. Subcontractor(s). The parties acknowledge that the following subcontractors or agents of Associate shall receive Protected Information in the course of assisting Associate in the performance of its obligations under this Contract:

No subcontractors.

4. Receipt. Associate's receipt of Protected Information pursuant to this Contract shall be deemed to occur as follows and Associate's obligations under the Addendum shall commence with respect to such Protected Information upon such receipt:

Upon receipt of PHI from the Department.

5. Additional Restrictions on Use of Data. CE is a Business Associate of certain other Covered Entities and, pursuant to such obligations of CE, Associate shall comply with the following restrictions on the use and disclosure of Protected Information:

No additional restrictions on Use of Data.

6. Additional Terms. This may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security or privacy specifications, de-identification/re-identification of data, etc.

No additional terms.

EXHIBIT A, STATEMENT OF WORK

SECTION 1.0 TERMINOLOGY

1.1. ADDITIONAL 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. "Adjusted Medical Expenditures" means encounter data submitted by the Contractor that are priced for internal providers to reflect the State's fee schedule and using the paid amount on the encounter data for external providers, and exclude any and all administrative costs and amounts equal to any Co-Payments the Contractor imposes or could impose on Enrollees. Actual Medical Expenditures must be reduced by any recoveries from other payers including those pursuant to coordination of benefits, third party liability, reinsurance, rebates, or adjustments in claims paid or from providers, including adjustments to claims paid.

1.1.1.2. "Administrative Services Fee" or "ASF" means the per member per month payment to Contractor to provide the range of administrative services contained in this Contract, as described in section 5.2 of this Statement of Work. The Administrative Services Fee shall not include the direct cost of medical care.

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

1.1.1.1. "Business Day" means any day in which the Department is open and conducting business, but shall not include weekend days or any day on which the Department observes one of the following holidays :

1.1.1.1.1. New Year's Day.

1.1.1.1.2. Martin Luther King, Jr. Day.

1.1.1.1.3. Washington-Lincoln Day (also referred to as President's Day).

1.1.1.1.4. Memorial Day.

1.1.1.1.5. Independence Day.

1.1.1.1.6. Labor Day.

1.1.1.1.7. Columbus Day.

1.1.1.1.8. Veterans' Day.

1.1.1.1.9. Thanksgiving Day.

1.1.1.1.10. Christmas Day.

1.1.1.2. “Care Coordination” means the process of identifying, screening and assessing Members’ needs, identification of and Referral to appropriate services, and coordinating and monitoring an individualized treatment plan. This treatment plan shall also include a strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

1.1.1.3. “Client” means a recipient of the Medicaid program.

1.1.1.4. "Communication Disability" means an expressive or receptive impairment that creates a barrier to communication between a Member and a person not familiar with that Member.

1.1.1.5. “Contractor’s Plan” means the Contractor’s network or those Covered Services provided by the Contractor to eligible Clients in accordance with the terms and conditions of this Agreement.

1.1.1.6. "Covered Drugs" means those drugs currently covered by the Medicaid program and includes those products that require prior authorization by the Colorado Medicaid program. Covered Drugs shall be dispensed by a Participating Provider except for Emergency Services and shall be prescribed by Participating Providers or requested by an authorized prescriber as a result of authorized Referral, Emergency Services, dental care, or obtained under the Medicaid Mental Health Capitation Program.

1.1.1.7. "Covered Services" means those services described in Exhibit D, attached hereto and made part of this contract, which the Contractor is required to provide or arrange to be provided to a Member in return for the Monthly Payment Rate.

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

1.1.1.9. "Designated Client Representative" means the person as defined at 10 C.C.R. 2505-10, Section 8.209.2.

1.1.1.10. “Disability" or "Disabilities" means, with respect to a Member, a physical or mental impairment that substantially limits one or more of the major life activities of such Member in accordance with the Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101, et seq.

1.1.1.11. "Disenrollment" or “Disenroll” means the act of discontinuing a Member’s Enrollment in the Contractor’s Plan.

1.1.1.12. “EI” means the Early Intervention program that provides developmental supports and services to children birth through two years of age who have special developmental needs. It can help improve a child’s ability to develop and learn. It can also help you and your family learn ways to support and promote your child’s development, within your family activities and community life. The EI Colorado program provides EI services, such as occupational, speech or physical therapy, to help infants and toddlers grow and develop, and to help their family in this process. It is a voluntary program and does not discriminate based on race, culture, religion, income level, or disability.

1.1.1.13. "Emergency Medical Condition" means a medical condition as defined at 42 C.F.R. Section 438.114(a).

1.1.1.14. "Emergency Services" means those services as set forth at 42 C.F.R. Section 438.114(a).

1.1.1.15. "Encounter Data" means an occurrence of examination or treatment of a patient by a medical practitioner or in a medical facility and includes pharmacy prescriptions. Mental health care is also included if provided under the auspices of this Contract. Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form.

1.1.1.16. "Enrollment", "Enroll" or "Enrolled" means that a Client becomes a Member of the Contractor's Plan.

1.1.1.17. "EPSDT" means the Early, Periodic, Screening, Diagnosis and Treatment program that provides comprehensive health care to all Medicaid eligible children through periodic screenings, diagnostic and treatment services.

1.1.1.18. "EPSDT Home Health Services" means home health services that are not listed under Exhibit D but are federally required to be available to an EPSDT child. The services shall be Medically Necessary and the child shall need a) Services that exceed the maximum allowable limit per day; b) Services to be provided away from home; or c) a Certified Nursing Assistant providing unskilled personal care. These services are covered by Medicaid as a Wrap Around Benefit and therefore, are not Covered Services under this contract.

1.1.1.19. "Experimental or Investigational Services" means 1) any treatment, procedure, drug or device that has been reviewed and found by the Department to be experimental or investigational or 2) the treatment, procedure, drug or device has been reviewed by the Contractor and found not to meet all of the "eligible for coverage criteria" below with respect to the particular illness or disease to be treated, or a treatment, procedure, drug or device. Eligible for coverage criteria include: a. The treatment, procedure, drug or device shall have final approval from the Food and Drug Administration (FDA), if applicable; b. The scientific evidence as published in peer-reviewed literature shall permit conclusions concerning the effect of the treatment, procedure, drug or device on health outcomes; The treatment, procedure, drug or device must improve or maintain the net health outcome; The treatment, procedure, drug or device must be as beneficial as any established alternative; and e. The improvements in health outcomes must be attainable outside the investigational settings. f. Additionally, the treatment, procedure, drug or device shall be Medically Necessary and not excluded by any other contract exclusion.

1.1.1.20. "Federally Qualified Health Center" (FQHC) means a Provider defined at 10 C.C.R. 2505-10, Section 8.700.1.

1.1.1.21. "Home Health Services" means those services described at 10 C.C.R. 2505-10, Section 8.520, et seq.

1.1.1.22. "Hospital Services" means those Medically Necessary Covered Services for patients that are generally and customarily provided by acute care general

Hospitals. Hospital Services shall also include services rendered in the emergency room and/or the outpatient department of any Hospital. Except for a Medical Emergency or written referral, Hospital Services are Covered Services only when performed by Participating Providers.

1.1.1.23. "Hospital" means an institution which: a. Is licensed by the state as a Hospital; b. Has a Utilization Review program that meets Medicare conditions of participation; c. Is primarily engaged in providing medical care and treatment for sick and injured persons on an inpatient basis through medical, diagnostic and major surgical facilities, under the supervision of a staff of Physicians and with twenty-four-hour-a-day nursing service; and, d. Is certified by Medicare; or e. In the case of a specialty care center not eligible for Medicare certification, meets criteria established or recognized by the Department in accordance with any applicable state and federal statute or regulation.

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

1.1.1.25. “Marketing” means any communication from the Contractor to a Medicaid recipient who is not enrolled in the plan that can reasonably be interpreted as intended to influence the recipient to enroll in the Contractor’s Plan, or either not to enroll in, or to disenroll from, another contractor’s Medicaid plan.

1.1.1.26. “Marketing Materials” means materials that are produced in any medium by or on behalf of the Contractor and can be reasonably interpreted as intended to market to potential enrollees.

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

1.1.1.28. “Medical Screening Examination” means screening of sick, wounded or injured persons in the emergency room to determine whether the person has an Emergency Medical Condition.

1.1.1.29. "Medically Necessary" is defined in Exhibit D.

1.1.1.30. "Member" means any Client who is enrolled in the Contractor's Plan.

1.1.1.31. "Monthly Payment Rate" means the capitated rate, as specified in Exhibit B, Rates, attached and incorporated herein by reference, payable for each Member under this contract.

1.1.1.32. “Non-emergency” or “Non-emergent” means non-acute or chronic medical condition, wellness maintenance, and/or prescription refills that require medical intervention, when the Member’s condition is stable.

1.1.1.33. "Nursing Facility" means an institution that can meet state and federal requirements for participation as a Nursing Facility.

1.1.1.34. “Open Enrollment Period” means the two (2) months immediately preceding the

month in which a member's birthday occurs.

1.1.1.35. "Passive Enrollment" or "Passively Enrolled" means enrollment of eligible fee-for-service (FFS) Medicaid clients within a geographical service area into a Contractor's Plan, subject to the Member's election not to accept enrollment and to "opt-out."

1.1.1.36. "Participating Provider" means a Provider who is in the employ of, or who has entered into an agreement with, the Contractor to provide medical services to the Contractor's Members.

1.1.1.37. "Persons with Special Health Care Needs" or "Special Health Care Needs" means persons as defined in 10 C.C.R. 2505-10, Section 8.205.9.

1.1.1.38. "Physician" means any doctor licensed to practice medicine or osteopathy in the State of Colorado or in the state in which such medical care is rendered.

1.1.1.39. "Primary Care Physician" or "Participating Primary Care Physician" means the Physician who has entered into a professional service agreement to serve the Contractor's Members.

1.1.1.40. "Provider" means a health care practitioner, institution, agency or supplier, which may or may not be a Participating Provider in the Contractor's Plan, but which furnishes or arranges for health care services with an expectation of receiving payment.

1.1.1.41. "Proprietary Information" means information relating to a Contractor's research, development, trade secrets, business affairs, internal operations and management procedures. It includes those of its customers, Members or affiliates, but does not include information (1) lawfully obtained from third parties or (2) that which is in the public domain.

1.1.1.42. "Psychiatric In Nature" means those occasions of service in which the Member has a diagnosis listed in Exhibit I, Covered Behavioral Health Procedure Codes, attached and incorporated herein by reference, and receives services listed in Exhibit I.

1.1.1.43. "Qualified Interpreter" means an interpreter who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary.

1.1.1.44. "Referral" or "Written Referral" means any form of written communication or other permanent record by the Contractor and/or authorized Participating Provider that authorizes a Member to seek care from other than the Primary Care Physician.

1.1.1.45. "Re-pricing" means adjusting the claim payment to reflect not more than one hundred five percent (105%) of the State FFS reimbursement level.

1.1.1.46. "Rural Health Center" (RHC) means a Provider defined at 10 C.C.R. 2505-10, Section 8.740.1.

1.1.1.47. "Serious Reportable Events or Never Events" means hospital acquired conditions (HAC) that were not present on admission (POA) as an inpatient and that alter the condition or diagnosis of the recipient/Client receiving care.

1.1.1.48. "Service Area" means that area for which the Department and the Contractor have agreed that the Contractor shall provide Covered Services to Members. The Service Area shall be Adams, Arapahoe, Denver and Jefferson counties.

1.1.1.49. "Site Review" means the visit of Department staff or its designees to the site or the administrative office(s) of a Participating Provider and/or the Contractor and its Participating Providers.

1.1.1.50. “Triage” means the assessment of a Member’s condition and direction of the Member to the most appropriate setting for Medically Necessary care.

1.1.1.51. "Urgently Needed Services" means Covered Services as defined at 42 C.F.R. Section 422.113(b)(1)(iii).

1.1.1.52. "Utilization Management" means the function wherein use, consumption, and outcomes of services, along with level and intensity of care, are reviewed using Utilization Review techniques for their appropriateness.

1.1.1.53. "Utilization Review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, Referrals, procedures or settings.

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

SECTION 2.0 CONTRACTOR AND SERVICE REQUIREMENTS

2.1. LICENSES, PERMITS AND RESPONSIBILITIES

2.1.1. The Contractor shall be licensed as a hospital pursuant to Colorado law, and shall maintain accreditation from the Joint Commission on Accreditation of Healthcare Organizations.

2.1.2. The Contractor shall notify the Department within two (2) Business Days, of any action on the part of the Colorado Department of Public Health and Environment or the Joint Commission on Accreditation of Healthcare Organizations of intent to suspend or revoke or modify licensure or full accreditation status. Any revocation, withdrawal or non-renewal of licensure or accreditation required for the Contractor to properly perform this contract and/or failure to notify the Department as required by this section, may be grounds for the immediate termination of this contract by the Department for default.

2.1.3. In order to maintain the ability to pay outside providers, and in place of usual Department of Insurance reserves, the Contractor shall hold in reserve one twelfth (1/12) of monthly paid (non Denver Health and Hospital Authority) claims until such time as twelve (12) months of reserves have been accrued. Thereafter, on an ongoing basis, the reserve amount shall be a rolling balance based on the 12 most current months

paid claims.

2.1.4. The Contractor shall provide the Department the opportunity to approve the contract manager assigned to manage this contract.

2.2. SUBCONTRACTS

2.2.1. The Contractor shall be responsible for all work performed under this contract, but may enter into subcontracts for the performance of aspects of the scope of work required under this contract. Prior to entering into such subcontract, the Contractor shall evaluate the proposed Subcontractor's ability to perform the activities to be delegated. No subcontract, which the Contractor enters into with respect to performance under the contract, shall in any way relieve the Contractor of any responsibility for the performance of duties required under this contract.

2.2.2. The Contractor shall have a written agreement with each Subcontractor. The agreement shall specify the activities and reporting responsibilities delegated to the Subcontractor. The agreement shall include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

2.2.3. The Contractor shall develop and implement written procedures for monitoring Subcontractor performance on an ongoing basis. These procedures are subject to the approval of the Department.

2.2.4. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractors shall take corrective action.

2.2.5. The Contractor shall make available to the Department copies of any existing subcontracts and a full description of its procedures and policies in effect to accomplish the duties and responsibilities described herein, upon request by the Department.

2.2.6. The Contractor shall submit fully executed subcontracts to the Department, within five (5) Business Days of a written request from the Department.

2.2.7. Subcontracts shall meet the requirements of 42 C.F.R Section 434.6, as amended. All subcontracts shall provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, as specified in 45 C.F.R. Section 74, as amended.

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

2.3. CLIENT ENROLLMENT AND DISENROLLMENT

2.3.1. Clients in the following aid categories are eligible for enrollment under this contract:

2.3.1.1. Aid to Families with Dependent Children – Adults (AFDC – A) (Contingent on system updates, this category will be transitioning to MAGI Parents/Caretakers).

2.3.1.2. Aid to Families with Dependent Children – Children (AFDC – C).

2.3.1.3. Aid to the Needy Disabled/Aid to the Blind (AND/AB).

2.3.1.4. Baby Care/Kids Care – Adults (BCKC-A).

2.3.1.5. Baby Care/Kids Care – Children (BCKC-C).

2.3.1.6. Foster Care (FC).

2.3.1.7. Old Age Pensioners – Age 65+ (OAP-A).

2.3.1.8. Old Age Pensioners under Age 65 (OAP-B).

2.3.1.9. Refugee Medical Assistance – Adults (RMA-A).

2.3.1.10. Refugee Medical Assistance – Children (RMA-C).

2.3.1.11. Adult Buy-in.

2.3.1.12. MAGI Adults.

2.3.2. Enrollment

2.3.2.1. Enrollment Requirements

2.3.2.1.1. Members Enrollment in the Contractor's Plan shall be voluntary.

2.3.2.1.2. Residents of Denver, Colorado, who are eligible for Medicaid but do not enroll in Medicaid fee for service, shall be Passively Enrolled in Contractor's Plan subject to performance requirements defined herein.

2.3.2.1.2.1. Passive Enrollment excludes the following populations:

2.3.2.1.2.1.1. Foster Care.

2.3.2.1.2.1.2. Refugees that utilize Volunteer Agencies as their residential addresses.

2.3.2.1.2.1.3. Clients with attribution with a non-DHMC provider.

2.3.2.1.3. Members who are Passively Enrolled in Contractor's Plan may Disenroll from Contractor's Plan within ninety (90) days of the effective date of Passive Enrollment.

2.3.2.1.4. Members who are Disenrolled from the Contractor's Plan solely because he/she loses Medicaid eligibility for a period of two (2) months or less, shall be reenrolled with the Contractor's Plan upon regaining eligibility within the two (2) month period. The effective date of reenrollment shall be the first day of the month following the month in which the Member regained eligibility. The Department retains the right to review and retroactively enroll the Member.

2.3.2.1.5. The Contractor shall not discriminate against Clients eligible to Enroll on the basis of race, color or national origin and shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

2.3.2.1.6. The Contractor shall not discriminate against Clients eligible to Enroll on the basis of health status or need for health care services.

2.3.2.1.7. Once Enrolled in the Contractor's Plan a Member shall be Enrolled until the Member's next Open Enrollment Period, at which time the Member shall receive an open enrollment notice. Subsequent Enrollment shall be for twelve

(12) months and a Member may not Disenroll except as provided in this Contract.

2.3.2.1.8. All Enrollment notices, informational materials and instructional materials relating to Enrollment of Members shall be provided in a manner and format that may be easily understood and, wherever possible, at a sixth grade reading level.

2.3.2.1.9. The Contractor may limit Enrollment of new Clients, other than newborns, by notifying the Department, in writing, that it will not accept new Clients as long as the Enrollment limitation does not conflict with applicable statutes and regulations.

2.3.2.2. Effective Date of Enrollment

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

2.3.2.2.1.1. If the Client has selected or been Passively Enrolled in the Contractor's Plan on or before the last day of the month, Enrollment shall be effective the first day of the next month.

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

2.3.2.2.1.3. Retroactive Enrollment of Members shall be limited to a period not to exceed ninety (90) calendar days from the date of Disenrollment of the Member from Contractor's Plan.

2.3.2.3. Enrollment of a Newborn

2.3.2.3.1. The Contractor shall furnish Covered Services to newborns determined Medicaid eligible of Enrolled Members from the date of birth up to sixty (60) calendar days or until the last day of the first full month following birth, whichever is sooner. The Department will Enroll newborns determined Medicaid eligible of Enrolled Members into Contractor's Plan upon receipt of the newborn's Medicaid identification number. Upon receipt of the newborn's Medicaid identification number, the newborn shall remain enrolled in the Contractor's plan, unless the newborn's Mother or other designated representative requests Disenrollment on behalf of the newborn during the ninety (90) days following the Enrollment of the newborn, or ninety (90) days after the Department sends the notice of Enrollment, whichever is later.

2.3.2.3.2. The Contractor shall ensure Covered Services are provided for a newborn beyond sixty (60) days from the date of birth when the newborn is either:

2.3.2.3.2.1. A Hospital inpatient on the last day of the month Enrollment is scheduled to expire.

2.3.2.3.2.2. Enrolled in the Contractor's Plan within sixty (60) days from the date of birth or before the last day of the second full month following the date of birth, whichever is sooner.

2.3.2.3.3. The newborn's continued Enrollment in Contractor's Plan, after the initial term, shall be governed by this Section.

2.3.3. Enrollment Postponed Due to Inpatient Hospital Stay

2.3.3.1. If a current Member of a Contractor's Plan or a Client, other than a newborn at birth, is an inpatient of a Hospital at 11:59 p.m. the day before his/her Enrollment into a new Contractor's Plan is scheduled to take effect, Enrollment shall be postponed. To postpone Enrollment of a current Member or Client, the new Contractor shall, within sixty (60) calendar days of the date the new Contractor discovers the Client's Hospital admission, request in writing to the Department that the Enrollment be delayed. The new Contractor's request shall include the name of the Hospital where the Client was inpatient and the date of admission. The Department shall respond to the Contractor in writing within five (5) Business Days of Contractor's request to postpone Enrollment or upon confirmation of the hospitalization, whichever is later.

2.3.3.2. If the Client is discharged from the Hospital before the fifteenth (15th) day of the month, the new Enrollment date shall be the first day of the month following discharge. If the Client is discharged from the Hospital on or after the fifteenth (15th) day of the month, the new Enrollment date shall be the first day of the month after the month following discharge.

2.3.3.3. If the Client was a Member of a Contractor's Plan at the time of admission to the Hospital and Enrollment into another Contractor's Plan, or the Medicaid Primary Care Physician Program, was postponed as set forth above, the Member shall not be Disenrolled from the Contractor's Plan of which he/she was a Member at the time of admission until after the Hospital discharge occurs.

2.3.4. Disenrollment

2.3.4.1. A Member may request Disenrollment without cause during the ninety (90) days following the date of the Member's initial Enrollment with the Contractor.

2.3.4.2. A Member may request Disenrollment without cause during the Open Enrollment Period. A Member may request Disenrollment upon automatic Reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual Disenrollment opportunity.

2.3.4.3. The Contractor shall notify a Member of his or her ability to terminate or change Enrollment at least sixty (60) calendar days before the end of the Open Enrollment Period. The Contractor shall bear all expenses of providing the required notice.

2.3.4.4. A newborn Member's mother or designated representative may request Disenrollment with cause of the newborn within ninety (90) days following Enrollment of the newborn. Said request must include mother's current address and a twenty-four (24) hour phone number both listed on file with the county. The Department may conduct reviews of the requests to determine HIPAA compliance and/ or compliance with the contract.

2.3.4.5. A Member may request Disenrollment when the Department imposes intermediate sanctions as set forth in this contract.

2.3.4.6. A Member (or the Contractor on the Member's behalf) may request Disenrollment at any time for any of the following causes:

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

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

2.3.4.6.3. The Member needs related services (for example, a caesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Member's Primary Care Physician or another Physician determines that receiving the services separately would subject the Member to unnecessary risk.

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

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

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

2.3.4.6.7. Lack of access to Providers experienced in dealing with the Member's health care needs, as documented by the Department.

2.3.4.6.8. The Member Enrolled in the Contractor's Plan with his/her Physician and the Physician leaves the Contractor.

2.3.4.6.9. The Member is a resident of long-term institutional care (e.g. hospice or skilled nursing facility).

2.3.4.6.10. The Member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than a Plan offered by the Contractor and Contractor cannot provide the Member with reasonable access to a Medicare approved Provider or, if the Member is enrolled in a Medicare managed care plan, Contractor cannot provide the Member with Providers participating in both Plans.

2.3.4.6.11. The Member is a foster child.

2.3.4.6.12. The Member is in long-term community based care (e.g. PACE, HCBS waiver programs).

2.3.4.6.13. Other reasons satisfactory to the Department. When allowing Disenrollment under this subclause, the Department or its enrollment broker shall inform the Contractor of the rationale for the decision. If a decision is based upon a policy or widely applicable practice, the Department will provide Contractor with the implementation criteria.

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

2.3.5. Effective Date of Disenrollment

2.3.5.1. When a Member voluntarily Disenrolls from the Contractor's Plan, the effective date of the Disenrollment shall be no later than the first day of the second month following the month in which the Member requested the Disenrollment.

2.3.5.2. If a decision regarding the Member's Disenrollment is not made by the Department, or its designee, by the first day of the second month following the month in which the Member requested the Disenrollment, the Disenrollment shall be considered approved.

2.3.5.3. Disenrollment Postponed Due to Inpatient Hospital Stay

2.3.5.3.1. If a current Member of a Contractor's Plan is an inpatient of a Hospital at 11:59 p.m. the day before his/her Disenrollment from the Contractor's Plan is scheduled to take effect, Disenrollment shall be postponed until discharged from the Hospital.

2.3.5.3.2. When the Member is discharged from the Hospital the new Disenrollment date shall be the last day of the month following discharge.

2.3.5.3.3. The Department shall respond to the Contractor in writing within five (5) Business Days of Contractor's request to postpone Enrollment.

2.3.5.4. Member Moves Outside of Service Area

2.3.5.4.1. When the Contractor determines a Member is no longer a permanent resident or has resided outside of its Service Area for ninety (90) consecutive days or more, the Contractor shall notify the Department.

2.3.5.4.2. When the Department is notified and confirms that a Member is no longer a permanent resident in the Contractor's Service Area or has resided outside of its Service Area for ninety (90) consecutive days or more, the Member shall be Disenrolled from the Contractor's Plan effective the first day of the next month.

2.3.5.5. Verification of Medicaid Eligibility and Member Enrollment

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

2.3.5.5.1.1. Disenrollment Report (R0305) and (M0305).

2.3.5.5.1.2. Prepaid Health Plan (PHP) Enrollment Change Report (R0310).

2.3.5.5.1.3. PHP Current Enrollment Report (R0315).

2.3.5.5.1.4. PHP New Enrollee Report (R0325 and M0325).

2.3.5.5.1.5. Capitation Summary Report (R0360).

2.3.5.5.1.6. When available, Benefit Enrollment and Maintenance Transaction report (ANSI X 12N 834).

2.3.5.5.1.7. When available, Payroll Deducted and Other Group Premium Payment for Insurance Products Transactions report (ANSI X 12N 820) for capitation.

2.3.5.5.2. The Contractor may rely on the above-referenced reports for purposes of making coverage determinations.

2.3.5.5.3. The Contractor shall not be liable for any Covered Services incurred prior to a Member's effective date of coverage under this contract or after the date of termination of coverage.

2.3.5.6. Reporting

2.3.5.6.1. The Contractor shall submit a quarterly Enrollment/Disenrollment report to the Department. The report shall provide a detailed summary and analysis of all Enrollment/Disenrollment activities, including overall trends and specific reasons for Disenrollment. The reports shall include voluntary Disenrollment, referrals to the Contractor's grievance process regarding requests for Disenrollment and involuntary Disenrollment information and trends. The report shall be submitted in a format specified by the Department and shall be submitted within thirty (30) calendar days following the end of the quarter being reported.

2.3.5.7. Contractor Requested Disenrollment

2.3.5.7.1. The Contractor may request, and the Department may approve or initiate, Disenrollment for specific cases or persons where there is cause. The following are acceptable reasons for Disenrollment for cause:

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

2.3.5.7.1.2. Receipt of Comprehensive Health Coverage other than Medicaid.

2.3.5.7.1.3. A Member leaves the State of Colorado for ninety (90) consecutive days or more.

2.3.5.7.1.4. Any other reason, as determined by the Department.

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

2.3.5.7.1.6. Child welfare eligibility status or receipt of Medicare benefits.

2.3.5.7.1.7. Abuse or Intentional Misconduct

2.3.5.7.1.7.1. Behavior which is disruptive or abusive to the extent that the Contractor's ability to furnish services to either the Member or other Members is impaired; an ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet other Member responsibilities described in this Contract.

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

2.3.5.9. Fraud or Knowingly Furnishing Incomplete/ Incorrect Information

2.3.5.9.1. A Member knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to the Contractor incident to Enrollment under this contract.

2.3.5.9.2. A Member who is an inpatient refuses a medically appropriate transfer to facility in Contractor's Plan with a twenty-four (24) notice to the client/guardian. Client's refusal to accept the transfer requires a notice of action filing and/or a grievance.

2.3.5.9.3. Disenrollment for cause shall not include adverse changes in a Member's health status, because of a change in the Member's utilization of medical services, because of diminished mental capacity, nor any behavior of the Member resulting from his or her special needs except those behaviors that seriously impair the Contractor's ability to furnish services to either this Member or other Members.

2.3.5.10. Contractor Requested Expedited Disenrollment

2.3.5.10.1. The Contractor, after giving verbal warning, may request an expedited Disenrollment where a Member is Disenrolled promptly without an additional period to allow the actions or behaviors to be corrected. The following are acceptable reasons for expedited Disenrollment for cause:

2.3.5.10.1.1. If the Member's actions or behaviors pose an imminent threat to the safety of Member(s) or Contractor, and the actions or behaviors do not result from causes specified in 14.a. above,

2.3.5.10.1.2. Fraud or Knowingly Furnishing Incomplete/Incorrect Information

2.3.5.10.1.3. A Member knowingly furnishes incorrect or incomplete information (including but not limited to) applications, questionnaires, forms, or statements submitted to the Contractor incident to Enrollment under this Contract.

2.3.5.10.1.4. A Member who is an inpatient refuses a medically appropriate transfer to facility in Contractor's Plan with a twenty-four (24) notice to the client/guardian. Client's refusal to accept the transfer requires a notice of action filing and/or a grievance.

2.3.5.10.2. Disenrollment for cause shall not include adverse changes in a Member's health status, a change in the Member's utilization of medical services, diminished mental capacity or any behavior of the Member resulting from his or her special needs except those behaviors that seriously impair the Contractor's ability to furnish services to either this Member or other Members.

2.4. COVERED SERVICES

2.4.1. Health Coverage

2.4.1.1. The Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit D. The Contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

2.4.1.2. The Contractor shall provide the same standard of care for all Members regardless of eligibility category and shall make all Covered Services as accessible in terms of timeliness, amount, duration and scope, to Members, as those services are to

non-Member Medicaid recipients within the same area.

2.4.1.3. The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the Member.

2.4.2. Coverage Limitations

2.4.2.1. The Contractor shall not be required to cover any service that does not meet the definition of Medically Necessary.

2.4.2.2. The Contractor shall not be liable for any Covered Services incurred prior to the Member's effective date of coverage under this contract or after the date of termination of coverage.

2.4.3. Covered Services Through Participating Providers

2.4.3.1. Covered Services shall be made available in the Service Area only through Participating Providers or non-Participating Providers authorized by the Contractor. A Participating Provider is an organization or agency that has contracts or affiliations with the Contractor to render Covered Services.

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

2.4.3.2.1. Special arrangements or Referrals are made by a Primary Care Physician or the Contractor, as specified in the Member handbook; or

2.4.3.2.2. The Member is receiving a service as described in Section 2.6.5.1.

2.4.4. Coverage of Specific Services and Responsibilities

2.4.4.1. Emergency Services

2.4.4.1.1. The Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a twenty-four (24) hour per day, seven (7) day per week basis.

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

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

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

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

2.4.4.2. Emergency Ambulance Transportation

2.4.4.2.1. The Contractor shall make reasonable efforts to ensure that Members within the

Service Area shall have access to emergency ambulance transportation on a twenty-four (24) hour per day, seven (7) day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.

2.4.4.3. Verification of Medical Necessity for Emergency Services

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

2.4.4.4. Post-stabilization Care Services

2.4.4.4.1. The Contractor shall provide coverage for Post-stabilization Care Services in compliance with 42 C.F.R. Section 438.114.

2.4.4.5. Coverage of Prescription Drugs

2.4.4.5.1. Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

2.4.4.5.1.1. The Contractor shall not provide drugs described in Medicare Part D to individuals eligible for both Medicare and Medicaid.

2.4.4.5.1.2. The Contractor shall comply with all federal and state statutes and regulations regarding prescription drug benefits described in Medicare Part D for individuals eligible for both Medicare and Medicaid.

2.4.4.5.1.3. The Contractor shall cover excluded Part D drugs as defined in 42 U.S.C. §1395w-101, *et seq.,* for individuals eligible for both Medicare and Medicaid in the same manner and to the same extent as they cover excluded Part D drugs for all other eligible Medicaid clients.

2.4.4.5.2. The Contractor shall provide coverage for prescription drugs approved for use and reimbursed by the Medicaid Program, including those products that require prior authorization by the Medicaid Program. Such Covered Drugs must be prescribed and dispensed within the Contractor's parameters for pharmaceuticals, and as follows:

2.4.4.5.2.1. The Contractor may establish a drug formulary, for all Medically Necessary Covered Drugs with its own prior authorization criteria provided the Contractor includes each therapeutic drug category in the Medicaid program.

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

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

2.4.4.5.3. If a Member requests a brand name drug for a prescription that is included on the Contractor's drug formulary in generic form, the Member may receive the brand name drug by paying the cost difference between the generic and brand name drug. In this event, the Member must sign the prescription stating that the member will pay the difference in price, between the generic and the brand name drug, to the pharmacy.

2.4.4.6. Coverage of New Services and Items

2.4.4.6.1. The Contractor shall not be responsible for providing any new health care services or new technology that is authorized, approved or adopted as a covered benefit under Medicaid fee-for-service during the term of this Contract. New prescription drugs shall be a Covered Service subject to the Contractor's formulary.

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

2.4.4.7. Responsibility Regarding Psychiatric and Medical Diagnoses

2.4.4.7.1. Inpatient Hospital Services

2.4.4.7.1.1. The Contractor shall be responsible for inpatient hospital stays based on the primary diagnosis that requires inpatient care.

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

2.4.4.7.1.1.2. The Contractor shall not be financially responsible for inpatient services when the Client's primary diagnosis is psychiatric in nature, even when the psychiatric hospitalization includes some medical conditions or procedures to treat a secondary medical diagnosis

2.4.4.7.1.1.3. The Contractor shall not be responsible for the hospital stay when the primary diagnosis is for substance abuse rehabilitation, unless the stay is for short-term, substance detoxification.

2.4.4.7.2. Coverage for Emergency Services

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

2.4.4.7.2.2. The Contractor shall not be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis.

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

2.4.4.7.3.1. For any procedure billed in a UB-92/ANSI 837I, Health Care Claim Institutional (ANSI 837I) format, the Contractor shall be responsible for all

Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

2.4.4.7.3.1.1. The procedure is billed on a UB-92/ANSI 837I claim form, and

2.4.4.7.3.1.2. The principal diagnosis is a medical diagnosis.

2.4.4.7.3.2. For any procedure billed in a HCFA-1500/ANSI 837P, Health Care Claim Professional Format, the Contractor shall be responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

2.4.4.7.3.2.1. The procedure is billed on a HCFA-1500/ANSI 837P claim form, and

2.4.4.7.3.2.2. The Covered Services are not listed as a required Behavioral Health Organization (BHO) Covered Service as defined in 10 C.C.R. 2505-10, Section 8.212.4.A. Diagnoses and procedures covered by the BHOs are listed in Exhibit I.

2.4.4.8. Additional Benefits and Services

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

2.4.4.9. Wrap Around (Fee For Service) Benefits

2.4.4.9.1. The Contractor shall communicate to its Participating Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this contract but are available to Members under Medicaid fee for service (FFS).

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

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

2.5. SERVICE DELIVERY

2.5.1. Access

2.5.1.1. Access to Services

2.5.1.1.1. The Contractor shall comply with all requirements described in §10-16-704 C.R.S. The Contractor shall attempt to include both Essential Community Providers, as designated at 10 C.C.R. 2505-10, §8.205.5.A, and other Providers in its network of providers.

2.5.1.1.2. The Contractor shall maintain and monitor a network of Providers that is sufficient to provide adequate access to all Covered Services. In order for the Contractor's network to be considered to provide adequate access, the Contractor shall ensure a minimum Provider to Member caseload ratio as follows:

2.5.1.1.2.1. 1:2000 Primary Care Physician to Member ratio. Primary Care Physician includes Physicians designated to practice Family Medicine and General Medicine.

2.5.1.1.2.2. 1:2000 Physician specialist to Member ratio. Physician specialist includes Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology.

2.5.1.1.2.3. Physician specialists designated to practice Gerontology, Internal Medicine, OB/GYN and Pediatrics shall be counted as either a Primary Care Physician or Physician specialist, but not both.

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

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

2.5.1.1.4.1. The anticipated Medicaid Enrollment.

2.5.1.1.4.2. The expected utilization of Covered Services.

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

2.5.1.1.4.4. The number of network Providers who are not accepting new Medicaid patients.

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

2.5.1.1.5. The Contractor shall provide female Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated Primary Care Physician if that source is not a women's health specialist.

2.5.1.1.6. The Contractor shall provide for a second opinion from a qualified health care professional within the network or arrange for the Member to obtain one outside the network at no cost to the Member.

2.5.1.1.7. The Contractor shall ensure that all Members have appropriate access to certified nurse practitioners and certified nurse midwives, as set forth at 42 C.F.R. §438.102(a), as amended, and §26-4-202(1)(j), C.R.S., as amended, through either Provider agreements or referrals. This provision shall not be interpreted as requiring the Contractor to provide any services that are not Covered Services under this Contract.

2.5.1.2. Out of Network Providers

2.5.1.2.1. In the event that the Contractor is unable to provide any Covered Service to a Member from a Provider within its network, then the Contractor shall provide that service through a Provider that is not within its network promptly and without compromising the Member's quality of care or health.

2.5.1.2.2. The Contractor shall ensure that the cost to the Member for any service provided by the Contractor from a Provider that is not within the Contractor's network is not greater than the cost to that same Member if that Member had received the service from a Provider that was within the Contractor's network. The Contractor shall coordinate with the out-of-network Provider with respect to payment.

2.5.1.3. Geographic Access

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

2.5.1.4. Service Availability

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

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

2.5.1.4.1.2. The Contractor shall have a comprehensive plan for triage of requests for services on a twenty-four (24) hour seven (7) day per week basis, including all of the following:

2.5.1.4.1.2.1. Immediate Medical Screening Exam by the Primary Care Physician or Hospital emergency room.

2.5.1.4.1.2.2. Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service.

2.5.1.4.1.2.3. Practitioner backs up covering all specialties.

2.5.1.5. Scheduling and Wait Times

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

2.5.1.5.1.1. Routine physicals.

2.5.1.5.1.2. Diagnosis and treatment of acute pain or injury.

2.5.1.5.1.3. Follow-up appointments for chronic conditions.

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

2.5.1.5.2.1. Non-urgent health care, non-symptomatic well care physical examinations scheduled within thirty (30) days.

2.5.1.5.2.2. Urgently Needed Services provided within forty-eight (48) hours of notification of the Primary Care Physician or Contractor.

2.5.1.5.3. The Contractor shall make these scheduling guidelines available to the Department for the Department's review. In the event that the Department determines that the guidelines are unacceptable to the Department, then the Contractor shall work with the Department to modify those guidelines to create acceptable guidelines.

2.5.1.5.4. The Contractor shall communicate all scheduling guidelines in writing to Participating Providers. The Contractor shall create and maintain an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and taking appropriate corrective action.

2.5.2. Service Area Standards

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

2.5.2.2. The Contractor shall provide the Department with written notice and a service plan analysis when seeking to expand into a new Service Area or expand the eligibility categories served. Such written notice and analysis shall include, but not be limited to:

2.5.2.2.1. The name of the proposed county or counties in which the Contractor seeks to expand or the categories of populations to be served.

2.5.2.2.2. An analysis by the Contractor concerning whether its Provider network is

adequate to serve Clients in the proposed county, able to provide the full scope of benefits, and can comply with the standards for access to care as specified in this Contract.

2.5.2.3. The Contractor shall provide to the Department an annual network adequacy strategic plan. The report is to be submitted not later than September 30, and is subject to the Department's approval. The plan shall reflect current and future network planning and include, at a minimum:

2.5.2.3.1. Geographic access standards.

2.5.2.3.2. Provider network standards.

2.5.2.3.3. Population demographics.

2.5.2.4. The Contractor shall, within thirty (30) Business Days following the close of each fiscal year quarter and as required by 42 C.F.R. Section 438.207(c), submit to the Department, a detailed written report regarding the Contractor's capacity and services. The report shall be in the format specified by the Department and shall demonstrate that the Contractor meets the following:

2.5.2.4.1. Provides an appropriate range of preventive care, primary care and specialty services that is adequate for the anticipated number of Members.

2.5.2.4.2. Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the Service Area.

2.5.2.5. The Contractor may discontinue providing Covered Services to Members within an entire county within the Contractor's Service Area, by providing no less than thirty (30) calendar days' prior written notice to the Department of the Contractor's intent to discontinue such services. Such discontinuance of the provision of Covered Services shall be effective on the first day of the month following conclusion of the thirty (30) calendar days notice period.

2.5.3. Selection and Assignment of Primary Care Providers

2.5.3.1. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a Primary Care Physician.

2.5.3.2. If a Member does not select a Primary Care Physician, the Contractor shall assign the Member to a Primary Care Physician or a Primary Care Facility and notify the Member, by telephone or in writing, of his/her Facility's or Primary Care Physician's name, location, and office telephone number.

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

as requiring the Contractor to provide any service, treatment or benefit that is not a Covered Service under this contract.

2.5.4. Coordination of Care

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

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

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

2.5.4.3.1. Procedures for and the capacity to:

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

2.5.4.3.1.2. Develop an individual treatment plan as necessary based on the needs assessment.

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

2.5.4.3.1.4. These procedures must be designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and shall allow Members with Special Health Care Needs direct access to a specialist as appropriate for the Member's condition and medical needs.

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

2.5.4.3.3. Procedures designed to address those Members who require ancillary services, including social services and other community resources.

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

medical treatment.

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

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

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

2.5.4.3.6.2. Assessment for appropriate technology and equipment available.

2.5.4.3.6.3. Procedures for evaluating adequacy of Participating Providers.

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

2.5.4.4. The Department may review any of the Contractor's procedures relating to care coordination and work with the Contractor to make changes to the procedures that it determines to be in the best interest of the Department or the Members.

2.5.5. Persons with Special Health Care Needs

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

2.5.5.1.1. The Contractor shall inform any new Member who is a Person with Special Health Care Needs as defined in 10 C.C.R. 2505-10, §8.205.9 that the Member may continue to receive Covered Services from the Member's current Provider for sixty (60) calendar days from the date of Enrollment in the Contractor's Plan. The Member may only continue to receive Covered Services from the Member's current Provider if the Member is in an ongoing course of treatment with that Provider and the previous Provider agrees as specified in §25.5-5-406(1)(g), C.R.S.

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

2.5.5.1.3. The Contractor shall inform a new Member who is in her second or third trimester of pregnancy, that she may continue to see her current Provider until the completion of post-partum care directly related to the delivery, as specified in §25.5-5-406(1)(g), C.R.S.

2.5.5.2. The Contractor shall have sufficient experienced Providers with the ability to meet the unique needs of all Members who are Persons with Special Health Care Needs. If necessary primary or specialty care cannot be provided within the Contractor's network, the Contractor shall make arrangements for Members to access these Providers outside the network. The Contractor shall implement procedures to share

the results of its identification and assessment of that Member’s needs with other Providers serving the Member with Special Health Care Needs, in order to prevent duplication of those activities.

2.5.5.3. The Contractor shall implement mechanisms to assess each Member identified as a Person with Special Health Care Needs in order to identify any ongoing special conditions of the Member that require a course of treatment or regular care monitoring.

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

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

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

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

2.5.6.2. To promote independent living, the Contractor shall:

2.5.6.2.1. Respond within twenty-four (24) hours, after written or oral notice to the Contractor by the Member, the Member's parents, guardian or Designated Client Representative, to any diminishment of the capacity of a Member with a Disability to live independently.

2.5.6.2.2. Deliver Covered Services that will restore the Member's ability to live independently as expediently as possible.

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

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

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

2.5.6.3.3. Make a reasonable effort to identify Members whose cultural norms and

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

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

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

2.5.6.3.4.2. The medical risks associated with the Client population's racial, ethical and socioeconomic conditions.

2.5.6.3.5. Make available written translation of Contractor materials, including Member handbook, correspondence and newsletters. Written Member information and correspondence shall be made available in languages spoken by prevalent non-English speaking Member populations within the Contractor's Service Area as directed by the Department or as required by 42 CFR 438.

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

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

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

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

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

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

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

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

2.5.6.3.12. Provide access to TDD or other equivalent methods for Members with a hearing

impairment in such a way that it will promote accessibility and availability of Covered Services.

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

2.5.7. Preventative Health Services

2.5.7.1. The Contractor shall establish and maintain a comprehensive program of preventive health services for Members. The Contractor shall ensure that Members with a Disability have the same access to preventative health services as other Members. The program shall include written policies and procedures, involve Participating Providers and Members in their development and ongoing evaluation, and are a part of the Contractor's comprehensive quality assurance program as specified in Section 2.9 of this Statement of Work. The Contractor's program of preventive health services shall include, but is not limited to:

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

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

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

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

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

2.5.7.2. EPSDT Program Requirements

2.5.7.2.1. The Contractor must ensure the delivery of EPSDT services for Contractor Covered Services. The Contractor must have written policies and procedures for providing EPSDT services including lead testing and immunizations to the eligible population.

2.5.7.2.2. The Contractor must comply with all EPSDT regulations set forth in 1905(a), 42 USC 1396d(r)(5) and 42 USC 1396d(a), 42 C.F.R. Sections 441.50 through 441.62, as amended and performance will be verified by paid claims.

2.5.7.2.3. The Contractor must assure the provision of all required components of periodic

health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. At a minimum, such efforts shall include:

2.5.7.2.3.1. Education and outreach to eligibles of the importance of EPSDT services.

2.5.7.2.3.2. A proactive approach to ensure eligibles obtain EPSDT services.

2.5.7.2.3.3. Systematic communication process with network providers regarding the Department's EPSDT requirements.

2.5.7.2.3.4. Process to measure and assure compliance with the EPSDT schedule.

2.5.7.2.3.5. A process to assure that the medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action.

2.5.7.2.3.6. Comply with all reporting requirements and data needs for federal reporting. All data required, including but not limited to raw data, shall be given to the Department no later than February 1st of each year for the October 1st through September 30th period of the previous contract year.

2.5.7.3. EI Program Requirements

2.5.7.3.1. The Contractor will provide Early Intervention (EI) Services and Supports as described in CRS 27-10.5 part 7. If Contractor does not meet the requirements specified in CRS 27-10.5-709, Contractor shall develop a process in coordination with the Department and CDHS to ensure EI Services and Supports are provided in accordance with CRS 27-10.5 part 7. Contractor must contract with providers who meet the qualifications for early intervention providers, as defined in CCR 2509-10-7.951, as outlined in Appendix F of the Qualified Personnel Standards as noted on the EI Colorado Website.

2.5.7.3.2. EI is a federally and state funded and regulated program for children birth through two years who have been identified with a developmental delay or have been diagnosed with a condition that has a high probability of resulting in a delay. In Colorado, Early Intervention Colorado is coordinated through the Colorado Department of Human Services (CDHS), Office of Early Childhood.

2.5.7.3.3. Contractor shall provide a list of their credentialed qualified providers to the Department annually by October 30th and assure that there are adequate providers to serve the eligible children. The Department will provide a template for this report.

2.5.7.3.4. EI services are family-centered. Families work together as a team with professionals to develop an Individualized Family Service Plan (IFSP). This plan identifies the strategies, supports and services necessary to reach developmental outcomes identified by the family and the rest of the IFSP team. An Early Interventionist's work with young children and families is guided by this plan.

2.5.7.3.4.1. EI services are independent of the home health program and therefore the rule in which at sixty (60) days payment for services be shifted to the Fee-For-Service program is not applicable.

2.5.7.3.4.2. The contractor is responsible for the EI services through the duration of the

services being received, subject to the member's eligibility and enrollment in the plan.

2.5.7.3.5. EI services are provided where the child lives, plays and learns. Service settings may include the child's home, a childcare center, a relative's home, or other community settings. The IFSP team identifies learning opportunities that occur within the family's typical, daily routines. Early Intervention professionals provide support and guidance to families to enhance those natural learning opportunities and to help their child achieve the identified developmental outcomes.

2.5.7.3.6. Services provided in a clinic or provider office do not qualify as Early Intervention services.

2.5.7.4. Training on Department Policies and Member Populations

2.5.7.4.1. The Contractor shall ensure that appropriate staff participates in periodic training programs sponsored by the Department designed to provide technical assistance to the Contractor with policy interpretation and coordination of services to maximize compliance with requirements.

2.5.7.4.2. The Contractor shall be responsible for training Participating Providers and any Subcontractors.

2.5.8. Services Delivered Only to Members

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

2.6. COMPLIANCE AND MONITORING

2.6.1. Utilization Management

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

2.6.1.2. The Contractor shall have a mechanism in effect to ensure consistent application of review criteria for authorization decisions and consultation with the requesting Provider when appropriate. The Contractor shall notify the requesting provider of any decision to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice to the Provider may be oral or in writing.

2.6.1.3. The Contractor shall provide information to Members and Participating Providers, in appropriate formats, about how the Contractor's Utilization Management program functions and is utilized to determine the Medical Necessity of Covered

Services. This information shall include appropriate points of contact with the program, contact persons or numbers for information or questions, and information about how to initiate appeals related to Utilization Management determinations.

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

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

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

2.6.1.5. The Contractor shall ensure that any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

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

2.6.2. Compliance Reporting

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

2.6.2.1.1. Late or absent submission of report.

2.6.2.1.2. Report(s) does not contain all required elements as stated in Department format.

2.6.2.1.3. Report(s) contains inaccuracies or insufficient data.

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

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

2.6.2.4. Upon the Department's request, the Contractor shall submit to the Department any appropriate information necessary for the Department to issue a Certificate of Creditable Coverage on behalf of a Member whose eligibility for Medicaid has ended as the Department is required to do under the Health Insurance Portability and Accountability Act (HIPAA), Pub.L. 104-191.

2.6.3. Other Monitoring Activities

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

2.6.3.1.1. Encounter Data analysis; Encounter Data validation (the comparison of Encounter Data with Medical Records).

2.6.3.1.2. Appeals analysis to identify trends in the Medicaid program and among managed care organizations.

2.6.3.1.3. Risk-adjusted rate studies.

2.6.3.1.4. Other reviews determined by the Department.

2.6.3.2. The Department reserves the right to determine Contractor compliance with individual requirements under this contract based upon satisfactory review by recognized state agencies or private accreditation organizations.

2.6.4. Inspection, Monitoring and Site Reviews

2.6.4.1. Inspections and Acceptance

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

2.6.4.2. Site Reviews

2.6.4.2.1. The Department may conduct Site Reviews of the Contractor’s, Subcontractors’ or Participating Providers’ locations on an annual basis or more frequently if the Department determines more frequent reviews to be necessary in its sole discretion. The Department will conduct these Site Reviews for the purpose of determining compliance by the Contractor with applicable Department regulations and the requirements of this Contract. In the event that right of access is requested under this section, the Contractor and/or its Subcontractors or Participating Providers shall, provide and make available staff to assist in the audit or inspection effort. They shall provide adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting

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

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

2.6.4.2.3. For non-emergency Site Reviews, the Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted for mutually agreed upon dates for a Site Review. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to the Contractor at least three (3) weeks prior to the visit. The Contractor shall submit copies of policies, procedures, manuals, handbooks, reports, and other requested materials to facilitate the Department's Desk Audit prior to the Site Review. The Contractor shall have a minimum of thirty (30) calendar days to submit the required materials for non-emergency reviews.

2.6.4.2.4. The Contractor shall make available, to the Department and its agents for Site Review, all records and documents related to the execution of this Contract, either on a scheduled basis as noted elsewhere in this section, or immediately on an emergency basis. Delays in the availability of such documents and records may subject the Contractor to remedial actions, as specified in this Contract. These records and documents shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records and documents.

2.6.4.2.5. A written report of the site visit will be transmitted to the Contractor within thirty (30) calendar days of the Site Review. The Contractor shall be allowed thirty (30) days to review the preliminary report and respond to the findings. The final report will indicate areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response will be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.

2.6.4.2.6. The Contractor shall respond to any required actions, if necessary, with a corrective action plan within thirty (30) calendar days of the final written report, specifying the action to be taken to remedy any deficiencies noted by the Department or its agents and time frames to implement these remedies. The corrective action plan is subject to approval by the Department. The Department will monitor progress on the corrective action plan until the Contractor is found to be in complete compliance. Department will notify the Contractor in writing when the corrective actions have been completed, accepted and the Contractor is considered to be in compliance with Department regulations and this Contract.

2.6.4.2.7. The Department may extend the time frame for corrective action in its sole discretion. The Department may also reduce the time frame for corrective action if delivery of Covered Services for Members is adversely affected or if

the time reduction is in the best interests of Clients or Members, as determined by the Department. For corrective action plans affecting the provision of Covered Services to Members, the Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.

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

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

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

2.6.5.1. The Department shall submit the results of any studies, inspections, Site Reviews or audits of the Contractor, or its Subcontractors or Participating Providers, to the Contractor for review. The Contractor shall have ten (10) Business Days to review the results of the study or audit prior to the Department releasing those results to the public. The Department may consider the Contractor's review or comments before releasing those results to the public.

2.6.6. Audits and Maintenance of Records

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

2.6.6.2. The Contractor and all Subcontractors shall maintain a complete file of all records, documents, communications, and other materials which pertain to the operation of the program/project or the delivery of services under this contract sufficient to disclose fully the nature and extent of services/goods provided to each Member. These records shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records. Such files shall be sufficient to properly reflect all direct and indirect costs of labor, materials, equipment, supplies and services, and other costs of whatever nature for which contract payments was made and shall include but are not limited to:

2.6.6.2.1. All Medical Records, service reports, and orders prescribing treatment plans.

2.6.6.2.2. Records of goods, including such things as drugs and medical equipment and supplies, and copies of original invoices for such goods.

2.6.6.2.3. Records of all payments received for the provision of such services or goods.

2.6.6.3. The Contractor shall maintain records or shall have a system in place to retrieve information sufficient to identify the Physician who delivered services to the patient.

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

2.6.7. Encounter Claims Data Provisions

2.6.7.1. The Contractor shall certify all Encounter Data and Financial Template information submitted are accurate, complete and truthful based on the Contractor's best knowledge, information and belief. These certifications shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer. The data shall be sent quarterly based on the contract year (July 15, October 15, January 15, and April 15 for the previous three months of data submitted). The financial template shall be sent annually on December 15 for the previous fiscal year.

2.6.7.2. Encounter Data for Current Rate Setting and Quality Assurance

2.6.7.2.1. Paid Encounter Data Submissions

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

2.6.7.2.2. Encounter Data Submission Schedule

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

2.6.7.2.2.1.1. July 15th submission reporting shall include encounters with paid dates between April 1st and June 30th of the prior fiscal year.

2.6.7.2.2.1.2. October 15th submission reporting shall include encounters with paid dates between July 1st and September 30th of the same calendar and fiscal year.

2.6.7.2.2.1.3. January 15th submission reporting shall include encounters with paid dates between October 1st and December 31st of the prior calendar year.

2.6.7.2.2.1.4. April 15th submission reporting shall include encounters with paid dates between January 1st and March 31st of the same calendar and fiscal

year.

2.6.7.2.3. Encounter Data Submission Categories

2.6.7.2.3.1. Encounter Data submitted to the Department shall include the following categories: EPSDT; Hospital inpatient and outpatient; medical group practices/clinics; Physicians, non-Physician practitioners; medical equipment; ambulatory surgical centers; family planning clinics; independent laboratories; optometrists; podiatrists; home health; dialysis centers; FQHCs; freestanding rehabilitation centers, pharmacies; and skilled nursing facilities.

2.6.7.2.4. Data Set Format Requirements

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

2.6.7.2.5. Encounter Data Transmissions

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

2.6.7.2.6. Encounter Data Processing and Reporting

2.6.7.2.6.1. The Department will process all submissions for Encounter Data for rate setting and quality assurance.

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

2.6.7.2.7. Financial Template for Current Rate Setting and Quality Assurance

2.6.7.2.7.1. For purpose of rate setting and quality assurance, the Contractor shall submit completed financial template to the Department by December 15th for the previous fiscal year.

2.6.7.3. Quality review of Encounter Data and Financial Template Report

2.6.7.3.1. In addition to financial template submission, the Contractor shall allow the Department to inspect and audit the financial records of the Contractor and its Subcontractors related to this contract per C.R.F. 438.6(g).

2.6.7.3.2. The Contractor shall participate in annual, external independent site reviews, and Performance Measure Validation in order to review compliance with Department standards and contract requirements.

2.6.7.3.3. External quality review activities shall be conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols.

2.6.7.3.4. The Contractor shall also participate in an annual 411 audit conducted by the External Quality Review Organization (EQRO) and the Department. The Contractor shall submit all data and records necessary for the performance of a 411 audit to the Department or its designee. The Department will inform the Contractor of all other steps necessary to complete the 411 audit.

2.6.7.4. Encounter Claims Data for MMIS Submissions

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

2.6.7.4.2. Encounter Claims Data Submission Schedule

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

2.6.7.4.3. Encounter Claims Submission Requirements

2.6.7.4.3.1. Hospital, Ambulatory Surgery Center and Home Health Encounter Claims

2.6.7.4.3.1.1. Hospital (both inpatient and outpatient) and home health encounter claims include paid and denied services provided by a Hospital, ambulatory surgery center or home health agency. These encounter claims shall contain revenue and procedure codes, as appropriate. One encounter claim shall be submitted for each hospitalization, outpatient visit or outpatient surgery. Multiple home health visits may be on one home health encounter claim. The encounter claim shall represent all services delivered to the Member during the billing episode billed.

2.6.7.4.3.1.2. Hospital, ambulatory surgery center and home health encounter claims shall be submitted electronically directly to MMIS, using the ANSI 837I, Health Care Claim Institutional format.

2.6.7.4.3.1.3. Certain services (such as an infusion during home health) may be billed on an ANSI 837P, Health Care Claim Professional format rather than an ANSI 837I, Health Care Claim Institutional format. Such services may be submitted in the format received by the Provider.

2.6.7.4.3.2. Pharmacy Encounter Claims

2.6.7.4.3.2.1. Pharmacy claims refer to all paid pharmaceuticals prescriptions.

2.6.7.4.3.2.2. A pharmacy claim encounter is a single prescription. Example: A Member who goes to one Provider and has two prescriptions filled would have two encounters.

2.6.7.4.3.2.3. Pharmacy encounters shall be submitted electronically directly to the MMIS, using the National Council for Prescription Drug Program (NCPDP) version 5.1 format.

2.6.7.4.3.3. Medical Encounter Claims

2.6.7.4.3.3.1. Medical encounter claims include paid and denied services delivered by medical groups practices/clinics, Physicians, non-practitioners, medical equipment suppliers, family planning clinics, independent laboratories, optometrists, podiatrists, FQHCs, and freestanding rehabilitation centers, and all other Providers not listed in sections a and b above.

2.6.7.4.3.3.2. When a Member receives services from multiple Providers in the same

day, the Contractor shall submit separate encounter claims for each visit for each Provider.

2.6.7.4.3.3.3. Medical encounters shall be be submitted electronically directly to the MMIS, using the ANSI 837P, Health Care Claim professional format.

2.6.7.4.4. Encounter Edits and Types

2.6.7.4.4.1. Encounter Data Edits

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

2.6.7.4.4.2. Encounter Types

2.6.7.4.4.2.1. Adjudicated encounter claims are encounters that have been accepted by the system edits as provisionally correct. If the Department discovers errors with previously adjudicated claims resulting from a federal or state mandate or request that requires the completeness and accuracy of the Encounter Data, the Contractor shall be required to correct the error.

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

2.6.7.4.4.2.3. Level 1 denied encounter claims are encounters that have been denied by the Contractor. Encounter claims denied by the Contractor shall be submitted to the MMIS edits as described in Section 2.6.7.4.4.1 of this contract. Level 2 denied encounter claims are encounter claims that fail to process correctly in the MMIS because of missing or erroneous data. These claims are not allowed into MMIS and will be reported to the Contractor on a routine basis.

2.6.7.4.5. Data Set Format Requirements

2.6.7.4.5.1. The Contractor shall submit all Encounter Data for MMIS in a format to be specified by the Department.

2.6.7.4.5.1.1. Detailed format information for the ASC 837 transaction is available at http://www.wpc-edi.com. HIPAA transaction data guides to prepare systems to work with the Colorado Medicaid program and detail acceptable Colorado Program values can be found at www.chcpf.state.co.us.

2.6.7.4.5.1.2. A detailed format for Pharmacy submissions has been emailed to the Contractor. Additional copies are available from the Department's Information Systems Section.

2.6.7.4.5.1.3. The Department reserves the right to change format requirements at any time, following consultation with the Contractor. The Department, however, retains the right to make the final decision regarding format submission requirements.

2.6.7.4.5.2. The Contractor shall take necessary measures to ensure the:

2.6.7.4.5.2.1. Accuracy of all required fields.

2.6.7.4.5.2.2. Completeness of encounter claims submitted.

2.6.7.4.5.2.3. Presence of Medical Record documentation and each encounter claim.

2.6.7.4.5.2.4. Submitted data include paid and denied claims identified in this section of the contract (paid only for Pharmacy encounter claims).

2.6.7.4.5.2.5. Submitted data excludes interim, serial, duplicate and late billings or claims in appeal status.

2.6.7.4.5.2.6. Submitted data include the most current version of adjusted claims.

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

2.6.7.4.6. Encounter Data Transmissions

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

2.6.7.4.7. Processing and Reporting

2.6.7.4.7.1. The Department will process all encounter claims received through the MMIS.

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

2.6.7.5. Client Services

2.6.7.5.1. The Contractor shall ensure that Providers supply services only to those eligible Colorado Medicaid Clients assigned as Members to the Contractor's Plan. It is the responsibility of the Provider to verify that the individual receiving medical services is Medicaid eligible on the date of service, whether the Contractor or the Department is responsible for reimbursement of the services provided, and whether the Contractor has authorized a Referral or made special arrangements with a Provider, when appropriate.

2.6.7.6. Contract Termination and Encounter Data

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

2.6.8. The Contractor shall begin tracking and reporting quarterly Serious Reportable Events as described in Exhibit K, Serious Reportable Events or Never Events, attached and incorporated herein by reference, for all subcontracted facilities that provide inpatient services to Clients. The report shall contain any service with the Present on Admission (POA) indicator at the time of a hospital admission. The Department will provide a

detailed report template. The Contractor or rendering provider cannot bill the Client or Medicaid for POA related services.

2.6.8.1. The Contractor shall not reimburse any provider for the additional costs resulting from the hospital acquired conditions and Serious Reportable Events per Exhibit K.

2.6.8.2. The Contractor shall not reimburse the professional nor the hospital for the following occurrences of associated inpatient charges:

2.6.8.2.1. Surgery performed on the wrong body part.

2.6.8.2.2. Surgery performed on the wrong patient.

2.6.8.2.3. Wrong surgical procedure on a patient.

2.6.9. Health Insurance Providers Fee Reporting

2.6.9.1. 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 to the Department that contains all of the following information:

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

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

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

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

2.6.9.2. 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.

2.6.9.2.1. DELIVERABLE: Health Insurance Providers Fee Report.

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

2.7. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

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

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

2.7.2.1. Practice Guidelines.

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

2.7.2.1.1.1. Perinatal, prenatal and postpartum care for women;

2.7.2.1.1.2. Conditions related to Persons with a Disability or Special Health Care Needs; and

2.7.2.1.1.3. Well child care.

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

2.7.2.1.2.1. The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field.

2.7.2.1.2.2. The guidelines consider the needs of the Member.

2.7.2.1.2.3. They are adopted in consultation with Participating Providers.

2.7.2.1.2.4. The Contractor reviews and updates the guidelines at least annually.

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

2.7.2.1.4. The Contractor shall ensure that decisions regarding Utilization Management, Member education, Covered Services and other areas to which the guidelines apply are consistent with the guidelines to the extent that services set forth in the guidelines are Covered Services hereunder.

2.7.2.2. Performance Improvement Projects

2.7.2.2.1. The Contractor shall conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

2.7.2.2.2. Performance improvement projects shall follow requirements as outlined in External Quality Review Organization (EQRO) Protocol Validating Performance Improvement Projects and as directed by the Department.

2.7.2.2.3. The Contractor shall conduct performance improvement projects on topics selected by the CMS when the Department is directed by CMS to focus on a particular topic.

2.7.2.2.4. The Contractor shall complete performance improvement projects in a reasonable time period in order to facilitate the integration of project findings and information into the overall quality assessment and improvement program and to produce new information on quality of care each year.

2.7.2.3. Performance Measurement Data

2.7.2.3.1. Healthcare Effectiveness Data and Information Set (HEDIS)

2.7.2.3.1.1. The Contractor shall calculate and submit specified HEDIS measures. The Department will collaborate with the Contractor's quality improvement committee to designate the required measures.

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

2.7.2.3.1.3. The Contractor shall contract with an individual entity to perform an external

audit of the HEDIS measures according to HEDIS protocols.

2.7.2.3.1.4. Any failed audit that nullifies more than three (3) required HEDIS measures is considered non-compliant with this requirement.

2.7.2.3.2. Mandatory Federal Performance Measurements

2.7.2.3.2.1. The Contractor shall calculate additional performance measures when they are developed and required by CMS.

2.7.2.4. Member Satisfaction

2.7.2.4.1. The Contractor shall monitor Member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor shall use tools to measure these Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, grievance and appeals data and Enrollment and Disenrollment information.

2.7.2.4.2. The Contractor shall fund an annual Member satisfaction survey, the Consumer Assessment of Health Plans Study (CAHPS), administered by a certified survey vendor according to appropriate survey protocols. In lieu of a satisfaction survey conducted by an external entity, the Department, at the Department's discretion, may conduct the survey. The Contractor shall deliver any surveys to the Department for review and shall not administer any survey until it has received the Department's approval of that survey. The Contractor shall report to the Department results of internal satisfaction surveys of Members designed to identify areas of satisfaction and dissatisfaction by June 30th of each fiscal year.

2.7.2.4.3. The Contractor shall develop a corrective action plan when Members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected or when a serious complaint is reported.

2.7.2.4.4. The Contractor shall implement and maintain a mechanism to assess the quality and appropriateness of care for Persons with Special Health Care Needs.

2.7.2.5. Mechanisms to Detect Over and Under Utilization

2.7.2.5.1. The Contractor shall implement and maintain a mechanism to detect over and under utilization of services. These mechanisms may incorporate those developed for the Contractor's Utilization Management program.

2.7.2.6. Quality of Care Concerns

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

2.7.2.6.2. In response to a request from the Department in relation to any quality of care concern, the Contractor shall submit a letter to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue and the outcome of the review as determined by the Contractor. The outcome shall include whether or not the issue was found to be a quality of care issue and what action the Contractor intends to take with the Provider or Providers involved. The letter shall not include any names of the persons conducting the investigation or participating in any peer review

process.

2.7.2.6.2.1. The letter shall be delivered to the Department within fourteen (14) Business Days of the Department's request. Upon request, the Department may allow additional time to investigate and report. If the Contractor refers the matter to a peer review process, it shall inform the Department of that referral.

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

2.7.2.7. Quality Improvement Committee

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

2.7.2.8. Program Impact Analysis and Annual Report

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

2.7.2.8.2. The Contractor shall submit an annual report to the Department, detailing the findings of the program impact analysis. The report shall describe techniques used by the Contractor to improve performance, the outcome of each performance improvement project and the overall impact and effectiveness of the quality assessment and improvement program. The report shall be submitted by the last Business Day of September for the preceding year's quality activity or at a time the contract has been terminated.

2.7.2.8.3. The Program Impact Analysis and Annual Report shall provide sufficient detail for Department staff to validate the Contractor's performance improvement projects according to 42 C.F.R. Section 438.240, External Quality Review of Medicaid Managed Care Organizations.

2.7.2.8.4. Upon request, this information shall be made available to Providers and Members at no cost.

2.7.2.9. Quality Improvement Plan

2.7.2.9.1. The Contractor shall provide a quality improvement plan to the Department The plan shall delineate current and future quality assessment and performance improvement activities. The plan shall integrate findings and opportunities for improvement identified in HEDIS measurements, member satisfaction surveys, performance improvement projects and other monitoring and quality activities as required by the Department. The plan is subject to the Department's approval.

2.7.2.9.1.1. DELIVERABLE: Quality Improvement Plan

2.7.2.9.1.2. DUE: Annually, by the last Business Day in September

2.7.2.10. External Review

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

2.7.2.10.1.1. Medical Record review.

2.7.2.10.1.2. Performance improvement projects and studies.

2.7.2.10.1.3. Surveys.

2.7.2.10.1.4. Calculation and audit of quality and utilization indicators.

2.7.2.10.1.5. Administrative data analyses.

2.7.2.10.1.6. Review of individual cases.

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

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

2.7.2.11. Health Information Systems

2.7.2.11.1. The Contractor shall maintain a health information system that collects, analyzes, integrates and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances and appeals, encounters and Disenrollment.

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

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

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

SECTION 3.0 MEMBER AND PROVIDER ISSUES

3.1. MEMBER ISSUES

3.1.1. Member Services, Rights and Responsibilities

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

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

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

3.1.1.1.3. Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

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

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

3.1.1.1.6. Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164.

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

3.1.1.1.8. To receive, from the Provider and at the times specified in 42 C.F.R. Section 489.102, information concerning the implementation of Advance Directives, including a clear and precise statement of limitation if the Provider cannot implement an Advance Directive on the basis of conscience. The information shall include the Member's rights under this Contract, the Contractor's policies regarding the implementation of those rights and a statement regarding the fact that complaints concerning noncompliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment. Such information shall be provided in writing or an alternate format appropriate for the Member. Changes in state law shall be reflected in the Contractor's written material no later than ninety (90) calendar days after the effective date of the change.

3.1.1.2. Member Responsibilities

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

3.1.1.3. Written Policies, Procedures and Information Relating to Members

3.1.1.3.1. The Contractor shall establish and maintain written policies and procedures regarding the rights and responsibilities of Members that incorporate the rights and responsibilities identified by the Department in this contract. These

policies and procedures shall include the components described in this section and address the elements listed in Exhibit F, Member Handbook Requirements, attached hereto and incorporated herein.

3.1.1.3.2. The Contractor shall provide to all Members, including new Members, a Member handbook. This Member handbook shall include general information about services offered by the Contractor and complete statements concerning Member rights and responsibilities as listed in this section within a reasonable time after the Contractor is notified of the Enrollment. The Member handbook shall include all of the minimum requirements listed in Exhibit F. The Department may review the Member handbook upon request and the Contractor shall make any changes to the Member handbook directed by the Department within forty-five (45) days of the Department's request.

3.1.1.3.3. Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department. Written information shall be translated into other non-English languages prevalent in the Service Area, and provided in alternative formats as required in this Contract. The Contractor shall inform Members that oral interpretation services are available for any language, that written information is available in prevalent languages and how the Member may access interpretation services.

3.1.1.3.4. The Contractor shall include in its Member handbook and Marketing Materials a provision clearly stating that Enrollment in the Contractor's Plan is voluntary. Contractor shall include information in its Member handbook about how to request disenrollment.

3.1.1.3.5. The Contractor may provide Members with similar information, in the same manner as that information is provided to private or commercial enrollees, but shall also provide Members with additional information as appropriate to promote compliance with this Contract.

3.1.1.3.6. The Contractor shall provide periodic updates to the Member handbook when needed to explain changes to the above policies. Prior to printing, the Contractor shall submit the updates to the Department for review and approval, at least thirty (30) calendar days prior to the targeted printing date.

3.1.1.3.7. The Member handbook shall be approved or disapproved by the Department in writing within forty-five (45) calendar days of receipt by Department. If the Member handbook is disapproved by the Department, the Department shall specify the reason(s) for disapproval in the written notice to Contractor.

3.1.1.3.8. The Contractor shall provide a copy of the policies on Members' rights and responsibilities to all Participating Providers and ensure that Participating Providers are aware of information being provided to Members.

3.1.1.3.9. The Contractor and its representatives shall not knowingly provide untrue or misleading information, as defined at §10-16-413 (1)(a)-(c), C.R.S., regarding the Contractor's Plan or Medicaid eligibility, to Clients or Members.

3.1.1.4. Notices of Changes, Information and Actions

3.1.1.4.1. The Contractor shall notify all Members of their right to request and obtain the information listed in Exhibit F, at least once per year. The Contractor shall also notify Members of any significant changes in the following information at least thirty (30) calendar days prior to the effective date of the change. Significant changes include, but are not limited to:

3.1.1.4.1.1. The amount, duration and scope of Covered Services available in sufficient detail to ensure that Members understand the benefits to which they are entitled.

3.1.1.4.1.2. Procedures for obtaining Covered Services, including authorization requirements.

3.1.1.4.1.3. The extent to which, and how, Members may obtain benefits, including family planning services, from out-of-network Providers.

3.1.1.4.1.4. The extent to which, and how, after-hours and Emergency Services are provided including:

3.1.1.4.1.4.1. What constitutes an Emergency Medical Condition, Emergency Services and Post-Stabilization Care Services.

3.1.1.4.1.4.2. The fact that prior authorization is not required for Emergency Services.

3.1.1.4.1.4.3. The process and procedures for obtaining Emergency Services, including use of the 911 telephone system or its local equivalent.

3.1.1.4.1.4.4. The locations of any emergency settings and other locations at which Providers and Hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the contract.

3.1.1.4.1.4.5. The fact that, subject to the provisions of this section, the Member has the right to use any Hospital or other setting for Emergency Services.

3.1.1.4.1.5. Policy on Referrals for specialty care and for other benefits not furnished by the Member's Primary Care Physician.

3.1.1.4.1.6. Any cost sharing or co-pays that the Member is responsible for in relation to the receipt of a Covered service.

3.1.1.4.1.6.1. All cost sharing and co-pays shall be implemented and imposed in accordance with 42 CFR 447.50 through 42 CFR 447.60.

3.1.1.4.1.7. How and where to access Wrap Around Benefits, including any cost sharing and how transportation is provided. For a counseling or Referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service.

3.1.1.5. Appeal Process and Reporting

3.1.1.5.1. The Contractor shall establish an internal appeal process under which a Member may challenge the denial of coverage of, or payment for, services in accordance with 42 C.F.R. Section 438.228, as amended.

3.1.1.5.2. The Contractor shall comply with all requirements of the managed care appeal

rules at 10 C.C.R. 2505-10, Section 8.209, set forth in Exhibit J, Medicaid Managed Care Grievance and Appeal Processes, attached and incorporated herein by reference, and as required in this contract and shall support the Department by attending and responding to state fair hearings notices regarding its Members. Please see 10 C.C.R. 2505-10, Section 8.209, for the current version of the rules.

3.1.1.5.3. The Contractor shall use the reporting format provided by the Department to document and maintain an organized system for recording, tracking, resolving, and assessing Members' appeals. The Contractor shall submit a completed data reporting form to the Department, on a quarterly basis, within thirty (30) calendar days following the end of the quarter being reported.

3.1.1.5.4. The Contractor shall use the Department's reporting format to provide a written analysis of the appeal data. The Contractor shall submit the written report to the Department on a quarterly basis, within thirty (30) calendar days following of the end of the quarter being reported.

3.1.1.5.5. The Contractor shall not be responsible for any grievance or appeal associated with a Wrap Around Benefit.

3.1.1.6. Patient Confidentiality

3.1.1.6.1. Contractor shall protect the confidentiality of all Member records and other materials, in any form, including electronic that are maintained in accordance with this contract. Except for purposes directly connected with the administration of the Medicaid program, no information about or obtained from any Member in possession of Contractor shall be disclosed in a form identifiable with the Member without the prior written consent of the Member or a minor's parent or guardian, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals. Contractor shall have written policies governing access to, duplication and dissemination of, all such information. Contractor shall advise its employees, agents, Participating Providers and Subcontractors, if any, that they are subject to these confidentiality requirements. Contractor shall provide its employees, agents, Participating Providers and Subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

3.1.1.6.2. The Contractor shall maintain or make provisions for the maintenance of a Medical Record for each Member according to state and federal laws and regulations. The Medical Record shall accurately represent the full extent of care provided to the Member. The record shall include, at a minimum, medical charts, prescription files, and other documentation sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed under this contract. It may be reflected and noted in the record that an Advance Directive has been discussed with the Member, if one has been executed. Each Member's record must be legible and maintained in detail consistent with good medical and professional practices that facilitate effective internal and external

peer review, medical audit and adequate follow-up treatment.

3.1.1.6.3. The Contractor shall conform to the requirements of 45 C.F.R Section 205.50, as amended, Section 10-16-423, C.R.S., as amended, 45 C.F.R. Sections 160 and 164, as amended, and 42 C.F.R Sections 431.304 - 431.307, as amended, regarding confidentiality of health information about any Member for Covered Services hereunder.

3.1.1.6.4. The Contractor agrees to abide by 42 C.F.R. Section 431.301, as amended, and Section 26-1-114, C.R.S., as amended, regarding the confidentiality of information concerning applicants for and Clients of medical assistance.

3.1.1.7. Marketing

3.1.1.7.1. The Contractor shall not distribute any Marketing Materials without first obtaining the Department's approval which shall include a review by a medical care advisory committee. The Department shall inform the Contractor of its decision on the materials, within three (3) Business Days of the medical care advisory committee's review. This includes materials that are produced in any medium, by or on behalf of the Contractor, which can reasonably be interpreted as intended to market to potential Members. All materials, including the Contractor's Member handbook, shall be submitted to the Department at least thirty (30) calendar days prior to the targeted release date.

3.1.1.7.2. The Contractor shall assure the Department, in writing, upon submission of any written material for the Department's approval that any marketing plans and materials are accurate and do not mislead, confuse or defraud the Clients, Members or the Department.

3.1.1.7.3. The Contractor's written materials or oral presentations shall not contain any assertion that the Client must Enroll in the Contractor's Plan or any other Managed Care Organization in order to obtain benefits or in order not to lose benefits.

3.1.1.7.4. The Contractor's written materials or oral presentations shall not contain any assertion that the Contractor's Plan is endorsed by the Centers for Medicare and Medicaid Services, the federal or state government or similar entity.

3.1.1.7.5. The Contractor shall not, directly or indirectly, engage in door-to-door, telephone, or cold-call marketing activities. Cold call marketing includes any unsolicited personal contact by the Contractor, its Subcontractors or Participating Providers with a potential Member for the purpose of marketing as defined at 42 C.F.R. Section 438.104(a).

3.1.1.7.6. The Contractor shall not seek to influence Enrollment in conjunction with the sale or offering of any private insurance.

3.1.1.7.7. Should the Contractor distribute Marketing Materials, it shall distribute the materials to its entire Service Area.

3.1.1.7.8. Any final copy of written education materials developed by the Department, which describes the Contractor or the Contractor's Plan, shall be submitted to the Contractor at least ten (10) Business Days prior to the release.

3.2. PROVIDER ISSUES

3.2.1. Licensure and Credentialing

3.2.1.1. The Contractor shall have written policies and procedures for the selection and retention of Providers.

3.2.1.2. The Contractor shall verify that all Participating Providers meet licensing and certification requirements.

3.2.1.3. The Contractor's credentialing program shall comply with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of Participating Providers. The Contractor may use information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to assist in meeting NCQA credentialing standards.

3.2.1.4. The Contractor's credentialing program shall include policies and procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.

3.2.1.5. The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. Those laboratories with Certificates of Waiver will provide only the nine (9) types of tests permitted under the terms of the Waiver. Laboratories with Certificates of Registration may perform a full range of laboratory tests.

3.2.1.6. The Contractor’s Provider selection policies and procedures shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

3.2.2. Provider Insurance

3.2.2.1. The Contractor shall ensure that Participating Providers comply with all applicable local, state and federal insurance requirements necessary in the performance of this contract. Minimum insurance requirements shall include, but are not limited to all the following:

3.2.2.1.1. Physicians participating in the Contractor’s Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and one million five-hundred thousand dollars ($1,500,000.00) in aggregate per year.

3.2.2.1.2. Facilities participating in the Contractor’s Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and three million dollars ($3,000,000.00) in aggregate per year.

3.2.2.1.3. Sections 3.2.2.1.1 and 3.2.2.1.2 shall not apply to Physicians and facilities in the Contractor's network which meet any of the following requirements:

3.2.2.1.3.1. The Physician or facility is a public entity or employee pursuant to §24-10-103, C.R.S. of the Colorado Governmental Immunity Act, as amended.

3.2.2.1.3.2. The Physician or facility maintains any other security acceptable to the Colorado Commissioner of Insurance, which may include approved plan of self-insurance, pursuant to §13-64-301, C.R.S., as amended.

3.2.2.1.4. The Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such coverage, the Contractor shall notify the Department of such cancellation within two (2) Business Days of when the coverage is cancelled.

3.2.3. Provider Quality of Care Issues

3.2.3.1. For alleged quality of care concerns involving Physician Providers, the Contractor may use the process of its professional review committee, as set forth in §§ 12-36.5-104 and 12-36.5-104.4, C.R.S., when a quality of care concern is brought to its attention. This provision shall not be construed to require the Contractor to disclose any information that is confidential by law.

3.2.4. Provider Incentive Plans

3.2.4.1. No specific payment can be made directly or indirectly under a Provider incentive plan to a Provider as an inducement to reduce or limit Medically Necessary services furnished to a Member.

3.2.4.2. The Contractor shall disclose to the Department or any Member or Member's Designated Client Representative, at the Department's request, information on any Provider incentive plan.

3.2.4.3. The Contractor shall ensure that agreements containing Physician incentives comply with 42 C.F.R. Section 438.6, as described in Exhibit G, Requirements for Physician Incentive Plans, attached and incorporated herein by reference. Please see 42 C.F.R. Section 438.6 for the current version of the regulations.

3.2.5. Program Integrity

3.2.5.1. The Contractor shall comply with the disclosure of ownership and control information set forth in 42 C.F.R. Section 455 Subpart B.

3.2.5.2. The Contractor shall report to the National Practitioner Data Bank and to the appropriate state regulatory board all adverse licensure or professional review actions it has taken against any Participating Provider in accordance with 45 C.F.R. Subtitle A, Part 60, Subpart B.

3.2.5.3. The Contractor shall establish and maintain a compliance program designed to prevent, detect investigate and report fraud, waste and abuse.

3.2.5.4. Contractor shall create a compliance program plan documenting Contractor's written policies and procedures, standards and documentation of practices. The Compliance Program Plan shall be approved by Contractor's Chief Executive Officer and Compliance Officer. The Compliance Program Plan shall be submitted to the Department for review and approval and shall contain:

3.2.5.4.1. Provisions for internal monitoring and auditing.

3.2.5.4.2. Provisions for prompt response to detected offenses and for development of corrective action initiatives.

3.2.5.4.3. Provisions for monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.

3.2.5.4.4. Effective processes to screen all Provider claims, collectively and individually, for potential fraud, waste or abuse.

3.2.5.4.5. Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste and abuse.

3.2.5.4.6. Effective mechanisms to identify and report suspected instances of up-coding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided.

3.2.5.4.7. Effective processes to ensure that covered services billed by network providers were received by clients and that the services received match the billing codes/descriptions

3.2.5.5. Contractor, its providers and subcontractors, are subject to the False Claims Act, §§ 3729 through 3733 of Title 31, United States Code.

3.2.5.6. Contractor shall establish written policies for employees, within thirty (30) days of the effective date of this contract, requiring all employees to be informed of and detailing compliance with:

3.2.5.6.1. The False Claims Act, 31 USC §§ 3729, et seq.

3.2.5.6.2. Administrative remedies for false claims and statements.

3.2.5.6.3. State laws relating to civil or criminal penalties for false claims and statements. if any.

3.2.5.6.4. Whistleblower protections under such laws.

3.2.5.7. Contractor shall establish a process for training existing and new employees on the compliance program and on the items in Sections 3.2.5.6.1 through 3.2.5.6.4 above. All training shall be conducted in such a manner that it can be verified by the Department.

3.2.5.7.1. Employee Education About False Claims

3.2.5.7.1.1. 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, Section 25.5-4-304 C.R.S. 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.

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

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

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

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

3.2.5.7.1.2.4. 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.

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

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

3.2.5.8. Contractor shall designate a compliance officer and compliance committee that are accountable to senior management.

3.2.5.9. Contractor shall have effective lines of communication between the compliance officer and the Contractor's employees for reporting violations.

3.2.5.10. Contractor shall enforce its compliance program through well-publicized disciplinary guidelines.

3.2.5.11. Contractor shall immediately report known confirmed intentional incidents of fraud and abuse to the Department's contract manager and to the appropriate law enforcement agency, including, but not limited to, the Colorado Medicaid Fraud Control Unit (MFCU).

3.2.5.12. Contractor shall immediately report indications or suspicions of fraud by giving a verbal report to the Department's contract manager. Contractor shall investigate its suspicions and shall submit its written findings and concerns to the contract manager within three Business Days of the verbal report. If the investigation is not complete in three Business Days, Contractor shall continue to investigate. A final report shall be submitted within fifteen Business Days of the verbal report. The contract manager may approve an extension of time in which to complete the final report upon a showing of good cause.

3.2.5.13. The Contractor shall not knowingly have a relationship of the type described below and specified in 42 CFR 438.610 with the following:

3.2.5.13.1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

3.2.5.13.2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in II.F.5.m.1. This section applies to the following types of individuals:

3.2.5.13.2.1. A director, officer, or partner of the Contractor.

3.2.5.13.2.2. A person with beneficial ownership of five (5) percent or more of the Contractor's equity.

3.2.5.13.2.3. A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the Department.

3.2.5.13.3. For all providers who do not have an independent Medicaid provider identification number, Contractor will comply with and perform all of the State's obligations identified in State Medicaid Director Letter #08-003, dated June 12, 2008, and State Medicaid Director Letter #09-001, dated January 16, 2009 (collectively, Letters) provided by the Department.

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

3.2.5.14. Contractor shall suspend payments to any network provider that is actively under investigation for a credible fraud allegation. The State may suspend managed care capitation payments when an individual network provider is under investigation based upon credible allegations of fraud, depending on the allegations at issue.

3.2.5.15. Contractor acknowledges that the State may suspend capitation payments to Medicaid managed care entities should the managed care entity be actively under investigation for credible fraud allegations. Accordingly, if the State fails to suspend payments to such an entity for which there is a pending investigation of a credible allegation of fraud, without good cause, FFP may be disallowed with regard to such payments to the managed care entity.

3.2.6. Pharmacy Providers

3.2.6.1. The Contractor shall provide or enter into subcontracts with qualified pharmacy Providers for the provision of Covered Drugs as required, and in the manner specified, by Department regulations at 10 C.C.R. 2505-10, Section 8.205.8. The Contractor may limit pharmacy Providers to its owned and operated pharmacies so long as the limitation does not adversely affect the delivery of pharmaceutical products in nursing facilities as required by 10 C.C.R. 2505-10, Section 8.205.8.A and B. All subcontracts with pharmacy Providers shall be subject to all standards set forth in this Contract.

3.2.7. Advance Directives

3.2.7.1. Advance Directives are defined in 42 C.F.R. Section 489.100, and Section 15-14-505(2), C.R.S.

3.2.7.2. Contractor shall maintain written policies and procedures concerning Advance Directives with respect to all adult individuals receiving medical care by or through

the Contractor, as provided in 42 C.F.R. Section 489.

3.2.7.3. Contractor must provide written information to those individuals with respect to the following:

3.2.7.3.1. Their rights under the law of the state.

3.2.7.3.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

3.2.7.3.3. Contractor shall inform individuals that complaints concerning noncompliance with the Advance Directive requirements may be filed with the Colorado Department of Public Health and Environment.

3.2.8. Prompt Payment of Claims

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

3.2.9. Termination of Participating Provider Agreements

3.2.9.1. The Contractor shall notify the Department, in writing, of its decision to terminate any existing Participating Provider agreement where such termination will cause the delivery of Covered Services to be inadequate in a given area. The notice to the Department shall include a description of how the Contractor will replace the provision of Covered Services at issue. In the event that the Contractor is unable to adequately replace the affected services to the extent that accessibility will be inadequate in a given area, the Department may impose limitations on Enrollment in the area or eliminate the area from the Contractor's Service Area.

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

3.2.10. Incentive to Members

3.2.10.1. The Contractor and Participating Providers are prohibited from providing material incentives unrelated to the provision of service as an inducement to the Members to Enroll or Disenroll in the Contractor's Plan or to use the services of a particular Provider.

3.2.11. Provider Applications

3.2.11.1. The Contractor shall not discriminate with regards to the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable state law, solely on the basis of that license or certification. If the Contractor declines to include an individual Provider or group of Providers in its network, it shall give the affected Providers' written notice of the reasons for its decision. In no event shall this provision be construed to:

3.2.11.1.1. Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members.

3.2.11.1.2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

3.2.11.1.3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

3.2.12. The Contractor shall monitor Covered Services rendered by Participating Providers for quality, appropriateness and patient outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting, and other applicable provisions of this contract.

SECTION 4.0 REIMBURSEMENT

4.1. PAYMENT OF MONTHLY PAYMENT RATE

4.1.1. For each Member Enrolled with the Contractor, the Department shall pay the Contractor the Monthly Payment Rate specified in Exhibit B.

4.1.2. The Department shall remit payment of the Monthly Payment Rate to the Contractor, on or before the twentieth (20th) business day of each month.

4.1.3. 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 and newborns, based on the Rates as specified in Exhibit B. 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 in the month.

4.1.4. The Department shall remit payment through an electronic transfer of funds to the bank account designated by the Contractor. The Department shall provide the Contractor with a monthly payment report through the MMIS.

4.1.5. The Contractor shall be responsible for the accuracy of direct deposit information provided to the Department and for updating such information as needed.

4.1.6. The Monthly Payment Rate shall be considered payment in full for all Covered Services set forth in Exhibit D.

4.2. CALCULATION OF MONTHLY PAYMENT RATE

4.2.1. The state shall pay the Contractor capitation rates effective July 1, 2015 – June 30, 2016. The capitation rates for this time period are appropriately certified by a qualified actuary. The rate table is part of and incorporated herein as Exhibit B.

4.2.2. The Monthly Payment Rate may be adjusted during the performance period of this contract pursuant to an executed amendment, upon approval of the State Controller or his/her designee.

4.2.3. Risk Sharing

4.2.3.1. The Contractor and the Department will share the financial risk for medical expenditures for July 1, 2015 to June 30, 2016 based on a calculation of the adjusted medical expenditures for the enrollees of the Medicaid expansion population, by engaging in a risk sharing reconciliation for any amounts due from the Contractor as follows:

4.2.3.1.1. Adjusted Medical Expenditures shall be determined by the Department based on Encounter Data for covered services for the contract period.

4.2.3.1.2. The Department reserves the right to audit and/or re-price the actual medical expenditures for external providers to ensure that the expenditures to providers are reasonable and reflective of arms-length transactions based on Encounter Data submitted by the Contractor. Expenditures shall be deemed reasonable by the parties if they are at, or under, one hundred five percent (105%) of the State fee-for-service (FFS) reimbursement. The Department will incur the cost of auditing plan encounter data used for the re-pricing.

4.2.3.1.3. The data used for the reconciliation will be the routine Encounter Data sent by the contractor.

4.2.3.1.4. The risk sharing procedures may include a review of the Contractor's Encounter Data and an audit, to be performed by the Department or its authorized agent, to verify that all paid claims for the Enrollee by the Contractor are reimbursed in amounts that are consistent with similar Medicaid reimbursements and are arms-length transactions. Should such an audit determine that Covered Services Claims were not paid in a manner consistent with other Medicaid reimbursements or were not arms-length transactions, then in addition to the risk sharing payment specified in this Section, the findings of such audit shall determine the amount, if any, that the Department shall recover from the Contractor for any overpayment resulting from such transactions.

4.2.4. Risk Corridor:

4.2.4.1. As a result of the unknown risk level associated with the emerging MAGI childless adults population, the State has developed the following risk corridor as a risk-mitigation strategy:

Min	Max	MCO Share	Federal/State Share
0%	98%	50%	50%

Min	Max	MCO Share	Federal/State Share
98%	102%	100%	0%
102%	+	50%	50%

4.2.4.2. The risk corridor percentage is calculated as total adjusted medical expenditures divided by the medical portion of the total capitation payment, for the same period.

4.2.4.3. Should the risk corridor percentage calculated as above, in the aggregate be greater than one hundred two percent (102%) the Department/Federal Government shall be responsible for fifty percent (50%) of the loss that is greater than one hundred two percent (102%) of the medical portion of the total capitation rate or the Department/Federal Government shall be responsible for fifty percent (50%) of the gain that is less than ninety-eight percent (98%) of the medical portion of the total capitation rate.

4.2.4.4. Should the risk corridor percentage in the aggregate be greater than or equal to ninety-eight percent (98%) or less than or equal to one hundred two percent (102%), the Department/Federal Government shall have no financial responsibility.

4.2.4.5. To the extent that the actual experience is below an eighty five percent (85%) medical loss ratio, the Federal Government will retain all profits below that threshold. On the top end of the corridor, the Federal Government will not provide financial participation above the fee-for-service-equivalent (FFSE), which will be calculated during the risk corridor process.

4.2.4.6. For the risk corridor calculations, the Department will use the encounter data priced at the Medicaid fee schedule for internal DH providers and will benchmark DH's actual costs for external providers to the Medicaid fee schedule to ensure reasonable provider contracting.

4.2.4.7. MAGI childless adults settlement plan for the rate period from July 2015 to June 2016:

4.2.4.7.1. To complete the MAGI childless adults service encounter identification and collection the Contractor shall:

4.2.4.7.1.1. Use the capitation file to identify the MAGI childless adults clients.

4.2.4.7.1.2. Use the same format as the regular MCO encounters.

4.2.4.7.1.3. Send the data together with the quarterly MCO encounter submission.

4.2.4.7.1.4. The complete MAGI childless adults encounters with at least four (4) months run-out.

4.2.4.7.1.5. Calculate the actual rate and risk sharing amount based on the risk corridors, and capped values in May 2017.

4.2.4.7.1.6. Reconcile dollar amount with DHHAs by June 30th, 2017.

4.2.5. Medical Loss Ratio (MLR)

4.2.5.1. As a result of the unknown risk level associated with the emerging Parent Expansion population, the State has developed the following MLR as a risk-mitigation strategy:

4.2.5.1.1. Payments for the Parent Expansion Population under this contract shall be subject to the eighty-five percent (85%) MLR as the lower bound. The ratio calculation is of the same method as that of risk corridor.

4.2.5.1.2. The Parent Expansion Population Rate Settlement process for the rate period July 2015 to June 2016 will include the following:

4.2.5.1.2.1. The Contractor will send Parent Expansion Population encounter data together with the DHHA regular encounter submissions to the Department.

4.2.5.1.2.2. The Department will identify Parent Expansion Population clients by the capitation file.

4.2.5.1.2.3. The Department will calculate settlements in May 2017 based upon the eighty-five percent (85%) MLR.

4.2.5.1.2.4. The Department will issue a demand letter by the end of June 2017 with the settlement amount that shall be either remitted to the Contractor or recouped from the Contractor.

4.2.5.1.3. To the extent that the actual experience is below an eighty-five percent (85%) medical loss ratio, the Federal Government will retain all profits below that threshold.

4.3. THIRD PARTY PAYER LIABILITY

4.3.1. All Members are required to assign their rights to any benefits to the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

4.3.2. The Contractor shall be responsible for collection of any third party liability. The Contractor shall submit an annual Third Party Recovery Report of all amounts recovered from third parties. The Department will remove the amount submitted in the annual Third Party Recovery Report from the calculation of the Monthly Capitation Rates

4.3.3. The Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing Covered Services under this contract.

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

4.3.3.2. The Contractor shall, on a monthly basis, notify the Department's fiscal agent, by

telephone or in writing, of any third party payers, excluding Medicare, identified by the Contractor. If the third party payer is Medicare, the Contractor shall notify the Department and provide the Member's name and Medicaid identification along with the Medicare identification number. If the Member has health insurance coverage other than Medicare, the Contractor shall submit the following information:

4.3.3.2.1. Medicaid identification number.

4.3.3.2.2. Member's social security number.

4.3.3.2.3. Member's relationship to policyholder.

4.3.3.2.4. Name, complete address, and telephone number of health insurer.

4.3.3.2.5. Policy Member identification and group numbers.

4.3.3.2.6. Policy Member's social security number.

4.3.3.2.7. Policy Member's full name, complete address and telephone number.

4.3.3.2.8. Daytime telephone number where Member can be reached.

4.3.3.3. The Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor. The Contractor, as a duly licensed hospital, shall have the lien rights provided in Article 27 of Title 38 of the Colorado Revised Statutes.

4.3.3.4. The Contractor shall provide a quarterly report of all third party recovery efforts and amounts recovered by Medicaid client ID, category of assistance and date of service to the Department. The report shall be provided on compact disc (CD) or by encrypted email, no later than thirty (30) calendar days following the end of each quarter.

4.3.3.5. In addition to compensation paid to the Contractor under the terms of this Contract, the Contractor may retain as income all amounts recovered from third party resources, up to the Contractor’s reasonable and necessary charges for services provided in-house and the full amounts paid by the Contractor to Participating Providers, as long as recoveries are obtained in compliance with this Contract and state and federal laws.

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

4.3.3.7. The Contractor shall inform Members, in its written communications and publications that Members shall comply with the Contractor’s protocols, including using Providers within the Contractor's network, prior to receiving Non-emergency medical care. The Contractor shall also inform its Members that failure to follow the Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that the Contractor would have been liable to pay. If the Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to the Contractor or the Provider for payment or cost of the care or services.

4.3.3.8. The Contractor shall inform Members, in its written communications and publications, that when a third party is primarily liable for the payment of the costs of a Member's medical benefits, the Member shall comply with the protocols of the third party, including using Providers within the third party's network, prior to receiving Non-emergency medical care.

4.3.3.9. With the exception of Section 4.3.3.10 and except as otherwise specified in contracts between the Contractor and Participating Providers, the Contractor shall pay all applicable co-payments, coinsurance and deductibles for approved Covered Services for the Member from the third party resource using the lower-of pricing methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service:

4.3.3.9.1. The sum of reported third party coinsurance and/or deductible or

4.3.3.9.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

4.3.3.10. The Contractor shall pay, except as otherwise specified in contracts between the Contractor and Participating Providers, all applicable co-payment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid fee-for-service.

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

4.3.3.12. The Contractor shall include information in the Contractor's Member handbook regarding its rights and the Member's obligations under this section of the contract and Section 25.5-4-301, C.R.S.

4.3.3.13. Benefits for Members shall be coordinated with third party auto insurance.

4.4. DISPROPORTIONATE SHARE HOSPITAL

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

4.5. FQHC & RURAL HEALTH CENTER (RHC) REIMBURSEMENT

4.5.1.1. The Department provided FQHC and RHC encounter rates effective for SFY14. As the Department is transitioning into building in the FQHC/RHC APM rate into the capitation rate to eliminate additional reconciliation, these rates were applied to each FQHC and RHC visit.

4.5.2. FQHC & Rural Health encounter reimbursement:

4.5.2.1. Payments from Contractor to FQHC or RHC Facilities

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

4.5.2.1.2. The Department shall notify the Contractor of the current FQHC or RHC rates on a quarterly basis.

4.5.2.1.3. The Contractor shall reimburse the FQHC or RHC the encounter rate in accordance with 10 CCR 2505-10 8.700.6 for each FQHC or 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. Should the Department become aware of any discrepancy in FQHC or RHC payments (less than the full encounter rate), then the Contractor shall be responsible for reimbursing the FQHC or RHC the difference of the encounter payment identified in 6.8.1.1. and the initial reimbursement amount.

4.5.2.1.4. An FQHC visit is defined in 10 CCR 2505-10 8.700.1, and a RHC visit is defined in 10 CCR 2505-10 8.740.1.

4.5.2.1.5. If multiple services are provided by an FQHC or RHC within one visit, the Contractor will require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. The Contractor is required to pay the FQHC no less than the encounter rate minus any third party payments, including Member copayments as identified in the Covered Services Exhibit D of this Contract for each visit.

4.5.2.2. The encounter data for FQHC and/or RHC visits are included in the routine encounter data submission to the Department.

4.5.2.3. FQHC or RHC payment is included in HMO capitation rate. No further wrap payment and/or reconciliation will be performed on FQHC or RHC payment.

4.6. DELIVERIES REIMBURSEMENT

4.6.1. The Contractor shall receive payment for delivery services provided to Members through a supplemental payment. The payment, which is set forth in Exhibit B, includes facility and professional service costs related to the delivery and post-partum care. One payment shall be made for each delivery regardless of the number of births associated with that delivery.

4.6.2. In order to receive payment for deliveries, the Contractor shall submit, to the Department, a cover letter and an electronic Excel spreadsheet in the format designated by the Department. Documentation of the delivery, e.g., a claim record of delivery, must accompany the request for payment. The request for payment shall be submitted to the Department no later than one hundred and fifty (150) days following the delivery.

4.6.3. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. This certification shall be signed by either the Chief Executive Officer or the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

4.6.4. The Department shall adjudicate the Contractor's request for payment within thirty-five (35) days of receipt of all documentation of the delivery.

4.7. ADDITIONAL REQUIREMENTS FOR REIMBURSEMENT

4.7.1. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 CFR Sections 95.1 and 95.7, the Department must file all claims for reimbursement of payments to the contractor with the Centers for Medicare and Medicaid Services (CMS) within two (2) years after the calendar quarter in which the Department made the expenditure. Therefore, if the Department is unable to file any claim(s) for an adjustment for prior year costs related to the Contractor's claims or capitation payments within two (2) years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate contractor records, and the Department does not meet any of the exceptions listed at 45 CFR Section 95.19, no claims or capitations paid to the Contractor for any period of time disallowed by CMS due to inadequate or inaccurate records on the part of the Contractor.

4.7.2. Payments to Primary Care Physicians

4.7.2.1. The Contractor shall demonstrate compliance with the provisions set forth in Section 1202 of the Patient Protection and Affordable Care Act, "Payments to Primary Care Physicians," (hereinafter "Section 1202") by the Effective Date. To demonstrate its compliance, the Contractor shall provide, at a minimum, documentation of its compliance as a Managed Care Organization, including all requirements set forth by CMS. The Department will then submit the information provided by the Contractor to CMS as part of the Department's compliance.

4.7.3. In accordance with 42 C.F.R. 438.6(c)(3)(v) and (c)(5)(vi) the Contractor shall adhere to all Contract requirements for this provision specifically:

4.7.3.1. The Contractor is required to pass on the full benefit of the payment increase to the eligible providers.

4.7.3.2. The Contractor is required to adhere to the definitions and requirements for eligible providers and services as specified in the statute and regulation.

4.7.3.3. The Contractor is required to submit sufficient documentation, as specified by the state, to validate that the enhanced payments were made to eligible providers.

4.7.4. Eligible physician services described in Section 1202 will be eligible for the appropriate supplemental payment retroactively to January 1, 2013 for eligible physicians that have submitted self-attestation forms to the Contractor on or before March 31, 2013. For eligible physicians that submitted self-attestation forms to the Contractor after March 31, 2013, the appropriate supplemental payment for eligible physician services as described in Section 1202 will apply only to services incurred on

or after the date of self-attestation. These supplemental payments shall terminate effective December 31, 12/31/2014.

4.7.5. Beginning on July 1, 2015, the Contractor shall reimburse physicians an enhanced payment. This enhanced payment shall be for eligible primary care services and vaccine administration furnished by a qualified physician, or under the personal direction of a physician.

4.7.5.1. The enhanced payment shall be paid to qualified physicians for eligible primary care services and vaccine administration rendered on and after July 1, 2015 through June 30, 2016.

4.7.5.2. The Contractor shall provide documentation to the Department, upon the Department's request, which provides assurances that physicians received the direct and full benefit of the enhanced payment described in this article.

4.7.5.2.1. The primary care services and vaccine administration that qualify for this additional reimbursement are those pursuant to Exhibit M, and only as approved in the Medicaid Plan.

SECTION 5.0 ADDITIONAL REQUIREMENTS

5.1. REMEDIAL ACTIONS AND SANCTIONS

5.1.1. The Contractor shall comply with all provisions of this contract and its amendments, if any, and shall act in good faith in the performance of the provisions of said contract. The Contractor agrees that failure to comply with the Contract provisions may result in the application of remedial actions and/or termination of this contract.

5.1.2. In addition to any other remedies available under this contract, and without limiting its remedies otherwise available at law, the Department may exercise the other remedial actions and intermediate sanctions, described in this section, if the Contractor substantially fails to:

5.1.2.1. Provide medically necessary services that the Contractor is required to provide, under law or this contract, to a Member.

5.1.2.2. Provide Medical Records and other requested documents for Non-emergency review within thirty (30) calendar days of the date of the written request as stated in Section 5.1.4.9.

5.1.2.3. Satisfy the scope of work found in this contract, as determined by the results of monitoring activities or audits.

5.1.2.4. Comply with the requirements for physician incentive plans, as stated in Exhibit G.

5.1.3. In addition to any other remedies available under this contract, and without limiting its remedies otherwise available under law, the Department may exercise the other remedial actions and intermediate sanctions, described in this section, if the Contractor:

5.1.3.1. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

5.1.3.2. Discriminates among Members on the basis of their health status or need for health care services including termination of Enrollment or refusal to reenroll a recipient,

except as permitted under the Medicaid program or any other practice that would reasonably be expected to discourage Enrollment by recipients whose medical condition or history indicates probable need for substantial future medical services.

5.1.3.3. Misrepresents or falsifies information furnished to the Department or the Centers for Medicare and Medicaid Services.

5.1.3.4. Misrepresents or falsifies information furnished to Members, potential Members, or Providers.

5.1.3.5. Distributes directly or indirectly, through any agent or independent contractor, any Marketing Materials that have not been approved by the Department or that contain false or materially misleading information.

5.1.3.6. Violates any applicable requirements of sections 1903(m) or 1932 of the Social Security Act and its implementing regulations.

5.1.3.7. Prohibits or otherwise restricts a health care professional acting within the scope of practice, from advising or advocating on behalf of an Enrollee who is his or her patient, for the following:

5.1.3.7.1. The Enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

5.1.3.7.2. Any information the Enrollee needs in order to decide among all relevant treatment options.

5.1.3.7.3. The risks, benefits, and consequences of treatment or nontreatment.

5.1.3.7.4. The Enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

5.1.4. The Department may choose to impose any of the following intermediate sanctions:

5.1.4.1. Civil monetary penalties to a limit of twenty-five thousand dollars ($25,000.00) for each determination of failure to adhere to contract requirements as stated in Sections 5.1.2.1, 5.1.2.4, 5.1.3.4, and 5.1.3.5.

5.1.4.2. Civil monetary penalties to a limit of one hundred thousand dollars ($100,000.00) for each determination of a failure to adhere to contract requirements as stated in Sections 5.1.3.2 and 5.1.3.3.

5.1.4.3. Civil monetary penalties to a limit of fifteen thousand dollars ($15,000.00) for each Client the State determines was not Enrolled because of a discriminatory practice under Section 5.1.3.2., up to a limit of one hundred thousand dollars ($100,000.00).

5.1.4.4. Civil monetary penalties to a limit of twenty-five thousand dollars ($25,000.00), or double the amount of excess charges, whichever is greater, for excess charges under Section 5.1.3.1.

5.1.4.5. Imposition of temporary management, if the Contractor has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act. Temporary management will continue until it has been determined that the Contractor can ensure that the sanctioned behavior will not recur. Enrollees

will be granted the right to terminate Enrollment without cause and notify the affected Enrollees of their right to terminate Enrollment.

5.1.4.6. Allow Members the right to terminate Enrollment without cause with notification to the Members of their right to terminate Enrollment, for each failure to adhere to contract requirements as stated in Section 5.1.3.6.

5.1.4.7. Suspension of all new Enrollments, after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section 5.1.3.6 until the necessary services or corrections in performance are satisfactorily completed as determined by the Department.

5.1.4.8. Suspension of payment for Enrollments after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section 5.1.3.6 until the necessary services or corrections in performance are satisfactorily completed as determined by the Department

5.1.4.8.1. Only the sanctions specified in 5.1.4.6, 5.1.4.7, and 5.1.4.8, of this section may be imposed for failure to meet any of the requirements of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

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

5.1.5. Liquidated Damages

5.1.5.1. Time is of the essence in the performance of this contract. The parties agree that the damages from breach of this contract are difficult to prove or estimate, and the amount of liquidated damages specified herein represents a reasonable estimation of damages that will be suffered by the Department from late performance, including costs of additional inspection and oversight, and lost opportunity for additional efficiencies that would have attended on-time completion of performance. Assessment of liquidated damages shall not be exclusive of or in any way limit remedies available to the Department at law or equity for Contractor's breach of contract.

5.1.5.2. If the Contractor fails to satisfactorily perform the services required under this contract, the Contractor shall, in place of actual damages, pay the Department liquidated damages as follows:

5.1.5.2.1. For each calendar day beyond the date: 1) specified in a corrective action plan approved by the Department by which Contractor compliance is to be achieved; or 2) the date that a corrective action plan is due but not submitted to the Department, the amount of three hundred dollars ($300.00) per calendar day until the compliance is achieved or an acceptable correction action plan is submitted. If the Contractor notifies the Department that it will not be able to achieve compliance by the date specified in the corrective action plan, and explains in writing its reasonable efforts to achieve compliance, the Department may grant in writing an extension of the deadline for Contractor compliance. No more than fifteen thousand dollars ($15,000.00) in such damages for failure

to comply with corrective action plans shall be assessed during any contract year.

5.1.5.2.2. For each calendar day beyond the date that all requested documents, including but not limited to policies, procedures, reports, manuals and handbooks are required to be produced either by the contract or specified in a written request of the Department, the amount of three hundred dollars ($300.00) per calendar day until the documents are produced. A written request of the Department will allow the Contractor a minimum of thirty (30) calendar days to produce documents. No more than fifteen thousand dollars ($15,000.00) in such damages shall be assessed during any contract year. If the Contractor notifies the Department that it will not be able to produce the documents within the specified timeframe and explains its reasonable efforts to produce the documents, if the Department determines, in its sole discretion, that an emergency or unannounced visit is necessary, the said documents shall be produced immediately, or on a schedule determined by the Department. Failure to produce the said documents may result in the assessment of liquidated damages as set forth herein.

5.1.5.2.3. For failure to issue and report notice of action when required by Colorado Code of Regulations (CCR) Section 2505-10, Section 8.209, and federal regulations at 42 CFR § 438.400 and §438.404, a fine of five hundred dollars ($500.00) for each occurrence shall be assessed.

5.1.5.2.4. For failure to process and report grievances when required by C.C.R. 2505-10, Section 8.209 and federal regulations at 42 CFR § 438.400, a fine of one hundred dollars ($100.00) for each occurrence shall be assessed.

5.1.5.2.5. For failure to comply with the Department's request for information, response to site visit requests or other reports by the defined timelines specified in the written request, the Department will assess five hundred dollars ($500.00) for each calendar day for which the request is late.

5.1.5.2.6. All Medical Records shall be produced by the date specified in the Department's (or its designee's) written request, which shall allow a minimum of thirty (30) calendar days for the Contractor to produce the records for Non-emergency reviews. For each record specified in the Department's written request that is not produced within the timeframe specified in the Department's written request or any extensions granted, liquidated damages of three hundred dollars ($300.00) per calendar day may be assessed against the Contractor. No more than fifteen thousand dollars ($15,000.00) in such damages for failure to produce Medical Records shall be assessed during any contract year.

5.1.5.2.6.1. If the Contractor notifies the Department (or designee) that it will not be able to meet the due date for the production of Medical Records, and explains in writing its reasonable efforts to produce the records, the Department may grant an extension of time for production of records in writing. If the Contractor notifies the Department that it cannot produce Medical Records due to the inability or unwillingness of a Participating Provider to produce the records, the Department may require exclusion of that Participating Provider

from the Contractor's Medicaid network. If the Department determines, in its sole discretion, that an emergency review is required, the Contractor shall have five (5) Business Days from the date of the request to produce the Medical Records to the Department. In the case of a Provider site visit, the Contractor shall submit the Medical Records to the Department within two (2) Business Days of the site visit, or on a schedule determined by the Department. Failure to produce the said Medical Records may result in the assessment of liquidated damages as set forth herein.

5.1.5.3. Notwithstanding any other provision of this Section, if the Contractor is provided notice of termination for breach of contractual obligations pursuant to Section 15, Remedies, and the Contractor fails to cure the alleged breached in the time specified, in addition to any other damages that are applicable as the result of the termination, the Contractor shall be liable for three hundred dollars ($300.00) per calendar day from the date set for cure until either the purchasing agency reasonable obtains similar supplies or services. If the Contractor is not terminated for default, liquidated damages shall not be due to the Department. The Contractor will not be required to pay liquidated damages when the delay in performance is beyond the control and without the fault or negligence of the Contractor.

5.1.5.4. If liquidated damages are imposed under this contract, the department may reduce the amount of any payments otherwise due to the Contractor by withholding the amount of such damages. Exercise of any of the remedial actions set forth in this section shall not relieve the Contractor from performance of any of its duties and obligations under this contract.

5.1.5.5. The Contractor will not be required to pay liquidated damages when the delay in performance is beyond the control and without the fault or negligence of the Contractor.

5.1.5.6. The remedies available to the Department set forth above are in addition to all other remedies available to the Department by law or equity, are joint and several and may be exercised concurrently or consecutively. Exercise of any remedy in whole or in part shall not limit the Department in exercising all or part of any remaining remedies. The Department's exercise of any of the remedies set forth in this section shall not excuse the Contractor from performance of its obligations and duties under this Contract.

5.1.5.7. Failure to produce statistically meaningful results for ninety five percent (95%) of CAHPS program survey questions within timelines as described in contract Section 2.7.2.4.2 shall result in liquidated damages of five thousand dollars ($5,000.00). Statistically meaningful results lower than ninety percent (90%) of CAHPS program survey questions within described timelines shall result in liquidated damages of an additional five thousand dollars ($5,000.00) plus one thousand dollars ($1,000.00) per each individual survey question where statistically meaningful results were not reported.

5.2. DISCLOSURES

5.2.1. The Contractor shall disclose the following information as set forth in Exhibit H,

Contractor Disclosure Template, attached and incorporated herein by reference:

5.2.1.1. Contractor shall submit, annually, the names and addresses of each person with an ownership or control interest in Contractor.

5.2.1.2. Contractor shall disclose, annually, the identity of each subcontractor that provides material and significant items or services to Contractor, and where the subcontractor is owned, in whole or in part, directly or indirectly, by any directors, officers, partners, owners, or employees of Contractor. The disclosure must identify the ownership person and contain a description of the magnitude of the beneficial ownership interest. An indirect ownership interest may be established by the ownership of a spouse, parent, child, or sibling of a director, officer, partner, owner or employee of Contractor.

5.2.1.3. Contractor shall disclose, annually, the identity of each subcontractor that provides material and significant items and services to Contractor, and where the subcontractor is controlled, in whole or in part, directly or indirectly, by any directors, officers, partners, owners, or employees of Contractor. The disclosure must identify the person with control and contain a description of the kind of control interest. An indirect control interest may be established by the control exercised by a spouse, parent, child, or sibling of a director, officer, partner, owner or employee of Contractor.

5.2.1.4. Contractor shall disclose, annually, the identity of the directors, officers, partners, owners, employees and contractors who have, and who have not, been surveyed in the prior twelve months about their relationships to individuals who have been disbarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under federal Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. Upon Department request, survey documentation shall be copied and delivered to the Department.

5.2.1.5. Contractor shall disclose, annually, to the Department the identity of any directors, managing employees, officers, partners, owners, employees or contractors who have an Ownership or control interest in Contractor and who have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

5.2.2. Any Contractor that is subject to periodic survey and certification of its compliance with Medicaid standards shall supply the information specified in paragraph 1 above to the Department or its survey agency at the time it is surveyed. The Department or its survey agency shall promptly furnish the information to the Secretary of Health and Human Services and the Department.

5.2.3. Any Contractor that is not subject to periodic survey and certification and has not supplied the information specified in paragraph 1 above to the Secretary of Health and Human Services within the prior 12-month period, shall submit the information to the Department before entering into a contract or agreement with the Department. The

Department shall promptly furnish the information to the Secretary of Health and Human Services.

5.2.4. Updated information shall be furnished to the Secretary of Health and Human Services, the Department or its survey agency at intervals between contract renewals, within thirty-five (35) days of a written request.

5.2.5. Before the Department enters into or renews an agreement, or at any time upon written request by the Department, Contractor shall disclose to the Department the identity of any person who:

5.2.5.1. Has ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor.

5.2.5.2. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

5.2.6. The Contractor shall disclose to the Department certain business transactions to include:

5.2.6.1. Any sale, exchange or lease of any property between the Contractor and a party in interest.

5.2.6.2. Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

5.2.6.3. Any lending of money or other extension of credit between the Contractor and a party in interest.

5.2.6.4. Parties of interest include:

5.2.6.4.1. Any director, officer, partner, or employee responsible for management or administration of Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the Contractor; or, in the case of a Contractor organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law.

5.2.6.4.2. Any organization in which a person described in Section 5.2.6.4.1 is a director, officer or partner; has a direct or indirect beneficial interest of more than five percent (5%) in the equity of the Contractor; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the Contractor.

5.2.6.4.3. Any person directly or indirectly controlling, controlled by, or under common control with a Contractor.

5.2.6.4.4. Any spouse, child, or parent of an individual described in Sections 5.2.6.4.1, 5.2.6.4.2, or 5.2.6.4.3.

EXHIBIT B, RATES

SFY16 DHHA Capitation Rate

Eligibility Category	FINAL SFY16 LB	FINAL SFY16 UB	SFY16 Capitation Rte
AFDC-A-F	$256.59	$282.32	**$263.02**
AFDC-A-M	$168.39	$187.15	**$173.08**
BCKC-A	$667.18	$755.37	**$689.23**
CHILD-C	$85.32	$92.28	**$87.06**
CHILD-U	$243.82	$274.88	**$251.59**
FC	$174.97	$201.93	**$174.97**
OAP-A	$229.78	$274.51	**$240.96**
OAP-B/AND - N	$794.70	$867.88	**$813.00**
OAP-B/AND - T	$104.22	$117.87	**$107.64**
MAGI childless adults (formerly AwDC)	$350.09	$402.38	**$350.09**
AFDC Expansion Adults - F	$176.27	$201.12	**$182.48**
AFDC Expansion Adults - M	$176.48	$203.70	**$183.28**
Delivery	$6,179.04	$6,349.29	**$6,179.04**

EXHIBIT C, SAMPLE OPTION LETTER

Date:	Original Contract Routing # CMS #	Option Letter #	Contract Routing #

1) **OPTIONS:** Choose all applicable options listed in §1 and in §2 and delete the rest.
   - **a.** Option to renew only *(for an additional term)*
   - **b.** Change in the amount of goods within current term
   - **c.** Change in amount of goods in conjunction with renewal for additional term
   - **d.** Level of service change within current term
   - **e.** Level of service change in conjunction with renewal for additional term
   - **f.** Option to initiate next phase of a contract
2) **REQUIRED PROVISIONS**. All Option Letters shall contain the appropriate provisions set forth below:
   - **a. For use with Options 1(a-e):** In accordance with Section(s) of the Original Contract between the State of Colorado, Department of Health Care Policy and Financing **,** and Contractor's Name, the State hereby exercises its option for an additional term beginning Insert start date and ending on Insert ending date at a cost/price specified in Section , AND/OR an increase/decrease in the amount of goods/services at the same rate(s) as specified in Identify the Section, Schedule, Attachment, Exhibit etc.
   - **b. For use with Option 1(f), please use the following:** In accordance with Section(s) of the Original Contract between the State of Colorado, Department of Health Care Policy and Financing **,** and Contractor's Name, the State hereby exercises its option to initiate Phase indicate which Phase: 2, 3, 4, etc for the term beginning Insert start date and ending on Insert ending date at the cost/price specified in Section .
   - **c. For use with all Options 1(a-f):** The amount of the current Fiscal Year contract value is increased/decreased by $ amount of change to a new contract value of Insert New $ Amt to as consideration for services/goods ordered under the contract for the current fiscal year indicate Fiscal Year. The first sentence in Section is hereby modified accordingly. The total contract value including all previous amendments, option letters, etc. is Insert New $ Amt.
3) **Effective Date**. The effective date of this Option Letter is upon approval of the State Controller or , whichever is later.

STATE OF COLORADO
John W. Hickenlooper, GOVERNOR
Department of Health Care Policy and Financing

____
By: Insert Name & Title of Person Signing for Agency or IHE

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: ___________________________________
Insert Name of Agency or IHE Delegate-Please delete if contract will be routed to OSC for approval
Date: ___________________

EXHIBIT D, COVERED SERVICES

DEFINITIONS

Dialysis Treatment Center: A health institution or a department of a licensed hospital, which is planned, organized, operated and maintained to provide outpatient treatment by means of dialysis and/or training for home use of dialysis equipment.

Durable Medical Equipment (DME) means Medically Necessary equipment prescribed by a physician that can withstand repeated use, serves a medical purpose, and is appropriate for use outside of a medical facility.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

Expanded EPSDT shall mean those services that are not provided under Exhibit D but which are Medically Necessary to correct or ameliorate defects and physical or mental illnesses or conditions discovered or shown to have increased in severity by an EPSDT screening. It does not include items or services that the Department determines are not safe and cost effective or which are considered experimental.

Family Planning are services and supplies furnished directly (or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active), which includes physical examinations, diagnosis, treatment, supplies and follow-up.

Medically Necessary, or Medical Necessity, shall be defined as a covered Medicaid service that will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Medical Screening Examination: Screening of sick, wounded, or injured persons in the emergency room to determine whether the person has an Emergency Medical Condition. An appropriate Medical Screening Examination (including ancillary services routinely available to an emergency treatment facility) must be available to any individual who comes to the emergency treatment facility for examination or treatment of a medical condition and on whose behalf the examination or treatment is requested.

Orthotic: An orthopedic appliance used to support, align, prevent or correct deformities or to improve the function of movable parts of the body.

Outpatient Services are those diagnostic, therapeutic, rehabilitative, preventive and palliative items and services furnished by or under the direction of a physician to an eligible person who is an outpatient in a participating hospital that is not providing the patient room and board on a continuous 24-hour basis.

Palliative Services means any medical services recommended by a physician within the scope of his/her practice under state law, for the purpose of affording a recipient relief from the symptoms of a condition or disease.

Poststabilization Care Services means Covered Services, related to an Emergency Medical Condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition, as set forth at 42 CFR §422.113.

Preventive Services: Services provided by a physician within the scope of his/her practice under state law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and, (3) promote physical and mental health and efficiency.

Prosthetic Device: replacement, corrective or supportive devices prescribed by a doctor of medicine or a doctor of osteopathy to:

- Artificially replace a missing portion of the body
- Prevent or correct physical deformity or malfunction
- Support a weak or malformed portion of the body

Rehabilitative Services: Any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

Speech Pathologist: Person specializing in the diagnostic evaluation and treatment of speech and language problems; the planning, directing or conducting of habilitative or rehabilitative treatment programs to restore communicative efficiency of communication problems or organic and non-organic etiology; provision of counseling and guidance for speech and language handicaps.

Telemedicine is defined as the delivery of medical services, and any diagnosis, consultation, treatment, transfer of medical data, or education related to health care services using interactive audio, interactive video, or interactive data communication instead of in-person contact.

Therapeutic Services means any medical service provided by a physician within the scope of his/her practice of medicine under state law, in the treatment of disease.

COVERED SERVICES

With the exception of EPSDT and Preventive Services as specified in this Exhibit, Covered Services and supplies must be Medically Necessary and provided for the diagnosis or treatment of an illness, pregnancy, or accidental injury. A covered person and his or her physician decide which services and supplies are given, but Contractors need only pay for the following Covered Services and supplies.

Abortion
Abortions are a Covered Service only in the following circumstances:

When a physician has found and certified in writing that in his or her professional judgment the life of the mother would be endangered if the fetus were carried to term, when documented in accordance with federal requirements. 42 C.F.R. § 441.203.

NOTE: For the purpose of this section, treatment for the following conditions is not considered to be an abortion:

- Ectopic pregnancies (Pregnancy occurring in other than a normal position or place)
- Miscarriage (spontaneous abortion)

Ambulance Services
Covered ambulance services shall be provided to the nearest appropriate medical facility when any other form of transportation is not medically advisable and when the ambulance service is provided in conjunction with emergency medical care. Such covered ambulance services include the following situations:

- Air ambulance
  Air ambulance services, including rotary- and fixed-wing aircraft, are covered only if the client requires medical attention, the client is transported to the nearest appropriate medical facility, and
  - The point of pickup is inaccessible by land emergency transport vehicles,
  - Great distances or other obstacles are involved in transport to the nearest appropriate facility and prompt admission is essential; or
  - The client is suffering from an illness, injury, or psychiatric condition that makes all other forms of transport inadvisable.
- Emergency Services which, due to the medical or psychiatric condition of the Client, are immediate in nature and cannot be arranged in advance.
- Non-emergency Services that are preplanned but due to the medical or psychiatric condition of the Client are the only mode that can be utilized safely. Must be prior authorized.

If the Client is transported from home to hospital by ambulance for treatment of a condition which a prudent layperson would perceive as an emergency, as defined at 10 CCR 2505-10 Section 8.303, the ambulance shall be reimbursed, even if the healthcare services rendered are subsequently determined to be urgent or non-emergent in nature. 42 C.F.R. 438.114 (c) (1) (ii).

Ambulatory surgical care
The allowable surgical procedures identified for Medicare coverage are reimbursable and covered Medicaid benefits.

Amniocentesis
Amniocentesis performed for medical reasons other than sex determination.

Anesthesia Services
Administration of anesthetics to achieve general, regional or supplementation of local anesthesia related resuscitative and supportive procedures.

Audiology and Speech Pathology

- Audiological services include medical/diagnostic ear testing using recognized diagnostic instrumentation/equipment in a clinical environment to assist or confirm in establishing a diagnosis.
- Speech pathology services include performance of medical/diagnostic procedures including, but not limited to, those communicative problems resulting from medical conditions such as cerebral palsy, cleft palate/lip, or brain dysfunction.

NOTE: The EPSDT benefit covers screening and Medically Necessary ear exams and audiological testing.

Autism
Autism shall be treated as a physical disorder.

Consultation
Covered Services include medical services rendered by a provider whose opinion or advice is requested by a Client's primary care provider or the health plan medical director for further evaluation of an illness or injury. Clients shall be granted a second opinion when requested, subject to referral requirements. Consultations by non-participating providers may be subject to prior authorization.

Detoxification
▪ Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

Dialysis, Hemodialysis or Peritoneal Dialysis
- Coverage includes placement or repair of the dialysis route ("shunt" or "cannula").

The organization providing dialysis shall be responsible for the provision of all supplies and the maintenance of all equipment and necessary fixtures required for home dialysis.

- Inpatient dialysis
  Coverage is provided in those cases where hospitalization is required.

- Outpatient dialysis
  Coverage is provided when provided by a separate unit within a hospital or a freestanding Dialysis Treatment Center. Coverage is provided for any other medical condition for which the Medical Assistance Program provides payment when the eligible recipient receives regular Medically Necessary maintenance treatment on an outpatient dialysis program.

- Home dialysis
  The participating separate dialysis unit within a hospital or free-standing Dialysis Treatment Center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.

Durable Medical Equipment and Disposable Supplies
The following Durable Medical Equipment (DME) and supplies are Medicaid benefits for clients of all ages if Medical Necessity has been established and use outside of a medical facility is considered appropriate. DME shall be covered as described at 10 CCR 2505-10, Section 8.590.

- Ambulation devices & accessories (canes, crutches, walkers),
- Bath and bathroom equipment,
- Bed and bedroom equipment and accessories, including specialized beds and mattress overlays,
- Manual or power wheelchairs, seating system orthosis used for wheelchair positioning,
- Diabetic monitoring equipment and related disposable supplies,
- Elastic supports/stockings,
- Monitoring equipment and supplies,
- Oxygen Equipment for home use, including nursing facility residents, See Exclusions
- Transcutaneous and/or neuromuscular electrical nerve stimulators (tens) and related supplies
- Trapeze/traction/fracture frames,
- Lymphedema pumps/compressors,
- Rehabilitation equipment (specialized use),
- Enteral formulas and supplies,
- Parenteral equipment and supplies, and
- Repairs and extensive maintenance as needed to keep the DME item functional.

The contractor shall provide an adequate number of disposable supplies when used in connection with approved DME and/or when related to one of the following categories:

- Surgical, wound and burn care,
- Syringes/needles,
- Bowel and bladder care,
- Antiseptics/solutions,
- Gastric feeding sets and supplies,
- Tracheostomy and endotracheal care supplies, or
- Diabetic monitoring.

Covered Services include the rental or purchase of DME and supplies including repair, maintenance and delivery. The Contractor is only required to provide DME that is covered by Medicaid, but may provide other DME when medically appropriate. Preference should be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the equipment will be operated. Coverage in a particular case is subject to the requirement that the equipment be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. DME and supplies may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.

Medicaid clients for whom wheelchairs, wheelchair component parts, and other specialized equipment were authorized and ordered prior to enrollment in the Contractor's plan, but for which delivery is delayed until after the HMO enrollment period begins, shall have those services provided by the Medicaid Program. The Contractor shall reimburse services approved and ordered by the Contractor providing the client remains Medicaid eligible, regardless of whether enrollment in the Plan continues. All other DME and disposable supplies approved by the Contractor shall be the responsibility of the Contractor.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Benefits

The Contractor must meet all state and federal requirements for EPSDT benefits under 42 C.F.R. Sections 441.50 through 441.61 and 10 C.C.R. 2505-10, Section 8.280. EPSDT services include comprehensive well child examinations, immunizations, assessment, diagnosis and treatment necessary to correct or ameliorate conditions, defects and illnesses discovered by EPSDT screening to all covered persons through the age of 20. EPSDT services also include provision benefit information, scheduling assistance and case management.

Information about EPSDT benefits must be provided to clients and parents, to include:

- Information about the periodicity table,
- Scheduling and transportation to make EPSDT appointments, and
- Information about the full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid.

Additionally, maintenance of a coordinated system to follow the client through the entire range of screening and treatment (case management) and coordination with other providers to ensure that clients receive Covered Services, must be provided.

Emergency Services

Emergency Services means covered inpatient and Outpatient Services that are as follows:

(1) Furnished by a provider that is qualified to furnish these services under this contract; and

- (2) Needed to evaluate or stabilize an Emergency Medical Condition.
- Emergency services are exempt from Primary Care Provider referral.

- **Family Planning Services**

Family Planning counseling, examination, treatment and follow-up; information on birth control (including insertion and removal of approved contraceptive devices); measurement for contraceptive diaphragms; and male/female surgical sterilization (see Surgical Services, Sterilization) is included even if the Member goes out of network. The fees are included in the rates. Contractor shall reimburse out-of-network family planning services at a rate equal to or better than fee-for-service reimbursement rates, or Contractor's internal reimbursement rates, whichever is higher. No referral is required.

Federally Qualified Health Care (FQHC)

Core services are provided in outpatient settings only, including a patient's place of residence. Core services means covered Outpatient Services that may include:

- Physician services;
- Physician assistant services;
- Nurse practitioner services;
- Nurse midwife services;
- Licensed psychologist services;
- Licensed social worker services;
- Pneumococcal and influenza vaccines and administration;
- Services and supplies incident to health professional services;
- Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area that is determined to have a shortage of home health agencies; and
- Any other reimbursable ambulatory services offered by the FQHC that are covered by the State

Plan.

Notwithstanding a BHO primary diagnosis, services provided to Members by a physician (not a mental health practitioner) are covered (and have been included in the rates). The BHO diagnosis code is attached as Exhibit I.

- **Home Health Services**

Acute Home Health and Long Term with Acute Episode Home Health services provided pursuant to 10 CCR 2505-10 8.520.K.3.b are Covered services. Long Term Home Health is excluded.

Services provided by other kinds of providers (i.e. other than a Medicaid-certified Home Health agency) to Members in their own homes are also Covered Services and are included in the capitation rates. These kinds of Covered Services include:

- Professional services of an RN, LPN or LVN on an intermittent basis
- Home health aide services for purposes of providing skilled personal care, in conjunction with a nurse or therapist and under the supervision of a nurse or therapist
- Physical evaluations and therapy, and speech/hearing evaluations and therapy, by licensed therapists
- Medical/surgical supplies delivered to the Member's home (e.g. DME, prosthetics, disposable supplies), but not other Wrap Around services (e.g. Oxygen)
- Services provided when the Member's medical condition requires teaching (e.g. self-care management training), which is most effectively accomplished in the Client's home on a short-term basis
- Developmental therapies and EPSDT screenings (e.g. Neuromuscular reeducation, Sensory integration, Cognitive skills development)

Nurse Home Visitor Program services provided in the Member's home are Wrap Around services. These services are billed on the 1500 claim form using CPT codes G9006 or T1017.

Imaging (Radiology or X-ray Services) Services authorized by a licensed physician.

- Services performed to diagnose conditions and illnesses with specific symptoms.
- Services are performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.
- Routine mammograms as described under Preventative Care Services.

Inpatient Hospital

Hospital services are a benefit of the Medicaid Program and include those items and services that are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a physician.

- Semi-Private Room and Board
- Private rooms must be covered:
    - When Medically Necessary
    - When furnished by the hospital as the only accommodation
    - If the hospital has no semi-private room available. Patient must be moved to a semi-private room as soon as available.

- Delivery and labor rooms, anesthesia, and equipment.
  - Limitations for a hospital stay following a normal vaginal delivery may be limited after 48 hours post delivery.
  - Limitations for a hospital stay following a cesarean delivery may be limited after 96 hours post delivery.
- All other Medically Necessary services and supplies during the inpatient hospital stay including pharmacy, therapies, blood and blood products, anesthetics, Durable Medical Equipment (DME) and specialty care services.
- Discharge oxygen
- Routine Newborn care is limited to period of time that the mother remains hospitalized. Inpatient newborn care following the mother's discharge is a covered benefit only when the child's medical condition necessitates ongoing inpatient care.
- Inpatient substance abuse rehabilitation DRG 936 is a wrap around. See Wrap Around Benefits Section.

Laboratory (clinical/pathological) Services authorized by a licensed physician.
- Services performed to diagnose conditions and illnesses with specific symptoms.
- Services performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.
- Services performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

- LIMITATIONS
- Collection, handling, and/or conveyance of specimens for transfer from the patient's home, a nursing home or a facility other than the physician's office or place of practice is a benefit only if the patient is homebound, bedfast, or otherwise non-ambulatory. However, when a specimen of this type could be reasonably mailed, the pickup is no longer considered Medically Necessary and therefore is non-reimbursable. The physician may be required to certify the Medical Necessity for the pick-up. Transfer of a specimen from one certified independent clinical laboratory to another is a benefit and reimbursable to the first certified laboratory only if the laboratory's equipment is not functioning or the laboratory is not certified to perform the tests ordered by the physician.

Medical Services

For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File as published in Provider bulletins or available on disc shall be considered the prevailing guide. The following is a general overview of such services.

- Direct physical examination of the patient's body and/or mental or cognitive status.
-
- Examination of some aspect of the patient's condition by means of radiological, non-radiological diagnostic imaging, pathology, laboratory or electronic monitoring procedures.

- Procedures for prescribing, administering, directing or supervising medical treatment.

- Manual manipulation. Department guidelines, which include manipulation by osteopathic physicians only, may be applied by the Plan.

- Diagnosis and treatment of eye disease or injury.

- Administration of injectables and allergens.

- Counseling: Diet and/or nutritional counseling when the diagnosis indicates or includes a clinical problem that is or could be impacted by obesity.

- Treatment for ear or hearing problems.

Newborn Hospitalization
Newborn hospitalizations shall extend only for the period of the mother's hospitalization unless Medical Necessity exists for the infant to remain hospitalized. When Medical Necessity for the infant to remain hospitalized exists, the additional days shall be covered.

Occupational/Physical Therapy
A physician may prescribe occupational or physical therapy for clients when Medically Necessary.

Outpatient Services
Covered Services include diagnostic, Therapeutic, Rehabilitative, Preventive, and Palliative Services furnished by or under the direction of a physician.

Outpatient Rehabilitation Services
Covered Services include speech therapy, occupational therapy, physical therapy, pulmonary therapy and cardiac rehabilitation when ordered by the Covered Person's Primary Care or Referring Physician.
All Medically Necessary care and treatment of conditions discovered as a result of EPSDT medical screenings, including habilitation secondary to birth injury or developmental delay and rehabilitation services following illness or injury, shall be provided to Clients covered by the EPSDT Program.

Oxygen and Oxygen Equipment

Oxygen generating equipment prescribed for use in any inpatient setting, or as discharge oxygen, is a covered service if inpatient services are included within the scope of this contract.

Oxygen in canisters, whether in gaseous of liquid form, prescribed for use in any inpatient setting is a covered service if inpatient services are included within the scope of this contract. Contractor is responsible for nursing facility charges. All other prescribed uses of oxygen in canisters, whether in gaseous or liquid form, are covered wrap-around services paid by the Department through fee-for-service reimbursement. See Exclusions for portable and liquid oxygen.

Physical examinations
Physical examinations for the purpose of:

- Diagnostic evaluation of disease, and
- Admission or placement in skilled nursing home care, intermediate nursing home care, residential care, or early and periodic screening, diagnosis and treatment.

Physical/Occupational Therapy
Occupational or physical therapy for clients when Medically Necessary and ordered by a physician.

Physician Services

- Age 65 and over: All Medically Necessary services.
- Under the age of 65: the following scope and range of benefits when Medically Necessary:
- Inpatient hospital services
- Inpatient surgery
- Outpatient surgery
- Outpatient diagnostic services
- Physician services provided to residents in a skilled nursing facility
- Home and physician office calls
- Family Planning is considered in the same manner as for any other medical visit. Services provided in connection with medication and devices to be employed are supplied for the purpose of Family Planning, depending on the preference of the individual recipient/patient. See Family Planning under Covered Services.
- Dental care is a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones, including dental splints or other devices. With respect to these services, a doctor of dental surgery or dental medicine, appropriately licensed, is classified as a physician and entitled to payment.
- Foot care services
- Vision care services are included as benefits in accordance with the following general policies:
  - Services performed within the scope of the Medical and Optometrist Practice Acts
  - Services for the provision of eyeglasses and contact lenses following eye surgery.
  - Corneal transplants
- Services in regard to laboratory testing in accordance with the Imaging and Laboratory sections of this exhibit
- Immunizations

Podiatry

- Foot care services are included as a benefit in the Medical Assistance Program whether provided by a physician or licensed podiatrist.

Prescription Drugs

The Contractor is responsible for prescription drugs.

Preventive Medicine

Examinations for the purpose of diagnosis and treatment of existing illness or injury are not included in this section. The client and the primary care physician will determine exam periodicity for members with a disability.

- Physical exams
  - Under age 21, see Early Periodic Screening, Diagnosis and Treatment (EPSDT)
  - Age 21 - 35, at least once every 5 years but not more than once a year
  - Age 36 - 50, at least once every 2 years but not more than once a year
  - Over age 50, once every 12 months
- Women's health
  - Routine yearly breast and pelvic examination with PAP smear, hematocrit and urinalysis
  - Routine mammograms as required by statute (Section 10-16-104 C.R.S.): a single baseline mammogram for women from age 35 to 39; at least once every two contract years for women from age 40 to 49, except women with risk factors to breast cancer, as determined

by the primary care physician, shall be at least once per year; and at least once per contract year for women age 50 to 65 years.

- Men's Health
  - Age 40 to 50 in high-risk categories (as determined by the primary care physician), in accordance with statute (Section 10-16-104 C.R.S.)
  - Age 50 years and older, screening for early detection of prostate cancer at least once per year.
  - Health education services
  - Instruction in personal health care measures, including those appropriate for clients with disabilities;
  - Instruction for a designated client representative, when the client is unable to receive or understand such services due to a disability;
  - Information about services, including recommendations on generally accepted medical standards for use and frequency of such service.

Prosthetics and Orthotics

- The following Prosthetic Devices and Orthotics, including but not limited to the following list, are Medicaid benefits for clients of all ages if Medical Necessity has been established and use in the home setting has been determined to be appropriate. Medical Necessity shall be determined based on criteria established by the Department, and in accordance with 10 CCR 2505-10, Section 8.590.2A:
  - Ankle-foot/knee-ankle-foot Orthotics
  - Artificial limbs
  - Augmentative communication devices and communication boards
  - Colostomy (and other ostomy) bags and necessary accouterments required for attachment, including irrigation and flushing equipment and other items/supplies directly related to ostomy care
  - Facial prosthetics
  - Lumbar-sacral orthoses (LSO)
  - Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements when an integral part of a leg or ankle brace
  - Recumbent ankle positioning splints
  - Rigid and semi-rigid braces
  - Specialized eating utensils and other Medically Necessary activities of daily living aids; and
  - Therapeutic shoes
  - Thoracic-lumbar-sacral orthoses (TLSO)

Covered Services include the rental or purchase of Prosthetic Devices and supplies including repair, maintenance and delivery. Preference will be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the devices will be operated. Coverage in a particular case is subject to the requirement that the devices be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. Prosthetic Devices may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.

Radiology – see Imaging

Radiation Therapy

Rural Health Clinics (RHC)

- All of the following are benefits of the program when provided by a rural health clinic that has been certified in accordance with 10 CCR 2505-10 8.740 insofar as these services provided are otherwise reimbursable under the Program.
- A. Services furnished by a physician.
- B. Services furnished by a physician assistant, nurse practitioner, or nurse midwife, under the medical supervision of a physician.
- C. Services and supplies that are furnished as an incident to professional services under (A) and (B) above.
- D. Part-time or intermittent visiting nurse care and related medical supplies (other than pharmaceuticals).
- E. Other ambulatory service that are otherwise a benefit of the program that meets specific programmatic requirements for the furnishing of that service. Such services are not subject to physician supervision requirements unless such supervision is generally required for such services under the Medicaid program.
- F. EPSDT services furnished by a rural health clinic that are not part of rural health clinic services. Such services may be provided only if the clinic meets any supervision or other requirements for EPSDT that are generally applicable wherever these services are furnished.

Speech Pathology (see Audiology and Speech Pathology)

- **Substance Abuse**
- Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

Surgical Services

For specific procedures and indications of basic Medicaid coverage, the Medicaid Master Procedure File shall be considered the prevailing guide.

- Reconstructive surgery
  - Medically Necessary reconstructive plastic surgery or surgery to correct disfigurement resulting from trauma or affecting function, regardless of when the injury, illness or defect occurred; or
  - Reconstructive services following mastectomy, subject to prior approval.

- Male genital system

- Female genital system

- Oral Surgical Services (limited to treat certain conditions, as follows):
  - Accidental injury to jawbones or surrounding tissues;
  - Correction of non-dental pathophysiological condition which has resulted in a severe functional impairment, including temporomandibular disorder; or
  - Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, floor of mouth.

- Sterilization
  Stipulations: In order to receive sterilization services, the following criteria must be met:
  - The client must be at least 21 years of age;
  - The client may not be currently institutionalized for the care and treatment of mental illness;
  - He or she must be mentally competent;
  - The MED 178 consent form, as utilized by the Medicaid Program, must be properly signed at least 30 but no more than 180 days prior to performance of the procedure. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and (1) in the case of premature delivery, must state the expected date of delivery; or (2) in the case of abdominal surgery, must describe the emergency.

Tobacco Cessation
Includes all FDA approved prescription medications and over the counter tobacco cessation products for a maximum of two 90-day sessions in a 12-month period, commencing upon beginning the first session. Tobacco Cessation benefit does not include any group or individual counseling services. Group or individual counseling services and all FDA approved prescription medications and over the counter tobacco cessation products related to Tobacco Cessation are available for all Medicaid members as a wrap-around benefit.

Telemedicine
- No Medicaid managed care organization, on or after January 1, 2002, may require face-to-face contact between a provider and a client for services appropriately provided through Telemedicine if the client resides in a county with a population with one hundred fifty thousand residents or fewer and if the county has the technology necessary for the provision of Telemedicine. The use of Telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance.
-
- Any health benefits provided through Telemedicine shall meet the same standard of care as in-person care.

Transplant Services
Includes services received in connection with bone, bone marrow/stem cell, cornea, heart, lung, heart-lung, kidney, liver (including living donor or partial liver), pancreas after kidney, simultaneous pancreas-kidney, skin:
- Charges for retrieval or harvest of donor organs or bone marrow, if not provided by any other health care program or insurance, including any necessary compatibility testing and donor search.
- Living donor transplant: Contractor is required to cover services to donor for costs directly related to the transplant. Services required due to complications or non-related care will be the responsibility of the donor's carrier.
- Immunosuppressive drugs as supportive therapy for the transplant.

Vision Services
Under age 21, see EPSDT.

Age 21 and over: Clients with certain medical conditions and/or disabilities such as diabetes, retinal dysplasia or glaucoma may require more frequent exams, which shall be determined by the primary care physician.

- Eye exams
  - One refraction once during any 24 month period for adults age 21 to 47;
  - One refraction each 12 months for adults age 48 or older;
- Vision correction: one pair of corrective lenses and no less than the Medicaid allowable contribution for frames ordered as a result of the covered examinations.

NOTE: The Contractor may require completion of six (6) continuous months of enrollment before providing vision benefits for adults age 21 years and older.

EXCLUSIONS: The following services are excluded from coverage:

Acupuncture

Air ambulance services when a Client could be safely transported by ground ambulance or by means other than ambulance.

Ambulatory surgical procedures not listed on the state approved list.

Ambulance services when a Client could be safely transported by means other than ambulance.

Audiology and Speech Pathology: With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids are not covered under this contract but may be provided to children under the age of 21 through the Health Care Program for Children with Special Needs. Simple articulation or academic difficulties that are not medical or surgical in origin are also excluded.

Autopsy charges

Biofeedback, stress management, behavioral testing and training, and counseling for sexual dysfunction.

Behavioral Health inpatient or outpatient psychiatric or psychological care that is a benefit of the Mental Health Capitation Program (MHCP). Exhibit I lists all of the contractor covered behavioral health procedure codes.

Chiropractic services unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.

Cosmetic Procedures or corrective plastic surgery performed solely to improve appearance. Cosmetic surgery exclusions include, but are not limited to, surgery for sagging or extra skin, any augmentation procedures, rhinoplasty and associated surgery, and any procedures utilizing an implant which does not alter physiologic functions, unless Medically Necessary and/or to correct disfigurement.

Counseling for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders or chronic situational reactions.

Dental services:

- Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.
- For adults, surgical correction of malocclusion, maxillofacial orthognathic surgery, oral surgery (except as otherwise provided under the Surgical Services), orthodontia treatment and procedures involving osteotomy of the jaw including hospital outpatient or ambulatory, anesthesia and related costs resulting from the services when determined by the Contractor to relate to a dental condition.

Durable Medical Equipment to include wheelchair lifts for vans or automobiles, hot tubs, Jacuzzis, exercise bikes or equipment, treadmills, stair glides, ramps for use with vehicles or homes, memberships in health clubs, or fees for swimming or other exercise or activities.

EPSDT services not provided under this contract are:

- Hearing aids and auditory training.
- Psychiatric/psychological care that is included and covered through the Mental Health Capitation Program. Community Mental Health Centers formally known as Mental Health Assessment and Service Agencies (MHASAs) are required to cover diagnoses and services as described at 10 CCR 2505-10 §8.212.
- Services that are experimental, not safe or cost effective, or services provided for the convenience of the caregiver need not be covered.
- Expanded EPSDT services.

Experimental or investigational services or pharmaceuticals.

Government-sponsored care

- Items and services provided by federal programs, such as a Veteran's Hospital.
- Services provided in facilities that serve a specific population, such as prisoners.
- Care for conditions that federal, state, or local laws require to be treated in a public facility.
- Services for which treatment is provided under any government law now existing or subsequently enacted or amended, including but not limited to Workmen's Compensation Act, Employer Liability Law or Colorado "No-Fault" automobile insurance.

Fertility procedures or services that render the capability to produce children, except when that capability is a side effect of Medically Necessary surgery for another purpose/diagnosis.

FQHC Services: Inpatient hospital stays are not covered under FQHC Services but may be a benefit under Inpatient Hospital Care.

- **HCBS Services**. Includes wrap around services such as case management (for Model 200 children), home modification, electronic monitoring, personal care, non-medical transportation & all other waiver services.

- **Hearing Aids** - With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution

of a hearing device are not covered. Hearing aids, repairs and batteries are not covered under this contract but may be provided to children under the age of 21 as a Wrap Around Benefit. Simple articulation or academic difficulties that are not medical or surgical in origin are not covered under this contract

High colonics

Holistic or homeopathic care including drugs and ecological or environmental medicine.

Home delivery: Services associated with non-emergent home delivery, unless prior authorized by the Contractor are excluded.

Home Health Services: Services provided specifically as benefits of the Home and Community Based Services Programs (HCBS), which include unskilled personal care, home modification, electronic monitoring, adult day services, alternative care facility services, homemaker services and respite care are not included under this Contract.

Long Term Home as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.

Home Health Services provided by a person who ordinarily resides in the Client's home or is an immediate family member are not covered.

Hospice services. Clients need not be disenrolled from their HMO to receive hospice services, but may continue to get care not related to the terminal illness from the HMO. Clients may request disenrollment.

Hospital back up level of care. Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470 is excluded.

Hypnosis

Immunizations related to foreign travel.

Imaging (Radiology or X-ray) Services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

Infertility treatment, including but not limited to embryo transplants, in vitro fertilization, and low tubal transfers, gamete interfallopian tube transfer and zygote interfallopian tube transfer.

Inpatient or residential rehabilitation for substance or alcohol abuse.

Inpatient hospital excluded services include:
- Psychiatric/psychological care included and covered through the Mental Health Capitation Program.
- Discharge medications and experimental drugs.
- Inpatient hospital services defined as experimental by the Medicare program.

- For Medicaid approved benefits, Medicare patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities.
- Inpatient substance abuse rehabilitation DRG 936 is a wrap-around. See Wrap Around Benefits.

Institutional care when provided for the primary purpose of controlling or changing Client's environment, or if custodial care, domiciliary care, convalescent care (other than extended care) respite care, rest cures or hospice care.

Isometric exercise

Expenses for medical reports, including presentation and preparation.

Laboratory services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

Long Term Home Health as defined at 10 CCR 2505-10, Sections 8.520 is excluded.

Newborn hospitalizations: Continued stay of healthy newborns for any other reason after the mother's discharge is not a benefit under the medical assistance program.

Portable and liquid oxygen is now carved out of the rates. Procedure codes and descriptions are listed below:

PROC_CD	Description
A4617	Mouth piece
E1340	Use K0739 or K0740 after 7/31/09
S8121	O2 contents liquid lb
A4619	Face tent
E0425	Gas system stationary compre
E0441	Oxygen contents, gaseous
E0550	Humidif extens supple w ippb
E1353	Oxygen supplies regulator
E0444	Portable 02 contents, liquid
E1392	Portable oxygen concentrator, rental
K0738	Portable gas oxygen system
E0434	Portable liquid 02
E0439	Stationary liquid 02
E1405	O2/water vapor enrich w/heat
E1406	O2/water vapor enrich w/o he
S8120	O2 contents gas cubic ft
A7046	Repl water chamber, PAP dev
E0430	Oxygen system gas portable
E0435	Oxygen system liquid portabl
E0443	Portable 02 contents, gas
E1355	Oxygen supplies stand/rack
A4615	Cannula nasal
A4616	Tubing (oxygen) per foot
E0455	Oxygen tent excl croup/ped t

E1390	Oxygen concentrator
A4483	Moisture exchanger
A4620	Variable concentration mask
E0424	Stationary compressed gas 02
E0431	Portable gaseous 02
E0440	Oxygen system liquid station
E0442	Oxygen contents, liquid
E1391	Oxygen concentrator, dual
E1354	Wheeled oxygen cart

Paternity Testing. Such services shall be reimbursed by the Medicaid Program and recouped through the court system.

Personal comfort or convenience items. Includes items such as hospital television, telephone, private room (except as Medically Necessary), modifications and alterations in homes, vehicles, or place of residence.

Physical examinations of the following nature are excluded:

- Examinations required by the county departments for the purpose of qualifying applicants for assistance or for the re-certification of recipients for assistance in the following categories: AND, AB, AFDC, or placement of children in Foster Care.

- Physical examinations for employment, licensing, marriage, insurance, school, camp, sports, or adoption purposes or requests by any institution, agency, or person other than the recipient's county department or the state department. Examination or treatment ordered by a court except when such treatment may be Medically Necessary and is provided by a network provider and/or authorized by the primary care physician.

Private Duty Nursing (PDN). Private duty nursing services are a Wrap Around Benefit.

Psychiatric/psychological care as follows:

- Milieu therapy
- Play therapy
- Day care
- Electroshock treatment rehabilitation
- Night care
- Family therapy
- Biofeedback

Reversal of surgically performed sterilization or subsequent re-sterilization.

Procedures, services and supplies relating to **sex change** or transformation.

Skilled Nursing Facility Services are a Wrap Around Benefit.

Substance or alcohol abuse, inpatient or residential rehabilitation.

- **Surrogate Mother Services** or supplies received in connection with a Client acting as or utilizing the services of a surrogate mother.

- **Transportation, non-emergent,** to medical appointments. This is a Medicaid benefit provided through the client's local county Department of Social Services, for the purpose of receiving covered medical services.

Travel, whether or not recommended or prescribed by a Physician or other medical practitioner.

Vision correction procedures for the purpose of vision correction that can be treated by corrective lenses, such as refractive keratoplasty, or radial and laser keratotomies.

Wrap Around Benefits are services that are Medicaid benefits not paid by the HMO. Wrap Around Benefits are paid for by the State of Colorado Medicaid program on a fee for service basis upon determination of Medical Necessity. Wrap-around services include, but may not be limited to the following:

- Auditory Services for children. HMO Covered Services include screening and Medically Necessary ear exams and audiological testing. Wrap Around Benefits include hearing aids, auditory training, audiological assessment and hearing evaluation.
- Comprehensive dental assessment, care and treatment for children.
- Dental services for adults are limited to emergency services and minimal Medically Necessary dental services for adults with concurrent medical conditions.
- Drug/Alcohol Treatment for pregnant women, to include assessment and treatment, is covered through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only.
- Extraordinary Home Health Services – Expanded EPSDT benefit which includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child's place of residence.
- HCBS Services including case management (for Model 200 children); home modification, electronic monitoring, personal care and non-medical transportation.
- Hospice services, however client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested.
- Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470.
- Inpatient substance abuse rehabilitation DRG 936 (Valley View).
- Intestinal Transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (i.e., liver); coordinated by Department & HMO Case Manager; provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai.
- Non-emergency transportation to medical appointments for Covered Services only, through the client's county of residence.
- Private Duty Nursing (PDN), nursing services only.
- Skilled Nursing Facility Services (skilled nursing and rehabilitation services) if client meets level of care certification. Wrap-around skilled nursing facility services include those services set forth at 10 CCR 2505-10, Section 8.440.1, notwithstanding the list of Covered Services set forth above. Wrap-around skilled nursing facility services also include any Medicare cross-over benefits.

EXHIBIT E, DISPROPORTIONATE SHARE AND GRADUATE MEDICAL EDUCATION HOSPITAL REPORTING BY CALENDAR YEAR QUARTER

Managed Care Contractor Name: ____

Quarter No.: ________ Calendar Year: ________

HOSPITAL	TOTAL MEDICAID DAYS (See Note Below)	TOTAL MEDICAID OUTPATIENT CHARGES (See Note Below)	# of Discharges
TOTAL			

NOTE: Medicaid needs hospital days and outpatient hospital charges for determining which hospitals are disproportionate share hospitals and to calculate the graduate medical education reimbursement rate per day. This form should be itemized by hospital and the days should include newborns as defined in Medicaid HEDIS, December 1995, National Committee for Quality Assurance, page 60. Outpatient hospital charges should include the charges for all services covered by your managed care organization for dates of service during the applicable quarter. The Department will consult with Contractors to develop any other specifications and formats required to appropriately calculate disproportionate share and graduate medical education payments.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
DUE:	July 31, ______	October 31, ______	January 31, ______	April 30, ______

SEND TO: Facility Rates Section, Colorado Department of Health Care Policy & Financing
1575 Sherman Street, 5th Floor, Denver, Colorado 80203-1714

EXHIBIT F, MEMBER HANDBOOK REQUIREMENTS

To inform Members of their rights and responsibilities, the Contractor shall publish and distribute to all Members a Member Handbook that shall include but is not limited to the following information:

1. A complete statement of Member rights and responsibilities as specified in 10 CCR 2505-10.8.205.3;

2. Covered Services and any additional benefits and services offered by the Contractor;

3. Excluded or non-covered services;

4. Information about the Contractor's standards for the availability and accessibility of services including points of access for primary care, specialty, Hospital, and other services and how to request accommodations for Special Needs, including materials in alternative formats;

5. Hours of service;

6. Location of facilities/offices;

7. Appropriate use of and procedures for obtaining after hours care and Emergency Care within the service area;

8. Appropriate use of and procedures for obtaining after hours care and Emergency Care when out of the service area;

9. Instructions about accessing urgently needed services;

10. The phone number that can be used for assistance in obtaining Emergency Care, including the 9-1-1 number if that number is operable within the service area;

11. Enrollment procedures of the Contractor, including how to change Primary Care Providers, and disenrollment information as required in Section 4.0. of the Contract to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so and members are informed about how to access the Department concerning disenrollment;

12. Complaint form;

13. Maximum number of days between appointment request and actual visit with appropriate Provider, as follows:

a. Non-urgent health care and adult, non-symptomatic well care physical examinations scheduled within thirty (30) days.

b. Urgently Needed Services provided within forty eight (48) hours of notification of the Primary Care Provider or Contractor.

14. Policies on referrals for specialty care;

15. Informal and formal procedures and timeframes to voice a complaint, file a grievance or obtain a fair hearing related to coverage, benefits, or any aspect of the Member's relationships to the Contractor through both the Contractor's internal grievance process and the Department's or the State's external process(es) to include:
    a. The requirements and timeframes for filing a grievance or appeal.
        1) The availability of assistance in the filing process.
        2) The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone.
        3) The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing; and the fact that the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
        4) Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.
    b. For State fair hearing:
        1) The right to hearing;
        2) The method for obtaining a hearing; and
        3) The rules that govern representation at the hearing.
    c. Additional information that is available upon request, including the following:
        1) Information on the structure and operation of the MCO.
        2) Physician incentive plans as set forth in §II.G.3.A.

16. Information about the Contractor's Utilization Management program and how it is used to determine Medical Necessity of services. Information shall include: appropriate points of contact with the Utilization Management program; contact persons or phone numbers for information or questions; and information about how to initiate appeals related to utilization management decisions;

17. EPSDT services;

18. Family planning policies;

19. Procedures for obtaining the names, qualifications, and titles of professionals providing and/or responsible for members' care;

20. Circumstances under which Members may have to pay for care;

21. Procedures for arranging transportation;

22. How Members will be notified of any change in benefits, services, or service delivery offices/sites;

23. Information regarding the Member's right to formulate Advanced Directives, according to applicable statutes and regulations and the Contractor's policies respecting the implementation of such rights;

24. How to request information about the Contractor's Quality Management and Improvement program;

25. How to obtain information regarding the Contractor's Participating Providers who serve members. The information shall include the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals;

26. Information regarding Member participation on the Contractor's consumer advisory committee, and notification of right to attend meetings of the committee. Such information shall include telephone contact number;

27. Information concerning a Member's responsibility for providing the Contractor with written notice to the Contractor after filing a claim or action against a third party responsible for illness or injury to the Member;

28. Information concerning a member's responsibility for following any protocols of a liable third party payor prior to receiving non-emergency services; and

29. Information on restrictions, if any, on the enrollee's freedom of choice among network providers.

EXHIBIT G, REQUIREMENTS FOR PHYSICIAN INCENTIVE PLANS

I. Definitions.

Bonus means a payment made to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

Capitation means a set dollar payment per patient per unit of time (usually per month) paid to a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Physician group means a partnership, association, corporation, individual practice association, or other group of physicians that distributes income from the practice among members. An individual practice association is defined as a physician group for this section only if it is composed of individual physicians and has no subcontracts with physician groups.

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 plan enrollee.

Potential payments means the maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction or committee participation, are not considered payments in the determination of substantial financial risk.

Referral services means any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish directly.

Risk threshold means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk.

Substantial financial risk means risk for referral services that exceeds the risk threshold.

Withhold means a percentage of payments or set dollar amounts deducted from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

II. Applicability. The requirements in this section apply to a Contractor and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting

arrangements may include an intermediate entity, which includes but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group such as those specified in Sec. 422.4.

III. Basic requirements. Any physician incentive plan operated by a Contractor must meet the following requirements:

A. The Contractor makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

B. If the physician incentive plan places a physician or physician group at substantial financial risk as determined under paragraph IV, for services that the physician or physician group does not furnish itself, the Contractor must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph IV.F of this section.

C. For all physician incentive plans, the Contractor provides to the Department the information specified in Sec. 422.210.

IV. Determination of substantial financial risk.

A. Basis. Substantial financial risk occurs when risk is based on the use or costs of referral services, and that risk exceeds the risk threshold. Payments based on other factors, such as quality of care furnished, are not considered in this determination.

B. Risk threshold. The risk threshold is 25 percent of potential payments.

C. Arrangements that cause substantial financial risk. The following incentive arrangements cause substantial financial risk within the meaning of this section, if the physician's or physician group's patient panel size is not greater than 25,000 patients, as shown in the table below.

1. Withholds greater than 25 percent of potential payments.

2. Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

3. Bonuses that are greater than 33 percent of potential payments minus the bonus.

4. Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a

particular withhold percentage may be calculated using the formula-- Withhold % = -0.75 (Bonus %) +25%.

5. Capitation arrangements, if:

   a) The difference between the maximum potential payments and the minimum potential payments is more than 25 percent of the maximum potential payments;

   b) The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.

6. Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

E. Stop-loss protection requirements.

1. Basic rule. The Contractor must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements.

2. Specific requirements.

   a) Aggregate stop-loss protection must cover 90 percent of the costs of referral services that exceed 25 percent of potential payments.

   b) For per-patient stop-loss protection if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size of the patient panel and may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled in accordance with paragraph IV.G of this section.

   c) Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient deductible limit. The per-patient stop-loss deductible limits are as follows:

Panel size	Single Combined limit	Separate Institutional limit	Separate Professional limit
1-1000	$6000	$10,000	$3000
1,001-5000	30,000	40,000	10,000
5,001-8,000	40,000	60,000	15,000
8,001-10,000	75,000	100,000	20,000
10,001-25,000	150,000	200,000	25,000
>25,000	None	None	None

F. Pooling of patients. Any entity that meets the pooling conditions of this section may pool commercial and Medicaid members or the members of several Contractors with which a physician or physician group has contracts. The conditions for pooling are as follows:

1. It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group.

2. The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled.

3. The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled.

4. The distribution of payments to physicians from the risk pool is not calculated separately by patient category.

5. The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

G. Periodic surveys of current and former members. A Contractor must conduct periodic surveys of current and former members where substantial financial risk exists. These periodic surveys must:

1. Include either a sample of, or all, current Medicaid members and individuals disenrolled in the past 12 months for reasons other than:

   a. The loss of Medicaid eligibility;

   b. Relocation outside the Contractor's service area;

   c. For failure to pay premiums or other charges;

   d. For abusive behavior; and

   e. Retroactive disenrollment.

2. Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

3. Measure the degree of members/former members' satisfaction with the quality of the services provided and the degree to which the members/former members have or had access to the services provided under the Contractor; and

4. Be conducted no later than 1 year after the effective date of the Contractor's contract and at least annually thereafter.

V. Sanctions. A Contractor that fails to comply with the requirements of this section is subject to intermediate sanctions.

A. Disclosure to the Department:

1. Basic requirement. Each Contractor must provide to the Department descriptive information about its physician incentive plan in sufficient detail to enable the Department to determine whether that plan complies with the requirements of Sec. 422.208. Reporting should be on the CMS PIP Disclosure Form (OMB No. 0938-0700).

2. Content. The information must include at least the following:

a. Whether services not furnished by the physician or physician group are covered by the incentive plan.

b. The type or types of incentive arrangements, such as, withholds, bonus, capitation.

c. The percent of any withhold or bonus the plan uses.

d. Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.

e. The patient panel size and, if the plan uses pooling, the ` pooling method.

f. If the Contractor is required to conduct member surveys, a summary of the survey results.

3. When disclosure must be made to the Department. A Contractor must disclose annually to the Department the physician incentive arrangements that are effective at the start of each year. In addition, the Department does not approve a Contractor's application for a contract unless the Contractor discloses the physician incentive arrangements effective for that contract.

B. Disclosure to Medicaid beneficiaries: Basic requirement. A Contractor must provide the following information to any Medicaid beneficiary who requests it:

1. Whether the Contractor uses a physician incentive plan that affects the use of referral services.

2. The type of incentive arrangement.

3. Whether stop-loss protection is provided.

4. If the Contractor was required to conduct a survey, a summary of the survey results.

EXHIBIT H, CONTRACTOR DISCLOSURE TEMPLATE

Insert the Contractor's name and address: ____

____

Insert the name, address, date of birth and SSN of any person with an ownership or control interest in the Contractor or any owned Subcontractors:

____

____

Insert the tax identification number of any corporate entity with an ownership or control interest in the Contractor or in any subcontractor in which the Contractor has a five percent (5%) or greater interest: ____

____

State whether any person with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor, or any owned Subcontractors, as a spouse, parent, child or sibling:

____

____

State whether any person with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or greater interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child or sibling: __________

____

____

Insert the name, address, date of birth and SSN or TIN of any other entity required to disclose under 42 CFR 455.104 in which any owner of the Contractor has an ownership or control interest: ____

____

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

____

EXHIBIT I, COVERED BEHAVIORAL HEALTH PROCEDURE CODES

Proc Code	Full description of the procedure codes
00104	Anesthesia for electroconvulsive therapy
90785	Interactive complexity (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient and/or family member
90833	Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90834	Psychotherapy, 45 minutes with patient and/or family member
90836	Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90837	Psychotherapy, 60 minutes with patient and/or family
90838	Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90839	Psychotherapy for crisis, first 60 minutes
90840	Psychotherapy for crisis, each additional 30 minutes (This code is an add-on. Please see the USCS or 2013 CPT for coding guidelines).
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90870	Electroconvulsive therapy (includes necessary monitoring)
90875	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
90876	Individual psycho-physiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96101	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96102	Psychological testing (includes psycho-diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report.

96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face
96120	Neuropsychological testing by a computer, with qualified health care professional interpretation and report.
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
98966	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone evaluation and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99221	Initial Hospital Care Low Complexity
99222	Initial Hospital Care Moderate Complexity
99223	Initial Hospital Care High Complexity
99231	Subsequent Hospital Care Low Complexity
99232	Subsequent Hospital Care Moderate Complexity
99233	Subsequent Hospital Care High Complexity
99238	Hospital Discharge Day Management/30 minutes
99239	Discharge day management; more than 30 minutes
99251	Initial Inpatient Consultation/20 minutes
99252	Initial Inpatient Consultation/40 minutes
99253	Initial Inpatient Consultation/55 minutes
99254	Initial Inpatient Consultation/80 minutes

99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional.
99367	Medical team conference, with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician.
99368	Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by non-physician qualified health care professional
99441	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion
99442	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion
99443	Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion
G0176	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more).
*H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
*H0004	Behavioral health counseling and therapy, per 15 minutes
*H0005	Alcohol and/or drug services; group counseling by a clinician
*H0006	Alcohol and/or drug services; case management (targeted)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
*H0020	Medication Assisted Treatment
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0036	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community psychiatric supportive treatment program, per diem

*H0038	Self-help/peer services, per 15 minutes
H0039	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive community treatment program, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite care services, not in the home, per diem
H1011	Family assessment by licensed behavioral health professional for state defined purposes
H2000	Comprehensive multidisciplinary evaluation
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2014	Skills training and development, per 15 minutes
H2015	Comprehensive community support services, per 15 minutes. Long definition: The purpose of Comprehensive Community Support Services is to coordinate and provide services and resources to individuals/families necessary to promote recovery, rehabilitation and resiliency. Comprehensive Community Support Services identifies and addresses the barriers that impede the development of skills necessary for independent functioning in the community; as well as strengths, which may aid the individual or family in the recovery or resiliency process. Community support activities address goals specifically in the following areas: independent living; learning; working; socializing and recreation. Comprehensive Community Support Services also include supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices.
H2016	Comprehensive community support services, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2021	Community-based wrap-around services, per 15 minutes
H2022	Community-based wrap-around services, per diem
H2023	Supported employment, per 15 minutes
H2024	Supported employment, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing support to maintain employment, per diem
H2027	Psychoeducational service, per 15 minutes
H2030	Mental health clubhouse services, per 15 minutes
H2031	Mental health clubhouse services, per diem
H2032	Activity therapy, per 15 minutes
H2033	Multi-systemic therapy for juveniles, per 15 minutes
M0064	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders
*S3005	Safety assessment including suicidal ideation and other behavioral health issues
S5150	Unskilled respite care, not hospice; per 15 minutes
S5151	Unskilled respite care, not hospice; per diem
*S9445	Drug screening and monitoring
S9453	Smoking cessation classes, non-physician provider, per session
S9454	Stress management classes, non-physician provider, per session
S9480	Intensive outpatient psychiatric services, per diem
S9485	Crisis intervention mental health services, per diem
T1005	Respite care services, up to 15 minutes
*T1007	Physical assessment of detoxification progression including vital signs monitoring
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes

*T1019	Provision of daily living needs including hydration, nutrition, cleanliness and toiletry for clients
*T1023	Level of motivation assessment for treatment evaluation

*Denotes services that have been approved by the Joint Budget Committee (JBC) for inclusion in the substance use disorder benefit.

Please note: The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

The below list of Evaluation and Management codes are covered by the BHOs when they are billed in conjunction with a psychotherapy add-on from the above list or when used for the purposes of medication management with minimal psychotherapy provided by a prescriber from the BHO network.

99201	Office or other outpatient visit, new patient/ 10 minutes
99202	Office or other outpatient visit, new patient/ 20 minutes
99203	Office or other outpatient visit, new patient/ 30 minutes
99204	Office or other outpatient visit, new patient/ 45 minutes
99205	Office or other outpatient visit, new patient/ 60 minutes
99211	Office or other outpatient visit, established patient/ 5 minutes
99212	Office or other outpatient visit, established patient/10 minutes
99213	Office or other outpatient visit, established patient/ 15 minutes
99214	Office or other outpatient visit, established patient/ 25 minutes
99215	Office or other outpatient visit, established patient/ 40 minutes
99217	Observation care discharge day management
99218	Initial observation / 30 minutes
99219	Initial observation care/ 50 minutes
99220	Initial observation care/ 70 minutes
99224	Subsequent observation care/ 15 minutes
99225	Subsequent observation care/ 25 minutes
99226	Subsequent observation care/ 35 minutes
99234	Observation or inpatient hospital care, patient admitted and discharged on same date of service, 40 minutes
99235	Observation or inpatient hospital care, patient admitted and discharged on same date of service/50 minutes
99236	Observation or inpatient hospital care, patient admitted and discharged on same date of service/ 55 minutes
99241	Office consultation/ 15 minutes
99242	Office consultation/ 30 minutes
99243	Office consultation/ 40 minutes
99244	Office consultation/ 60 minutes
99245	Office consultation/ 80 minutes
99255	Initial inpatient consultation/ 110 minutes.
99304	Initial nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99305	Initial nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99306	Initial nursing facility care/per day/ 45 minutes spent at bedside or on patient floor/unit
99307	Subsequent nursing facility care/per day/ 10 minutes spent at bedside or on patient floor/unit
99308	Subsequent nursing facility care/per day/ 15 minutes spent at bedside or on patient floor/unit

99309	Subsequent nursing facility care/per day/ 25 minutes spent at bedside or on patient floor/unit
99310	Subsequent nursing facility care/per day/ 35 minutes spent at bedside or on patient floor/unit
99315	Nursing facility discharge day management/ 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Annual nursing facility assessment/ 30 minutes spent at bedside or on patient floor/unit
99324	Domiciliary or rest home visit, new patient/ 20 minutes
99325	Domiciliary or rest home visit, new patient/ 30 minutes
99326	Domiciliary or rest home visit, new patient/ 45 minutes
99327	Domiciliary or rest home visit, new patient/ 60 minutes
99328	Domiciliary or rest home visit, new patient/ 75 minutes
99334	Domiciliary or rest home visit, established patient/ 15 minutes
99335	Domiciliary or rest home visit, established patient/ 25 minutes
99336	Domiciliary or rest home visit, established patient/ 40 minutes
99337	Domiciliary or rest home visit, established patient/ 60 minutes
99341	Home visit, new patient/20 minutes
99342	Home visit, new patient/30 minutes
99343	Home visit, new patient/45 minutes
99344	Home visit, new patient/60 minutes
99345	Home visit, new patient/75 minutes
99347	Home visit, established patient/15 minutes
99348	Home visit, established patient/25 minutes
99349	Home visit, established patient/40 minutes
99350	Home visit, established patient/60 minutes

Please Note: This list of covered procedures is to be used as a guideline rather than a contractual requirement. The Department and its Contractors will continue to refine and update the covered procedures list on an ongoing basis.

EXHIBIT J, MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES

8.209. MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES

8.209.1. GENERAL PROVISIONS

Medicaid members or their Designated Client Representatives enrolled in Managed Care Organizations (MCOs) may access and utilize the Medicaid Managed Care Grievance and Appeal Systems. The Grievance and Appeal Systems shall include a grievance process and an appeal process for handling grievances and appeals at the MCO or Prepaid Inpatient Health Plan (PIHP) level and access to the State fair hearing process for appeals.

8.209.2. DEFINITIONS

Action shall mean:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service (except payment denials issued by a mental health prepaid inpatient health plan);
4. The failure to provide services in a timely manner;
5. The failure to act within the timeframes provided below; or
6. The denial of a Medicaid member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one MCO.

Appeal shall mean a request for review of an action.

Designated Client Representative shall mean any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services.

Fair Hearing shall mean the formal adjudication process for appeals described at 10 CCR 2505-10, § 8.057.

Grievance shall mean an oral or written expression of dissatisfaction about any matter other than an action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights.

Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

Quality of Care Complaint shall mean any grievance made in regards to the professional competence and/or conduct of a physician or other health care provider, which could adversely affect the health, or welfare of a member.

Timely Filing shall mean filing on or before the later of the following: within ten days of the MCO or PIHP postmarking the notice of action; or the intended effective date of the MCO's or PIHP's proposed action.

8.209.3. GRIEVANCE SYSTEM

8.209.3.A. The Grievance System is the overall system that includes grievances and appeals handled at the MCO and PIHP level and access to the State fair hearing process for appeals.

8.209.3.B. The MCO or PIHP shall provide a Department approved description of the grievance, appeal and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the MCO or PIHP. The description shall include:

1. The member's right to a State fair hearing for appeals.
    a. The method to obtain a hearing, and
    b. The rules that govern representation at the hearing.
2. The member's right to file grievances and appeals.
3. The requirements and timeframes for filing grievances and appeals.
4. The availability of assistance in the filing process.
5. The toll-free numbers that the member can use to file a grievance or an appeal by telephone.
6. The fact that, when requested by a member:
    a. Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and
    b. The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member.

8.209.3.C. The MCO or PIHP shall maintain record of grievances and appeals and submit a quarterly report to the Department.

8.209.4. APPEAL PROCESS

8.209.4.A. Notice of Action

1. The MCO or PIHP shall send the member written notice for each action. The notice shall be in writing and shall be available in English and the prevalent non-English languages spoken by members throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of members in the service area as identified by the State.

2. The notice shall state the following:

   a. The action the MCO or PIHP or its contractor has taken or intends to take;

   b. The reasons for the action;

   c. The member's or the Designated Client Representative's right to file an MCO or PIHP appeal;

   d. The date the appeal is due;

   e. The member's right to request a State fair hearing;

   f. The procedures for exercising the right to a fair hearing;

   g. The circumstances under which expedited resolution is available and how to request it;

   h. The member's right to have benefits continue pending resolution of the appeal, and how to request that benefits be continued; and

   i. The circumstances under which the member may be required to pay the cost of these services.

3. The MCO or PIHP shall mail the notice of action within the following timeframes:

   a. For termination, suspension or reduction of previously authorized Medicaid covered services, at least ten (10) calendar days before the date of action, except in the following circumstances:

      i) The MCO or PIHP may shorten the period of advance notice to five (5) calendar days for the date of action if:

         1) The MCO or PIHP has facts indicating probable fraud by the member; and

2) The facts have been verified, if possible, through secondary sources.

ii) The MCO or PIHP may mail notice not later than the date of action if:

1) The MCO or PIHP has factual information confirming the death of the member;

2) The MCO or PIHP receives a clear written statement signed by the member stating that:

a) He or she no longer wishes services; or

b) Gives information that requires termination or reduction of services and indicates that he/she understands that this is the result of supplying the information;

iii) The member has been admitted to an institution where he/she is ineligible under the plan for further services;

iv) The member's whereabouts is unknown and the post office returns mail directed to him or her indicating no forwarding address;

v) The MCO or PIHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;

vi) A change in the level of medical care is prescribed by the member's physician;

vii) The notice involves an action made with regard to the preadmission screening requirements of 1919(e) (7) of the Social Security Act; or

viii) Notice may be made as soon as practicable before transfer or discharge when:

1) The safety of individuals in the facility would be endangered;

2) The health of individuals in the facility would be endangered;

3) The resident's health improves sufficiently to allow a more immediate transfer or discharge;

4) An immediate transfer or discharge is required by the resident's urgent medical needs; or

5) A resident has not resided in the facility for 30 days.

b. For denial of payment (except for payment denials issued by a mental health prepaid inpatient health plan), at the time of any action affecting the claim.

c. For standard service authorization decisions that deny or limit services, within ten (10) calendar days.

4. If the MCO or PIHP extends the timeframe it must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file an appeal if he or she disagrees with that decision and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the due date the extension expires.

5. For service authorization decisions not reached within ten (10) calendar days on the date the timeframes expire.

6. For expedited service authorization decisions, within three (3) days.

8.209.4.B. The member of an MCO or PIHP shall file an appeal within twenty (20) calendar days from the date of the MCO's or PIHP's notice of action.

8.209.4.C. The MCO or PIHP shall give members reasonable assistance in completing any forms required by the MCO or PIHP, putting oral requests for a State fair hearing into writing and taking other procedural steps, including, but not limited to, providing interpretive services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

8.209.4.D. The MCO or PIHP shall send the member written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution.

8.209.4.E. The MCO or PIHP shall ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeals that involves clinical issues.

8.209.4.F. The MCO or PIHP shall accept appeals orally or in writing.

8.209.4.G. The MCO or PIHP shall provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO or PIHP shall inform the member of the limited time available in the case of expedited resolution.

8.209.4.H. The MCO or PIHP shall provide the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process.

8.209.4.I. The MCO or PIHP shall include as parties to the appeal, the member and the designated client representative or the legal representative of a deceased member's estate.

8.209.4.J. The MCO or PIHP shall resolve each appeal, and provide notice as expeditiously as the member's health condition requires, not to exceed the following:

1. For standard resolution of an appeal and notice to the affected parties, ten (10) working days from the day the MCO or PIHP receives the appeal.

2. For expedited resolution of an appeal and notice to affected parties, three (3) working days after the MCO or PIHP receives the appeal.

8.209.4.K. The MCO or PIHP may extend timeframes for the resolution of appeals by up to fourteen (14) calendar days:

1. If the member requests the extension; or

2. The MCO or PIHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO or PIHP shall give the member prior written notice of the reason for delay if the timeframe is extended.

8.209.4.L. The MCO or PIHP shall notify the member in writing of the resolution of an appeal. For notice of an expedited resolution, the MCO or PIHP shall also make reasonable efforts to provide oral notice.

8.209.4.M. The written notice shall include the results of the disposition/resolution process and the date it was completed.

1. For appeals not resolved wholly in favor of the member,

    a. The right to request a State fair hearing and how to do so;

    b. The right to request and to receive benefits while the hearing is pending, and how to make the request; and

    c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.

8.209.4.N. The member of an MCO or PIHP need not exhaust the MCO or PIHP level appeal process before requesting a State fair hearing. The member shall request a State fair hearing within twenty (20) calendars [sic] days from the date of the MCO's or PIHP's notice of action.

8.209.4.O. In cases where the parent or guardian submits a request for a third party review to the Department of Human Services under 27-10.3-104 (1)(b) C.R.S. of the Child Mental Health Treatment Act, the member, parent or guardian and the MCO or PIHP shall have the right to request a state fair hearing. The request for the state fair hearing shall be submitted to the Division of Administrative Hearings within

twenty (20) calendar days from the date of the determination. The state fair hearing shall be considered a recipient appeal.

8.209.4.P. The MCO or PIHP shall establish and maintain an expedited review process for appeals when the MCO or PIHP determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

8.209.4.Q. The MCO or PIHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

8.209.4.R. If the MCO or PIHP denies a request for expedited resolution, it shall transfer the appeal in the timeframe for standard resolution, make reasonable effort to give the member prompt oral notice of the denial and send a written notice of the denial for an expedited resolution within two (2) calendar days.

8.209.4.S. The MCO or PIHP shall provide for the continuation of benefits while the MCO or PIHP level appeal and the State fair hearing are pending if the member files the appeal timely, the appeal involves the termination, suspension or reduction of a previously authorized course of treatment, the services were ordered by an authorized provider, the original period covered by the original authorization has not expired and the member requests extension of benefits.

8.209.4.T. If at the member's request, the MCO or PIHP continues or reinstates the member's benefits while the appeal is pending, the benefits shall be continued until the member withdraws the appeal, ten days pass after the MCO or PIHP mails the notice providing the resolution of the appeal against the member, a State fair hearing office issues a final agency decision adverse to the member, or the time period or service limits of a previously authorized service has been met.

8.209.4.U. If the final resolution of the appeal upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the member while the appeal is pending to the extent that the services were furnished solely because of the requirements of this rule.

8.209.4.V. If the final resolution of the appeal reverses the MCO's or PIHP's action to deny, limit or delay services that were not furnished while the appeal was pending, the MCO or PIHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

8.209.4.W. If the final resolution of the appeal reverses the MCO's or PIHP's action to deny authorization of services and the member received the services while the appeal was pending, the MCO or PIHP must pay for those services.

8.209.5. GRIEVANCE PROCESS

8.209.5.A. The member of the MCO or PIHP shall have twenty (20) calendar days from the date of the incident to file a grievance expressing his/her dissatisfaction with any matter other than an action.

8.209.5.B. The MCO or PIHP shall send the member written acknowledgement of each grievance within two (2) working days of receipt.

8.209.5.C. The MCO or PIHP shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding a grievance that involves clinical issues.

8.209.5.D. The MCO or PIHP shall accept grievances orally or in writing.

1. The MCO or PIHP shall dispose of each grievance and provide notice as expeditiously as the member's health condition requires, not to exceed fifteen (15) working days from the day the MCO or PIHP receives the grievance.

8.209.5.E. The MCO or PIHP may extend timeframes for the disposition of grievances by up to fourteen (14) calendar days:

1. If the member requests the extension; or

2. The MCO or PIHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO or PIHP shall give the member prior written notice of the reason for delay if the timeframe is extended.

8.209.5.F. The MCO or PIHP shall notify the member in writing of the disposition of a grievance.

8.209.5.G. The written notice shall include the results of the disposition/resolution process and the date it was completed.

8.209.5.H. If the member is dissatisfied with the disposition of a grievance provided by the MCO or PHIP, the member may bring the unresolved grievance to the Department.

1. The Department will acknowledge receipt of the grievance and dispose of the issue.

2. The disposition offered by the Department will be final.

EXHIBIT K, SERIOUS REPORTABLE EVENTS OR NEVER EVENTS

Effective for inpatient hospital claims with discharge dates on or after October 1, 2009, reimbursement will not be increased for additional costs resulting from the hospital-acquired conditions and serious reportable events identified below:

a. Foreign object inadvertently left in patient after surgery;
b. Death/disability associated with incompatible blood;
c. Stage 3 or 4 pressure ulcers after admission;
d. Hospital-acquired injuries: fractures, dislocations, intracranial injury, crushing injury, burn and other unspecified effects of external causes;
e. Catheter-associated urinary tract infection;
f. Vascular catheter-associated infection;
g. Mediastinitis after coronary artery bypass graft surgery;
h. Manifestations of poor glycemic control;
i. Surgical site infection following certain orthopedic procedures;
j. Surgical site infection following bariatric surgery for obesity; and
k. Deep vein thrombosis & pulmonary embolism following certain orthopedic procedures.

In addition, no payment will be made for hospitalizations for:

l. Surgery performed on the wrong body part;
m. Surgery performed on the wrong patient;
n. Wrong surgical procedure on a patient.

EXHIBIT L, ENROLLMENT RETENTION RATE DISENROLLMENT CODES

Included in Numerator	Value Code	Code Description
No		NO DATA
No	100	S100-SYSTEM DISENROLLMENT
No	110	S110-ELIGIBILITY TERMINATION
No	111	S111-TERM-LOST ELIGIBILITY
No	112	S112-TERM-DECEASED
No	120	S120-EX-ELIG STATUS TO EXEMPT
No	121	S121-EX-QMB, SLMB, QWDI
No	122	S122-EX-EMERGENCY ONLY
No	123	S123-EX-TPL COMP INSURANCE
No	124	S124-EX-PRESUMPT ELIGIBILITY
No	125	S125-EX-OAP-STATE ONLY
No	126	S126-EX-SSI-TEMP MINERAL CTY
No	130	S130-NOT ELIGIBLE FOR CONTRACT
No	131	S131-N/E-ELIGIBILITY CATEGORY
No	132	S132 N/E-COUNTY
No	133	S133-N/E-TPL
No	134	S134-N/E-AGE
No	135	S135-N/E-LTC CERTIFICATION
No	136	S136-N/E-MEDICARE
No	137	S137-N/E-MAJOR PROGRAM
No	138	S138-N/E-LIVING ARRANGEMENT
No	139	S139-N/E-WAIVER PROGRAM
No	140	S140-MASS CHANGE
No	150	S150-CAPITATION DISENROLLMENT
No	151	S151-CAP-RATE CELL MISSING
No	152	S152-CAP-CTCT/PROV NOT ACTIVE
No	160	S160-VOL-ELIG STATUS TO VOL
No	161	S161-VOL-SYSASN PENDING DEL
No	162	S162-VOL-PENDING EXCL DELETED
No	163	S163-VOL-EXCLUSION SPAN CLOSED
No	164	S164-VOL-NOT ENOUGH CHOICES
No	170	S170-LOCKIN SPAN CLOSED
Yes	**200**	**200-OPEN ENROLLMENT CLIENT REQ**
Yes	**210**	**210-OPEN-QUALITY, ADMIN**
Yes	**211**	**211-OPEN-QUAL,PROV/FACIL/STAFF**
Yes	**212**	**212-OPEN-QUAL, COMMUNICATION**
Yes	**220**	**220-OPEN-NETWORK, PHARMACY**
Yes	**230**	**230-OPEN-ACCESS, LOCATION**
Yes	**231**	**231-OPEN-APPT UNAVAIL, ROUTINE**
Yes	**232**	**232-OPEN-APPT UNAV, OB OR INIT**
Yes	**233**	**233-OPEN-APPT UNAVAIL, URGENT**
Yes	**234**	**234-OPEN-WAIT TIME UNACCEPT**

Included in Numerator	Value Code	Code Description
Yes	**235**	**235-OPEN-WAIT TIME, EMERG CARE**
Yes	**260**	**260-OPEN PREFERS PCPP TO HMO**
Yes	**261**	**261-OPEN-DOES NOT LIKE CLINIC**
Yes	**262**	**262-OPEN PLAN REQUEST**
No	263	263-OPEN-HOSPICE
No	264	264-OPEN-MENTAL HEALTH INSTIT
No	265	265-OPEN-INPAT AT ENROLLMENT
No	266	266-OPEN-NURSING FAC RESIDENT
Yes	**267**	**267-OPEN-REFUSED TO GIVE REASN**
Yes	**268**	**268-OPEN-OTHER**
Yes	**270**	**270-OPEN-REFERRALS, 2ND Opin**
Yes	**271**	**271-OPEN-REFERRALS, SPEC-ADULT**
Yes	**272**	**272-OPEN-REFERRALS, SPEC-PED**
Yes	**280**	**280-OPEN PROV LIMIT, PHYSICIAN**
Yes	**281**	**281-OPEN PROV LIMIT, HOME HLTH**
Yes	**282**	**282-OPEN PROV LIMIT, HOSPITAL**
Yes	**283**	**283-OPEN PROV LIMIT, DME**
Yes	**284**	**284-OPEN PROV LIMIT, OTHER**
Yes	**285**	**285-OPEN PROV LIMIT, PT ADULT**
Yes	**286**	**286-OPEN PROV LIMIT, PT CHILD**
Yes	**290**	**290-OPEN-BENEFIT LIMIT, DENIED**
Yes	**291**	**291-OPEN-BENEFIT LIMIT, DME**
Yes	**292**	**292-OPEN-BENEFIT LIMIT, PHARM**
Yes	**293**	**293-OPEN-BENEFIT LIMIT, OTHER**
No	300	300-NEW-CLNT REQ IN TIME LIMIT
No	310	310-NEW-QUALITY, ADMIN
No	311	311-NEW-QUAL, PROV/FACIL/STAFF
No	312	312-NEW-QUAL, COMMUNICATION
No	320	320-NEW-NETWORK, PHARMACY
No	330	330-NEW ACCESS, LOCATION
No	331	331-NEW-APPT UNAVAIL, ROUTINE
No	332	332-NEW-APPT UNAV, OB OR INIT
No	333	333-NEW-APPT UNAVAIL, URGENT
No	334	334-NEW-WAIT TIME UNACCEPT
No	335	335-NEW-WAIT TIME, EMERG CARE
No	340	340-NEW-CHG ELIG TO VOLUNTARY
No	341	341-NEW-VOLUNTARY, FOSTER CARE
No	342	342-NEW-VOLUNTARY, MEDICARE
No	350	350-NEW-INVOLUNTARY ASSIGN
No	351	351-NEW-DATA ENTRY ERROR
No	352	352-NEW-MASS CHANGE
No	353	353-NEW-DEFAULT ASSIGN
No	354	354-NEW-NEWBORN
No	360	360-NEW-PREFERS PCPP TO HMO
No	361	361-NEW DOSE NOT LIKE CLINIC
No	362	362-NEW PLAN REQUEST

Included in Numerator	Value Code	Code Description
No	363	363-NEW HOSPICE
No	364	364-NEW-MENTAL HEALTH INSTIT
No	365	365-NEW-INPAT AT ENROLLMENT
No	366	366-NEW-NURSING FAC RESIDENT
No	367	367-NEW-REFUSED TO GIVE REASN
No	368	368-NEW-LANGUAGE BARRIER
No	369	369-NEW-OTHER
No	370	370-NEW-REFERRALS, 2ND OPIN
No	371	371-NEW-REFERRALS, SPEC-ADULT
No	372	372-NEW-REFERRALS, SPEC-PED
No	380	380-NEW-PROV LIMIT, PHYSICIAN
No	381	381-NEW-PROV LIMIT, HOME HLTH
No	382	382-NEW-PROV LIMIT, HOSPITAL
No	383	383-NEW-PROV LIMIT, DME
No	384	384-NEW-PROV LIMIT, OTHER
No	385	385-NEW-PROV LIMIT, PT ADULT
No	386	386-NEW-PROV LIMIT, PT CHILD
No	390	390-NEW-BENEFIT LIMIT, DENIED
No	391	391-NEW-BENEFIT LIMIT, DME
No	392	392-NEW-BENEFIT LIMIT, PHARM
No	393	393-NEW-BENEFIT LIMIT, OTHER
No	400	400-LOCKIN PERIOD CLIENT REQ
No	410	410-LOCK-HMO GOOD CAUSE
No	411	411-LOCK-NEWBORN, WRONG HMO
No	412	412-LOCK-HOSPICE
No	413	413-LOCK-INPAT AT ENROLLMENT
No	414	414-LOCK-MENTAL HEALTH INSTIT
No	415	415-LOCK-HMO PCP LEAVES PLAN
No	416	416-LOCK-HMO CLIENT DEATH
No	417	417-LOCK-HMO DOESNT COVER COA
No	418	418-LOCK-HMO, CLIENT MOVES
No	420	420-LOCK-HMO QUALITY OF CARE
No	421	421-LOCK-HMO, CLIENT HOSTILE
No	422	422-LOCK-HMO, OTHER
No	430	430-LOCK-PCPP GOOD CAUSE
No	431	431-LOCK-PCP NO LONGER ACTIVE
No	432	432-LOCK PCP CLIENT MOVES
No	433	433-LOCK PCP PROV RELOCATES
No	434	434-LOCK-PCP QUALITY OF CARE
No	435	435-LOCK-PCP, CLIENT HOSTILE
No	436	436-LOCK-PCP, CLIENT DEATH
No	437	437-LOCK-PCP, OTHER
No	440	440-LOCK-CHG ELIG TO VOLUNTARY
No	441	441-LOCK-VOLUNTARY, FOST CARE
No	442	442-LOCK-VOLUNTARY, MEDICARE
No	450	450-LOCK-INVOLUNTARY ASSIGN

Included in Numerator	Value Code	Code Description
No	451	451-LOCK-DATA ENTRY ERROR
No	452	452-LOCK-MASS CHANGE
No	453	453-LOCK-DEFAULT ASSIGN
No	454	454-LOCK-NEWBORN
No	460	460-OTHER
No	500	500-MASS CHANGE CLIENT REQ
No	600	600-MHASA CLIENT REQ
No	610	610-MHASA EXEL, CLIENT REQ
No	611	611-MHASA EXCL, CLINICAL
No	612	612-MHASA EXCL, DIV YTH CORR
No	613	613-MHASA EXCL, ADMINISTRATIVE
No	620	620-MHASA DISENL, PACE ENROLL
No	660	660-MHASA, OTHER
No	700	700-LOCK-IN AND EXCLUSION
No	710	710-LOCK-IN
No	720	720-EXCLUSION
No	721	721-EXCLUSION ENDED BY ANALYST
No	722	722-EXCLUSION, CLIENT REQUEST
No	999	999-INACTIVE ENROLLMENT SPAN

EXHIBIT M, COVERED 1202 PROCEDURE CODES

CPT or HCPCS Procedure Code	Procedure Code Description	FY16 1202 rate
90460	INTERMEDIATE SERVICE	$ 25.22
90471	Immunization admin	$ 25.22
90472	Immunization admin, each add	$ 12.59
90473	Immune admin oral/nasal	$ 25.22
90474	Immune admin oral/nasal add	$ 12.59
99201	OFFICE OR OP VISIT EVALU & MGMT OF NEW P	$ 43.52
99202	OFFICE OR OP VISIT NEW PT; EXPANDED PROB	$ 74.77
99203	OFFICE OR OP VISIT NEW PT; LOW COMPLEXIT	$ 108.52
99204	OFFICE OR OP VISIT COMPREHENSIVE MOD CPX	$ 166.64
99205	COMPREHENSIVE VISIT; HIGH COMPLEXITY	$ 207.55
99211	OFFICE OR OP VISIT ESTABL PT PHYS NOT RQ	$ 20.16
99212	OFFICE OR OP ESTABL PT 2 OF 3 KEY COMPON	$ 43.88
99213	OFFICE OR OP VISIT ESTABL PT LOW COMPLEX	$ 73.32
99214	OFFICE OR OP VISIT ESTABL PT MODER COMPX	$ 108.16
99215	OFFICE OR OP VISIT ESTABL PT HIGH COM	$ 144.79
99217	OBSERVATION CARE DISCHARGE DAY MGMT	$ 72.86
99218	INITIAL OBSERVATION CARE PER DAY LOW COM	$ 99.73
99219	INIT OBSERVE CARE PER DAY-COMPREHEN EXAM	$ 136.32
99220	INIT OBSERVE CARE--HIGH COMPLEXITY	$ 186.53
99221	INITIAL HOSPITAL CARE PER DAY LOW COMPLX	$ 102.20
99222	INITIAL HOSPITAL CARE MODERATE COMPLEXIT	$ 138.79
99223	INITIAL HOSPITAL CARE HIGH COMPLEXITY	$ 204.45
99224	INITIAL HOSPITAL CARE HIGH COMPLEXITY	$ 40.17
99225	INITIAL HOSPITAL CARE HIGH COMPLEXITY	$ 72.84
99226	INITIAL HOSPITAL CARE HIGH COMPLEXITY	$ 105.12
99231	SUBSEQUENT HOSPITAL CARE LOW COMPLEXITY	$ 39.45
99232	SUBSEQUENT HOSPITAL CARE MODERATE COMPLX	$ 72.47
99233	SUBSEQUENT HOSPITAL CARE HIGH COMPLEXITY	$ 104.40
99234	EVAL/MGMT ADMISS/DISCHARGE SDOS	$ 135.92
99235	EVAL/MGMT ADMISS/DISCHARGE MOD SEVERITY	$ 170.03
99236	EVAL/MGMT HIGH COMPLEXITY	$ 219.51
99238	HOSP DISCHARG DAY MANAGE 30 MIN OR LESS	$ 72.87
99239	HOSP DISCHARGE-MANAGE 1UOS = 30MIN PLUS	$ 107.68
99281	ER DEPT VISIT EVALUATION AND MGMT	$ 21.15
99282	ER DEPT VISIT EXPANDED LOW COMPLEXITY	$ 41.57
99283	ER DEPART VISIT FOR E&M OF PT-MOD COMPLE	$ 61.99
99284	ER DEPT VISIT MODERATE COMPLEXITY	$ 118.22

99285	EMERGENCY DEPT VISIT	$	173.76
99291	Critical care, first hour	$	275.35
99292	Critical care, addl 30 min	$	123.41
99304	Nursing facility care, init	$	93.65
99305	Nursing facility care, init	$	133.47
99306	Nursing facility care, init	$	168.99
99307	Nursing fac care, subseq	$	44.88
99308	Nursing fac care, subseq	$	69.29
99309	Nursing fac care, subseq	$	91.20
99310	Nursing fac care, subseq	$	135.69
99315	NF discharge day manage <= 30 min	$	73.58
99316	NF discharge day manage > 30 min	$	105.52
99318	Annual nursing fac assessmnt	$	96.55
99324	Domiciliary e/m new patient 20 min	$	55.97
99325	Domiciliary e/m new patient 30 min	$	81.44
99326	Domiciliary e/m new patient 45 min	$	140.29
99327	Domiciliary e/m new patient 60 min	$	187.30
99328	Domiciliary e/m new patient 75 min	$	217.07
99334	Domiciliary e/m est patient 15 min	$	61.01
99335	Domiciliary e/m est patient 25 min	$	95.46
99336	Domiciliary e/m est patient 40 min	$	134.58
99337	Domiciliary e/m est patient 60 min	$	194.11
99341	Home visit evalu& mgmt new patient low	$	55.61
99342	Home Visit e/m new pt moderate complexit	$	80.34
99343	Home Visit E/M New PT high Complexity	$	131.27
99344	Home Visit E/M Mod Complexity	$	183.35
99345	Home Visit E/M High Complexity	$	221.02
99347	Home e/m est patient 15 min	$	55.98
99348	Home e/m est patient 25 min	$	84.67
99349	Home e/m est patient 40 min	$	128.12
99350	Home e/m est patient 60 min	$	178.68
99354	Prolong service office first hour	$	100.49
99355	Prolong service office each add 30 min	$	98.33
99356	Prolong serv inpatient first hour	$	92.57
99357	Prolong serv inpatient each add 30 min	$	91.84
99360	PHYS Standby svc each 30min	$	62.83
99363	Anticoag mgmt, init	$	129.20
99364	Anticoag mgmt, subseq	$	43.77
99381	Init pm e/m, new pat, inf	$	112.17
99382	Init pm e/m, new pat 1-4 yrs	$	116.88
99383	Prev visit, new, age 5-11	$	121.93
99384	Prev visit, new, age 12-17	$	137.82

99385	Prev visit, new, age 18-39	$ 133.84
99386	Prev visit, new, age 40-64	$ 154.43
99387	Init pm e/m, new pat 65+ yrs	$ 167.81
99391	Per pm reeval, est pat, inf	$ 100.95
99392	Prev visit, est, age 1-4	$ 107.81
99393	Prev visit, est, age 5-11	$ 107.44
99394	Prev visit, est, age 12-17	$ 117.57
99395	Prev visit, est, age 18-39	$ 120.10
99396	Prev visit, est, age 40-64	$ 128.04
99397	Per pm reeval est pat 65+ yr	$ 137.82
99401	Counsel&/or Risk Factor approx 15min	$ 36.91
99402	Counsel&/or risk factor approx 30min	$ 63.27
99403	Counsel &/or Risk factor approx 45 min	$ 88.19
99404	Counsel &/or Risk Factor approx 60 min	$ 113.12
99406	Behav chng smoking 3-10 min	$ 14.00
99407	Behav chng smoking < 10 min	$ 27.63
99408	Audit/dast, 15-30 min	$ 35.77
99409	Audit/dast, over 30 min	$ 69.71
99411	Counsel Group Setting approx 30 min	$ 16.67
99412	Counsel &/or risk factor approx 60 min	$ 21.73
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	$ 95.06
99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center	$ 98.86
99462	Subsequent hospital care, per day, for evaluation and management of normal newborn	$ 42.32
99463	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date	$ 115.19
99464	Attendance at delivery (when requested by the delivering physician or other qualified health care professional) and initial stabilization of newborn	$ 71.36
99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output	$ 148.45

99466	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; first 30-74 minutes of hands-on care during transport	$	264.17
99467	Critical care face-to-face services, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or younger; each additional 30 minutes (List separately in addition to code for primary service)	$	123.76
99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	$	937.93
99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	$	397.78
99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	$	859.08
99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	$	404.22
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	$	579.51
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	$	350.37
99477	Init day hosp neonate care	$	348.99
99478	Init day hosp neonate care	$	138.43
99479	Init day hosp neonate care	$	125.52
99480	Init day hosp neonate care	$	120.86