At a minimum, ECPs shall:

1. **Dedicate Appropriate Resources to Achieve the RAE Objectives**

    a. Hire/train/maintain appropriate staff (existing/new) to implement interventions to drive performance metrics and ensure appointment access to meet member needs;
    b. Utilize team based care within the ECP site to support care coordination efforts appropriately across staff members;
    c. Demonstrate Advanced Patient Centered Medical Home (PCMH) capabilities;
        i. Participate in initial ECP practice assessment and on-going regular audits
        ii. Practices that have accomplished PCMH accreditation (NCQA, The Joint Commission, URAC) will be able to utilize this information in the RAE assessment and on-going auditing process; and
    d. Maintain the ability to address gaps in services, participate in quality improvement activities to advance capabilities over time.

2. **Participate as a Leading Provider in Clinical Practice**

    a. Support and implement integrated behavioral healthcare activities;
    b. Identify on-going alignment opportunities with other Colorado state led programs (APM, SIM, CPC+, CO Opportunity Framework etc.);
    c. Contribute to RAE clinical program design, implementation, and improvements;
    d. Utilize and implement evidence-based tools and promising practices; share lessons learned with RAE partners;
    e. Implement practice improvement activities and campaigns to drive RAE performance metrics (coding/billing best practices, quality improvement cycles); and
    f. Collaboration to align ECP activities with RAE goals and complementary activities across the region(s).

3. **Improve Coordination Efforts with Medical and Non-medical Providers**

    a. Collaborate with specialty providers to implement and operationalize care compact agreements;
    b. Improve referral processes to achieve "referral to outcome" results to ensure appropriate member follow-up; and
    c. Participate in provider-to-provider communication and consults.

4. **Contain Healthcare Costs**

    a. Identify system utilization issues and collaborate within the RAE region to implement programs that will reduce overall costs and further, participate in the implementation of these programs.

5. **Provide Population Management and Care Coordination**

    a. Design and implement a population management strategy that utilizes risk stratification to identify different categories of membership for clinical care, care coordination and member engagement.
    For example:
        i. Transitions of care that include:
            1. Transitions of Members from institutional settings to community-based services
            2. Transitions of Members from in-patient hospital stays to the community
            3. Medicaid-eligible Members transitioning out of the criminal justice system
            4. Children involved with Child Welfare
            5. Transitions of Members from one RAE to another RAE
            6. Other
        ii. Non-engaged members, members who need prevention and wellness services, chronic disease management, special populations (criminal justice and child welfare), ED utilization, and members who have complex needs.
    b. Ability to utilize registries to identify and manage the different populations, specific interventions and outcomes.

c. Identify and provide short term/long term care coordination for members.
d. Sites may utilize their own established risk methodologies but should be willing and able to translate this into the broad HCPF established four-quadrant model to address members who have both physical and behavioral health needs.
e. If a site does not have its own risk methodology, the HCPF four quadrant model should be implemented (at a minimum) to manage the population.

6. **Required Data and Reporting**

a. Quarterly submission of quantitative (member-level data) and narrative reports to COA via a specified file format/mechanism.
   i. Specific interventions that are appropriate for practice size, composition, population and role within the RAE system
   ii. Reporting template will require specific identifiers to allow for data aggregation, de-duplication, analysis
   iii. Unique member level reporting and narrative reporting could include but is not limited to:
      1. Deliberate Interventions—
         a. Referral/Linkage—Medical
            i. Telephonic/Electronic Outreach
            ii. Other
         b. Referral/Linkage--Social
            i. Referral/Linkage – Social
            ii. Telephonic/Electronic Outreach
            iii. Other
      2. Extended Care Coordination
         a. Care Plan Activity
         b. Face-to-Face Activity
         c. Extended Care Coordination: Other
      3. Transitions of Care
         a. Transitions of Members from institutional settings to community-based services
         b. Transitions of Members from in-patient hospital stays to the community
         c. Medicaid-eligible Members transitioning out of the criminal justice system
         d. Children involved with Child Welfare
         e. Transitions of Members from one RAE to another RAE
         f. Other populations identified through risk stratification or state initiatives
         g. Ability to participate, exchange and utilize data.
         h. Financial accountability of Medicaid funding to practice sites.
            i. Demonstrate how ECP funds are spent
            ii. Participate in value-based payment (VBP) initiatives

Timely meeting of reporting requirements is mandatory.