AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Agreement; Care Coordination - Rocky Mtn Health

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Gunnison County and Rocky Mountain Health Plan

Term Begins: 1/1/2019 **Term Ends:** 12/31/2019 **Grant Contract #:**

Summary:

Care Coordination Services provided to clients with Medicaid

Fiscal Impact: $33,280.00

Submitted by: Randy Morgan **Submitter's Email Address:** rmorgan@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:
No concerns, included in the 2019 adopted budget. ln

Reviewed by: GUNCOUNTY1\lNienhueser Discharge Date: 2/1/2019

County Attorney Review: (●) Required ( ) Not Required

Comments:
ok db 1/30/19

Reveiwed by: Discharge Date: 1/30/2019 Certificate of Insurance Required Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 2/1/2019

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 2/5/2019

Revised April 2015

COMMUNITY INTEGRATION AGREEMENT

INTEGRATED COMMUNITY CARE TEAM

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC.,
a Colorado corporation d/b/a Rocky Mountain Health Plans, (herein "RMHMO")

Address of RMHMO and RME:

2775 Crossroads Boulevard
Post Office Box 10600
Grand Junction, CO 81502-5600

GUNNISON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
(Contractor)

Address of Contractor:
220 N. Spruce St
Gunnison, CO 81230

Tax ID No: 84 6000 770

Rocky Mountain Entities (RMEs) offer and administer Health Care Plans in Colorado.

Health Care Plans offered by RMEs are marketed under the trade name of "Rocky Mountain Health Plans."

RMHMO, on behalf of RMEs, desires to delegate Care Coordination activities to Contractor, and Contractor desires to accept such delegation, subject to the attached Terms and Conditions. Contractor will be reimbursed for such Care Coordination activities as set forth in the attached Terms and Conditions.

This Agreement shall have no effect on any other agreements that may exist between the parties.

Contractor and RMHMO agree to all Terms and Conditions, attached, along with the Exhibits described below, all of which are incorporated herein by this reference.

This Agreement is dated and shall be effective on the date set forth below by RMHMO as the effective date.

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC.,
a Colorado corporation d/b/a Rocky Mountain Health Plans

By:_____

_____
(Print/type name)

Title:_____

GUNNISON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
(Contractor)

By: _____
(Signature)

Jonathan Houck
(Print/type name)

Title: Chairperson, BOCC

ATTACHMENTS:

Exhibit A – Scope of Work	Exhibit D – BAA Accountable Care Services: RMHMO and Contractor
Exhibit B – Law Exhibit	
Exhibit C – BAA- Agreement For Protection of Information	

TERMS AND CONDITIONS

1. **Definitions**. The words and terms below each have the following definitions:

A. "Anchor Organization" shall mean organizations who have partnered with RMHMO to develop community appropriate strategies related to the wellbeing of Medicaid Recipients. Anchor Organizations will be responsible for convening the Health Neighborhood and community to inform and implement strategies to improve the health of Medicaid members.

B. "Behavioral Health Services" shall mean all behavioral health services which a Covered Person is entitled to receive pursuant to the Covered Person's Health Care Plan.

C. "Care Coordination Services" or "CC" shall mean the deliberate organization of Covered Persons care activities between two or more participants (including the Covered Person and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional Long Term Services and Supports (LTSS) supports, oral health, specialty care, and other services. Care Coordination Services may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a Covered Persons' health and social needs. These services are described in Exhibit A – Scope of Work and as further described and as assigned to Contractor in Exhibit D – Business Associates Agreement Accountable Care Services: RMHMO and Contractor.

D. "Care Coordination Committee" shall mean the committee established by Contractor to be responsible for implementation, oversight and review of the Care Coordination Program in accordance with this Agreement.

E. "Care Coordination Program" shall mean the program established and implemented by Contractor to perform the CC activities delegated by this Agreement.

F. "Covered Person" shall mean a person enrolled in the Medicaid Accountable Care Collaborative Program (ACC) under a contract between RMHMO and the Colorado Department of Health Care Policy and Financing (CDHCPF).

G. "Health Care Plan" shall mean any health care plan administered by RME that is provided pursuant to a contract between CDHCPF and RME for Covered Persons.

H. "Health Care Services" shall mean those services provided to Covered Persons, limited to the benefits and subject to the exclusions of the Covered Person's Health Care Plan.

I. "Health Neighborhood" shall mean a network of Medicaid providers ranging from specialists, hospitals, oral health providers, LTSS providers, home health care agencies, ancillary providers, local public health agencies, and county social/human services agencies that support Covered Person's health and wellness.

J. "Key Performance Indicators" (KPIs) — Performance measures tied to incentive payments for the Accountable Care Collaborative.

K. "Medicaid Recipient" shall mean a person CDHCPF certifies as eligible for Medicaid benefits under a Medicaid Contract. Medicaid Recipients are not necessarily considered Covered Persons under this Agreement.

L. "Medical Services" shall mean all medical, surgical, pharmacy, radiological, anesthesia and pathological outpatient and inpatient services which a Covered Person is entitled to receive pursuant to the Covered Person's Health Care Plan.

M. "Medicare Beneficiary" shall mean a person entitled to the benefits provided under the federal health insurance program for people 65 or over and certain disabled people pursuant to an agreement between RME and CMS.

N. "Primary Care Procedures" shall mean those procedures established by CDHCPF for obtaining and receiving Health Care Services.

O. "Rocky Mountain Entity" or "RME" shall mean RMHMO, or any health maintenance organization, insurance company, health service corporation, or third party administrator that is a subsidiary of RMHMO.

2. Delegated Care Coordination.

A. Delegation of CC. RMHMO, on behalf of RMEs, hereby delegates responsibility for CC to Contractor, as detailed in the attached Exhibit A - Scope of Work to this Agreement and Contractor accepts such delegation. Contractor shall perform CC activities and administer the CC Program in accordance with the terms and conditions of this Agreement, as required by the CDHCPF and with any state or federal laws applicable to CC.

B. CC Program

(1) Intent of Care Coordination Services. The intent of Care Coordination Services is for Contractor to provide the following services for the benefit of Covered Persons:

(a) Maintain and improve the health and well being of Covered Persons;

(b) Reduce emergency room visits;

(c) Reduce unnecessary hospital admissions and re-admissions;

(d) Prevent duplication of costly treatment;

(e) Increase the family's understanding of recommended treatments;

(f) Increase Covered Person and provider satisfaction;

(g) Augment the support of families by utilizing community resources;

(h) Ensure long-range comprehensive planning;

(i) Create independent families;

(j) Encourage families to maintain continuous health care coverage for primary and specialty Medical Services; and

(k) Improve communication across service and support agencies, professionals, volunteers and families.

(2) Essential Activities of Care Coordination Services. Essential activities are delivered through office consultations, home visits, team conferences and telephone conferences. The following are the essential activities that Contractor shall perform in order to provide Care Coordination Services:

(a) Communication/Trust Building. Identifying and supporting family strengths, cultures and values.

(b) Assessment. Collecting and reviewing medical and educational records, and identifying strengths, needs and available resources in concert with the family and providers.

(c) Planning. Assisting the family in determining specific objectives, goals, and actions designed to meet identified needs. The care plan is action oriented and time-specific.

(d) Implementation. Executing specific activities and/or interventions that will lead to accomplishing the goals set forth in the care plan. This involves organizing, securing, integrating, and modifying the resources necessary to accomplish the goals.

(e) Monitoring and Evaluation. Gathering ongoing information from all relevant sources about the care plan and its activities and/or services to enable the Contractor and family to determine the care plan's effectiveness in reaching desired outcomes and goals. This might lead to a change in the care plan in its entirety or any of its component parts.

C. Quality of Care Monitoring Information. Contractor shall notify the RMHMO Quality Improvement (QI) Manager of any potential adverse outcome event related to a Covered Person as soon as Contractor is informed of the situation. RMHMO's QI Manager shall be notified of any occurrence which raises the potential of quality concern issue, including but not limited to the following: (a) unplanned return to the operating room on the same admission, (b) unexpected death during inpatient stay, (c) unplanned removal, injury or repair of organ or structure during a surgical or other invasive procedure; and (d) any other unusual or potentially adverse event of which Contractor becomes aware.

D. Joint Operating Committee. RMHMO and Contractor agree to meet at least quarterly to discuss any operational issues of concern or need with regard to the provision of Care Coordination Services to Covered Persons by Contractor.

E. Records.

(1) Contractor shall maintain records of all CC activities related to Covered Persons on a case-specific basis, including a narrative of CC activities performed, referrals, dates of requests for Health Care or Behavioral Health Services, dates of resolution of requests for Health Care or Behavioral Health Services and Covered Person and identifiers for a minimum of ten (10) years.

(2) Additional records required to be kept by Contractor pursuant to this Agreement and provided to RMHMO shall include, but not be limited to, the following: (1) care coordination assessment tools; (2) annual reports; (3) applicable evaluations, audits, surveys and reports regarding the CC Program; (4) complaints regarding CC activities and actions taken with respect to such complaints; and (5) all CC policies and procedures. All records required by this Agreement shall be retained for not less than ten (10) years.

(3) Contractor shall immediately provide any records and/or reports regarding CC activities to RMHMO upon RMHMO's request.

(4) In providing any records under this Agreement, RMHMO and Contractor shall comply with applicable state and federal laws relating to privacy and confidentiality of medical records, including, but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

F. No Recourse Against Covered Persons or Colorado. Contractor hereby agrees that in no event, including, but not limited to, nonpayment by RME, RME's insolvency, or breach of this Agreement, shall Contractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person, the State of Colorado, any Federal Health Care Program or State Health Care Program or persons (other than the RME) acting on the Covered Person's behalf, for services provided pursuant to this Agreement. This provision does not prohibit Contractor from collecting deductibles, coinsurance or co-payments as specifically provided in the Covered Person's Health Care Plan or fees or supplemental charges for uncovered services delivered on a fee-for-service basis to Covered Persons. Contractor further agrees that (1) this provision shall survive the termination of this Agreement, regardless of the reason for termination, including insolvency of RME, and shall be construed to be for the benefit of Covered Persons, the State of Colorado, any Federal Health Care Program or State Health Care Program, and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contractor and a Covered Person or persons acting on a Covered Person's behalf insofar as such contrary agreement relates to liability for payment for or continuation of services provided pursuant to this Agreement. No changes, modifications, additions or deletions shall be made to the provisions of this paragraph without the prior written consent of the Secretary of the United States Department of Health and Human Services and such changes, modifications, additions or deletions shall become effective on a date no earlier than thirty (30) days after the Colorado Commissioner of Insurance has received written notice of such proposed changes, modifications, additions or deletions with regard to Health Care Plans which are not self insured Health Care Plans.

G. Compliance with Law. Contractor agrees to comply with the terms of Exhibit B, the Law Exhibit.

H. Compliance with The Business Associate Agreement for Protection of Information. The parties agree to execute and comply with the terms of Exhibit C, the Business Associate Agreement for Protection of Information.

I. Additional Obligations. To the extent any state or federal law requires that RME have Contractor perform certain duties or obligations, Contractor shall perform such duties and obligations.

3. Compensation.

A. Compensation for CC. RME will pay Contractor as set forth in attached Exhibit A – Scope of Work for CC services provided to Covered Persons. Contractor agrees to accept the compensation set forth on Exhibit A as full payment and complete satisfaction of any claim for compensation due for CC services provided to Covered Persons. The payment will be made upon RMHMO's acceptance of deliverables described in Exhibit A and after Contractor submits invoices to RMHMO for such deliverables and ongoing services.

4. Reporting. Contractor shall provide RMHMO with a report detailing the CC Services provided by Contractor. Contractor shall use a format agreed to by the parties, which may include a list of the names and contact information for the organizations visited with during outreach activities. RMHMO shall review the report and shall contact Contractor within ten (10) business days from receipt of the report if RMHMO requires additional information. Specific reporting requirements are set forth in Exhibit A – Scope of Work.

5. RMHMO Audit. RMHMO may conduct audits of CC Program records during regular business hours upon seventy-two (72) hours' advance written notice to Contractor. The audits shall occur quarterly during the first year of this Agreement, and at least annually thereafter, at intervals to be determined by RMHMO. Contractor shall provide RMHMO with working space for the purpose of such audits. During said audits, RMHMO will need access to consent and release forms, triage interview records, care coordination assessment tools, annual reports, and any other documentation related to CC.

6. Sub-delegation. Contractor shall not sub-delegate any CC activities without the express written approval of RMHMO, and any approved sub-delegation shall be subject to any terms and conditions imposed by RMHMO.

7. Notice of Noncompliance. In the event that Contractor is unable or unwilling to perform any duty or obligation required by this Agreement, Contractor shall immediately notify RMHMO of such fact in writing.

8. Effective Date and Termination.

A. Effective Date/Duration. This Agreement shall be effective as of the Effective Date set forth on the signature page of this Agreement, and shall continue in effect until December 31, 2019, unless otherwise terminated in accordance with the provisions of this Agreement.

B. Unilateral Termination. Notwithstanding the foregoing, this Agreement may be terminated by RMHMO or Contractor without cause on at least sixty (60) days' prior written notice to the other party.

C. Right to Immediate Termination. RMHMO may terminate this Agreement immediately with notice to Contractor if 1) Contractor is suspended from doing business in Colorado; 2) Contractor is not performing CC activities in compliance with CDHCPF requirements; 3) RMHMO revokes the delegation of CC activities pursuant to this Agreement; or 4) RMHMO reasonably determines that continuation of this Agreement may negatively affect Covered Persons' care.

D. Effect of Termination. Contractor's obligations with respect to CC activities performed prior to the effective date of termination shall survive termination of this Agreement.

9. General Provisions.

A. No Rights to Covered Persons. This Agreement shall not be construed to provide any right to a Covered Person or to increase the duties or responsibilities of the parties hereto beyond the requirements established by this Agreement. The sole purpose of this Agreement is to establish the respective rights and duties of the parties hereto, each to the other. Any rights of a Covered Person are derived solely from the Covered Person's Health Care Plan.

B. Governing Law and Venue. This Agreement shall be governed by the laws of the State of Colorado. This Agreement shall be governed by and construed in accordance with all laws, regulations and contracts of CDHCPF relating to Medicaid Recipients and CHP+ Covered Persons and all laws, regulations and contracts of CMS relating to Medicare Beneficiaries who are Covered Persons. Venue of all matters shall be in Mesa County, Colorado.

C. Severability. If any provision of this Agreement is held to be invalid or unenforceable, the remaining provisions shall continue in full force and effect, unless the invalid or unenforceable provision is material to this Agreement and its invalidity or unenforceability results in substantial economic detriment to either party to this Agreement.

D. Assignment. Contractor's rights, duties and responsibilities pursuant to this Agreement may not be assigned or delegated by Contractor without the prior written consent of RMHMO. RMHMO may assign its rights, duties and responsibilities pursuant to this Agreement, but only if such assignee assumes all such rights, duties and responsibilities.

E. Right of Setoff. If any amounts are owed to RME by Contractor, RME shall have the right to setoff such amounts from any amounts owed to Contractor by RME.

F. Relationship of Parties. This Agreement is intended to create the relationship of independent contractor on the part of Contractor as to the performance of the duties and obligations under this Agreement. Nothing contained herein shall be interpreted to create any relationship of agency, partnership or joint venture between RME and Contractor. Neither party shall represent or hold themselves out to any person or entity other than is consistent with the relationship of independent contractor.

G. Cooperation with RME Providers/ Non-Exclusive Agreement. Contractor acknowledges that RMHMO and RME may enter into other agreements with other entities and persons to assist in the promotion and implementation of Health Care Plans. Contractor agrees to cooperate with RMHMO and RME and all contractees and providers to RMHMO and RME in the provision of health care to Covered Persons.

H. Entire Agreement. This Agreement, and the Exhibits attached to this Agreement, constitute the entire understanding and agreement of the parties, and shall supersede all prior understandings and agreements of the parties on the subject matter of this Agreement.

I. Amendments. This Agreement may be amended as follows:

(1) Mutual Amendments. This Agreement may be amended upon the mutual written consent of the parties.

(2) State and Federal Law Amendments. RMHMO may unilaterally amend this Agreement in order to comply with any applicable federal or state laws or regulations. Any such unilateral amendment shall become effective on the date stated in the notice of amendment provided that such date is fifteen (15) days following RMHMO's notice to Contractor of the amendment, except that the amendment may become effective on an earlier date if any applicable state or federal law, statute or regulation that was the basis of the amendment requires a specific date of compliance, which date is less than fifteen (15) days following RMHMO’s notice.

J. Notices. Whenever required hereunder, notices, except notices of termination and breach, shall be deemed sufficiently given if made in writing, upon mailing, via United States Mail or a recognized overnight delivery service, to the address of the parties set forth on the signature page of this Agreement. Notices of termination and breach shall be deemed sufficiently given if made in writing, upon mailing, via United States Mail, postage prepaid, certified mail, return receipt requested, or via a recognized overnight delivery service to the addresses of the parties set forth on the signature page of this Agreement. The address to which notices are given may be changed by notice of change of address given in the method and manner provided herein.

K. Waiver. No party will be deemed to have waived any rights hereunder unless the waiver is made in writing and signed by the waiving party or that party’s duly authorized representative. The failure to exercise any right or remedy under this Agreement shall not operate as a waiver of such right or remedy. All rights and remedies provided for under this Agreement are cumulative. A waiver by any party of a breach of a provision of this Agreement or warranty or representation set forth herein will not constitute a waiver of the breached provision, warranty or representation or any other provision, warranty or representation.

L. Benefit. The terms and provisions of this Agreement shall bind and benefit Contractor and permitted assigns, and shall bind and benefit RMHMO and its agents, employees, representatives, successors and assigns. An RME other than RMHMO shall be a third party beneficiary of this Agreement to the extent that Contractor provides services to Covered

Persons enrolled under such RME's Health Care Plan, or under a Health Care Plan for which such RME is a third party administrator. To the extent an RME other than RMHMO is a third party beneficiary of this Agreement, such RME shall also have the obligations of RME under this Agreement as set forth herein. Each RME shall only have obligations under this Agreement for those services provided under the terms of this Agreement to Covered Persons enrolled under such RME's Health Care Plan or for which Health Care Plan such RME is a third party administrator. Except as provided in this paragraph, no other person or entity shall be a third party beneficiary of this Agreement.

ROCKY MOUNTAIN HEALTH PLANS®

Exhibit A

for Integrated Community Care Team Services

Prioritized Activities and Interventions for RAE Region 1 Enrollees
Regional Accountable Entity
Program Year Ending December 31, 2019

Gunnison County Health and Human Services -Gunnison County
Community Integration Agreement – Scope of Services

I. Purpose and Background

Reunion Health and RMHMO (collectively known as the Reunion Health partnership) have elected to participate in the Colorado Medicaid Accountable Care Collaborative as the Region 1 Regional Accountable Entity (RAE). Integrated Community Care Teams (ICCTs) are a critical component of the Reunion Health partnership's approach, which honors local intelligence and leadership to drive community-level vision and innovation aimed at improving the health and well-being of all community Covered Persons served by Medicaid.

The ICCT builds capacity and infrastructure in the Health Neighborhood by providing care transitions services, care coordination and complex care management. ICCTs are typically housed within an Anchor Organization, which will provide the infrastructure for the team, including a supervisor and human resources support for the team; management of payroll, benefits and compensation; access to HIPAA-secure electronic devices like computers, laptops, tablets or mobile phones; work space (if needed); compensation for mileage and other necessary and usual supports.

ICCTs are multi-disciplinary and can be comprised of nurses, licensed behavioral health professionals, Certified Addiction Counselors (CAC), social workers, and highly trained and experienced non-credentialed professionals that serve as community health workers. The ICCT structure is flexible and can be adapted to the needs of the community being served. Additionally, ICCT staff can be located in a number of settings, including a shared administrative office space, within a community mental health center (CMHC) or primary care medical practice (PCMP) or remotely. Care coordinators meet with Covered Persons in safe locations, like homeless shelters, hospitals and other public meeting places, or via a telehealth tool, available to all ICCT staff.

II. Key Community Partners

The ICCT, its host organization and RMHMO acknowledge and agree that, while all three parties are collectively as well as independently accountable for the achievement of Accountable Care Collaborative goals, their ability to be successful does not rest solely within the scope of their respective or collective control. To that end, Contractor and RMHMO agree to collaborate actively

with other organizations in the community, which share responsibility for program success. These include, but are not limited to:

- Gunnison Valley Family Physicians
- Town Clinic of Crested Butte
- Independent Primary Care Physician Practices
- Specialty Care Providers
- Center for Mental Health
- Independent Behavioral Health Providers
- Gunnison Valley Hospital
- RMHMO Care Coordinators and Care Coordination teams
- Community Options
- DHS in Gunnison County
- Health Department in in Gunnison County
- Nurse Family Partnerships
- Healthy Communities
- Community Health Workers
- Family Resource Center
- Local Interagency Operating Groups (IOGs)
- Hub and Spoke Model for Substance Use Treatment
- Rx for Health
- Licensed Public Health Agency
- Long Term Supports and Services Agencies
- Foster Care Agencies
- Long Term Residential Facilities serving older adults and disabled individuals
- Single Entry Point Agencies

This agreement outlines the specific strategies and initiatives the ICCT will use to accomplish the care coordination activities described briefly above (providing care transitions services, care coordination and complex care management).

III. Outreach to and Coordination with the Health Neighborhood

- To be successful, ICCTs will have documented as well as informal relationships with Key Community Partners in the Health Neighborhood, including but not limited to community based organizations that provide social services, long term care service organizations, Local Public Health Agencies (LPHAs), Primary Care Medical Providers (PCMPs), behavioral health providers, Nurse Family Partnerships, Health Communities, Community Health Workers, Family Resource Center, Local Interagency Operating Groups (IOGs), Hospitals, Hub and Spoke Model for Substance Use Treatment, Rx for Health, LPHAs, LTSS, CMHCs, SEPs, CCBs, specialists, police, jails, schools, other Regional Accountable Entities (RAEs) statewide, other ICCTs within Region 1, and other sources for care coordination and case management in the community. To this end, the ICCT will:

1. Outreach to and coordinate with the key entities described above to establish a point of contact with each entity and with the ICCT.
    a. Outreach includes the following activities:
        i. Participation in relevant Community efforts, including regional RMHMO initiatives, such as Community Corrections programs, AHCM, IOGs etc.
        ii. Activities to engage LTSS providers
        iii. Collaboration with Local Public Health Agencies
        iv. Activities to engage Covered Persons using evidence-based/promising practice programs in the community to address social determinants of health
        v. Identification of barriers that Covered Persons experience when accessing the Health Neighborhood and community resources

2. Develop internal policies and procedures for coordinating care with each of the above Key Community Partners who comprise the Health Neighborhood.

3. Reach out to RMHMO for support in establishing more formal memorandums of understanding (MOUs) to support these relationships.

4. Offer to meet with and/or present to entities and providers within the Health Neighborhood to introduce the ICCT as a shared resource for the community, describe the services and supports the ICCT provides, how to refer to the ICCT, and develop collaborative processes for referrals and ongoing communication.

5. ICCTs will also support regular communication between care coordinators and the providers delivering services to Covered Persons to ensure that the PCMP is aware of the Covered Person's status and progress towards goals.

IV. Geographic Catchment Area

1. The ICCT is responsible for the RAE Covered Persons (inclusive of RMHP Medicaid Prime Covered Persons) assigned to Region 1 in a geographic catchment area as defined by RMHMO.

2. Contractor is responsible for all Covered Persons attributed to the following provider clinic locations:

- Gunnison Valley Family Physicians
- Town Clinic of Crested Butte

3. If it is confirmed that a referral the Contractor receives is for a Covered Person who does not receive care within the geographically defined catchment area, then upon receiving a referral for a Covered Person, regardless of catchment area, the ICCT will assess and manage the Covered Person for immediate urgent or emergent needs prior to a warm handoff to the appropriate ICCT.

4. If the Covered Person is not eligible for Medicaid or has lost eligibility, the ICCT will assist the Covered Person with either gaining eligibility (if the Covered Person qualifies) or do everything they can to ensure a connection is made with a community partner who is able to provide care coordination for Covered Person prior to disengaging with Covered Person. In this case, the ICCT may provide care coordination services while Medicaid eligibility is established.

5. Contractor will provide care coordination and support for Covered Persons assigned to the defined geographic catchment area but receiving care outside of the catchment area. This may include individuals receiving care outside of Region 1 in Colorado, or receiving care from an out-of-state provider.

V. Organizational Structure

ICCTs will:

1. Establish a supervisory/management structure

2. Multidisciplinary ICCTs will organize their work to optimize the use of each staff covered person's professional credentials, experience and individual skills. ICCTs may have the following skill sets within their staff and these roles may overlap:
    a. Behavioral health skilled or credentialed staff (i.e. LCSW),
    b. Physical health skilled or credentialed staff (i.e. registered nurse),
    c. Staff who have skills related to addressing SDOH (i.e. social worker)

    d. Staff who are skilled at broad outreach, including telephone outreach to support transitions of care
    e. Staff who are skilled at supporting very complex Covered Persons

3. Follow RMHMO Medicaid Care Coordination Policy and Procedure (See Attachment A-1) for care coordination activities including specific policies and protocols for:
    a. Receiving and processing referrals
    b. Conducting follow up outreach calls
    c. Complex case management screening, assessment, person centered care planning and goal setting, ongoing management and case closure due to loss of contact or completion of goals

4. Develop strategies and workflows specific to meeting the requirements under this Agreement, including the RMHMO policies and protocol listed above.

5. Each ICCT will have a "super-user" who is an expert in the RMHMO care management documentation platform and the Community Resource Network (CRN) and can support light troubleshooting and training for other ICCT staff.
    a. That person will also interact with Rocky's Essette/CRN support when more complicated issues arise.

RMHMO will offer support in developing policies, training staff and other elements of the ICCT organizational structure as needed.

VI. Support of Key Performance Indicator (KPIs) Improvement

The ICCT will be responsible for supporting RMHMO and Reunion Health programs that address the following Key Performance Indicators (KPIs):

A. Potentially Avoidable Costs
B. Emergency Department Visits
C. Behavioral Health Engagement - percent of Covered Persons who received behavioral health care
D. Well Visits
E. Prenatal Care
F. Annual Dental Care
G. Health Neighborhood Measure

The ICCT will be responsible for supporting RMHMO and Reunion Health programs that address the following Behavioral Health (BH) Incentive Measures:

A. Engagement in Outpatient Substance Use Disorder Treatment
B. Follow-up within 7 days of an inpatient hospital discharge for a Mental Health Condition

C. Follow-up within 7 days of an Emergency Department (ED) Visit for a Substance Use Disorder
D. Follow-up after a Positive Depression Screen
E. Behavioral Health Screening or Assessment for Children in the Foster Care System

VII. Support of Risk Stratified Covered Persons

RMHMO is developing a stratification model that allows us to identify and address health risk in three distinct, related domains: behavioral, physical and social determinants of health. This model will allow RMHMO to classify all Covered Persons into the contractually required four quadrants. Once individuals are identified with emerging risk, the Contractor can provide support and stabilization thus avoiding high utilization episodes.

Intervention frequency: Using the four quadrant model to identify Covered Persons related to their physical and behavioral health risk as well as identifying those in other special populations.

- **Low Risk: Health Promotion and Prevention Activities**: Covered Persons receive health promotion and prevention activities provided by RMHMO only.
- **Medium Risk: Emerging Risk High in One Category (either Behavioral or Physical)** Covered Persons receive at least two touches bi-annually; one of these attempted face to face
- **High-high Risk: Managing Multiple Chronic Conditions:** A comprehensive assessment will occur within 1 month of initial outreach. This comprehensive assessment will be face-to-face, if possible. Follow-up will occur at a minimum every 30 days (monthly), but as frequently as daily depending on the Covered Person's needs both telephonically and face to face with the Covered Person, Family and Care Team. Care coordinators will make best efforts to reach out to other support systems the Covered Person is connected with (LTSS, CCBs etc) and offer support.
- **Triggering events and special populations requiring outreach:** may be additional indicators attached to a Covered Person. (This is in addition to being at one of the risk levels above)

Risk Stratification on Covered Persons will be identified in the RMHMO Care Management platform (currently Essette).

VIII. Covered person Engagement Expectations

Contractor is expected to develop a Covered person engagement strategy. Specific tools or strategies can include the following themes:

- Communication, cultural responsiveness and disability competent care
- Proactive education promoting the effective use of Medicaid benefits
- Training resources for care coordination staff and providers
- Use of technology to outreach covered persons
- Promotion of health and wellness – engaging covered persons in the state's priority areas

Contractors engaging with any Covered Person for care coordination purposes will integrate the following approaches when performing outreach activities:

1. ICCT staff will use a person- and family-centered approach to Care Coordination, which takes into consideration the preferences and goals of Covered Persons and their families, and then connects them to the resources required to carry out needed care and follow up.

2. All care coordination activities must be culturally and linguistically responsive and support prevention and early intervention, where possible and appropriate.

3. ICCTs will facilitate Covered Person referrals to resources as identified through screening or assessment as it is a best practice to close the referral loop, the ICCT will follow-up with the Covered Person to determine whether the Covered Person acted on referrals.

4. Covered Persons who are lower risk may request care coordination services - ICCT must respond and act upon these requests as they would with Complex case management

5. ICCTs will connect Covered Persons with agencies for determination of eligibility for other available benefits and community resources (TANF, HCBS Waivers, SNAP etc.)

6. ICCTs will coordinate services across all providers within the Health Neighborhood and ICCT staff will support regular communication between care coordinators and the providers who deliver services to Covered Persons, as well as all other community partners/care coordinators involved in the Covered Person's care

7. ICCT staff may accompany Covered Persons to appointments, supporting them to navigate health and social services when requested by the Covered Person

8. Supporting a Covered Person to choose and make an appointment with a PCMP

9. Encouraging timely preventive care, including well-child visits, immunizations, prenatal and postpartum care, annual dental visits, timely health screenings for adults

10. Provide care coordination to all individuals who screen positive on the AHCM screener and have two or more ER visits. Follow the AHCM workflow defined in Essette and document in an AHCM Compliant way. (See AHCM Policy and Procedure, attachment A-2)

11. Support and refer Covered Persons to current and future programs that address SDOH, like B4 Babies, transportation programs, AHCM referral loop closure, Gunnison County Community Corrections, etc.

12. Encourage and support self-management of chronic conditions, including diabetes, Cardiovascular Disease, Congestive Heart failure, mild to moderate depression and anxiety, and asthma.

13. Support and refer Covered Persons to programs designed to support special populations, like Healthy Harbors, crisis programs for intellectual or developmentally disabled individuals, programs for Covered Persons who are involved with criminal justice, etc.

14. Support and refer Covered Persons to other programs as identified by the ICCT or RMHMO

15. It is the ICCT's responsibility to respect when a Covered Person has chosen another agency to coordinate their transitions of care and necessary for the ICCT to work collaboratively with that agency to ensure a successful transition of care. Care coordinators will make best efforts to reach out to other support systems the Covered Persons is connected with (LTSS, CCBs etc) and offer support.

16. ICCT will support regular communication between care coordinators and the practitioners delivering services to Covered Persons

IX. Complex Care Coordination

It is a best practice, that as much as possible, care coordination should take place at the point of care. ICCTs serve as practice extenders and add to the overall capacity of the Health Neighborhood to support care coordination for Covered Persons with complex needs.

1. Care coordination activities are specified within the RMHMO Medicaid Care Coordination Policy and Procedure (Attachment A-1), which guides the required activities of each ICCT. The policy requires:

a. Open door entry into care coordination – ICCTs must be able to accept referrals from any entity in the Health Neighborhood such as RMHMO care management, other ICCTs, AHCM referrals, referrals from another RAE, referrals from practices and hospitals, referrals from community partners, self-referral etc.
b. Initial screening to determine need for services for Covered Persons who are referred to Care Coordination (through providers, through self-referral)
c. Ongoing review of the monthly Covered Person risk stratification report to proactively identify and reach out to high-risk individuals or individuals that have an increased risk compared with previous reports, as defined in the RMHMO Medicaid Care Coordination Policy and Procedure (Attachment A-1)
d. A comprehensive assessment inclusive of physical, behavioral health and SDOH, cognitive and functional (ADLs, IADLs) status, and condition-specific issues, as specified by the Medicaid Assessment in RMHMO's care management platform will occur within 2 months of initial outreach. The comprehensive assessment includes documentation of clinical and behavioral health history, including medications, initial assessment of life-planning activities, evaluation of cultural and linguistic needs, preferences or limitations, evaluation of visual and hearing needs, preferences or limitations, evaluation of caregiver resources and involvement and identification of barriers to Covered Person meeting goals or complying with the case management plan.
e. This comprehensive assessment will be face-to-face, if possible. Follow-up will occur at a minimum monthly, but as frequently as daily depending on the Covered Person's needs both telephonically and face to face with the Covered Person, Family and Care Team.
f. Person-centered care planning with collaborative S.M.A.R.T.[1] goal setting which considers preferences and desired level of involvement in the case management plan.
g. Follow up with covered persons that miss specialty care appointments to ensure transportation is secure for rescheduled appointment
h. Appropriate case closure due to loss of contact or completion of goals

2. All activities must be completely documented as set forth in RMHMO's documentation workflows provided during training.

3. For Covered Persons with a behavioral health issue as their primary concern, a designated staff covered person of the ICCT, preferably a person with a

[1] S.M.A.R.T. goals are specific, measurable, achievable, results-focused, and time- bound

behavioral health background and training, will serve as the designated liaison and collaborate with the Covered Person and the Covered Person's preferred behavioral health provider to support the care plan developed by the behavioral health provider. If the Covered Person does not have an established relationship with a behavioral health provider, then ICCT will work with the Covered Person to establish a relationship.

4. For complex care coordination, a 6 to 9 month time-limited engagement is preferred, with ongoing efforts to move towards Covered Person self-sufficiency

5. ICCT staff will use therapeutic techniques like motivational interviewing to achieve progress and should focus on recovery and resilience, have a trauma-informed approach and be Covered Person and family-centered

6. Some ICCTs may provide non-emergent transport or support to access NEMT in areas where available- not applicable for all ICCTs

7. A designated contact from RMHMO's Care Management ICCT leadership will serve as a resource for ICCTs to support case reviews, provide guidance, answer questions and coordinate needed resources.

X. Screening and Navigation for Social Determinants of Health (AHCM)

Screening and Navigation Requirements for Social Determinants of Health are specified within the AHCM Policy and Procedure, Attachment A-2, which guides the required activities of each ICCT. The policy requires:

1. Open door entry into care coordination – ICCTs must be able to accept referrals through the AHCM screening performed by practices and hospitals and work to coordinate services across all social determinants of health providers within the Health Neighborhood (food, housing, transportation etc.)

2. Follow the AHCM workflow defined in Essette and document in an AHCM Compliant way

XI. Transitions of Care

ICCTs are responsible for supporting transitions of care activities for the population in their given geographic catchment area. Transitions of care activities have timeliness and other requirements as follows:

1. Transitions of care activities will be performed for the following Covered Persons including, but not limited to, children involved with child welfare, Medicaid-eligible individuals transitioning out of the criminal justice system, Covered Persons receiving LTSS services, and Covered Persons transitioning out of institutional settings. ICCT will support transitions for Covered Persons who
    a. Transfer from one RAE to another RAE when Covered Persons are actively engaged in Care Coordination and/or receiving covered services through the Capitated Behavioral Health Benefit.
    b. Transfer from institutional settings to community-based services
    c. Are children involved with child welfare, children aging out of the foster/kinship care system and other targeted special populations
    d. Are Medicaid-eligible Covered Persons transitioning out of the criminal justice system

2. The ICCT will designate staff to serve as the Contractor's single point of contact with the different systems and settings.

Activities to support transitions of care include: answering the Covered Persons questions, supporting scheduling of follow-up appointments, ensuring that home care services are established if ordered and proactively identifying and addressing risks associated with hospital readmission or avoidable ER visits and connecting with other agencies to support SDOH, BH etc

XII. Special Populations

1. ICCTs are responsible for supporting RMHMO programs that address the needs of Special Populations:
    a) Criminal Justice Transitions Program: outreach and intervene with Covered Persons in the program in order to link the Covered Persons to appropriate and available services.
    b) High Risk Pregnant Women Outreach: outreach and intervene with Covered Persons in the program in order to link the Covered Persons to appropriate and available services.
    c) COUP: The Contractor shall outreach and intervene with Covered Persons identified as meeting overutilization criteria in order to link the Covered Person to appropriate and available services.

    The contractor shall review quarterly COUP report on its attributed Covered Persons, outreach to all Covered Persons on report and complete COUP report with outreach feedback by report deadline so that RMHMO can forward report to the Department.

    d) Participation in UHG Hot Spotters Program

Hot spotters is a national high touch, low volume program led by United Health Group focused on identifying the highest acuity covered persons and creating a multi-disciplinary care team. The four pillars used to identify covered persons are medical, psychological, social and opioid use. The goal is to create a community dialogue, engage resources and work through complexities and barriers to find solutions. RMHP has identified covered persons who fit this criteria, and is reviewing data regularly on these covered persons. RMHP will share referrals with the ICCT teams to focus resources on covered persons who meet the criteria for participation in the hot spotters program. RMHP will send referrals via Essette or secure email to ICCT teams.

XIII. Care Coordination Standards for Individuals with Complex Needs, Transitions of Care and Special Populations

1) Outreach once alert received via discharge notification from physical or behavioral health facility, SNF, rehab or other LTC facility or IMD denial – within 48 hours of discharge
   a) PH: go through Discharge orders, Rx, Red Flags, set up appts.
   b) BH: follow up – appointment occurring within 7 days with a CMHC or PCP with behavioral health services on site; discharge orders Rx; red flags
   c) IMD: look for other services and appropriate level of care placement
2) ED follow up post discharge –30 calendar days on high ED or COUP list, or drug safety program
3) COUP: 2 outreach calls to each Covered Persons on COUP list per quarter
4) ED follow up post discharge for primary substance use disorder (SUD) diagnosis: Outreach within 5 days to make sure appointment scheduled within 7 days with BH provider
5) Transfer from one RAE to another RAE when Covered Persons are actively engaged in Care Coordination and/or receiving covered services through the Capitated Behavioral Health Benefit - within 2 business days of referral from other RAE
6) Referral to care coordination – follow up within 2 business days
   -includes United Health Group Hot Spotters program and AHCM referrals (within 48 hours), referrals from another RAE, referrals from practices, Statewide Crisis Line and Nurse Advice Line, referrals from community partners, self-referral etc.

XIV. Referral Protocols

1. ICCTs will be trained on and use available technology to close the referral loop, ensuring to the extent possible that the Covered Person is supported to act on the referral for services and the service provider acknowledges the referral.
    a. The ICCT is encouraged to create a close-the-loop protocol in collaboration with key community partners
2. When the ICCT receives a referral from any Health Neighborhood partner, the ICCT is required to acknowledge and respond to the referral within 2 business days.

XV. Use of Technology and Tools

In order to support an integrated network of communication across care coordination resources throughout the region, RMHMO or its partners will provide and support shared technology. ICCTs will be trained on and adopt the following tools:

1. RMHMO Care Management platform (currently Essette) and use of ADT data
2. EasyCare – a tool to enhance communication between care coordinators and Covered Persons which supports HIPAA-secure text messaging and video supported encounters.
3. Community Resource Network (CRN) – a tool used to document AHCM screenings, referrals, identify a Covered Person's care team Covered Person across systems, facilitate high-level communication across social, medical and behavioral health sectors and support ADT message transfers to social services agencies.
4. ICCTs agree to adopt future technologies designed to be non-duplicative and enhance communication across systems, the network and support services

XVI. Training

A. All current ICCT staff will be required to attend the following trainings annually (and newly hired ICCT staff within a 6-month period after initiation of employment). A trainer employed by the ICCT host organization or by RMHMO or one of the Reunion Health partners may provide trainings. Other Community Health Neighborhood partners who provide best practices trainings may be approved.

1. Use of Essette & documentation Standards
2. Transitions of Care
3. Comprehensive Assessment
4. Strategies for supporting high-complexity clients
5. RMHMO reports and data as needed to support ICCT activities
6. RMHMO and State systems as needed to support ICCT activities
7. RMHMO Care management workflows & policies

8. Bridges Out of Poverty
9. Person centered approach to care planning and care coordination
10. Establishing referral protocols with Community Mental Health Centers (CMHCs) and overview of CMHC systems
11. Cultural Competency
12. Disability competency
13. Trauma-informed care
14. Knowledge of local resources and services
15. Ethics
16. Healthy Eating & Active Living and how to promote these activities with Covered Persons
17. Stress management & self-care
18. Zero Suicide Initiative
19. Knowledge of how to support access to Medicaid benefits, and other means-tested benefits including SNAP, WIC, TANF, Medicaid Waivers and other state programs
20. Training for the 7 core competency skills: patient engagement, stages of change, Motivational Interviewing, care coordination, supporting behavior change, Adherence support, group self-management
21. Additional advanced training includes: Trans-theoretical model of stages of change, management of chronic pain, family planning and pregnancy/child development, Basic understanding of common disease processes (addiction disorders, diabetes, anxiety, depression, CV disease, etc.)

B. Additional Training Required for Care Coordinators who work with pediatric Covered Persons:

1. Child and adolescent development
2. Family planning and pregnancy
3. IEPs & IDEA
4. EPSDT
5. Behavior Management Training

C. RMHMO will be an ongoing resource for Essette training and support. Through the Essette platform, ICCTs will receive Admissions, Discharge and Transfer data (ADT), care plans, assessments etc. for Covered Persons.

D. RMHMO will work provide Essette reports to ICCT that allow them to monitor their own performance under this Agreement

XVII. Reporting

1. Care Coordination Activity Report (Monthly):

Note: If the ICCT documents all of its care coordination activities in Essette, RMHMO will pull all RAE 1 Care Coordination data out of that system.

If the ICCT *does not* document all of its care coordination activities in Essette, then the ICCT is required to complete RAE 1 Care Coordination Report by the 15th working day of the month following the previous month. (see attachment A-3)

The report is due to the State on the 10th business day of the month following the end of the previous month.

2019 due dates:

February 14, 2019
May 15, 2019
August 14, 2019
November 14, 2019

2. **COUP Report (Quarterly):**
The Contractor shall review quarterly COUP report on its attributed covered persons, outreach to all covered persons on report and complete COUP report with outreach feedback by report deadline so that RMHMO can forward report to the Department. The report is due to the State on the 10th business day of the month following the end of the previous quarter. For ICCTs who document in Essette outreach must be complete and documented in Essette 14 business days prior to the below due dates.

Note: For ICCTs who do not document in Essette, the COUP Report is due to RMHMO 14 business days prior to the below due dates:

2019 due dates:

January 14, 2019
April 12, 2019
July 12, 2019

3. **ICCT Staffing Measures (Monthly):**
    a. Number of FTEs dedicated to care coordination
    b. Professional credentials of each staff covered person
    c. Trainings completed during the reporting period for each staff covered person (RMHMO will provide a template)
    d. Staff retention
        i. Staff turnover in the reporting period
        ii. Positions filled
        iii. Length of time position is open

4. **Narrative and Qualitative Reporting**
    a. Frequency: as requested
    Qualitative stories on Covered Persons who benefitted from ICCT support and examples of care coordination activities performed during the reporting period,
    b. Frequency: Quarterly
    Communications with and outreach to the Health Neighborhood – this may include attendance at community meetings, presentations to community organizations, discussions with practices, etc.
    c. Frequency: Annually
    Support RMHMO in pulling records and creating case studies for RHMMO annual HSAG audit.
    d. Frequency: Biannually This information will be shared with RMHMO in narrative form twice annually. RMHP would like to review the initial response by the end of Q1, 2019 – March 31, 2019. The responses from the ICCTs will be included in the covered person engagement report shared with HCPF, per the RAE contractual requirements.
    Covered person Engagement: ICCT will share with RMHMO any specific tools or strategies that they use as an organization to increase covered person engagement.

XVIII. Meetings & Oversight

1. **Meetings**

    A. Quarterly meetings with policy and program updates

    B. A supervisory/leadership representative from the ICCT or their designee must attend monthly regional meetings and quarterly region wide meetings

    C. A supervisory/leadership representative from the ICCT or their designee must attend ad hoc care conferences with other key community partners and RMHP Care Management to problem-solve specific complex cases.

    D. A supervisory/leadership representative from the ICCT or their designee must attend ad hoc meetings with RMHP care management Leadership, RMHP Community Integration Leadership to bilaterally address operational questions and concerns and to strategically plan as needed.

    E. Scheduled and ad hoc meetings with ICCT and host organization leadership and/or staff covered persons

2. **Oversight**

RMHMO will oversee and monitor ICCT activities to ensure that they conform to the goals of its Care Coordination program.

RMHMO will measure the performance of the ICCTs

RMHMO will use reports we pull from Essette and those reports sent by ICCT teams who do not use Essette that measure and will request information from the ICCT on the following:

- Completion of covered person outreach by ICCT for all campaigns as detailed above in Care Coordination Standards for Individuals with Complex Needs, Transitions of Care and Special Populations section
- Care Coordinator training completion
- Community Engagement
- Development of a Covered person engagement strategy

3. **Assessment:**

There will be a quarterly visit to each ICCT by RMHMO to review performance

4. **Audits**

Frequency: Semiannual: Audit of each ICCT by RMHMO to include review of documentation for clarity, completeness and quality including a review of Reporting as described in section XVI of this agreement

Frequency: Annual: Audit conducted by RMHMO in preparation for contract renewal: will use results of quarterly audits and feedback, dashboard results, review of any covered person feedback, review of any community feedback, and outcomes for catchment area as reporting becomes available.

Frequency: Semiannual: Audit of compliance with delegated care coordination per NCQA

As a result of audits, there may be progressive corrective action as needed to correct concerns identified by RMHMO Care Management leadership.

XIX. Budget & Payment

I. ICCT shall receive payment from RMHMO for the implementation and maintenance of resources required to fulfill requirements set forth in this Community Integration Agreement.

Resources and Budget

The Contractor will hire and maintain the following positions to support coordination of care for Covered Persons in Contractors Geographic catchment area. The Contractor will notify RMHMO if any of the named positions are vacant for greater than two months.

Position Title	Licensure	FTE	Employer
Care Coordinator		0.5	Gunnison County HHS
TOTAL:		0.5	

Contractor shall receive payment from RMHMO for the implementation and maintenance of resources required to fulfill requirements set forth in this Community Integration Agreement. This budget is inclusive of all expenses including but not limited to FTEs salary and benefits, administrative time, computer, phones and travel expenses:

II. Payment Schedule will be as follows:

Payment Dates	Payment amounts (per quarter)
March 15, 2019	$8,320.00
June 15, 2019	$8,320.00
September 15, 2019	$8,320.00
December 15, 2019	$8,320.00
Total amount payable for January 1 – December 31, 2019	$33,280.00

Payment will be contingent upon the satisfactory completion by the Contractor of milestones agreed by the parties pursuant to this Community Integration Agreement. The parties explicitly acknowledge that the Medicaid Accountable Care program and the Regional Accountable Entity is a new and novel initiative, in which payment and/or enrollment levels established by the State of Colorado may be adjusted suddenly and dramatically without substantial notice. In the event that the State of Colorado makes unexpected, material reductions in RAE payment, enrollment or program requirements, RMHMO reserves the right to revise payment to Contractor hereunder commensurately. Contractor may likewise reduce the scope of services performed hereunder commensurately. The parties agree to respond collaboratively and constructively to address unexpected changes by the State of Colorado.

Attachments:

A-1 RMHMO Medicaid Care Coordination Policy and Procedure

A-2 AHCM Policy and Procedure
A-3 RAE 1 Care Coordination Report
A-4 RAE 1 Population Health Plan

EXHIBIT B
TO
COMMUNITY INTEGRATION AGREEMENT

The terms of this Exhibit are made a part of and are included within the Agreement to which this Exhibit is attached. All capitalized terms not defined in this Exhibit are defined in the Agreement. Any party (Contractor) entering into the Agreement with RMHMO shall comply with all applicable terms and conditions of this Exhibit. The applicability of each paragraph depends on the type of Health Care Plan for which Contractor provides Health Care Services and is noted below.

SECTION I. The paragraphs in Section I apply to all Health Care Plans.

1. Non-Discrimination. Contractor agrees to comply with all applicable state and federal laws respecting discrimination and unfair employment practices.

2. Equal Opportunity. It is the policy of RMHMO to provide equal opportunity and to prevent discrimination based on race, color, sex, sexual orientation, gender identity, national origin, age or disability in admission or access to, or treatment or employment in, RMHMO programs, health care plans, and activities to the extent required by applicable law. Contractor shall comply with this policy as may be required by law. All federally funded benefits and services are provided in accordance with Title VI of the Civil Rights Act, as amended, Section 504 of the Rehabilitation Act, as amended, the Age Discrimination Act of 1975, as amended, the Americans with Disabilities Act of 1990, as amended, Section 1557 of the Patient Protection and Affordable Care Act, as amended, as well as other related laws. **In addition, the parties hereby incorporate the requirements of 41 C.F.R. § 60-1.4(a), 60-300.5(a), and 60-741.5(a), if applicable. These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, protected veteran status or disability.** All Contractors and subcontractors are notified of their responsibility to comply with these laws. The EEO Officer is responsible for compliance with state and federal equal opportunity laws. The EEO Officer is also responsible for implementing the Equal Opportunity Plan. If Contractor or a Covered Person has any questions concerning this policy, Contractor or Covered Person should contact the RMHMO Member Concerns Coordinator at (800) 346-4643or (970) 243-7050, or TTY (970) 248-5019 or (800) 704-6370; para asistencia en Español llame al (800) 346-4643.

3. Compliance Plan. RMHMO has a compliance plan (Compliance Plan) in place. Contractor shall not take any action to cause a violation of the terms of this Compliance Plan. A copy of the Compliance Plan will be provided to Contractor upon written request. Contractor shall contact the Compliance Officer at RMHMO if Contractor becomes aware of or suspects any fraud, waste, abuse or non-compliance with the Compliance Plan.

4. Illegal Aliens. Contractor certifies that Contractor does not knowingly employ or contract with any illegal aliens to perform services under the Agreement. If RME obtains actual knowledge that Contractor knowingly employs or contracts with an illegal alien to perform services under the Agreement, RME shall (1) notify Contractor within three (3) days that RME has actual knowledge that Contractor is employing or contracting with an illegal alien to perform services under the Agreement; and (2) terminate the Agreement, unless, within three (3) days of receiving notice from RME, (a) Contractor stops employing or contracting with the illegal alien to perform services under the Agreement, or (b) Contractor provides information to RME to establish that Contractor has not knowingly employed or contracted with the illegal alien to perform services under the Agreement. If Contractor becomes aware that Contractor has employed an illegal alien to perform services under the Agreement, whether knowingly or unknowingly, Contractor must end such employment immediately.

5. Program Eligibility. RMHMO and Contractor represent to the other that they have not been debarred,

suspended or made otherwise ineligible to participate in any State Health Care Program or Federal Health Care Program. Neither RMHMO nor Contractor will take any action during the term of this Agreement which would result in it being debarred, suspended or made otherwise ineligible to participate in any State Health Care Program or Federal Health Care Program. In addition, during the term of this Agreement, Contractor has not and will not arrange or contract with any employee, contractor, or agent for the provision of items or services under this Agreement who Contractor knows or should know is debarred, suspended or made otherwise ineligible to participate in any State Health Care Program or Federal Health Care Program. Contractor will provide RMHMO with validation that all its employees, contractors, subcontractors, or agents have been screened for debarment, suspension or exclusion in Medicare or any other State Health Care Program or Federal Health Care Program. If either party determines that the other party is, or becomes during the term of this Agreement, debarred, suspended or made otherwise ineligible to participate in any State Health Care Program or Federal Health Care Program, the party that is not debarred, suspended, or made otherwise ineligible may terminate this Agreement immediately.

SECTION II. The paragraphs in Section II apply to Federal Health Care Programs.

1. Incorporation of Federal Acquisition Regulations by Reference. Because RMHMO is a contractor with the federal government, the following provisions are incorporated by reference into the Agreement with the same force and effect as if the provisions were given in full text. These provisions are incorporated into the Agreement only to the extent required by applicable law. Upon request, RMHMO will make the full text of the provisions available:

A. Equal Opportunity (48 C.F.R. § 52.222-26);

B. Covenant Against Contingent Fees (48 C.F.R. § 52.203-5)

C. Utilization of Small Business Concerns (48 C.F.R. § 52.219-8);

D. Small Business Subcontracting Plan (48 C.F.R. § 52.219-9);

E. Convict Labor (48 C.F.R. 52.222-3)

F. Prohibition of Segregated Facilities (48 C.F.R. § 52.222-21) To the extent required by applicable law, Contractor certifies that Contractor does not and will not maintain or provide for Contractor's employees any segregated facilities as defined in 48 C.F.R. § 52.222-21(a) at any of Contractor's establishments, and that Contractor does not and will not permit Contractor's employees to perform their services at any location under Contractor's control where segregated facilities are maintained. Contractor agrees that a breach of this certification shall be a violation of the Equal Opportunity provision in paragraph 1;

G. Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (48 C.F.R. § 52.222-35);

H. Affirmative Action for Workers with Disabilities (48 C.F.R. § 52.222-36);

I. Anti Kickback Procedures (48 C.F.R. § 52.203-7); and

J. Government Property (48 C.F.R. § 52.245-1).

2. Prohibition Against Use of CMS Funds to Influence Legislation on Appropriations. No part of any funds paid to Contractor under this Agreement for Health Care Services provided to Medicare Beneficiaries shall be used to pay the salaries or expenses of Contractor or any agent acting for Contractor to influence legislation or appropriations pending before Congress.

3. Disclosure of Information. Contractor shall establish and maintain procedures and controls so that no information contained in its records or obtained from CMS or others in carrying out the terms of the Agreement shall be used by or disclosed by it, its agents, officers or employees, except as provided in Section 1106 of the Social Security Act (42 U.S.C. § 1306) and regulations prescribed thereunder.

4. Termination of CMS Contract. In the event RMHMO's Medicare contract is terminated or non-renewed, the Agreement, to the extent it concerns RMHMO's Medicare contract with CMS, will be terminated

unless CMS and RMHMO agree to the contrary. Such termination shall be accomplished by delivery of a written notice to Contractor of the date upon which said termination will be effective. Notwithstanding the foregoing, if RMHMO desires to continue the Agreement relative to RMHMO's business after the Medicare contract between CMS and RMHMO has been terminated or non-renewed, RMHMO may do so provided that RMHMO assures to CMS in writing that CMS' obligations will terminate at the time the Medicare contract terminates or is non-renewed, subject to termination cost provisions provided for in the Medicare contract.

5. Liquidated Damages. The following provision is applicable only if the Agreement contains a liquidated damage provision which is related solely to Medicare. CMS, after consultation with RMHMO, shall have the right to determine that the specified levels of performance have not been attained by Contractor. In such event, CMS may direct RMHMO to notify Contractor of CMS' determination that liquidated damages apply and to set-off the liquidated damages against Contractor. CMS shall reimburse RMHMO for all reasonable costs relating to this activity and shall honor any judgment or award rendered against RMHMO directly resulting from the enforcement of such provision as directed by CMS. Failure of RMHMO to timely comply with such direction, shall constitute cause for the application of any and all administrative, statutory, and judicial remedies which may be available to CMS pursuant to CMS' agreement with RMHMO, including, but not limited to, offsetting an amount equivalent to the amount of such unenforced liquidated damages. In the event that such offset is made, RMHMO shall be obligated to continue to perform all terms and conditions of such agreement without additional payment from CMS attributable to such offset amounts.

6. Downstream Contractual Obligations. To the extent not already set forth herein, Contractor agrees to comply with all applicable requirements and obligations to which RMHMO is bound, including but not limited to, the applicable requirements of 42 C.F.R. § 422.504 and 42 C.F.R. § 423.505. In addition, Contractor represents and agrees all services and activities performed by Contractor and any agent or subcontractor shall be consistent with RMHMO's contractual obligations with CMS.

7. CMS Requirements for Medicare Contracts. Contractor shall comply with all applicable requirements of law, with regard to providing Health Care Services to Medicare Beneficiaries. Contractor agrees to the following regarding providing Health Care Services to Medicare Beneficiaries:

A. The Department of Health and Human Services (HHS), the Comptroller General, or their designees may audit, evaluate, or inspect any pertinent information for any particular contract period, including but not limited to, any books, contracts, computer or other electronic systems, including medical records, patient care documentation, as well as all other records of Contractor that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the Agreement, or as HHS, the Comptroller General, or their designees may deem necessary to enforce RMHMO's contract with CMS to provide services to Medicare Beneficiaries. Contractor shall comply with the provisions of 45 C.F.R. § 74, et seq., concerning granting HHS and the Comptroller General of the United States, and any other authorized representatives, access to books, documents, papers and other records.

B. Contractor shall make available, for the purposes specified in paragraph (A) above, its premises, physical facilities and equipment, records relating to its Medicare Beneficiaries, and any additional relevant information that CMS may require.

C. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the end of the final contract period or completion of audit, whichever is later unless--

(1) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Contractor at least 30 days before the normal disposition date;

(2) There has been a termination, dispute, or allegation of fraud or similar fault by Contractor, in which case the retention may be extended to 6 years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or

(3) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Contractor at any time.

D. Contractor agrees that it will require all related entities, contractors and subcontractors to agree to the terms above regarding audits, evaluations, and inspections by HHS, the Comptroller General or their designees.

E. Contractor agrees to provide Health Care Services to Medicare Beneficiaries in a manner consistent with professionally recognized standards of health care.

F. Contractor shall comply with the confidentiality and enrollee accuracy requirements of CMS regulations with regard to Medicare Beneficiaries including: (1) abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

G. Medicare Beneficiaries will not be held liable for payment of any fees that are the legal obligation of RMHMO. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

H. For all enrollees eligible for Medicare and Medicaid, Contractor may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Contractor will: (1) accept RMHMO's payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §422.504(g)(1)(iii)]

I. Any services or other activity related to the Agreement which are performed by Contractor are consistent and comply with RMHMO's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

J. All contracts or written arrangements between Contractor and subcontractors or first tier or downstream entities for the provision of Health Care Services to Medicare Beneficiaries must contain a provision requiring that any services or other activity performed by such subcontractor, or first tier or downstream entity are consistent and comply with RMHMO's contractual obligations under its contract with CMS, and include the requirements, as applicable, of this subsection.

K. RMHMO may only delegate functions regarding services for Medicare Beneficiaries to Contractor, a subcontractor or downstream entity in a manner consistent with the requirements, laws, rules, and regulations governing Medicare. All contracts or written arrangements, including the delegation of any of RMHMO's activities or responsibilities under RMHMO's contract with CMS, must specify that the related entity, contractor or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. Any delegated activities or responsibilities under the Agreement shall be delineated in a separate exhibit attached to the Agreement. CMS and RMHMO reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or RMHMO determine that such parties have not performed satisfactorily. RMHMO, its affiliates, or its designee will monitor the performance of Contractor on an ongoing basis. Such monitoring may include, but not be limited to, review of reports, documentation, source code, etc. requested by RMHMO or its designee which demonstrate that delegated functions are being appropriately completed by Contractor. Contractor, any related entity, or any subcontractor providing services pursuant to the underlying contract or agreement shall permit and will fully cooperate with such ongoing monitoring, including allowing RMHMO, its affiliates or its designee access to systems, documents, records and any other information necessary to monitor delegated activities or responsibilities. Any costs incurred by RMHMO in monitoring the performance of Contractor, any related entity, or any subcontractor will be the responsibility of RMHMO. Any costs incurred by Contractor, any related entity, or any subcontractor for the performance of activities as part of the ongoing monitoring will be the responsibility of Contractor. RMHMO will not pay for Contractor travel expenses related to monitoring and auditing activities, unless agreed to in advance by the parties. The credentials of medical professionals affiliated with Contractor will be either reviewed by RMHMO or the credentialing process will be reviewed and approved by RMHMO and RMHMO must audit the credentialing process on an ongoing basis. If RMHMO delegates the selection of providers, contractors, or subcontractor, RMHMO retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4) and (5)]

8. Fraud Training. Contractor agrees to complete fraud training annually as required by 42 CFR §

422.503(b)(4)(vi)(C) and 42 CFR § 423.504(b)(4)(vi)(C). RMHMO will accept the certificate of completion of the CMS training as satisfaction of this requirement.

9. Overpayments. Contractor agrees to report and return to RMHMO, as required by 42 U.S.C. § 1320a-7k(d) any funds received, retained or derived from payments under Title XVIII or XIX of the Social Security Act to which Contractor is not entitled. Contractor shall report and return such funds to RMHMO no later than 60 days after Contractor identifies the overpayment. The report to RMHMO shall include a written statement of the reason of the overpayment.

In the event of a conflict between the terms and conditions above and the terms of the Agreement, the terms above control.

SECTION III. The paragraphs in Section III apply to State Health Care Programs.

1. Confidentiality. RMHMO is subject to the requirements of 45 C.F.R. § 205.50, as amended, section 10-16-423, C.R.S., as amended, and 42 C.F.R. §§ 431.304 ─ 431.307, as amended, regarding confidentiality of health information about Medicaid Recipients. Contractor shall hold and receive any health information about Medicaid Recipients subject to the above confidentiality requirements. Contractor shall comply with 42 C.F.R. part 431, subpart F, including 42 C.F.R. § 431.301, and section 26-1-114, C.R.S., regarding the confidentiality of information concerning applicants for and recipients of public assistance. Contractor shall protect the confidentiality of all Medicaid Recipient and CHP+ Covered Person records and other materials that are maintained in accordance with the terms of RMHMO's Medicaid Contract and CHP+ Contract. As part of these requirements, Contractor shall advise its employees and subcontractors, if any, that they are subject to these confidentiality requirements. Except for purposes directly connected with administration of RMHMO's Medicaid Contract or CHP+ Contract, no information about or obtained from any Medicaid Recipient or CHP+ Covered Person in the possession of Contractor shall be disclosed in a form identifiable with the Medicaid Recipient or CHP+ Covered Person without prior written consent of the Medicaid Recipient or CHP+ Covered Person, as applicable, or, if such Medicaid Recipient or CHP+ Covered Person is a minor, without the written consent of such minor's parent or guardian.

2. Records and Audits. Contractor 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 to Medicaid Recipients and CHP+ Covered Persons under this Agreement sufficient to disclose fully the nature and extent of services/goods provided to each Covered Person. 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 a payment was made and shall include, but are not limited to:

A. All medical records, service reports, and orders prescribing treatment plans;

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

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

All such records, documents, communications, and other materials shall be maintained by Contractor for a period of ten (10) years from the date services are provided under this Agreement, or for such further period as may be necessary to resolve any matters which may be pending with regard to such services, or until an audit by or on behalf of the federal or state government 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 ten (10) year period, or if audit findings have not been resolved after a ten (10) year period, the materials shall be retained until the resolution of the audit finding. Further, Contractor agrees to grant the State of Colorado, CMS, HHS OIG, and the Comptroller General the right to audit, evaluate and inspect any books, contracts, electronic systems and rights to access the premises, physical facilities and equipment of contractors and subcontractors where work is conducted pertaining to the services and the Agreement at any time and this right is preserved for ten (10) years after

completion of the contract or completion of an audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit Contractor at any time.

3. Insurance. The terms of this paragraph only apply to Contractor if and to the extent it is a "Subcontractor" providing goods and services under the Medicaid Contract. For purposes of this paragraph, "Subcontractor" means a third party engaged by RMHMO to aid in performance of its obligations under the Medicaid Contract. If Contractor is a Subcontractor which is a public entity within the meaning of the Colorado Governmental Immunity Act, section 24-10-101, et seq., C.R.S., as amended (the GIA), then Contractor shall maintain at all times during the term of this Agreement 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 if requested by RME. If Contractor is not a public entity within the meaning of the GIA, but is a Subcontractor, Contractor shall obtain and maintain during the term of this Agreement the following:

A. Worker's Compensation Insurance as required by the state of Colorado (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.

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

(1) $1,000,000 each occurrence;

(2) $1,000,000 general aggregate;

(3) $1,000,000 products and completed operations aggregate; and

(4) $50,000 any one fire.

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

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

(1) $1,000,000 each occurrence; and

(2) $2,000,000 general aggregate.

D. 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.

E. The State shall be named as additional insured on all Commercial General Liability policy (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.

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

G. The above insurance policies shall include provisions preventing cancellation or non-renewal without at least 30 days prior notice to RMHMO and RMHMO shall forward such notice to the State within seven days of RMHMO's receipt of such notice.

H. All insurance policies in any way related to this Agreement and secured and maintained by Contractor or its subcontractors shall include clauses stating that each carrier shall waive all rights of recovery,

under subrogation or otherwise, against RMHMO or the State, its agencies, institutions, organizations, officers, agents, employees and volunteers.

Contractor shall provide certificates showing insurance coverage required to RMHMO within seven (7) business days of the effective date of this Agreement. No less than fifteen (15) days prior to the expiration date of any such coverage, Contractor shall deliver to RMHMO certificates of insurance evidencing renewals. Upon request of RME, Contractor shall within ten (10) days of such request, supply to RME evidence satisfactory to the State of compliance with the provisions of this paragraph.

4. Untrue or Misleading Information. Contractor shall not knowingly provide untrue or misleading information, as defined at sections 10-16-413(1)(a)-(c), C.R.S., regarding RMHMO's Medicaid Plan, CHP+ Program, other Medicaid managed care organizations, or Medicaid or CHP+ Program eligibility, to RMHMO Medicaid Recipients or CHP+ Covered Persons.

5. Medicaid Recipient Rights. Contractor shall comply with the requirements of RMHMO's Medicaid Contract with regard to the rights of Medicaid Recipients, including but not limited to the following:

A. Contractor shall provide interpreter services for Medicaid Recipients with communication disabilities or non-English speaking Medicaid Recipients when such an interpreter is necessary in order to render effective communication in connection with the provision of Health Care Services. RMHMO will assist Contractor in providing information in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example are visually limited or have limited reading proficiency.

B. Contractor shall provide Medicaid Recipients, in terms the Medicaid Recipients can understand, an explanation of the Medicaid Recipients complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives. If the Medicaid Recipient is not capable of understanding the information, the explanation shall be provided to the Medicaid Recipient's biological, adoptive or foster parent, guardian or designated client representative, and documented in the Medicaid Recipient's medical record.

C. Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v).

6. Medicaid and CHP+ Contracts Statutes and Regulations. Pursuant to requirements of RMHMO's Medicaid Contract and CHP+ Contract, Contractor and any subcontractor of Contractor shall comply with the following statutes and regulations:

A. Age Discrimination Act of 1975, as amended (42 U.S.C. Sections 6101, et seq.)

B. Age Discrimination in Employment Act of 1967 (29 U.S.C. 621-634)

C. Americans with Disabilities Act of 1990 (ADA) (42 U.S.C. 12101, et seq.)

D. Equal Pay Act of 1963 (29 U.S.C. 206(d))

E. Immigration Reform and Control Act of 1986 (8 U.S.C. 1324b)

F. Clean Air Act (42 U.S.C. 7401, et seq.)

G. Equal Employment Opportunity (E.O. 11246, as amended by E.O. 11375, amending E.O. 11246 and as supplemented by 41 CFR Part 60)

H. Federal Water Pollution Control Act, as amended (33 U.S.C. 1251, et seq.)

I. Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794)

J. Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000d, et seq.)

K. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e)

L. Title IX of the Education Amendments of 1972, as amended (20 U.S.C. 1681, et seq.)

M. Section 24-34-301, et seq., Colorado Revised Statutes 1997, as amended (Civil Rights Division)

N. Section 1557 of the Patient Protection and Affordable Care Act, as amended.

Contractor shall also comply with any and all laws and regulations applicable to these laws prohibiting discrimination on the basis of race, color, national origin, age, sex, sexual orientation, gender identity, disability, religion or handicap, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions. In addition, 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. Any provider who feels that he/she has been discriminated against has the right to file a complaint either with the Colorado Department of Human Services or with the U.S. Department of Health and Human Services Office for Civil Rights.

7. Certifications. Pursuant to requirements of RMHMO's Medicaid Contract and CHP+ Contract, RMHMO is required to include in the Agreement and obtain Contractor's agreement to the following:

A. Lobbying.

(1) No Federal or appropriated funds have been paid or will be paid by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any contract, grant, loan or cooperative agreement that utilizes Federal funds.

(2) 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 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 this Federal Contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit Standard Form – LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions.

(3) Contractor shall require that the language of this certification be included in the award documents for subawards at all tiers (including subgrants and Contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of the certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Contractor shall include, without modification, the above certification in any subcontract to the Agreement it may enter into.

B. Suspension and Debarment. Contractor certifies that, to the best of its knowledge and belief, that the Contractor and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal department or agency.

Contractor shall require that the language of the above certification be included in any subcontract to this Agreement into which it may enter and shall require any subcontractor to include the language of the above certification in any sub-subcontract to this Agreement into which subcontractor may enter. Contractor shall provide immediate written notice to RMHMO if it has been debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any Federal department or agency. The terms "covered transaction," "debarment," "suspension," "ineligible," "principal," and "voluntarily excluded," as used in this paragraph have the meanings set out in 2 CFR Parts 180 and 376.

8. Enrollment Requirements. Contractor shall be enrolled with the State of Colorado in accordance with the disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and the requirements of the State of Colorado for Medicaid and CHP+ providers. Contractor shall include in its application to RME, its Medicaid identification number and the date of Colorado Medicaid enrollment or most recent validation.

9. State Contracts. In addition to the foregoing, to the extent Contractor provides services to Medicaid Recipients and/or CHP+ Covered Persons, Contractor agrees to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and the requirements of the Medicaid Contract and CHP+ Contract that are applicable to subcontractors, as defined in such contracts.

EXHIBIT C
BUSINESS ASSOCIATE AGREEMENT FOR PROTECTION OF INFORMATION

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC., a Colorado corporation d/b/a Rocky Mountain Health Plans (herein "RMHMO")

Address of RMHMO and RME:

2775 Crossroads Boulevard
Post Office Box 10600
Grand Junction, CO 81502-5600

GUNNISON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES (Contractor)

Address of Contractor:
220 N. Spruce St.
Gunnison, CO 81230

Tax ID No: 84 6000 770

The purpose of this Business Associate Agreement for Protection of Information (Business Associate Agreement) is to comply with HIPAA, as hereinafter defined.

RME and Vendor/Contractor are parties to an underlying agreement for services.

The terms of the underlying agreement for services result in Vendor/Contractor's providing services to RMHMO, who is classified as a "Business Associate" of the Colorado Department of Health Care Policy and Financing under the Health Insurance Portability and Accountability Act of 1996.

The HIPAA regulations require RME to enter agreements that include mandated provisions and terms with all vendors and contractors and subcontractors who require access to PHI in order to perform functions on behalf of an RME.

Vendor/Contractor and RMHMO agree to all Terms and Conditions, attached.

This Agreement is dated and shall be effective on the date set forth below by RMHMO as the effective date.

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC., a Colorado corporation d/b/a Rocky Mountain Health Plans

By: _____
(signature)

_____
(print/type name and title of signatory)

Effective Date: _____
(To be completed by RMHMO)

GUNNISON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES (Contractor)

By: _____
(Signature)

Jonathan Houck, Chairperson, BOCC
(Print/type name)

TERMS AND CONDITIONS

I. Definitions. Terms used but not otherwise defined in this Business Associate Agreement shall have the same meaning as those terms in 45 C.F.R. Parts 160 and 164. All terms defined in this Business Associate Agreement shall have a meaning consistent with terms defined in 45 C.F.R. Parts 160 and 164. Capitalized terms in this Business Associate Agreement are defined as follows:

A. "Business Associate" shall mean, with respect to a Covered Entity, a person who is defined in 45 C.F.R. 160.103.

B. "Business Associate Agreement" means this document/agreement, which may be incorporated by reference into the underlying agreement, or entered by the parties separately from the underlying agreement.

C. "Covered Entity" shall have the meaning of the term "covered entity" as defined in 45 C.F.R. 160.103.

D. "Designated Record Set" means PHI maintained by or for RME, including but not necessarily limited to (i) the medical records and billing records about Individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, case or medical management records; and (iii) any other records used, in whole or in part, to make decisions about Individuals.

E. "Disclose," "Disclosing" or "Disclosure" means the release, transfer, provision of access to, or divulging in any manner of information outside the entity holding the information.

F. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91, as amended), the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005, and related HIPAA regulations (45 C.F.R. Parts 160-164) including specifically any amendments or additions to such regulations and the HIPAA Omnibus Rule.

G. "HIPAA Omnibus Rule" shall mean the Modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act, 78 Federal Register 5566 (January 25, 2013), and any amendments thereto.

H. "Individual" means a natural person who is the subject of PHI.

I. "Information Privacy and Protection Laws" mean (i) HIPAA; (ii) the Gramm-Leach-Bliley Act, as amended and including any implementing regulations; (iii) any statute, regulation, administrative or judicial ruling requiring a party to protect the privacy or security of information pertaining to the health or medical status or condition of an individual, and/or the payment for health or medical care for an individual; (iv) any statute, regulation, administrative or judicial ruling requiring a party to protect the privacy of information pertaining to the financial or credit status or condition of an individual; (v) any statute, regulation, administrative or judicial ruling requiring a party to protect information pertaining to Individuals based upon the Individuals' status as consumers; and (vi) any other statute, regulation, administrative or judicial ruling requiring a party to protect the confidentiality, privacy and/or security of information pertaining to Individuals; all to the extent that such Information Privacy and Protection Laws have been enacted, promulgated, issued or published by any federal or state governmental authority with jurisdiction over a Covered Entity, a Business Associate, an individual or RME.

J. "Minimum Necessary Information" means (i) in the case of routine and recurring types of Disclosures, information or records which the Disclosing party's policies and procedures have established as reasonably necessary to achieve the purpose of such Disclosures; (ii) in the case of non-routine or non-recurring Disclosures, the information or records which the Disclosing party determines is reasonably necessary to accomplish the purpose of the Disclosure, upon review of each Disclosure according to criteria developed by the Disclosing party; (iii) in the case of a Disclosure (A) to a Covered Entity, (B) to a professional for purposes of providing professional services to the Disclosing party, or (C) to a public official for Disclosures which are permitted by law without Individual consent, the Minimum Necessary Information shall be the information or records requested by that party, upon the party's reasonable representation that the request is for the minimum necessary given the purpose of the Disclosure(s).

K. "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and 164 (Subparts A and E), and as amended.

L. "Protected Health Information" or "PHI" shall have the meaning as the term "protected health information" in 45 C.F.R. 160.103 and generally includes any information that identifies or could reasonably be believed used to identify an Individual, which in any way concerns that Individual's health status, health care, or payments for his or her health care.

M. "Receive," "Receiving" or "Receipt" means (i) to take physical delivery of media containing information, or (ii) in the case of electronic delivery, for information to come into existence in a party's information processing system in a form capable of being processed by or perceived from a system of that type by the Receiving party if the Receiving party has designated that system or address as a place for Receipt of Information to a Disclosing party and the Disclosing party does not know that the information cannot be accessed from the particular system.

N. "Rocky Mountain Entity" or "RME" means RMHMO and any present or future subsidiaries of RMHMO.

O. "Security Rule" means the Security Standards for Protection of Electronic Protected Health Information at 45 C.F.R. Part 164, Subpart C, and as amended.

P. **"**Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 CFR § 164.304.

Q. "Third Party" means any individual, person, or organization not a party to this Business Associate Agreement.

R. "Unsecured PHI" shall have the same definition as the term is given in 45 C.F.R. 164.402.

S. "Use" means the sharing, employment, application, utilization, examination, analysis, de-identification or commingling with other information, of information by a party that holds that information.

II. Permitted Uses and Disclosures by Vendor/Contractor.

A. Permitted Uses. The purpose(s) for which Vendor/Contractor may Use, Disclose, or have access to PHI includes those Uses, Disclosures, or access specifically identified in the underlying agreement when Vendor/Contractor is performing a function, service, or activity on behalf of RME. Specifically, the scope of PHI that may be Used, Disclosed, or accessed and/or the functions performed by Vendor/Contractor includes PHI necessary to perform functions required by the underlying agreement for services.

B. Compliance with Law. Vendor/Contractor will not Use, Disclose, or access PHI in violation of any Information Privacy and Protection Laws.

C. Limitations on Use and Disclosure. Vendor/Contractor further agrees to not Use or Disclose PHI other than as permitted or required by this Business Associate Agreement or as required by law. Vendor/Contractor will not transfer PHI outside the United States without the prior written consent of RME. In this context, a "transfer" outside the United States occurs if Vendor/Contractor's workforce members, agents, or subcontractors physically located outside the United States are able to access, Use, or Disclose PHI. Vendor/Contractor may not use or disclose PHI in a manner that would violate HIPAA if done by RME, except as provided in Section III.D.

D. Management and Administration. Vendor/Contractor may use PHI for the proper management and administration of Vendor/Contractor or to carry out its legal responsibilities. Vendor/Contractor may Disclose PHI for the proper management and administration of Vendor/Contractor or to carry out its legal responsibilities, provided the Disclosures are required by law, or Vendor/Contractor obtains reasonable assurances from the person to whom the PHI is Disclosed that the PHI will remain confidential and Used or further Disclosed only as required by law or for the purposes for which it was Disclosed to the person, and the person notifies Vendor/Contractor of any instances of which it is aware in which the confidentiality of the PHI has been breached.

III. Obligations and Activities of Vendor/Contractor.

A. Independent Obligation. Vendor/Contractor, consistent with its independent obligations under HIPAA, will comply with applicable provisions of the Security Rule and the Privacy Rule with respect to PHI created or obtained by it through the underlying agreement and this Business Associate Agreement.

B. Access to Records. Vendor/Contractor agrees to provide access, at the request of RME and in the time and manner designated by RME, to PHI in a Designated Record Set to RME or, as directed by RME, to an Individual in order to meet the requirements under 45 CFR 164.524. This is not

necessary if Vendor/Contractor does not have PHI in a Designated Record Set.

C. Amendment to Records. Vendor/Contractor agrees to make any amendment(s) to PHI in a Designated Record Set that RME directs or agrees to pursuant to 45 CFR 164.526 at the request of RME and in the time and manner designated by RME. This is not necessary if Vendor/Contractor does not have PHI in a Designated Record Set.

D. Accounting for Disclosure of Records. Vendor/Contractor shall maintain an accounting or record of all Disclosures of PHI it makes as required by and in accordance with 45 C.F.R 164.528. The record of the Disclosure shall include the following information: (a) the date of the Disclosure, (b) the name and address of the organization and/or individual Receiving the information; (c) a brief description of the information Disclosed; (d) if the Disclosure was not to the Individual, the purpose for the Disclosure; and (e) a copy of all requests for Disclosures. Vendor/Contractor agrees to provide to RME, in the time and manner designated by RME, information collected in accordance with this section, to permit RME to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

E. Mitigation. Vendor/Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Vendor/Contractor of a Use or Disclosure of PHI by Vendor/Contractor in violation of the requirements of this Business Associate Agreement.

F. Minimum Necessary and Limited Data Set. Generally, Vendor/Contractor's Use, Disclosure, or request for or of PHI shall utilize a limited data set if practicable. If use of a limited data set is not practicable, Vendor/Contractor shall limit the Use, Disclosure, or request to the Minimum Necessary Information for purposes of that transaction in accordance with HIPAA. Information required to be provided or submitted in standard transactions adopted under HIPAA and implementing regulations and authority are presumed to meet the Minimum Necessary Information requirements.

G. Security/Notification of Breach. At all times following the Receipt of PHI, until such time as the PHI is no longer in Vendor/Contractor's possession or subject to its control:

(1) Vendor/Contractor shall implement administrative, physical, and technical safeguards, as required by the Security Rule that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, Receives, maintains, or transmits on behalf of RME. Such administrative, physical, and technical safeguards, and other appropriate safeguards, shall be implemented in order to prevent any Use or Disclosure of PHI other than those permitted under this Business Associate Agreement; and

(2) Vendor/Contractor shall notify RME within five (5) days of becoming aware of (i) any Use or Disclosure of PHI not provided for by or contrary to the terms of this Business Associate Agreement; and (ii) any Security Incident. Any breach of Unsecured PHI must be reported by Vendor/Contractor to RME as required at 45 CFR 164.410, without unreasonable delay and in no case later than five (5) calendar days after discovery of the breach.

H. Agents and Subcontractors. Vendor/Contractor agrees to ensure that any agent or subcontractor of Vendor/Contractor that creates, Receives, maintains, or transmits PHI agrees to the same restrictions and conditions that apply to Vendor/Contractor with respect to the PHI. Further, Vendor/Contractor shall implement and maintain sanctions against agents and subcontractors, if any, that violate such restrictions and conditions. Vendor/Contractor shall maintain the right to terminate any agreement with an agent or subcontractor who fails to abide by such restrictions and obligations or cure such violations within thirty (30) days, and shall take such other action as required by HIPAA, including reporting the violation to the U.S. Secretary of the Department of Health and Human Services.

I. Covered Entity Obligations. To the extent that Vendor/Contractor is carrying out RME's obligations under HIPAA, Vendor/Contractor shall comply with the requirements of HIPAA that apply to RME in performing such obligations.

J. Audits. Vendor/Contractor agrees to make its internal practices, books, and records relating to its access to, and Use and Disclosure of, PHI received from or on behalf of RME or created by Vendor/Contractor on behalf of RME available to RME or, at the request of RME, to the U.S. Secretary of the Department of Health and Human Services (Secretary) in a time and manner designated by RME or the Secretary for purposes of determining compliance with Information Privacy and Protection Laws.

K. Compliance with Law and Agreement. Each party to this Business Associate Agreement shall comply with, and as applicable shall require its directors, officers and employees to comply with, all

applicable Information Privacy and Protection Laws and with each party's duties and obligations pursuant to this Business Associate Agreement.

IV. Information Transmission Agreement

A. Transmission of PHI. In arranging for transmission or exchange of PHI with RME, regardless of the format of the information or the method of transmission utilized, Vendor/Contractor will cooperate with RME to reasonably safeguard such information from unauthorized Disclosure.

V. Term and Termination

A. Effective Date. The Effective Date of this Business Associate Agreement shall be the effective date indicated on the signature page of this Business Associate Agreement.

B. Term. Except as otherwise agreed, this Business Associate Agreement shall be in effect for the term of the underlying agreement and shall be renewed with any renewal or extension of the underlying agreement.

C. Termination for Cause. Notwithstanding anything to the contrary in this Business Associate Agreement or the underlying agreement, following RME's discovery and determination of a material breach by Vendor/Contractor of the terms of this Business Associate Agreement, and Vendor/Contractor's failure to cure or end the violation within any time period agreed to by RME, if any, RME may:

(1) Terminate this Business Associate Agreement and the underlying agreement or contract upon written notice to Vendor/Contractor without any judicial intervention being required and without liability for such termination; or

(2) If termination is not feasible, report the issue to the Secretary of the U.S. Department of Health and Human Services.

D. Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Business Associate Agreement, for any reason, Vendor/Contractor shall return or destroy all PHI Received from RME, or created or Received on behalf of RME. Vendor/Contractor shall retain no copies of the PHI. This provision shall apply to PHI that is in the possession of subcontractors or agents of Vendor/Contractor, and to PHI Disclosed by Vendor/Contractor to Third Parties.

(2) In the event that Vendor/Contractor determines that returning or destroying PHI is not feasible, Vendor/Contractor shall provide to RME notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the parties that return or destruction of PHI is infeasible, Vendor/Contractor shall extend the protections of this Business Associate Agreement to any PHI that is so retained and not destroyed and limit further uses and disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as such PHI is maintained.

E. Archiving of Information. Any Information retained by Vendor/Contractor pursuant to paragraph V.D.2. above shall be returned or destroyed when the circumstances making its return or destruction infeasible no longer exist, and until such time, Vendor/Contractor shall continue to comply with all requirements and protections that apply to PHI under this Business Associate Agreement for as long as such information is retained.

VI. General Provisions

A. Amendment of Agreement. This Business Associate Agreement shall not be changed, modified or altered except by amendment, which, to be valid and enforceable, shall be in writing and signed by the parties. Notwithstanding the foregoing: (1) RME may unilaterally amend this Agreement in order to comply with HIPAA and any other applicable federal or state laws or regulations, effective immediately upon written notice to Vendor/Contractor; and (2) upon the addition of, change, or amendment to HIPAA or any other applicable federal or state laws or regulations relevant to the terms of this Business Associate Agreement which would require an amendment, this Business Associate Agreement shall be deemed to be amended to comply with such addition, change or amendment.

B. Indemnification. Each party will indemnify, hold harmless, and defend the other parties to this Business Associate Agreement from and against any and all claims, losses, liabilities, costs, and other expenses incurred as a result or arising directly or indirectly out of or in connection with (a) any non-fulfillment of any obligation on the part of the responsible party under this Business Associate Agreement; and (b) any claims, demands, awards, judgments, actions, and proceedings made by any person or organization, arising out of or in any way connected with the party's performance under this Business Associate Agreement.

C. Survival. The obligations of Vendor/Contractor under section V.D. of this

Business Associate Agreement shall survive termination of the underlying agreement.

D. No Agency or Partnership. This Business Associate Agreement does not create a joint venture, partnership, or employer-employee relationship between the parties. In performing under this Business Associate Agreement, each party is at all times acting and performing as an independent contractor and is not an agent or representative of any other party.

E. No Rights to Individuals. This Business Associate Agreement shall not be construed to provide any right to an Individual or to increase the duties or responsibilities of the parties hereto beyond the requirements established by this Business Associate Agreement. The sole purpose of this Business Associate Agreement is to establish the respective rights and duties of the parties hereto (and of RME). Any rights of an Individual are derived solely from law and not from this Business Associate Agreement.

F. RMEs Benefit from Agreement. An RME other than the signatory to this Business Associate Agreement shall be a third party beneficiary of this Business Associate Agreement to the extent that Vendor/Contractor provides services to such RME. To the extent that an RME other than the signatory to this Business Associate Agreement is a third party beneficiary of this Business Associate Agreement, such RME shall also have the obligations of the signatory to this Business Associate Agreement as set forth herein.

G. Assignment. No party may assign or transfer any or all of its rights and/or obligations under this Business Associate Agreement or any part of it, nor any benefit or interest in or under it, to any Third Party without the prior written consent of all other parties.

H. Interpretation. Any ambiguity in this Business Associate Agreement or inconsistency with a provision of the underlying agreement shall be resolved in favor of a meaning that permits RME to comply with applicable Information Privacy and Protection Laws.

EXHIBIT D – BUSINESS ASSOCIATE AGREEMENT ACCOUNTABLE CARE SERVICES: RMHMO AND CONTRACTOR

Rocky Mountain Health Maintenance Organization, Inc. ("RMHMO") and ("Partnering Organization") identified as "Contractor" in the signature block desire to enter into this BUSINESS ASSOCIATE AGREEMENT ("AGREEMENT") to describe the purposes, activities, scope, limitations, requirements, and roles of the parties with respect to the collaborative data use, access and aggregation in order to conduct research, treatment and health care operations activities associated with various Initiatives described herein.

RECITALS

RMHMO has been, and may in the future be, engaged in projects, pilot programs, government programs, and other activities related to innovative health care programs, transformative care models, and payment reform and related assessments ("Initiatives"), including for example: efforts to increase the integration and coordination between primary care and behavioral health care, mental health care and substance abuse treatment, and community based resources; Medicaid Accountable Care Collaborative and "medical home" models of care; the Colorado Primary Care Initiative; efforts to increase the efficient and secure exchange of health information and data among authorized health care providers.

On occasion, RMHMO and its participating providers and Partnering Organizations want to assess the impacts of such Initiatives and models in order to contribute to generalizable knowledge through research to report on such Initiatives, or provide information that is useful in relation to assessing and improving RMHMO's and the various practices' health care operations activities and the practice's treatment protocols or guidelines. For example, RMHMO may work with the University of Colorado to conduct research into the impact of primary care physician global payment methodologies and the integration and coordination of behavioral health care, mental health and substance abuse treatment with primary care.

NOW THEREFORE, RMHMO and the Partnering Organization identified in the signature block below (collectively referred to herein as the "Parties") in consideration of the promises and assurances contained herein, and other good and valuable consideration, agree to the terms set forth below:

1. Purposes. The Parties may use protected health information held by RMHMO and the Partnering Organization for purposes of research projects related to the Initiatives, or to engage in data aggregation and to obtain data analysis for purposes of case management, care coordination, treatment, quality improvement and other health care operations. Any and all such uses shall comply with requirements of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91, as amended), related regulations (45 CFR Parts 160-164) including any amendments or additions to such regulations ("HIPAA"), and other applicable state and federal laws.

2. Limited Data Set and Business Associate Agreement. The Partnering Organization hereby grants authority to RMHMO to conduct data analysis, aggregation and research, to assist the Partnering Organization with health care operations activities, and to engage third parties to

assist in performance of such activities. RMHMO may have access to and use protected health information obtained from or on behalf of the Partnering Organization to create a "limited data set," as such term is defined and described by 45 C.F.R. 164.514(e), and to use such information for RMHMO's own research and health care operation activities. Such limited data sets may be aggregated with protected health information maintained by other health care providers other sources. In creating a "limited data set" and performing other activities for or on behalf of the Partnering Organization, RMHMO is acting as a Business Associate of the Partnering Organization, and therefore agrees to the HIPAA compliant business associate agreement terms attached hereto as Attachment A.

3. Data Use Agreement. In addition, to the extent RMHMO is conducting research or health care operations for its own purposes and using a limited data set, RMHMO expressly agrees:

a. Not to use or further disclose information in the limited data set in a manner that would violate the requirements of HIPAA if done by a HIPAA "covered entity;"

b. Not to use, or disclose the information and data in the limited data set other than as permitted by this AGREEMENT or as otherwise required by law;

c. To use appropriate safeguards to prevent the use or disclosure of the limited data set other than as provided for by this AGREEMENT;

d. To report to the Partnering Organization any use or disclosure of the limited data set not provided for and permitted by this AGREEMENT of which RMHMO becomes aware;

e. To ensure that any agents, including subcontractors, to whom it provides the limited data set agrees to the same restrictions and conditions that apply to RMHMO with respect to the limited data set;

f. Not to identify information in the limited data set or attempt to identify the individuals whose information is contained in the limited data set or contact such individuals;

g. That the Partnering Organization shall have the right to terminate use of the limited data set (i) at any time, without cause, by providing 30 days advance written notice, or (ii) immediately, by providing written notice, if RMHMO has violated any of the conditions set forth in this paragraph 3 or has accessed or used the limited data set for any purpose not described herein.

4. Grant of Authority. RMHMO is hereby granted authority to enter HIPAA compliant Data Use Agreements on behalf of the Partnering Organization with other third-party researchers so that such third parties may conduct research.

5. Miscellaneous.

a. Termination. Any party may terminate its participation in this AGREEMENT for any reason upon thirty (30) days prior written notice given to the other Party.

b. Liability. Each Party shall be responsible for its own acts or omissions, including those of its agents, officers, or employees, while performing their duties under this AGREEMENT to the full extent allowed by law.

c. Patient Confidentiality. With respect to a research subject's or patient's medical records, the Parties agree to hold in confidence the identity of the patients and their Protected Health Information ("PHI") as that term is defined by HIPAA in accordance with Applicable Laws, except to the extent necessary to be disclosed to regulatory agencies as part of the review process and as permitted by an Institutional Review Board (IRB)-approved Informed Consent form.

d. Assignment. No Party shall assign any part of this AGREEMENT without the prior written permission of the other Parties. This AGREEMENT shall inure to the benefit of and be binding upon each Party signatory hereto, its successors and permitted assigns, subsidiaries and affiliates.

e. Counterparts. This AGREEMENT may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

f. Effective Date. The effective date of this AGREEMENT shall be_____.

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC., a Colorado corporation d/b/a Rocky Mountain Health Plans	GUNNISON COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES (Contractor)
By:_____	By: _____ (Signature)
_____ (Print/type name)	(Print/type name)
Title:_____	Title:

Attachment A: Business Associate Agreement

ATTACHMENT A - BUSINESS ASSOCIATE AGREEMENT

RECITALS

WHEREAS, Rocky Mountain Health Maintenance Organization, Inc. ("RMHMO") and ("Partnering Organization") identified in the signature block of the Accountable Care Services Agreement ("Services Agreement") to which this Attachment A is attached have agreed to engage in collaborative data use, access and aggregation in order to conduct research, health care operations, and treatment related activities associated with various Initiatives described in the Services Agreement.

WHEREAS, RMHMO will be performing functions on behalf of the PARTNERING ORGANIZATION, as further described in the Services Agreement, which will require that RMHMO have access to PHI that RMHMO would not otherwise have in its independent role as a Covered Entity.

WHEREAS, in the performance of such functions described above, RMHMO is a Business Associate of the PARTNERING ORGANIZATION.

WHEREAS, the purpose of this BUSINESS ASSOCIATE AGREEMENT ("Agreement") is to comply with HIPAA as it applies to the PARTNERING ORGANIZATION and RMHMO.

WHEREFORE, In consideration of the mutual promises made between RMHMO and the PARTNERING ORGANIZATION in the underlying Services Agreement, the parties agree as follows:

I. Definitions.

The following terms (whether capitalized or not) used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Treatment, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103.

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

II. Obligations and Activities of RMHMO.

RMHMO agrees to:

(a) Not use or disclose protected health information other than as permitted or required by this Agreement and the underlying Services Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by this Agreement;

(c) Report to PARTNERING ORGANIZATION any use or disclosure of protected health information not provided for by the Services Agreement or this Agreement of which it becomes aware that occur when RMHMO is performing services as a Business Associate, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware. PARTNERING ORGANIZATION and RMHMO will work cooperatively to complete breach assessments, and address and comply with breach notification requirements of HIPAA.

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of RMHMO agree to the same restrictions, conditions, and requirements that apply to RMHMO with respect to such information;

(e) Make available protected health information in a designated record set to PARTNERING ORGANIZATION as necessary to satisfy the PARTNERING ORGANIZATIONS's obligations under 45 CFR 164.524;

(f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the PARTNERING ORGANIZATION pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy the PARTNERING ORGANIZATION's obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to PARTNERING ORGANIZATION to satisfy obligations under 45 CFR 164.528;

(h) To the extent that RMHMO is to carry out one or more of the PARTNERING ORGANIZATION's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the PARTNERING ORGANIZATION in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

III. Permitted Uses and Disclosures by RMHMO

(a) RMHMO may only use or disclose protected health information as necessary to perform the services described and for the purposes described in the underlying Services Agreement to which this Agreement is attached as an Attachment. Notwithstanding the foregoing, no provision or term of this Agreement shall prevent, restrict, or prohibit RMHMO's use or access to PHI that RMHMO has otherwise created, obtained or maintains in its individual capacity as a

Covered Entity or in RMHMO's capacity as a Business Associate of a Covered Entity other than the Partnering Organization.

(b) RMHMO may use or disclose protected health information as required by law.

(c) RMHMO agrees to make uses and disclosures and requests for protected health information consistent with its own Minimum Necessary policies and procedures that RMHMO has established in its independent capacity as a Covered Entity health plan.

(d) RMHMO may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by PARTNERING ORGANIZATION.

(e) RMHMO may use protected health information for the proper management and administration of the RMHMO or to carry out the legal responsibilities of the RMHMO.

(f) RMHMO may provide data aggregation services relating to the health care operations of the PARTNERING ORGANIZATION.

IV. Provisions for PARTNERING ORGANIZATION to Inform RMHMO of Privacy Restrictions

(a) PARTNERING ORGANIZATION shall notify RMHMO of any limitation(s) in the notice of privacy Partnering Organizations of PARTNERING ORGANIZATION under 45 CFR 164.520, to the extent that such limitation may affect RMHMO's use or disclosure of protected health information.

(b) PARTNERING ORGANIZATION shall notify RMHMO of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect RMHMO's use or disclosure of protected health information.

(c) PARTNERING ORGANIZATION shall notify RMHMO of any restriction on the use or disclosure of protected health information agreed to or that PARTNERING ORGANIZATION is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect RMHMO's use or disclosure of protected health information.

V. Term and Termination

(a) Term. The Term of this Agreement shall be effective as of the effective date of the underlying Services Agreement, and shall terminate when the Services Agreement terminates or on the date PARTNERING ORGANIZATION terminates for cause as authorized in paragraph (b) of this Section V., whichever is sooner.

(b) Termination for Cause. RMHMO authorizes termination of this Agreement by PARTNERING ORGANIZATION if RMHMO has violated a material term of the Agreement and has failed to cure the breach or end the violation within the timeframe specified by PARTNERING ORGANIZATION.

(c) Obligations of RMHMO Upon Termination. Upon termination of this Agreement for any reason, RMHMO, with respect to protected health information received from

PARTNERING ORGANIZATION under the Services Agreement, or created, maintained, or received by RMHMO on behalf of PARTNERING ORGANIZATION, shall:

1. Retain only that protected health information which is necessary for RMHMO to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to PARTNERING ORGANIZATION (or destroy if agreed to by PARTNERING ORGANIZATION) the remaining protected health information that the RMHMO still maintains in any form;

3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as RMHMO retains the protected health information;

4. Not use or disclose the protected health information retained by RMHMO other than for the purposes for which such protected health information was retained and subject to the same conditions set out at paragraphs (e) and (f) of Section III above under "Permitted Uses and Disclosures By RMHMO" which applied prior to termination; and

5. Return to PARTNERING ORGANIZATION, or if agreed to by PARTNERING ORGANIZATION, destroy the protected health information retained by RMHMO when it is no longer needed for RMHMO's proper management and administration or to carry out its legal responsibilities.

6. Survival. The obligations of RMHMO under this Section shall survive the termination of this Agreement.

VI. Miscellaneous

(a) Amendment of Agreement. Except as otherwise set forth in this Agreement, this Agreement shall not be changed, modified or altered except by amendment, which, to be valid and enforceable, shall be in writing and signed by the parties. Notwithstanding the foregoing, PARTNERING ORGANIZATION may unilaterally amend this Agreement in order to comply with any applicable federal or state laws or regulations, effective immediately upon written notice to RMHMO. Upon the addition of, change, or amendment to any applicable federal or state laws or regulations which would require an amendment to this Agreement, this Agreement shall be deemed to be amended to comply with such addition, change or amendment.

(b) Indemnification. Each party will indemnify, hold harmless and defend the other parties to this Agreement from and against any and all claims, losses, liabilities, costs, and other expenses incurred as a result or arising directly or indirectly out of or in connection with (a) any non-fulfillment of any obligation on the part of the responsible party under this Agreement; and (b) any claims, demands, awards, judgments, actions and proceeding made by any person or organization, arising out of or in any way connected with the party's performance under this Agreement.

(c) No Agency or Partnership. This Agreement does not create a joint venture, partnership, or employer-employee relationship between the parties. In performing under this

Agreement, each party is at all times acting and performing as an independent contractor and is not an agent or representative of any other party.

(d) Assignment. No party may assign or transfer any or all of its rights and/or obligations under this Agreement or any part of it, nor any benefit or interest in or under it, to any third party without the prior written consent of the other party to this Agreement.

(e) Interpretation. The requirements of applicable law pertaining to PHI are, to the extent not adequately provided for in this Agreement, hereby incorporated by this reference and shall become a part of this Agreement. This Agreement shall be construed as broadly as necessary to implement and comply with HIPAA.