Colorado Department of Health Care Policy and Financing

Request for Proposals
RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
For The Accountable Care Collaborative Program

Final

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I. INTRODUCTION

The Colorado Department of Health Care Policy and Financing (the Department) is soliciting competitive proposals from experienced and innovative entities with a strong community presence to partner with the Department in its Accountable Care Collaborative (ACC) Program. Selected Contractors will be accountable for controlling costs and improving the health of Medicaid Clients in one (or more) of seven regions statewide. These entities will be referred to as Regional Care Collaborative Organizations (RCCOs). The RCCOs will meet the definition of Primary Care Case Managers (PCCMs) as defined by the Centers for Medicare and Medicaid Services (CMS) and must meet the pertinent PCCM requirements set forth in 42 CFR 438. The ACC Program is a hybrid model, adding characteristics of a regional Accountable Care Organization to the Primary Care Case Management system.

The two central goals of the ACC Program are to improve health outcomes of Medicaid Clients through a coordinated, Client/family-centered system that proactively addresses Clients' health needs, whether simple or complex, and to control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources. To reach these goals, the Department seeks to contract with RCCOs that will focus on the following ACC Program objectives:

1. Expand access to comprehensive primary care.
2. Provide a focal point of care/Medical Home for all Members including coordinated and integrated access to other services.
3. Ensure a positive Member and provider experience and promote Member and provider Engagement.
4. Effectively apply an unprecedented level of statewide data and analytics functionality to support transparent, secure data-sharing and enable the near-real-time monitoring and measurement of health care costs and outcomes.

The ACC Program's design supports a paradigm shift from a volume-driven, Fee-For-Service (FFS) model to a coordinated outcomes-based system that will control costs in a responsible manner. At present, about 15% of Clients are enrolled in managed care programs; these programs will continue to be offered on a voluntary basis as well. The ACC Program is not designed to take the place of the Department's managed care programs; rather, it is a new model for coordinating care that works within the FFS system. It will not take over the management of any of the Department's behavioral health care, which will remain with the behavioral health managed care organizations.

The Department will select one RCCO for each of the seven regions. Offerors may propose to provide services in one or more regions of the state. A separate, complete, and unlinked proposal must be submitted for each region for which the Offeror wishes to propose. See Section III of this document for more information about the ACC Program; Sections IV and V for more information about the RCCOs and their responsibilities; and Section VI for detailed instructions about submitting proposals.

II. ADMINISTRATIVE INFORMATION

A. ISSUING OFFICE

The Department's Contracts and Purchasing Section has issued this RFP, #HCPFKQ1102RCCO, on behalf of the State of Colorado for the benefit of the Medicaid Program Division and the Clients it serves. The Department's Contracts and Purchasing Section is the sole point of contact concerning this RFP. All inquiries must be directed to Katherine Quinby at the Department's Contracts and Purchasing Section, at katherine.quinby@state.co.us. See Paragraph A of the Administrative Information Document, published as Attachment B to this RFP, on inquiries. Please also see Section II.E of this document, Schedule of Activities and Timeline.

B. REQUEST FOR PROPOSALS

The Department's Contracts and Purchasing Section, State of Colorado is posting this RFP on the Colorado Bid Information and Distribution System (BIDS) website so that Offerors who have an interest may submit a proposal in accordance with the terms of this RFP. The RFP provides prospective Offerors with sufficient information to enable them to prepare and submit proposals for the Department to consider that ultimately meet the RFP requirements stated herein.

This RFP contains the instructions governing the proposals to be submitted and material to be included therein, mandatory requirements which must be met to be eligible for consideration, and other requirements to be met by each proposal submission. Attachment B to this RFP, Administrative Information Document, contains terms governing the solicitation and the solicitation process. The State of Colorado Solicitation Instructions and Terms and Conditions linked through the Colorado BIDS Solicitation Page govern, except as modified or supplemented in these instructions and the Administrative Information Document, Attachment B.

By submitting a proposal, the Offeror accepts the terms and requirements of this RFP without exception, deletion, qualification, contingency, condition or qualification. Any exception, deletion, qualification, contingency, condition or qualification by the Offeror may be cause for a proposal to be rejected. A proposal submitted in response to this RFP shall constitute a binding offer. Acknowledgement of the binding offer is indicated by signature on the Request for Proposal Signature Page, included in this RFP as Attachment F.

Modifications, addenda and responses to inquiries regarding this RFP will be posted on the Colorado BIDS website. It is the Offeror's responsibility to periodically check the website for information, changes or modifications that pertain to this solicitation.

C. PROPOSAL REQUIREMENTS

The Offeror's response must meet all requirements of and respond to all requests for information set forth in this RFP. Requests for information found in this RFP are identified in Sections IV

and V in **bold font**. Requests for information regarding the price proposal are identified in Section VI.E. Requests for information regarding the price proposal are identified in Section VI.E. All requests for information must be addressed, with supporting detail and data as requested, in the Offeror's proposal. Section VI, Offeror's Response Format, contains submission details and additional requirements for the Technical and Price Proposals. Failure to respond to all requests for information and meet all requirements set forth in the RFP may result in the Offeror's disqualification.

The Offeror is required to submit one hard copy original, clearly marked, nine exact hard copies, clearly marked with the number of the copy, and an exact electronic copy on CD with each hard copy (10 total) of the Technical Proposal for each region for which it is submitting a proposal. In addition, the Offeror is required to submit in a separate binder one hard copy original, clearly marked, nine exact copies, clearly marked with the number of the copy, and an exact electronic copy on a separate CDs with each hard copy (10 total) of the Price Proposal for each region proposed. Electronic copies of both the Technical and the Price proposals on CD must be created with Microsoft Word or Excel, but may be submitted in Adobe PDF to ensure format integrity.

Offerors may submit proposals to provide services in one or more region, but they must submit separate, complete and independent proposals for each region for which they wish to apply. Offerors should refer to Attachment D for a map of the regions for this RFP. For each region, the Offeror's response shall describe how it proposes to meet each of the requirements in the RFP. Each proposal shall describe a comprehensive, quality package of services and programs the Offeror agrees to provide, and demonstrate the Offeror's ability to serve as a RCCO and ACC Program partner with respect to all of the detailed questions and requirements posed in this RFP.

D. SCHEDULE OF ACTIVITIES AND TIMELINE

The following table summarizes the schedule of key activities for this RFP:

		TIME (Mountain Time)	**DATE**
1.	RFP PUBLISHED ON BIDS WEBSITE www.gssa.state.co.us/VenSols		August 20, 2010
2.	PROSPECTIVE OFFERORS WRITTEN INQUIRY DEADLINE - NO INQUIRIES WILL BE ACCEPTED AFTER THIS DATE. E-mail is the preferred method of inquiry. Please send questions to katherine.quinby@state.co.us	11:59 PM	September 10, 2010
3.	PUBLICATION OF DEPARTMENT'S ANSWERS TO WRITTEN INQUIRIES *(ESTIMATED)*		September 29, 2010
4.	MANDATORY LETTER OF INTENT TO PROPOSE SUBMISSION DEADLINE		October 5, 2010

5.	PROPOSAL SUBMISSION DEADLINE See Section VI for submission details.	3:00 PM	October 22, 2010
6.	PROPOSAL SELECTION ***Estimated the week of***:		November 29, 2010
7.	CONTRACT FINALIZED ***Estimated the week of***:		January 10, 2011
8.	CONTRACT PERIOD: February 1, 2011 through June 30, 2012		

The Department reserves the right to revise the dates published in this schedule. Any such revisions will be made via a modification to the RFP posted on the Colorado BIDS website, except for items #6 and #7. Dates for items #6 and #7 are estimates only and revisions will not be made by modification.

E. PERFORMANCE PERIOD

The anticipated initial term of the resulting contracts for performance of RCCO services is February 1, 2011, or upon final execution of the contract, through June 30, 2012, contingent upon funds being appropriated, budgeted and otherwise made available. There will be a Start-Up Phase (see Section V.I.) that will be from the execution of the contract until April 1, 2011 for regions 1, 2 and 4 and June 1, 2011 for regions 3, 5, 6 and 7. A readiness review will be conducted to ensure that each new RCCO will be ready to perform on the "go live" date for its region (see Section V.B.4). There will be no payments for the Start-Up Phase.

The resulting contracts may be renewed for up to three additional one-year periods, at the sole discretion of the Department, contingent upon funds being appropriated, budgeted and otherwise made available, and other contractual requirements, if applicable, being satisfied.

F. FUNDING

Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted and otherwise made available. The funding for State Fiscal Year 2010-11 is available.

The resulting contracts are subject to and contingent upon the continuing availability of federal and state funds for the purpose hereof. The Offeror recognizes that it is to be paid, reimbursed or otherwise compensated with funds provided to the Department by the state and federal governments for the purpose of contracting for the services provided herein. The Offeror expressly understands and agrees that all its rights, demands and claims to compensation resulting under the resulting contracts are contingent upon receipt of such funds by the Department. In the event that the Department does not receive such funds or any part thereof, the Department may immediately terminate the resulting contracts without liability, including liability for termination cost.

The budget limitation for the RCCOs for the Initial Phase is $13 Per Member Per Month (PMPM). If the total price proposed exceeds the budget limitation for any fiscal year, the proposal shall be disqualified. The budget limitation for the RCCOs for the Expansion Phase is $12 PMPM with the potential for additional earned incentive payments of up to $1 PMPM.

G. DISCLAIMER

All statistical and fiscal information contained within this RFP, and any amendments and modifications thereto, reflect the best and most accurate information available to the Department at the time of RFP preparation. No inaccuracies in such data shall constitute a basis for legal recovery of damages or protests, either real or punitive, except to the extent that any such inaccuracy was a result of intentional misrepresentation by the Department.

H. MANDATORY LETTER OF INTENT TO PROPOSE

Offerors are required to submit a letter of intent to submit a proposal by close of business on Thursday, September 30, 2010. The letter of intent to propose shall be on official business letterhead of the Offeror and must be signed by an individual authorized to commit the Offeror to the proposal. It is required to include the RFP Number, the Offeror's name, mailing address, electronic mail address, fax number, telephone number, a statement of intent to submit a proposal pursuant to this RFP, and be signed by an authorized individual. The Letter of Intent to Propose may be sent by mail, e-mail, or fax to the Department contact provided below.

Send to:

Katherine Quinby
State of Colorado
Department of Health Care Policy and Financing
Contracts and Purchasing Section
1570 Grant Street
Denver, CO 80203

Email: katherine.quinby@state.co.us
FAX No.: (303) 866-4411

If the letter is provided via email, please place the following in the subject line of your email: "Letter of Intent to Propose for RFP # HCPFKQ1102RCCO." Faxes should be addressed to the attention of Katherine Quinby. Please place the following in the subject line on your fax and attached letter of intent: "Letter of Intent to Propose for RFP # HCPFKQ1102RCCO." The Department may reject the proposal of any Offeror that fails to submit a Letter of Intent to Propose by the deadline specified. Submitting a Letter of Intent to Propose does not bind the Offeror to submit a proposal.

I. LIMITED DATA SET OF MEDICAID CLAIMS DATA

The Department is making available a set of Medicaid claims data for Fiscal Years 2007, 2008 and 2009 to Offerors that submit a Letter of Intent to Propose.

Offerors that have submitted a timely Letter of Intent to Propose may request, in writing or via e-mail, a CD containing the limited data set described below. Such requests should be sent, if emailed, to Katherine Quinby at katherine.quinby@state.co.us; or, if sent by letter, to Katherine Quinby at the same address as for submittal of the Letter of Intent to Propose in paragraph II.H above. The email or letter should state that you wish to receive a set of CDs with the limited data set of Medicaid claims data and the name and address of the custodian of the CDs for the Offeror. Specify state whether you wish the CDs send by US Mail, overnight services or will be picked up. There will be no charge for the CDs and to have the CD mailed via US Mail. If delivery is requested via express delivery, the requester must provide an account number for the express shipment, or arrange for prepayment in some other fashion.

A confidentiality agreement executed by an authorized representative of the Offeror will be required prior to the CDs being provided. Copies of the confidentiality agreement may be requested from Katherine Quinby after posting of the responses to inquiries.

The sole purpose of the limited data set is to provide information to Offerors on Colorado Medicaid, its claims and eligibility groups, and the costs associated with them. Offerors are not permitted to copy the data or use it for any other purpose. This is a limited data set under HIPAA; there is Client-level data but no actual Client identifiers, with the exception of a masked ID number for matching claims to Clients. The data set is solely for the use of the Offeror, and may only be used to inform the response to this RFP. The original CDs must be returned together with the proposal. The proposal shall be disqualified and will not be evaluated or considered for award if an Offeror which has received the CDs does not return the original CDs with the proposal.

The data includes the following:

- FFS diagnosis codes
- FFS procedure codes
- Client eligibility category
- County of residence
- Client race, age and gender
- Claim type (inpatient, outpatient, transportation, physician service, etc.)
- Provider type
- Drug type (for pharmacy claims)

For more information, see Attachment C, Data Set.

J. MULTIPLE AWARDS

The Department reserves the right to make multiple awards as the result of this RFP. One award will be made for each of the seven regions (see Attachment D for the map of regions). An Offeror may be selected in multiple regions. A separate, complete, and unlinked proposal must be submitted for each region for which the Offeror wishes to propose.

If the Department does not receive any qualified proposals for a region, or if, after award, the

successful Offeror in a region is unable to meet the requirements for contracting identified in this RFP, the Department will consider it a failed procurement for that region. If there is a failed procurement in a region(s), the Department may contract with the Offeror that has submitted the next most qualified proposal or the most qualified Offeror in another region.

K. ACC PROGRAM

To support the ACC Program, the Department will contract with an organization that has the requisite health information technology expertise. This organization, known as the Statewide Data and Analytics Contractor (SDAC), will support ACC Program operations and work closely with RCCOs, providers, and the Department. Because the SDAC will have access to the performance data of all seven RCCOs, the SDAC will not be permitted to serve as a RCCO as well.

L. CONFLICT OF INTEREST

Offerors are cautioned that the RCCOs and the SDAC must not be affiliated in any way due to the roles that each will serve for the ACC Program. An Offeror that submits a proposal in response to this RFP will have a conflict of interest for the SDAC contract. If an Offeror submits a proposal for any RCCO region may not submit a proposal in response to the RFP which will be posted to select the SDAC. Any proposal submitted for the SDAC RFP shall be disqualified if the Offeror or affiliated entity submitted a proposal in response to this RFP.

M. DRAFT CONTRACT

The contracts resulting from this RFP will be substantially similar to the Draft Contract included with this RFP as Attachment E. The terms of the Draft Contract may become contractual obligations following award of this RFP.

N. DEBARMENT AND SUSPENSION

1. By submitting a proposal in response to this RFP, the Offeror certifies to the best of its knowledge and belief that it, its principals and proposed Subcontractors:

    a. Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions.

    b. Have not within a three year period preceding the proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

    c. Are not presently under investigation for, indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the offenses enumerated in Section II.N.1.b above.

d. Have not within a three year period preceding this application had one or more public transactions (federal, state, or local) terminated for cause or default.

2. If the Offeror is unable to certify to any of the statements in this section, provide an explanation as an attachment to the Price Proposal. This explanation is exempt from page limitations on the Price Proposal, if any. The inability of the Offeror to provide the certification will not necessarily result in disqualification of the Offeror. The explanation will be considered in connection with the Department's determination whether to award a contract to the Offeror.

O. VENDOR IDENTIFICATION

Offerors must be legal entities at the time they submit their proposal; it will not be acceptable to become a legal entity only after being selected as a RCCO. The tax identification number provided on the RFP Signature Page (Attachment F) must be that of the legal entity submitting the proposal to the RFP. The Offeror must be a legal entity with the legal right to contract. The Offeror that submits the proposal must be the legal entity that will perform the services described in the RFP. The Offeror must be registered with the Colorado Secretary of State to do business in the state and registered on BIDS. If the Offeror is not registered to do business in the state and registered on BIDS, the proposal shall be disqualified.

P. TERMINOLOGY

Acronyms are defined at their first occurrence in this RFP. A list of terminology and definitions is provided to assist the reader in understanding language used throughout the document. A complete glossary of terms and abbreviations used in this RFP is included in Attachment A, Definitions.

The word "Member" is used throughout this Request for Proposals (RFP) to refer to a Medicaid Client who is enrolled in the ACC Program. The term "Client" refers to an individual eligible for and enrolled in the Colorado Medicaid program, whether or not he/she is enrolled with a RCCO in the ACC Program.

Q. RFP ORGANIZATION

The remainder of this RFP is organized as follows:

SECTION III – Background and Overview – Describes the initiatives and legislation that led to the development of the ACC Program, and gives an overview of the design and core elements of the ACC Program.

SECTION IV – General Requirements – Presents mandatory minimum requirements, required experience and general contract requirements.

SECTION V – Statement of Work – Describes the required scope of work for RCCOs, including the Start-Up Phase, Initial Phase, Expansion Phase and transition requirements.

SECTION VI – Offeror's Response Format – Defines the process and requirements for the submission of Technical and Price Proposals by Offerors.

SECTION VII – Proposal Evaluation – Includes an overview of the proposal evaluation methodology and a summary of evaluation criteria.

ATTACHMENTS - Provided to support information presented in these sections.

III. BACKGROUND AND OVERVIEW

A. CURRENT CARE DELIVERY SYSTEM

Today, the Colorado Medicaid program serves over 500,000 Coloradans and has an annual budget of approximately $4 billion. The Colorado Medicaid program is annually funded from appropriations authorized by the Colorado General Assembly and matched by federal funds. Covered benefits include such services as preventive care and screenings, prenatal care, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for Clients aged 20 and under, dental care, behavioral health services, and both acute and long-term care services offered in settings ranging from inpatient facilities and nursing facilities, to the community. The Department has a long history of innovation and service to improve access and the health of its Clients. Many providers, practices, community groups, and other stakeholders have dedicated significant effort to improving care around the state. At present, more than 85% of Clients receive physical health coverage through the FFS model. The majority of behavioral health services is delivered through behavioral health managed care organizations, and will continue to be.

B. CHANGE AND INNOVATION

Three years ago, the State of Colorado embarked on a journey to improve Coloradans' access to cost-effective, quality health care services. The Blue Ribbon Commission for Health Care Reform (the Commission) assessed a variety of health care reform models in Colorado. After months of careful deliberation and discussion with stakeholders, constituents, legislators and executive officials, the Commission presented a comprehensive report in 2007 that provided a blueprint for health care reform in Colorado. Drawing upon the Commission's recommendations, the Administration proposed a series of legislative initiatives referred to as the "Building Blocks to Health Care Reform." During the 2008 legislative session, the legislature passed all of the initiatives. The new legislation expanded children's health care coverage, increased reimbursement for providers, improved efficiencies in private and public health insurance programs, increased transparency and accountability across the health coverage system and identified further strategies to expand access to cost-effective, quality health care.

The Department began to implement the legislative initiatives contained in the Building Blocks to Health Care Reform and to make plans for the additional reform strategies that had been identified. The Department was particularly interested in how to better contain health care costs

while improving the overall health and functioning of the Clients we serve. We have learned over the years that higher health care spending is not necessarily associated with higher quality care or improved outcomes. Currently, the majority of our Medicaid Clients access their health care services in a service delivery model that does not always support coordinated care and the appropriate utilization of services. Clients often seek care in emergency rooms or other sites that offer episodic services. As a result, providers may not know the Clients' history or ongoing health care needs. Since clients interact with a host of Medicaid and non-Medicaid provider organizations ranging from schools and county government services to independent living centers and transportation vendors, access to and interaction between these providers and support organizations varies, and little or no data is available to facilitate coordination and continuity of care.

Two of the additional reform efforts were the Medicaid Value-Based Care Coordination Initiative (now known as the ACC Program) and the Colorado Health Care Affordability Act. The Department worked simultaneously on these efforts. The Department submitted a formal budget action for the ACC Program on November 3, 2008 and in April 2009, the Colorado Health Care Affordability Act (Colorado House Bill 09-1293), became law. Hailed as the state's most significant health reform initiative in the past 40 years, the legislation authorizes the Department to generate revenue through a hospital provider fee and draw down federal matching funds. A portion of the fees will be used to provide coverage to additional uninsured Coloradans and make health care more affordable by reducing uncompensated care and cost-shifting, without costing taxpayers or businesses more in taxes. Through this legislation, at least 100,000 more Coloradans will be eligible to apply for medical assistance programs over the next five years.

The passage of the Health Care Affordability Act, coupled with the unprecedented growth in Medicaid caseload because of the economic recession reinforced the need for the Department to implement the ACC Program, a strategy that will contain costs while improving health outcomes for our Clients. Additionally, with the passage of national health care reform, the Department recognizes that significant changes to the way health care services are delivered to our Medicaid Clients are essential to maximize their health, functioning and independence. In response to the changing health care environment, the ACC Program was designed to address on the two central goals of improving health outcomes and controlling costs while focusing on the following objectives:

1. Expand access to comprehensive primary care.
2. Provide a focal point of care/Medical Home for all Members including coordinated and integrated access to other services.
3. Ensure a positive Member and provider experience and promote Member and provider engagement.
4. Effectively apply an unprecedented level of statewide data and analytics functionality to support transparent, secure data-sharing and enable the near-real-time monitoring and measurement of health care costs and outcomes.

The ACC Program represents an innovative way to accomplish the Department's goals for Medicaid reform. The ACC Program differs from a Capitated managed care program by

investing directly in community infrastructure to support care teams and care coordination. It also creates aligned incentives to measurably improve Client health and reduce avoidable health care costs. The ACC Program makes the people and organizations that actually provide the care accountable for the quality and the cost of that care. Previous health care reform initiatives involved insurers and made them ultimately accountable. The fundamental premise of the ACC Program is that communities are in the best position to make the changes that will address the cost and quality problems resulting from our system of fragmented care, variation in practice patterns and volume-based payment systems. While the commitment and participation of providers will be essential to driving these changes, we realize that the supportive infrastructure that is necessary to make this paradigm shift is currently lacking. The ACC Program strengthens this infrastructure.

To support these reform measures and improve health information technology in Colorado, the Department is working with stakeholders to support communities and individual health care providers interested in participating in the Colorado Regional Health Information Organization (CORHIO) health information exchange. This will help providers become better equipped to use technology to facilitate the exchange of health information. Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health care professionals can qualify for Medicare and Medicaid incentive payments when they adopt certified electronic health record technology and meaningfully use it to improve the quality and safety of care, improve care coordination, engage Clients and families, promote public health, and promote the security of private health information. The ACC Program will work with CORHIO's regional extension centers to encourage providers in each region to participate in the HITECH program and improve their health information technology.

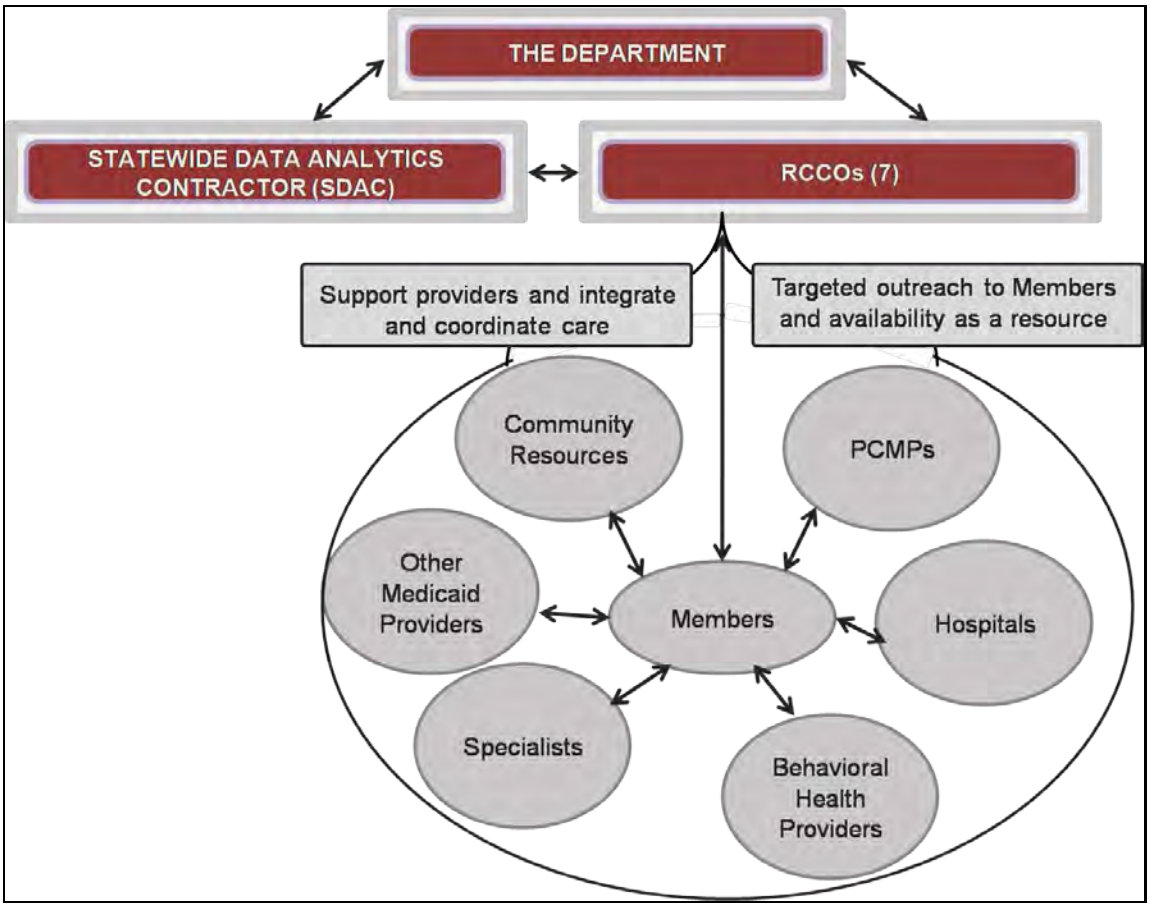
The ACC Program provides the framework within which other health care initiatives can thrive such as the Medical Home, health information technology, and payment reform. The ACC Program is a hybrid model, adding the characteristics of an Accountable Care Organization to the Primary Care Case Management system. While other states have structured their Accountable Care Organizations in a variety of ways, certain fundamental Accountable Care Organization characteristics are essential to the success of the ACC Program. These include managing and integrating the continuum of care across different settings, including primary care, inpatient care and post-acute care; having a large enough number of Clients to support comprehensive performance measurement; being capable of prospectively planning budget and resource needs; and having the ability to develop and organize provider networks.

C. ACC PROGRAM DESIGN

The ACC Program is designed not only to improve the Client/family experience and improve access to care, but to establish accountability for cost management and health improvement. By integrating the principles of a Patient-Centered Medical Home model, applying best practices in care coordination and medical management, and combining unprecedented access to Client data and resource utilization, RCCOs will become valued partners in the Department's efforts to move away from a focus on volume-driven, sick care and towards an outcomes-based, efficient, health improvement model of care. RCCOs will use both Patient-Centered Medical Home and

accountable care principles, and their own expertise to help the Department control costs and improve health outcomes.

Central to the success of the ACC Program is the interaction among three key roles: the RCCOs, the SDAC, and Primary Care Medical Providers (PCMPs). The RCCOs are responsible for ensuring accountable care. The SDAC will be responsible for bringing a new level of information and data analytics to the Medicaid program, providing insight into variations within and across RCCOs, benchmarking across key performance indicators, and serving as conduit for health information exchange between the Department and the RCCO. The RCCOs will be required to establish written agreements with PCMPs in their regions to serve as Medical Homes for Members. The diagram below reflects the general model and working relationships between the Department and these key roles.



This Primary Care Case Management system is subject to the applicable federal requirements in 42 CFR 438. Like other Primary Care Case Management programs, the ACC Program will continue to reimburse medical services on a FFS basis, using the Department's claims payment system. The Department will fund the ACC Program, which includes the RCCO PMPM and incentive payments, the PCMP PMPM and incentive payments and the SDAC, from a PMPM budgeted amount of $20 PMPM. In addition, RCCOs will have the potential for Shared Savings in the future. During the Initial Phase, the statewide funding for the RCCOs will reach approximately $9.3 million

under this new model. In each year of the Expansion Phase, the statewide funding for the RCCOs will reach approximately $57 million.

At the foundation of the ACC Program design are several core elements that when combined and executed properly, will drive accountability and success in achieving improved health outcomes and managing costs. These core elements include a regional approach to managing, providing and coordinating care; the principles of the Patient-Centered Medical Home model; an integrated network of providers; the provision of high-quality care coordination and medical management services; an unrelenting focus on accountability to improve outcomes and control costs; analysis and application of informatics and benchmarking to review, measure and compare utilization, outcomes and costs; and a focus on continuous improvement and innovation, constant learning and sharing best practices.

1. Regional Approach

The design of the ACC Program focuses on regional collaboration that demands a constant focus on cost management and health improvement. Rather than having several competing entities within one region, the Department will award a contract to a single RCCO in each region, thus promoting collaboration within the region. This approach allows for collaboration among stakeholders, providers, Members, and other entities toward achieving results rather than Marketing for Membership. This regional approach promotes more comprehensive and coordinated care, encourages the RCCOs to leverage local relationships with and between providers and community-based organizations and to build upon existing regional systems of care. By managing Members on a regional basis and focusing on regional outcomes, performance and costs, the RCCOs and the SDAC will enhance Members' abilities to appropriately utilize the health system, offer providers consistent data and analysis to support care delivery, and enhance providers' efforts to deliver outcomes-based care. The regional approach also promotes the sharing of best practices.

2. Medical Home and Provider Network

The ACC Program builds upon the Patient-Centered Medical Home model and also incorporates additional elements to improve Member care and outcomes while supporting providers and protecting the safety net. Critical to the success of the ACC Program will be the PCMP. The PCMP is an individual provider or pod of providers that work closely as a team to serve as the Medical Home for the Member. Establishing a link between the Member and a PCMP who provides the majority of his/her care will be an essential function for the RCCO to facilitate. Currently, the Medicaid program has established the Medicaid and CHP+ Medical Homes for Children program (see Attachment G). The ACC Program extends this practice to other Medicaid Clients. In order to serve as a PCMP and establish an agreement with a RCCO, the PCMP must either be certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program or be a physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and

gynecology, and meet all additional criteria described in Attachment H, PCMP Requirements. The ACC Program will build upon the success and lessons learned through the Medicaid and CHP+ Medical Homes for Children program and other Medical Home projects.

In order to serve as a PCMP in the ACC Program, and to therefore be eligible for the additional payments described in Section V.H., Compensation, RCCOs must have a written agreement with the PCMPs operating in their county. RCCOs will not be required to have agreements with PCMPs from other regions. PCMPs may serve Members who live in any region.

Members will be assigned to a RCCO based on their residence address, may select a PCMP in another region and obtain care in other regions if they choose. RCCOs will assist their Members in selecting a PCMP who will deliver the majority of the Member's care.

RCCOs shall act as integrators, bringing together disparate provider types and leveraging community resources in their region to efficiently serve and improve the health of Members. The Department recognizes that a robust Medical Home is necessary but not sufficient to optimize efficiency and health. The RCCO is charged with establishing links between providers who currently operate relatively independently at the expense of efficiency and coordination. Links can take the form of compacts, communication, financial relationships, transition or coordination services, or other similar interventions to create what might be more accurately called a "medical neighborhood."

Because Members have health needs that require access to a spectrum of care that differs by eligibility type, the Department also envisions a system where each RCCO builds upon the existing Medicaid network according to strengths and opportunities within that region. Members will continue to receive behavioral health services through the behavioral health managed care plans, and the RCCOs will work with these organizations to integrate physical and behavioral health care needs. Members may obtain other medical services with a referral from their PCMP, which helps the Medical Home remain aware of the Member's condition and access treatment records from those providers.

The RCCO will support the providers in its network administratively and operationally by highlighting those who engage in best practices, facilitating communication between providers and with the Department, and providing a forum for learning across the ACC Program. RCCOs may supply providers with evidence-guided clinical tools, Member- and practice-specific data, assistance in navigating and communicating with other Department contractors such as the Medicaid fiscal agent, the utilization management contractor, and the Enrollment Broker. Because most services outside the scope of the PCMPs will require referral, the RCCO shall play an integral role in facilitating the referral process between providers in its network.

3. Medical Management and Care Coordination

Among the primary functions of the RCCOs will be care coordination and medical

management, two key components often lacking in the FFS model. Generally, the current system of care is fragmented and difficult for Clients to navigate. Additionally, within the Medicaid population there is a prevalence of medically and behaviorally complex Clients who require focused case management efforts and interventions to ensure that they are getting the right care, in the right order, at the right time, and in the right setting. Care coordination efforts extend beyond physical health to include efforts to link to resources available in behavioral health, long-term care, social services, criminal justice, and public health systems.

The Department recognizes that healthy lifestyles contribute tremendously to better health outcomes. The use of community health educators who reinforce healthy lifestyles, promote medication adherence, and empower Members to interact with the health care system, is another element that RCCOs should consider in their models. The health promotion and education function may be a separate skill or incorporated into a care coordinator's expectations.

Some Members may benefit from intensive case management. The RCCO may employ various predictive modeling, risk stratification, claims based triggers, or other approaches to identify those Members who would benefit from more intensive case management. RCCOs are expected to help Members navigate the system, facilitate and enhance communication between Members and providers and between providers themselves, and coordinate with providers and Members to ensure high-quality medical management services are provided. Innovations in care management such as group visits, cell phone reminders, patient activation and motivational interviewing are welcomed for consideration.

Transitions of care represent a particular area of vulnerability for Clients. The RCCO will ensure continuity of care during transitions from institutional settings (such as hospital, nursing home, inpatient psychiatric care) to home or community-based settings. The RCCO will also assist with other transitions (for example, moving from children's health services to adult health services, moving from hospital or home to nursing care) that require active coordination to maintain effective care for Members.

At its discretion, the RCCO may choose to delegate certain RCCO care coordination and medical management responsibilities to high-performing PCMPs that have demonstrated they have the necessary systems in place.

4. Accountability and Innovation

The goals of the ACC Program are to improve health outcomes and control health care costs. Successful performance in achieving these goals is expected from each RCCO. The Department encourages RCCOs to be innovative and forward-thinking in their approach. The Department expects certain core functions to be performed but offers the RCCO the flexibility necessary to achieve this goal by any effective and efficient means available.

The Department will pay RCCOs a PMPM in exchange for the services described in this RFP. While providers will continue to bill the Department on a FFS basis for health care services provided to Members, PCMPs will be paid a separate PMPM by the Department. To further encourage accountability throughout the chain of care, both RCCOs and their PCMPs may earn incentive payments for reaching defined utilization targets, moving away from a purely volume-driven FFS model.

The Department also is building a mechanism for sharing with both the RCCOs and the PCMPs a portion of program savings beyond budget neutrality. Both the incentive payments and the Shared Savings will be based on the RCCO's network-wide performance. This is described in detail in Section V.H, Compensation.

The ACC Program supports a shift by the Department from a volume-driven model to an accountable, outcome-based system of care. As such, RCCOs will be expected to use data to support providers and Members, bring down costs, and improve health outcomes from care delivered. RCCOs must have plans to monitor their own performance and that of their provider networks, and quickly integrate this information into their system of care, adjusting as needed. The Department will support them in these efforts.

5. Use of Information from Statewide Data and Analytics Contractor

To support the ACC Program, the Department will contract with the SDAC, an organization that has business intelligence, health care data and analytics experience, performance improvement expertise, and familiarity with medical management to support population Informatics needs to enhance near real-time decision-making. The SDAC supports ACC Program operations as the statewide overseer of data, analytics, performance management, and performance improvement support.

The SDAC will be responsible for bringing a new level of information and data analytics to the Medicaid program. Colorado Medicaid supports multiple eligibility groups (see Attachment I, Eligibility Groups and Regional Caseload Overview), across 56 provider types (see Attachment J, Provider Types), across the state. The SDAC will provide business intelligence insights to identify unexplained variation within and across RCCOs. It will also support benchmarking across key performance indicators and support collaborations to identify best practices to improve efficiency and effectiveness. The SDAC will be the conduit for health information exchange between the Department and the RCCOs to enable effective, Member-specific medical management, risk prediction, and risk management.

For more information on the SDAC's responsibilities and its role in the ACC Program, review the Request for Proposals for the Statewide Data and Analytics Contract (SDAC) services which will be published on the BIDS website, www.gssa.state.co.us/VenSols.

An organization will not be allowed to perform both as a RCCO and the SDAC because the SDAC will have access to data from all RCCOs. See Section II.L for more information.

In order to manage its regional system of care and measure success, RCCOs must also have capabilities and experience with data management and analysis including accessing, understanding, interpreting, sharing and acting upon the data to effect change.

6. Continuous Improvement

To effectively deliver on the promise of the ACC Program, RCCOs will need to coordinate their efforts with the Department, the SDAC, the utilization management contractor, and the provider and Member community. To enable this close collaboration, the Department will require the development of an advisory committee structure, composed of four interdependent workgroups. The advisory committees will be formal vehicles through which the RCCOs and stakeholders can advance the principles of continuous improvement and foster an environment of constant learning. These ACC Program committees, described more thoroughly in Section V.F, will provide a structure for ensuring collaboration and alignment among the key organizations in this initiative. They are a forum for Member input, and a place for clinical experts to provide sound advice on evidence-guided standards of care. Finally, they provide a way for RCCOs to share best practices across the state, and to identify opportunities to improve business processes.

In addition to participating in the ACC advisory committees, the RCCOs will develop and participate in performance improvement planning, targeted performance improvement activities and the proactive analysis of data from the SDAC to effect positive change. Health outcomes improvement and the overall success of the ACC Program will require the development and ongoing engagement in performance improvement programming.

7. Program Phases

The ACC Program will be implemented in three phases: the Start-Up Phase, the Initial Phase and the Expansion Phase. The Start-Up Phase extends from contract execution through the region's "go-live" date (either April 1, 2011 or June 1, 2011). During the Start-Up Phase, the RCCO will take the preparatory steps needed to be ready to serve its Members. During the Initial Phase, which extends from the region's "go-live" date through June 30, 2012, Member enrollment will be limited to 60,000 statewide. In the Expansion Phase, which begins July 1, 2012 provided the initial program goals have been met and the Department has given the RCCO authorization to expand, the Department envisions that the majority of Medicaid Clients not currently enrolled in a physical health managed care program will be enrolled as Members in the ACC Program. This may include the Colorado Health Care Affordability Act Expansion Populations: parents of Medicaid children with income up to 100% of the federal poverty level (FPL); previously ineligible disabled individuals now able to "buy in" to existing programs; and Adults without Dependent Children (AwDC) with income up to 100% of the FPL. The AwDC expansion is expected to result in the addition of 65,000 Clients not formerly covered by Medicaid beginning in early 2012 and grow to more than 100,000 by 2014, when combined with federal reform measures for childless adults.

In the Initial Phase, 60,000 Members will be enrolled in the ACC Program, divided evenly among the regions shown in Attachment D so that there will be approximately 8,600 Members per region. About one-third of the Members in each region (2,900 in each region or 20,000 total Members statewide) will be children from the Medicaid and CHP+ Medical Homes for Children program. The remaining two-thirds will be drawn from the existing adult Primary Care Physician Program (PCPP), the Department's Primary Care Case Management program, and FFS populations in each region. Clients who are dually eligible (that is, they have both Medicare and Medicaid) and Clients residing in institutions will not be eligible for participation in the ACC Program during the Initial Phase. Dually eligible Clients will be passively enrolled into the ACC Program during the Expansion Phase of the program. More information about the Medicaid population in each region can be found in Attachment I.

The ACC Program will be built up over time, and the current PCPP, as well as existing Medicaid managed care organizations and PCCM contracts will continue through the ACC Program implementation. Specific details about the regional roll-out schedule can be found in Section V.B.4.

Since the Initial Phase of the ACC Program is limited to 60,000 Clients statewide (approximately 8,600 per region), the Department assumes that it will not be practical for each RCCO to implement the program region-wide. Instead, the Department anticipates that RCCOs will target or focus on a particular community or communities when initiating the ACC Program in their region. RCCOs will be motivated to identify communities where the RCCO has experience, where there are especially strong connections between providers and community resources, where there is an opportunity to promote best practices and reduce unnecessary utilization of services and variation in care, or where there are excellent systems of care already in place upon which the RCCO can build.

Selecting Focus Communities will make it easier for the RCCO to implement the program during the Initial Phase. It will ensure that the RCCO does not have Members scattered across a large geographic area, allowing PCMPs to have a concentration of ACC Members in their practices. This will ensure that the RCCO's strategies for coordinated and accountable care are having an impact on practices that serve Medicaid Clients regularly.

When the RCCO has demonstrated improved health outcomes and cost control, the Department plans to expand the ACC Program region-wide and be able to offer the ACC Program to most Medicaid Clients in a region (Expansion Phase). The RCCO will be able to expand Membership once they have demonstrated cost neutrality. In addition, there is the potential that the RCCO and PCMPs will be able to share in any savings generated beyond cost neutrality defined as an aggregate reduction in costs of 7%. More information on compensation is described in Section V.H, Compensation.

D. STATE AND FEDERAL AUTHORITY

The Department is the single state agency that operates the Colorado Medicaid program in

accordance with the Colorado Medical Assistance Act (Section 25.5-4-104, et seq. C.R.S.) and Title XIX of the Social Security Act. The Colorado Medicaid program is annually funded from appropriations authorized by the Colorado General Assembly and matched by federal funds.

C.R.S. 25.5-5-402 Statewide Managed Care System requires the Department to adopt rules to implement a managed care system for Colorado under the state Medical Assistance Program (Medicaid). The Department has the authority for this program under Section 1932(a) of Title XIX of the Social Security Act.

IV. GENERAL REQUIREMENTS

A. MANDATORY MINIMUM REQUIREMENTS

The Offeror must fully meet the requirements outlined in this mandatory minimum requirements section. Offerors who are unable to demonstrate that they meet these requirements shall be disqualified. The experience of he Offeror, its parent company, partner, subsidiary or Subcontractor, will be considered. The Offeror must meet the following requirements:

1. Meet the definition of a Primary Care Case Manager (PCCM) set forth in 42 CFR § 438.2;

2. A minimum of three years of Medicaid experience in the past five years; and

3. A minimum of three years of experience with coordinating and delivering, or arranging for the delivery of, comprehensive health care services spanning both the inpatient and outpatient continuum of care. Experience with comprehensive services must include experience with at least two of the following: physical health, behavioral health, oral health and/or specialty care.

OFFEROR'S RESPONSE:

The Offeror's proposal shall:

1. **Demonstrate that the Offeror meets the definition of a PCCM.**
2. **Describe in detail the type of experience and specify the years during which the experience was acquired to demonstrate that the Offeror meets the experience requirements set forth above**.

B. EXPERIENCE AND ORGANIZATION

1. Enrolled Medicaid Provider

The Offeror must be an enrolled Medicaid provider prior to the execution of a contract resulting from this RFP.

2. Additional Experience

The Department is seeking organizations that have recent experience coordinating and delivering, or arranging for the delivery of, comprehensive health care services to a diverse population of Clients in a health care system, as well as proven experience with managing medical costs and using data to positively effect change. The Offeror is expected to have experience coordinating, delivering or arranging for the delivery of care across the continuum of care, including in both the inpatient and outpatient setting. Ideally, the Offeror's experience should include:

a. Successfully managing medically and socially complex populations across multiple systems and settings;

b. Improving health outcomes;

c. Effectively using health and expenditure data to monitor and improve health care delivery;

d. Creating positive and lasting relationships with providers, community organizations, Clients and other stakeholders;

e. Taking all necessary and appropriate measures to ensure successful program results; and

f. Coordinating and delivering care, or arranging for the delivery of care, that resulted in:

   i. Improved access to care

   ii. Enhanced integration

   iii. Improved health

   iv. Reduced costs

3. Organizational Structure and Subcontracting

The Offeror shall possess the corporate resources and structure necessary to perform as a RCCO and successfully implement and operate the ACC Program in the region it is proposing to serve. The Offeror shall have an office in the region it is proposing to serve.

The Offeror shall have an internal organizational structure of sufficient size to perform, or direct the performance of, the services described in this RFP. The organizational structure shall clearly define lines of responsibility, authority, communication and coordination within and between various program components and activities.

The Offeror shall be solely responsible for all of the work performed under the contract resulting from this RFP, regardless of whether Subcontractors are used. The Department shall work solely with the Offeror with respect to all services to be performed under this contract. The Offeror shall have written subcontracts with all Subcontractors which shall require the same standards for performance as the Offeror. Agreements with providers, including PCMPs are not considered subcontracts.

All subcontracts require the approval of the Department prior to start of work by a Subcontractor. Subcontracts may not exceed 40% of the total Statement of Work. No single subcontract may exceed 20% of the total Statement of Work.

4. Personnel

a. Key Personnel. The Offeror shall employ, at a minimum, the permanent staff described below. These key personnel must be employed by the RCCO and will need to be

available in Colorado as directed by the Department for key meetings. The Department reserves the right to approve the key personnel prior to being assigned to work on the contract. Key personnel that the Offeror proposes shall serve in the positions for which they are proposed. Any new key personnel appointed during contract performance period shall have at least the same qualifications as the individual proposed for that position in the Offeror's proposal. The Offeror shall have the following permanent staff:

i. Contract Manager (or similar title), is the Department's primary point of contact for contract and performance issues and responsibilities. All communication between the Department and the RCCO shall go through the primary point of contact. The Contract Manager shall work out of either the regional office or an office in the Denver metro area.

ii. Financial Manager (or similar title), with experience and demonstrated success in managed health care, responsible for effective implementation and oversight of the budget, accounting systems, and all financial operations of the Offeror in compliance with federal and state laws and the requirements of the contract.

iii. Chief Medical Officer (or similar title), who must be a Colorado-licensed, Board-certified physician, and who has responsibility for the effective implementation of all clinical/medical programs and quality management programs in compliance with federal and state laws and the requirements of the contract.

b. Other Staff Functions. In addition to providing key personnel, the RCCO shall ensure the following functions are performed:

i. Outcomes or Performance Improvement Management, which includes overseeing Member and administrative outcomes, coordinating quality improvement activities across the RCCO, benchmarking performance against other RCCOs, ensuring alignment with federal and state guidelines, and setting internal performance goals and objectives.

ii. Medical Management and Care Coordination Activities, which includes overseeing medical management and care coordination activities to assist providers and Members in rendering and accessing necessary and appropriate services and resources.

iii. Communications Management, which includes organizing, developing, modifying and disseminating information, including written material and forums, to providers and Members.

iv. Provider Relations and Network Management, which includes establishing agreements with PCMPs and all other formal and informal relationships with providers. This includes provider education, data-sharing, and addressing providers' questions and concerns.

5. Health Insurance Portability and Accountability Act (HIPAA) of 1996

a. The Offeror shall ensure that all federal regulations regarding standards for privacy, security, electronic health care transactions and individually identifiable health information, the privacy regulations found at 45 CFR 160, 162 and 164, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the American Recovery and Reinvestment Act of 2009 (ARRA)/HITECH Act (P.L. 111-005), are continuously met. The Offeror must comply with any future HIPAA requirements. . The Offeror shall execute a HIPAA Business Associate agreement attached with the Draft Contract, in Attachment E. The Offeror shall maintain comprehensive confidentiality policies and procedures approved by the Department.

b. The Offeror shall control the use or disclosure of Protected Health Information (PHI) as required by the HIPAA Busincess Associate agreement or as required by law. No confidentiality requirements contained in this RFP shall negate or supersede the provisions of the HIPAA privacy requirements.

6. CyberSecurity

The Offeror shall ensure that its information technology systems and websites are maintained and operated in accordance with both state and federal regulations, and shall comply with all State of Colorado Cyber Security Policies. See Colorado Cyber Security Policies at http://www.colorado.gov/cs/Satellite/Cyber/CISO/1207820732279.

OFFEROR'S RESPONSE:

The Offeror's proposal shall:

1. **Provide detailed information about all experience coordinating and delivering, or arranging for the delivery of care to a diverse population in the past five years. Discuss the actual results of service coordination and delivery projects that were achieved in terms of the expected results discussed in Section IV.B.1 above. For each project described, include the following information:**
    a. **The name and location of the Client and the number of years performing for the Client.**
    b. **The nature of the project, including the population(s) served and number of covered lives, and how the organization used health and expenditure data to monitor and improve health care delivery.**
    c. **Any corrective action plans entered into over the course of the project, or any findings related to contract non-compliance or deficient performance.**
    d. **Contact information for the Client's project manager. If the services were not provided under contract with another entity, provide the contact information for an individual who can discuss project performance. Contact**

information shall include the person's name, title, phone number, and email address.

e. A list of three other key individuals, with contact information, willing to provide a reference regarding the abilities and performance of the Offeror or, for a new organization, its key personnel.

2. Provide information about the organization and its capabilities, and why the Offeror should be selected for this contract. Describe the organization's ability to perform the services required for this contract. Please include the number of years in business and number of employees. Identify the organization's location(s), including any offices in Colorado.

3. Provide a detailed description of the Offeror's internal organization structure, including delineated management structure. An organizational chart shall be included with the description, showing the number and types of employees.

4. Propose personnel to fill each of the positions and functions described in Section IV.B.3 above. Include names, titles, résumés, and a description of relevant experience. Provide the number of proposed staff by job title, a brief job description for each title, and evidence that the organization has a sufficient number of qualified staff to manage all RCCO requirements as described in this RFP.

5. Provide a detailed subcontracting plan if the Offeror plans to subcontract with other entities to perform portions of the Statement of Work, listing names and addresses of the Subcontractors to be used. Identify the Subcontractor's location(s), including any offices in Colorado. Describe the services that the Subcontractor will provide and an estimate of the percentage of the total Statement of Work to be performed by each Subcontractor. Provide the plan to oversee the Subcontractor to ensure quality performance. Describe the Offeror's experience managing Subcontractors.

6. Provide a positive statement that the Offeror will comply with all applicable HIPAA and CyberSecurity requirements.

V. STATEMENT OF WORK

The Statement of Work outlined in this RFP describes the necessary components of the ACC Program, for which the primary goals are to improve health outcomes for Medicaid Clients and control costs in a responsible manner. The ACC Program takes the principles of a Patient-Centered Medical Home, the characteristics of Accountable Care Organizations, and the successes within Colorado's provider community, and builds upon them to gain accountability for regional health and cost management across all provider types.

Offerors chosen to perform as a RCCO shall perform the services described in the RFP in compliance with the provisions of the Draft Contract, included in this RFP as Attachment E, and all pertinent state and federal statutes, regulations and rules. The following requirements shall be met, in their entirety, by any RCCO that contracts with the Department as a result of this RFP process.

A. THE ACCOUNTABLE CARE MODEL

The Department seeks to promote the ACC Program as a Client/family-centered, outcomes-focused system of care that affordably maximizes the health, functioning and self-sufficiency of Members. The Department envisions RCCOs driving accountability through provider and Member support services, access to sophisticated data analysis, outcomes-focused contracting, health information technology services and outcomes-based incentive payments.

The Offeror shall demonstrate a commitment to the accountable care model throughout its proposal by identifying specific programs, services, policies and procedures that embody the described principles. The Offeror shall demonstrate a commitment to proactive care rather than relying solely upon reactive models of care. The Offeror's proposal shall not include a separate section narrating their commitment to this requirement, but shall demonstrate its commitment to the accountable care model and the ACC Program goals and objectives throughout the responses to Sections IV and V of the RFP. Throughout its proposal, the Offeror shall describe how the Offeror plans to achieve the ACC Program goals of improving health outcomes and controlling costs, incorporating the following objectives:

1. Expand access to comprehensive primary care.
2. Provide a focal point of care/Medical Home for all Members including coordinated and integrated access to other services.
3. Ensure a positive Member and provider experience and promote Member and provider engagement.
4. Effectively apply an unprecedented level of statewide data and analytics functionality to support transparent, secure data-sharing and enable the near-real-time monitoring and measurement of health care costs and outcomes.

As part of accountable care, the ACC Program will require Members to obtain a PCMP's referral for most services outside the scope of care provided by the PCMP. RCCOs and PCMPs will serve as conduits to care, helping their Members gain access to needed services.

B. MEMBERSHIP AND ENROLLMENT

This section describes the ACC Program roll-out schedule, as well as the Membership and enrollment process during the three phases of the ACC Program. The Start-Up Phase from extends from contract initiation to the region's "go-live" date, the Initial Phase extends from the "go-live" date through June 30, 2012 and the Expansion Phase begins July 1, 2012 provided initial program goals have been met and authorization is given to expand. During the Initial Phase, Member enrollment will be limited to 60,000 statewide, but once in the Expansion Phase, the Department envisions that the majority of Medicaid Clients not currently enrolled in a managed care program will be enrolled as Members in the ACC Program. During the Expansion phase, regional Membership will grow to anywhere from 40,000 Members to over 120,000 Members in the largest region.

1. Membership

During the Initial Phase of operations, there will be 60,000 Members assigned evenly among the seven regions shown in Attachment D, or approximately 8,600 Members per region. About one-third of the members in each region (2,900 in each region or 20,000 total Members statewide) will be children who are currently part of the Medicaid and CHP+ Medical Homes for Children program. The remaining two-thirds will be drawn from the adult PCPP and FFS Medicaid populations in each region. Clients who are dually eligible (receive both Medicare and Medicaid) and Clients residing in institutions (state psychiatric institutions and nursing facilities) will not be eligible for participation in the ACC Program during the Initial Phase. Members who are transferred to a nursing facility will retain their Membership in the ACC Program unless they opt out. More information about the Medicaid population in each region can be found in Attachment I.

2. Enrollment

The Department will attempt to maintain an enrollment of 60,000 Members in the ACC Program during the Initial Phase. The 60,000 Member cap will be reached over the course of five months as outlined in Section V.B.4, Region Roll-Out. Once the enrollment cap is reached and as Members lose Medicaid eligibility and are therefore no longer able to participate in the ACC Program, additional Clients will be enrolled monthly to replenish Membership in order to maintain a total of approximately 60,000 Members.

Enrollment in the ACC Program will be on a voluntary basis only. Clients will have the choice to participate in the ACC Program or to "opt out" of participating in the program. During the Initial Phase, all Members will be enrolled utilizing the voluntary process called Passive Enrollment. The RCCOs will not be allowed to perform Marketing activities to increase their enrollments during the Start-Up Initial Phases.

a. Passive Enrollment. Passive Enrollment is the process of voluntarily enrolling Clients into a specific program and includes the selection of Clients appropriate for enrollment, notification of Clients selected for enrollment, and Choice Counseling to assist Clients in making a decision regarding enrollment.

i. Selection of Clients appropriate for enrollment will be performed by the Department through the SDAC. The SDAC will identify Clients appropriate for enrollment from two Client populations: Clients who are newly eligible for Medicaid and existing Medicaid Clients that have an established relationship with a PCMP participating in the RCCO's network and Focus Community. The SDAC will be given a list of participating PCMPs, and use an Attribution Method to determine whether a PCMP-Client relationship already exists. The SDAC will mine historical claims data to identify the primary care provider the Client has seen most often during the past 12 months. As depicted in the enrollment timeline below, Clients will be selected and notices mailed two months prior to the date of actual enrollment, during the Start-Up Phase.

ii. Critical to the Passive Enrollment process is that all Clients receive advance notice and have the opportunity to make an informed choice. The Enrollment Broker will be responsible for sending notices to all Clients identified for enrollment by the Department through the SDAC. The notice informs Clients of the Department's intent to enroll them in the ACC Program, provides them with information about their Colorado Medicaid enrollment choices, provides contact information for the Enrollment Broker's Choice Counseling services and allows 30 days for the Client to make an active choice or be enrolled in the ACC Program. A Client that chooses not to participate in the ACC Program must contact the Enrollment Broker. The Client may choose to enroll in another Colorado Medicaid managed care organization, if available, or to remain in the FFS program or PCPP. Clients that do not opt out of participation in the ACC Program will be enrolled with the RCCO responsible for the region in which they live. The enrollment will be effective the first day of the month following the Client's 30-day choice period.

3. RCCO Responsibilities

a. Client Materials. All materials the RCCO develops for distribution to Clients or Members shall be culturally and linguistically appropriate for its Members, written in English and Spanish (and other prevalent languages if directed by the Department), and written in easily understood language and formats. The RCCO shall coordinate with the Department's Enrollment Broker during the Start-Up Phase by providing the following Member materials:

i. A region-specific section of the ACC Program Member handbook including a description of the RCCO roles, responsibilities and functions that support the ACC Program, how to access RCCO care coordination services, and relevant telephone numbers and Web addresses.

ii. A directory of PCMPs and any other providers with which the RCCO contracts.

b. Member Outreach. Members will be assigned to a RCCO based on their county of residence, but may select a PCMP in another region and obtain care in other regions if they choose. The RCCO shall contact all Members not linked with a PCMP within 30 days of enrollment to connect the Member with a PCMP who will deliver the majority of the Member's care.

c. Marketing. The RCCO shall be knowledgeable of federal standards regarding Marketing, set forth at 42 CFR 438.104. The RCCO shall not perform Marketing activities during the Start-Up or Initial Phases. Once in the Expansion Phase, the RCCO shall comply with all Marketing requirements.

4. Region Roll-Out

a. Initial Phase. The Department will roll out the ACC Program by region, beginning with three regions (Regions 1, 2 and 4) on April 1, 2011 and the remaining four regions (Regions 3, 5, 6 and 7) two months later on June 1, 2011. The Department anticipates that it will take five months to reach the 60,000 Member cap. The following table identifies the region roll-out schedule, including the enrollment process start date and when the RCCO will begin serving Members ("go-live" date).

Monthly Cycle	Regions 1, 2 & 4	Monthly Cycle	Regions 3, 5, 6 & 7
Month 1 (February)	• Enrollment Broker mails 8,600 Client notices.		
Month 2 (March)	• Month 1 Clients may opt out within 30 days. • Additional Client notices to meet 8,600 enrollments are sent.		
Month 3 (April)	• Month 1 Clients that do not opt out are enrolled as Members. • RCCO goes live – serves Members. • Month 2 Clients may opt out within 30 days. • Additional Client notices to meet 8,600 are sent.	Month 1 (April)	• Enrollment Broker mails 8,600 Client notices.
Month 4 (May)	• Replenish enrollment – as Members lose Medicaid eligibility, Client notices to maintain 8,600 are sent.	Month 2 (May)	• Month 1 Clients may opt out • Additional Client notices to meet 8,600 enrollments are sent.
Months 5 + (June and monthly thereafter)	• Replenish enrollment monthly.	Month 3 (June)	• Month 1 Clients that do not opt out are enrolled as Members. • RCCO goes live – serves Members. • Month 2 Clients may opt out within 30 days. • Additional Client notices to meet 8,600 are sent.
		Month 4 (July)	• Replenish enrollment – as Members lose Medicaid eligibility, Client notices to maintain 8,600 are sent.
		Months 5 + (August and monthly thereafter)	• Replenish enrollment monthly.

b. Expansion Phase. As each of the RCCOs demonstrates attainment of program cost goals, the Department will grant permission to expand region-wide. The RCCO shall have the capacity to expand their Membership to all remaining Medicaid Clients in its region over 12 months. New enrollments during this period of time may reach 5,000 or

more per month, depending upon the size of Client population in the region. The RCCO will also be expected to incorporate new Clients associated with the Colorado Health Care Affordability Act Expansion Populations, expected to grow to more than 100,000 Clients statewide by the end of 2014.

OFFEROR'S RESPONSE:

The Offeror's proposal shall address each of the requirements outlined above including:

1. **Describe how the Offeror will be prepared to meet the scheduled rollout. Identify activities the Offeror will perform in preparation for the go-live date.**

2. **Provide a detailed plan and timeline for developing Member materials in a manner and format that may be easily understood, is available in the prevalent non-English languages, and is culturally sensitive. Include a sample of Member materials the Offeror has created.**

3. **Describe the process for helping Members understand their options for finding a PCMP, assisting Members with finding a PCMP if needed, and ensuring that all Members are linked to a PCMP.**

4. **A detailed plan on how the Offeror will be prepared for region-wide expansion and have capacity for receiving new enrollments through the Expansion Phase.**

5. **Provide a positive statement that the Offeror will comply with all applicable Marketing regulations identified at 42 CFR 438.104 during the Expansion Phase.**

C. NETWORK AND REGIONAL STRATEGY

1. Network Overview

a. Building on the Existing Medicaid Network. There are over 30,000 enrolled Medicaid providers of all types across the state. More than 80% of licensed primary care providers in the state are enrolled as Medicaid providers. However, in many areas there is an absence of meaningful communication and coordination between these providers in their care of Medicaid Clients. One of the main functions the RCCO will serve on a regional basis will be first to develop relationships with the providers in its region and then to aid in the development of relationships between providers. The RCCO will help the Department to transform its existing fragmented provider base into a cohesive regional network with strong avenues of communication, coordination and learning. Using the existing Medicaid provider base, the RCCO shall secure sufficient PCMP commitments and relationships with an array of other Medicaid providers broad enough to serve the approximately 8,600 Members in the Initial Phase and afterwards, anywhere from 40,000 to over 120,000 Members in the region during the Expansion Phase. For additional information on Medicaid providers in each region, see *Regional Provider Data* on the Department's website at www.colorado.gov/cs/Satellite/HCPF→ Initatives → Accountable Care Collaborative.

Colorado Medicaid serves Clients in multiple eligibility categories and waiver programs. Clients within eligibility categories are served by overlapping, but not identical, sets of providers. For example, Clients within the developmental disability community in general have patterns and providers of care that differ from those Clients served through the Department's Elderly, Blind, and Disabled Home and Community-Based Services Waiver. Awareness of the different needs, providers and care communities of Client groups is important in designing interventions, as opportunities for improvement vary dramatically. Effective care communities may exist that would benefit from greater access to specific services such as dental care and specialist care; whereas for other Client groups little community infrastructure may exist. A list of eligibility categories and their sizes can be found in Attachment I.

b. PCMP Network. The foundation of the RCCO's network will be the PCMP, an individual provider or pod of providers that work closely as a team to serve as Medical Homes for Members in the ACC Program. The RCCO shall administer a network of PCMPs. PCMP requirements and interdependencies between the RCCO and each PCMP shall be documented in a written agreement. The RCCO shall ensure the existence of a network of PCMPs robust enough to serve all Members' primary care needs, meet strict access-to-care standards, and allow for adequate freedom of choice for Members. See Attachment K for a regional overview of selected primary care provider types.

c. Network of Other Medicaid Providers. In addition to the core network of PCMPs, the RCCO shall develop and maintain relationships with other Medicaid providers. Providers such as durable medical equipment providers, dentists, pharmacists, home health providers, ancillary prenatal service providers, nursing homes, alternative care facilities, and physical, occupational, and speech therapists, are essential for the provision of full-spectrum health care because they serve Members' varied needs beyond basic primary, preventive and sick care. Annually, approximately one-fifth of the Department's medical services expenditures are for primary care services and providers and the remainder on other Medicaid services and providers. These figures exclude payments to managed care organizations, behavioral health organizations, and long-term care services which together represent and additional $1 billion in expenditures. As these figures illustrate, care is delivered and expended largely outside of the primary care setting and it is therefore critical that these non-primary care provider partners participate in this model of care.

d. Focus Communities During Initial Phase. Since the Initial Phase of the ACC Program is limited to approximately 60,000 Members, the RCCO is expected to concentrate efforts on a core network of PCMPs and other Medicaid providers in Focus Communities. Focus Communities are those communities where the RCCO has identified excellent systems of care, where there is an opportunity to promote best practices and reduce unnecessary variation in care, and where there are especially strong connections between health providers and community resources, thereby reducing the overall cost of care and improving the health and functioning of the Members. The RCCOs should

locate their Focus Communities in an area large enough to serve the 8,600 Members enrolled in the Initial Phase and have the ability to scale that area up or down as needed to maintain Member base throughout the Initial Phase. In addition, the RCCOs will need to grow to accommodate five to fourteen times more Members that will enroll in the program during the Expansion Phase, depending on the region.

e. Regional Strategy for Distribution of Resources. Central to the success of the ACC Program in general and the RCCOs' success in improving outcomes and managing costs in particular will be the regional strategy employed by each RCCO to ensure that the needs of the population are being met. While ensuring a sufficient number of providers in the network is integral, attention must also be paid to how the RCCO's delivery system functions as a whole, regardless of the specific number of providers. In the Focus Communities and during the Expansion Phase, the RCCO's regional strategy should guide the efficient distribution of resources and efforts across the communities and region-wide. See Attachment L, Utilization and Cost Variance Maps, for examples of service utilization and cost variance across the state. A comprehensive and cohesive system of care should force interplay between provider types, promote and facilitate frequent communication, aim to eliminate health and utilization variances and incorporate the use of data and Informatics to foster continuous improvement and accountability.

2. Network Development

The RCCO shall ensure that it has the resources necessary to transform the existing Medicaid provider base into a comprehensive network of PCMPs and other Medicaid providers.

a. PCMP Network. The RCCO shall enter into written agreements with all PCMPs it includes in its network. As a principle of the Patient-Centered Medical Home model, the relationship between the individual PCMP or practice pod and the Member is the foundation of successful health care management and comprehensive care. Each Member shall be in the care of an individual PCMP or practice pod who provides the majority of a Member's primary care services. The Department recognizes the importance of team-based care but validates the need for a coordinating primary care provider. The Department also recognizes, however, that, in many cases, the agreements and payment aspects of care delivery occur at the practice or clinic level. The RCCO may therefore establish agreements with PCMP Practices (such as FQHCs, RHCs, clinics, and other group practices) but each Member shall be linked with an individual practitioner or practice pod within that PCMP Practice.

i. The RCCO shall establish written agreements only with providers who meet the following PCMP criteria:

(1) Both the PCMP Practice and each individual PCMP shall be an enrolled Colorado Medicaid provider, currently licensed and able to practice in the State of Colorado.

(2) The individual PCMP shall act as the primary care provider for a Member and be capable of delivering the majority of a Member's comprehensive primary,

preventive and urgent/sick medical care.

ii. The PCMP Practice shall:

(1) Be certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program, or

(2) Be an FQHC, RHC, clinic, or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology, and meet all additional criteria described in Attachment H.

(a) The individual PCMP(s) within the practice shall be a physician, advanced practice nurse, or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology, and meet all additional criteria described in Attachment H.

iii. The RCCO shall have a written agreement with each participating PCMP Practice.

iv. The RCCO shall focus initial PCMP network development efforts on current FFS Medicaid providers by striving to increase providers' capacity to accept Medicaid Clients, as well as increase overall participation by primary care providers in Colorado Medicaid.

v. The RCCO shall ensure the inclusion of both Essential Community Providers as defined at CRS 25.5-5-403 and private, for-profit, and not-for-profit providers in the RCCO's network.

vi. The RCCO shall ensure that its PCMP network is capable of serving a diverse Member population and has identified PCMPs with interest and expertise in serving special Member populations including but not limited to the physically or developmentally disabled; children (including foster children), adults, and the aged; non-English speakers; the AwDC Expansion Population; and Members with complex physical and/or behavioral health needs.

vii. The RCCO shall have a process for accommodating a Member's PCMP choice. If the desired provider is not part of the broader ACC Program PCMP network, the RCCO shall make an effort to enroll that provider into its network.

b. Coordinated Relationships with Other Medicaid Providers. The services of non-PCMP providers play an integral role in the provision of whole-person care. For many of those services outside of the scope of practice of the PCMPs, Members shall have access to a broad array of other Medicaid providers and the RCCO will be responsible for facilitating this linkage. Many services not provided by the PCMPs will require referral to ensure that Members are appropriately utilizing the health care delivery system. The Medicaid claims payment system is set up to enforce this referral requirement. The RCCO shall ensure that all of its network providers are aware of this and shall facilitate this process. Specifically:

i. The RCCO shall outreach to and educate specialists and other Medicaid providers regarding the ACC Program, its structure, the role of the RCCO and the supports it will offer to providers in its network.

ii. The RCCO shall focus initial relationship-building efforts on current FFS Medicaid providers by striving to increase providers' capacity to accept Medicaid Clients, as well as increasing overall provider participation in Colorado Medicaid.

iii. The RCCO shall seek input from the Department, Members and the provider community to determine where access to these services is limited and may require focused efforts to increase coverage capacity.

iv. The RCCO shall determine how best to foster relationships and coordinate with specialists and other Medicaid providers so that Members have sufficient freedom of choice and timely access to these services.

3. Access-to-Care Standards

In developing its cohesive regional network inclusive of PCMPs and other Medicaid providers, the RCCO shall be mindful of the need to ensure adequate and timely access for primary care as well as specialty care and other medical services. The RCCO shall ensure its provider network has the following characteristics and is able to meet the following access requirements:

a. PCMP Network. The RCCO's PCMP network, as a whole, shall include:

i. A sufficient number of PCMPs so that every Member has a PCMP, and has a choice of at least two PCMPs per ZIP code, or a choice of two PCMPs within 30 minutes driving time to reach the provider's office.

ii. The systems and services below, required for the RCCO's PCMP network as a region (not necessarily for each PCMP Practice):

(1) Extended hours in evenings and on weekends.

(2) Alternatives to visiting the emergency room for after-hours urgent care.

(3) Systems to track access at the individual PCMP provider-level including day-of-the-week call volume, requests for same-day care, requests for routine care and time frames in which appointments can be scheduled.

(4) Ability to comply with access standards. Specifically, appointments with PCMPs shall be available to all Members:

(a) Within 48 hours of a Member's request for urgent care;

(b) Within 10 calendar days of a Member's request for non-urgent symptomatic care; and

(c) Within 45 calendar days of the Member's request for non-symptomatic care, unless an appointment is required more quickly to ensure the provision of screenings in accordance with accepted EPSDT schedules.

b. Other Medicaid Provider Networks. The ACC Program aims to facilitate appropriate Member access to specialists and other Medicaid providers. Access to these providers is integral to Members' health and wellbeing. The RCCO shall:

i. Ensure that Members have adequate access to specialists and other Medicaid providers promptly with a referral, and without compromise to quality of care or health.

ii. Highlight and promote those providers who demonstrate exemplary access capacity.

4. Ongoing Network Management and Regional Strategy

The RCCO shall be responsible for developing relationships with the providers in its region and then to aid in the development of relationships between providers. The RCCO shall have resources and personnel dedicated to this function including ongoing provider relations, reporting on network relationships and improvement plans, and commitment to facilitating and enhancing communication between and across provider types and settings. The RCCO's ongoing promotion of cohesion and communication shall be a significant component of the RCCO's regional strategy for affecting the key factors of health outcomes and costs, upon which the RCCOs and the ACC Program performance will be measured.

The RCCO shall continually assess and evaluate the strength of its network relationships and strategy, and report on its strength to the Department as described in Section V.G. The RCCO shall take all necessary steps required to manage and maintain its network, and continuously evaluate the effectiveness of its regional strategy. On an ongoing basis, the RCCO's responsibilities shall include the following:

a. Continually promote better access to services by encouraging providers to expand the capacity of their panels.

b. Monitor the referral process to ensure that Members have appropriate access to needed services and that providers' adminstrative burden is minimized. Identify referral patterns between PCMPs and other providers, and recruit needed providers to the network when possible. Coordinate with other RCCOs so that a Member has access to care if he/she works in another region or lives near a regional boundary.

c. Employ systems to communicate with all providers in the network, as well as the behavioral health managed care organizations, and promote communication among the providers themselves. This may include methods such as:

i. Assigning providers to a specific provider relations consultant or point-of-contact at the RCCO to emphasize and ease communication.

ii. Holding informational sessions for interested providers at practice association meetings and conferences.

iii. Providing orientation training to providers new to its network.

iv. Hosting forums for ongoing training regarding the ACC Program and the services the RCCO offers.

v. Posting provider tools, trainings, informational material, and RCCO contact details online in easily accessible formats (see Section V.D).

vi. Developing standard communication intervals at which all providers will be contacted to maintain connection and lanes of communication.

vii. Distributing a network newsletter with quick tips and tools promoting continuous provider interest and involvement.

d. Have a mechanism for accepting provider concerns and complaints and prompt response standards.

e. Make a good faith effort to give written notice of termination of a PCMP within 15 days after receipt or issuance of the termination notice to each Member who received his/her primary care from or was seen on a regular basis by the PCMP.

f. Evaluate and adjust its regional strategy for meeting goals and objectives and administering a comprehensive, cohesive system of care.

5. Network Expansion Region-Wide

After the Initial Phase of the ACC Program, when funding is available to expand Membership above the 60,000 cap, the RCCO will be expected to administer a robust provider network of PCMPs and other Medicaid providers available across their entire region, meeting all requirements in Section V.C.3 above including a regional strategy that can be applied to a larger network. The RCCO shall plan from the very beginning of the program to develop the capacity to serve Members region-wide and have a clear plan for expanding their provider networks beyond the Focus Communities to the entire region, including the Colorado Health Care Affordability Act Expansion Populations.

OFFEROR'S RESPONSE:

The Offeror's response shall include a detailed description of the Offeror's approach to transforming the existing Medicaid provider base into a cohesive regional network with strong avenues of communication, coordination and alignment toward outcomes-based goals. The Offeror's description shall address each of the requirements outlined above as well as:

1. **Describe which Focus Communities the Offeror intends to target in the Initial Phase of the ACC Program and why. Identify the Focus Communities by county and ZIP code.**
2. **Specifically describe:**
   a. **Estimated number of committed PCMPs and established relationships with specialists and other Medicaid providers the Offeror will have by the time Passive Enrollment begins and plans for tracking and reporting on network**

adequacy and improvement. Include a map of PCMPs' and other providers' locations if available.

b. **How the Offeror's network is representative of and capable of serving the diverse Member population's complex and special needs, specifically how the network will offer care for special populations such as the physically disabled or developmentally disabled; children (including foster care), adults, and the aged; non-English speakers; the AwDC Expansion Population; and Members with complex physical and/or behavioral health needs.**

c. **How the Offeror will ensure that the network can meet the access standards described above.**

3. **Describe how the Offeror plans to actively and continuously administer the provider network including the which activities, methods, and measures the Offeror will take to ensure maintenance of an adequate network.**

4. **Describe how the Offeror will monitor its network strength on an ongoing basis and how quickly it expects to be able to identify and address deficiencies. Include how the Offeror intends to monitor referral patterns between providers and work to increase the capacity of participating providers to accept Medicaid Clients.**

5. **Explain how the Offeror will expand from its Focus Communities to serve the entire region and the length of time the Offeror will need before its network is ready to serve the entire region.**

6. **Members' assignment to a RCCO will be based on their home address. Describe how the Offeror plans to coordinate with other RCCOs so that a Member might access care if he/she works in another region, lives near a regional boundary, etc.**

7. **Describe the Offeror's approach to developing a regional strategy that will guide the Offeror in administering a comprehensive and cohesive health care delivery system. Include examples of the components the Offeror believes are integral to a successful regional strategy.**

D. PROVIDER SUPPORT

A critical role of the RCCOs is to support providers in their ongoing efforts to provide a Client/family-centered Medical Home that improves outcomes, and reduces costs. The ACC Program promotes Medical Homes through PMPM payments, care coordination and care management supports, incentive payments, and efforts to reduce administrative burden on practices. The RCCO shall be readily available to providers to successfully provide the following:

1. Administrative Support

a. The RCCO shall be responsible for ensuring that network providers are aware of Colorado Medicaid programs, policies and processes, including benefit packages and

coverage policies, prior authorization and referral requirements, claims and billing procedures, eligibility and enrollment processes, and other operational components of service delivery.

b. In order for PCMPs, specialists and other Medicaid providers to focus their time and effort on providing necessary care and achieving positive health outcomes, the RCCO shall serve as a "one-stop-shop" for providers regarding administrative issues, which include the following:

   i. Provide information and education on the roles other Department contractors and partners play in the Colorado Medicaid system including but not limited to the SDAC, the Enrollment Broker, the Medicaid fiscal agent, the utilization management contractor, the managed care ombudsman, the county departments of human and social services, and the Community-Centered Boards and Single Entry Point agencies.

   ii. Serve as a link and liaison between these contractors and partners and assist providers in navigating these administrative systems when barriers or problems are encountered in administrative processes like Medicaid provider enrollment; prior authorization and referral issues; Member eligibility and coverage polices and benefit packages; PCMP designation problems; and PCMP PMPM payment issues. This supportive function shall be provided network-wide including PCMPs, specialists, and other service providers.

2. Practice Support

a. One of the fundamental functions of the RCCO will be to assist the PCMPs and other providers in providing the highest levels of care in the most efficient and effective manner possible. Aside from easing the administrative burden on providers by performing the support functions discussed above in Section V.D.1, the RCCO shall be responsible for supplying providers with the practical tools and resources necessary to fulfill the basic elements of a Medical Home, to implement additional/advanced elements of comprehensive, efficient, Client/family-centered care and to help shift from a volume-driven environment to an outcomes-based health care delivery system.

b. The RCCO is expected to offer support to practices, which may range from comprehensive assistance with practice redesign to providing assistance with other efficiency and performance-enhancing activities. The RCCO shall have a suite of clinical tools and resources readily available to support providers in offering evidence-guided, comprehensive primary care in a manner that is accountable and outcomes-oriented. The suite of tools and resources should be comprehensive and offer a continuum of support for PCMPs, specialists and other Medicaid providers alike.

   The suite of tools and resources should include both clinical and operational tools and supports, Client materials, Web-based resources and directories, as well as practice-specific data and reports. The RCCO shall have a suite of tools and resources that may

include, but not be limited to, those items described below.

c. Examples of Practice Support Tools and Resources.

Clinical Tools	Client Materials
• Clinical care guidelines and best practices. • Clinical screening tools (e.g. depression screening tools, substance use screening tools). • Health and functioning questionnaires. • Chronic care templates. • Registries.	• Client reminders. • Self-management tools. • Educational materials about specific conditions. • Client action plans. • Behavioral health surveys and other self-screening tools.
Operational Practice Support	**Data, Reports and Other Resources**
• Guidance and education on the principles of Medical Home. • Training on providing culturally competent care. • Training to enhance the health care skills and knowledge of supporting staff. • Guidelines for motivational interviewing. • Tools and resources for phone call and appointment tracking. • Tools and resources for tracking labs, referrals, etc... • Referral and transitions of care checklists. • Visit agendas or templates. • Standing pharmacy order templates.	• Expanded provider network directory. • Comprehensive directory of community resources. • Directory of other Department-sponsored resources such as the managed care ombudsman and nurse advice line. • Link from main ACC Program website to the RCCO-specific website where all tools and resources are centrally located and easily accessible.

3. Accessible Provider Supports and Resources

Administrative and practice support tools and resources will be integral to achieve the transformational improvements fundamental to the Members' health, the providers' success, and the ACC Program's overall mission. As such, these tools and resources must be readily available and easily accessible. In the Start-Up Phase, the RCCO shall therefore design a website on which the tools and resources can be found, and continually maintain and update this website throughout the contract period. This website shall contain at a minimum:

a. General information about the ACC Program, the RCCO entity, the RCCO's role and purpose, the principles of a Medical Home, a network directory of PCMPs and any other providers with which the RCCO contracts, including characteristics of these

providers (such as gender, languages
spoken, whether they are currently accepting new Medicaid Clients, links to providers' websites when available, etc.)

b. An area specific to providers that contains a description of the supports the RCCO offers to the providers, as well as an online "encyclopedia" of all of the evidence-based tools, screenings, clinical guidelines, practice improvement activities, templates, trainings and other resources the RCCO has compiled.

c. Immediately available resources to guide providers and their Members to other needed community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance, and other non-medical supports.

4. Data Analysis and Reports

Another fundamental aspect of the ACC Program will be RCCO and PCMP access to Member data and information that has not previously been available. Claims data will be provided by the Department directly to the SDAC, which is responsible for hosting the data, applying data analytics and making the information available to the RCCO and PCMPs through an ACC Program Web Portal. The SDAC will provide advanced analytical functions using predictive modeling, trending analysis, and other methods. The RCCO will have access to Medicaid claims history for its Members, as well as SDAC-created reports. The Department expects the SDAC to develop complex and sophisticated reports to highlight opportunities for improvement and to facilitate communication among the seven RCCOs on best practices that are resulting in best outcomes and best performance.

The SDAC will provide access to standard reports that the RCCO can query through the SDAC Web Portal. The RCCO may request that the SDAC prepare ad-hoc reports to respond to specific information needs, but shall make these requests through the Department. The RCCO shall be able to utilize dynamic reporting capabilities to specify various report parameters that will enable the RCCO to identify and isolate health, utilization and cost trends or answer a specific question. Parameters might include such variables as Client characteristics, date ranges, diagnoses, procedure codes and region- or provider-level data (region-wide, ZIP code, practice or individual provider). The RCCO shall utilize all information available to it and the PCMPs to inform decision-making, guide providers and help attain ACC Program goals.

During the Initial Phase of the Program, the RCCO will be required to provide network and care coordination data to the SDAC, such as referrals to non-medical services. In the Expansion Phase of the program the RCCOs will be required to provide clinical data to the SDAC.

The RCCO shall have the capacity and expertise necessary to:

a. Access the various available reports and applications, become familiar with their

functionality and purpose, understand how to design searches, query for specific information, and interpret the results.

b. Educate and inform the PCMPs about the data reports and systems available to them, the various reports and their practical uses, and share with PCMPs, the SDAC, and the Department any specific findings or important trends discovered through analysis of the data.

c. Act upon information obtained through data reports and analyses to improve performance, target efforts on areas of concern, and apply the information to make changes and improve outcomes. The RCCO shall use the data to improve performance region-wide and on a provider-specific level.

OFFEROR'S RESPONSE:

The Offeror's proposal shall address how it will meet all requirements listed above. The proposal shall describe the Offeror's general administrative support capabilities and its capacity for data management and the application of data to drive region-wide and practice-level improvements. Specifically, the Offeror's proposal shall:

1. **Explain the Offeror's global philosophy and approach to provider support. Describe how the Offeror will demonstrate a high level of commitment to being accessible and available to providers and what mechanisms will be employed to assure this access (for example, by phone, question/comment email box, site visits, etc.).**

2. **Describe the Offeror's plan to learn about the current Colorado Medicaid and Child Health Plan Plus (CHP+) programs and benefits. Describe how the Offeror will support providers by sharing information and answering questions on topics such as: the acute care benefit coverage policies, special programs, HCBS Waiver programs, and EPSDT benefits; prior authorization and referral requirements; and claims and billing guidelines.**

3. **Describe the spectrum of tools and resources the Offeror intends to make available to providers. Include specific examples and explain why the Offeror recommends these tools. Explain what role these tools and resources will play in the Offeror's overall practice support and performance improvement activities.**

4. **Describe how the Offeror will use its website to support the network of providers and Members.**

5. **Describe how the Offeror will use the data at its disposal. Describe the Offeror's capacity for understanding, interpreting, sharing, and acting upon the information to make needed changes. Specify if there will be staff specifically dedicated to data management, report analysis and queries, communication with PCMPs about accessing data and sharing important findings and trends.**

E. MEDICAL MANAGEMENT AND CARE COORDINATION

To fully deliver on the promises of the ACC Program, the RCCOs shall provide Member-focused care coordination and medical management. The RCCO shall take an interdisciplinary team approach to managing Member care throughout the care continuum, to deliver the right care, in the right order, at the right time, and in the right setting. The RCCO shall fill the care coordination gaps in the current health care delivery system by identifying the range of medical, behavioral, and social service needs of Members and removing barriers between systems of care. The RCCO shall have resources to provide the full spectrum of care coordination for Members, but may delegate some or all of the care coordination activities to PCMPs who demonstrate exemplary care coordination capabilities.

Though medical management and care coordination strategies vary, these strategies are all driven by certain values. First, Members should play an active role in their own health care. Care should be less fragmented across settings and disciplines, and coordination should address transitions from the hospital to the community, primary to specialty care, youth to adulthood, and across physical, behavioral, and long term care services. Finally, primary care providers should have the support and information they need from the ACC Program to provide whole-person care.

The RCCOs shall select a mix of traditional and innovative medical management and care coordination practices and tools to ensure that care is appropriate, integrated, and cohesive.

1. Assist Providers with the Referral Process

Referrals are an important way to keep PCMPs aware of and involved in the care their Members receive from other providers.

a. Members are required to obtain a PCMP's referral for most services outside of the scope of the PCMP's care. The RCCO shall facilitate a referral process that prevents unnecessary utilization but does not create barriers to needed care.

   i. The RCCO shall facilitate compliance with this requirement by educating PCMPs, specialists and other Medicaid providers, and Members about this policy, and assisting with the completion and submission of referral documents, as needed.

   ii. The RCCO shall allow PCMPs to refer Members to any specialists or any other Medicaid provider, including those not associated with the RCCO. However, the following services do not require a PCMP referral:

      (1) Emergency care

      (2) EPSDT screening examinations

      (3) Emergency and non-emergent medical transportation

      (4) Anesthesiology services

      (5) Dental and vision services

      (6) Family planning services

(7) Behavioral health services

(8) Home and Community-Based Waiver services

(9) Obstetrical care

2. Support Medical Management

In addition to referrals, other traditional medical management tools should be used to ensure optimal health outcomes while managing costs. These activities may include coordinating with the utilization management contractor to detect inappropriate utilization of services, and integrating disease management into the care of Members with multiple chronic conditions. Traditional medical management may also include catastrophic case management, the coordination of medical services for Members with serious, life-changing, and possibly life-threatening illnesses and injuries. These traditional medical management strategies will enable the RCCO to work with providers, Members, and families to make the best medial care choices, based on possible outcomes, quality of life, and cost effectiveness.

In addition, the RCCO may evaluate and recommend to PCMPs other innovative medical management practices that are proven or promising practices. These may include strategies such as:

a. Using technologically enhanced communication, such as cell phone messages, e-mail and texts to communicate with Members.

b. Giving PCMPs tools and resources to support informed medical decision-making with Members.

c. Alternative formats for delivering care, such as group visits

d. Methods for diversion to the most appropriate care setting.

3. Promote Member Empowerment, Healthy Lifestyle Choices, and Informed Decision-Making

The Department encourages innovative approaches to facilitate and promote active Member involvement in his/her health. Members should be involved in all aspects of their health, from building healthy lifestyles to working with providers to choose appropriate procedures and tests. Healthy behaviors and lifestyles play an enormous role in extending life expectancy and reducing morbidity. In the Medicaid population, rates of tobacco exposure and use are twice as high and obesity rates in children three times as high as those in Colorado's general population. Promotion of healthy lifestyles is a core expectation of a health care system that is focused not only on delivering outstanding sick care but also maintaining health. The Department has prioritized its healthy behavior activities and goals around four activities reflected in the acronym C.D.O.T.: Caries reduction, Depression reduction, Obesity reduction and Tobacco exposure reduction.

The RCCO shall work to promote Member education and informed decision-making, using strategies that may include:

a. A comprehensive approach to promoting healthy behavior, which may include clinical, personal and community-based strategies. This approach takes into consideration the range of factors that affect health behavior, including community/cultural practices and standards, daily work/life opportunities and limitations, and Member awareness of how behavior affects health.

b. Motivational interviewing and patient activation (Member-centered, directive methods for enhancing intrinsic motivation to change behavior).

c. Use of Member decision aids.

d. Community health education, either provided by the RCCO itself or in partnership with existing community health educators, to help Members make lifestyle choices that lead to better better health.

4. Assure Care Coordination

The RCCO shall ensure that all Members receive the level of services and care coordination necessary to achieve desired health outcomes in an efficient and responsible manner. The RCCO is not required to be the sole provider of the care coordination services described in this section; a PCMP, for example, may provide some or all of care coordination activities. However, the RCCO is accountable for the effective delivery of care coordination services, and should provide the care coordination services not provided by the PCMP or other member of the care team.

a. Assess Current Care Coordination Services. The RCCO shall determine whether the providers involved in the Member's care are currently providing the necessary care coordination services. For example, a PCMP, a behavioral health case manager, or an FQHC may already provide some or all necessary care coordination services.

b. Fill Gaps. The RCCO should provide the needed care coordination services that other coordinators are not providing.

c. Clarify Roles and Responsibilities. The RCCO shall work with all providers on the Member's care coordination team and develop a plan for regular communication with the Member's care coordinator(s).

d. Ensure Care Coordination Services. The RCCO shall ensure that all care coordination, even that provided by other care coordinators, is meeting the needs of the Member.

5. Meeting the Goals of Care Coordination

Care coordination helps the Member receive the right care in the right order, at the right

time and in the right setting. As necessary, a full spectrum of participants may be involved, including the Member, family caregivers, clinical staff, pharmacists, social workers, transportation providers, and other professional and support staff involved in the delivery of care. The RCCO shall work with these participants to connect Members not only to medical services, but to social and community services.

To ensure that these participants work together most effectively, the RCCO shall develop a formal system of care coordination with these characteristics:

a. Comprehensive. The RCCO shall develop tools and processes for care coordination that follows the Member through all stages of care, places of care, and providers of care, and addresses social and economic barriers to health. Comprehensive care coordination includes:

    i. Assessing and care planning. This includes assessing the Member's health and health behavior risks, and medical and non-medical needs. It also includes establishing whether there is an existing care plan and, if not, ensuring that a care plan is created for any Member who needs one.

    ii. Identifying and linking Members to services. Linking Members to services may be as simple as giving a Member a telephone number and contact name, or as complicated as arranging the needed services and acting as a liaison between providers. RCCOs shall link Members to medical services as well as community-based services, such as child care, food assistance, services supporting elders, housing, utilities assistance, and other non-medical supports.

    iii. Assisting with care transitions. Care coordinators ensure continuity of care during transitions from hospitals and other institutions to home or community-based settings, to promote continuity of care and prevent unnecessary re-hospitalizations. The RCCO will also assist with other transitions (for example, moving from children's health services to adult health services, moving from hospital or home to nursing care) that require active coordination to maintain effective care for Members.

    iv. Documenting and communicating. This includes all activities that make it easier for those involved in a Member's care to document and share necessary information about the Member's care.

    v. Monitoring and problem-solving. This includes solving problems that providers or Members experience in receiving care and services, and informing the Member of Medicaid's Ombudsman service for grievances.

    vi. Evaluating and adjusting plans. This includes following up to assess whether the Member has received needed services, and whether the Member is on track to reach the desired health outcomes.

b. Client/Family-Centered. Members and their families are at the center of the care coordination process. The RCCO shall engage in Client/family-centered care coordination by designing policies, processes and practices that achieve these standards:

   i. Members and their families are active participants in their care to the extent they are able.

   ii. Care and care coordination activities are linguistically appropriate and consistent with the Member's cultural beliefs and values.

   iii. Care coordination is responsive to the special needs of certain populations, including but not limited to the physically or developmentally disabled; children (including foster children), adults and the aged (including Colorado Health Care Affordability Act Expansion Populations); non-English speakers; those in need of assistance with transitions; and Members with complex physical or behavioral health needs.

   iv. Care coordination aims to keep Members out of facilities and in the community whenever possible. The Department is aligned with the Olmstead Supreme Court decision, dictating that care occur in the least restrictive and most integrated settings possible for individuals at risk for living in a nursing home or other facility-type setting.

c. Integrated. The RCCO shall ensure that physical, behavioral, long-term care, social, and other services are continuous and comprehensive. In order to reach the Member's desired health outcomes in the most efficient way possible, services should not be duplicative and should be mutually reinforcing. The RCCO shall integrate Member care by using strategies such as:

   i. Developing a knowledge base of care providers, case management agencies, and available services, both within the network and in the community.

   ii. Becoming familiar with all Department initiatives and programs.

   iii. Knowing the eligibility criteria and contact points for each community-based service available to Members in the RCCO's area.

   iv. Identifying and addressing barriers to health in the region (for example, transportation issues or medication management challenges).

OFFEROR'S RESPONSE:

The Offeror shall describe in detail its approach to medical management and care coordination. The Offeror's response should address all requirements above, including at least the following elements:

1. **The Offeror's plans for integrating traditional and innovative medical management strategies with broader care coordination activities. Describe which medical management strategies the Offeror will employ and how activities will be**

coordinated with the Department's utilization management contractor. Describe the Offeror's approach to assisting providers with the referral process.

2. **The Offeror's methods for establishing a Member's care coordinator(s). Describe how the Offeror will work with the PCMP, other providers, and other resources to provide effective care coordination.**

3. **The Offeror's strategies for connecting Members to the right care in the right order, at the right time in the right setting. Include a description of how the Offeror will**

   develop comprehensive knowledge of community resources, address the needs of special populations, and assist with care transitions.

4. **The Offeror's system for documenting information relevant to a Member's care, and for communicating this information to the right providers at the right time.**

5. **The Offeror's capability to address Member needs and solve Member problems in a timely manner. Will the Offeror operate a Member Help Line with dedicated toll-free number, or combined with an existing line? Include a description of the gaps between types of care and care settings that need to be addressed, and structures the Offeror will put into place to bridge these gaps. Include a description of how the Offeror will work with community resources to help Members overcome social and economic barriers to care.**

6. **The Offeror's system for monitoring, re-assessing and adjusting Member care and services.**

F. ACCOUNTABILITY

The ACC Program's performance is measured by controlling the costs of the Medicaid program and measurably improving the health of Members. The Department is purchasing performance from each RCCO. Up to this point, this RFP has outlined many of the steps that the RCCO shall take in order to fulfill the goals of the ACC Program. However, it is the attainment of health improvement and cost control that essentially demonstrates the RCCO's true success. Setting performance targets, measuring performance, and rewarding performance are essential to ensuring and maintaining accountability. The Department recognizes its shared responsibility in supporting the RCCO's performance.

This section describes how RCCOs will be held accountable for performance during the Initial and Expansion Phases of the program. It includes measurement, performance improvement, continual feedback, and innovation.

1. Initial Phase

a. Focus on Quality and Cost Control. During the Initial Phase, the RCCO will focus on ensuring quality services and managing costs to achieve budget neutrality. It will be

essential to measure performance against budget neutrality goals on a regular basis to ensure RCCO efforts are resulting in the desired performance. Real-time calculations of simple utilization measures will provide the RCCO with the feedback necessary to adjust strategies to meet budget neutrality goals. To help the RCCO track its progress on managing costs throughout the Initial Phase, the SDAC will provide monthly calculations of three utilization measures. These utilization measures will provide a quick, easily calculated estimate of whether overall program costs have decreased. The utilization measures will be calculated at both the regional level and individual PCMP level, taking into account all enrolled Members. At the beginning of the Initial Phase, the SDAC will calculate regional baseline costs and utilization measures, against which future cost and utilization measures will be measured to track progress. The RCCO performance on utilization measures will not only provide the RCCO and PCMPs immediate and direct feedback on progress toward budget neutrality, but will also be the basis for incentive program that will be piloted during the Initial Phase.

b. Incentive Program. The Department is reserving a portion of available funding for earned incentives. Calculations for earned incentives will be based on RCCO performance on key utilization measures determined by the Department (see Section V.H.2). The process of establishing a baseline, calculating measures on a monthly basis and providing direct feedback to the RCCOs and PCMPs will be piloted during the Intial Phase. During the Initial Phase, incentive payments will not be made to the RCCO or PCMPs. In the Initial Phase, the budgetary limiation will be slightly higher than during the Expansion Phase. During this pilot period, utilization measures will be calculated and tracked, and used to determine the RCCO's and PCMPs' progress in controling costs and adjusting strategies for performance improvement. In the Expansion Phase, the base PMPM budget limitation will be slightly lower but the RCCO and PCMPs will have the opportunity to earn the incentive payments by meeting utilization and ouctomes targets.

c. Budget Neutrality. The funding for this program was approved with the expectation that the program will result in an agregate reduction of costs of 7% which fully covers the costs of the program. The SDAC will calculate the program costs at the end of the Initial Phase, to determine whether it has achieved budget neutrality. The Department will authorize any RCCO that has demonstrated budget neutrality to move to the Expansion Phase.

2. Expansion Phase

During the Expansion Phase (beginning July 1, 2012), the RCCO will continue to manage quality and costs, but will also focus more formally on health improvement and outcomes.

a. Additional Members. Any RCCO that has attained budget neutrality goals will be authorized to expand its program region-wide and to add Member lives. The Department will work with its Enrollment Broker to rapidly enroll the balance of Medicaid Clients into the ACC Program, including the Colorado Health Care Affordability Act Expansion Populations. The additional Members will increase the

program's total PMPM revenue, and expand the program by a factor ranging from five to fourteen, depending upon the region.

b. Incentives. During the Expansion Phase, the incentive program will be operational, and the RCCO may earn incentives based on its performance toward specific utilization and outcomes targets.

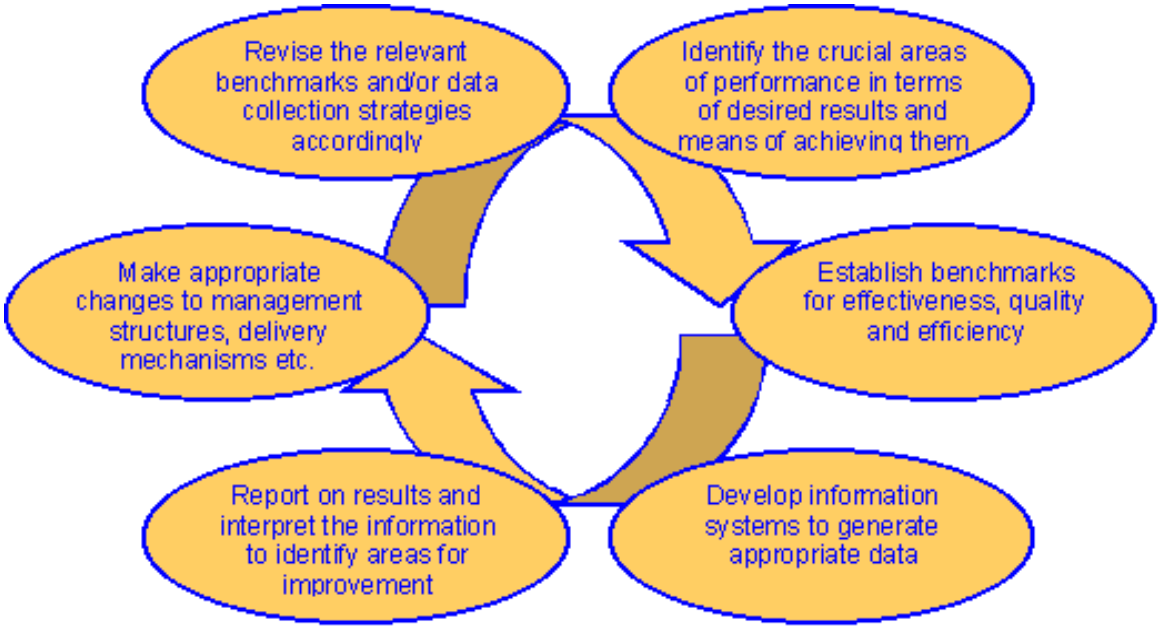
c. Health Improvement Initiatives. After the first year of the Expansion Phase, as the RCCO broadens its focus beyond managing the quality and volume of care, it will look at health improvement goals and initiatives in addition to utilization targets. The Department will use HEDIS, CAHPS, Healthy People 2020, and its own health improvement efforts to choose priorities and set targets. The Department will also use the standards defined by its Managed Care Measures and Standards Advisory (MCMSA) work group, which was created in 2009 and tasked with building accountability into all Department managed care contracts. During the Expansion Phase of this program, the Department will, in collaboration with the RCCO, determine which of these measures it will use for future incentive payments. This decision will be based upon regional or statewide health concerns, the regional population, and Department and RCCO priorities.

d. Shared Savings. As the program enters the Expansion Phase, the Department plans to finalize arrangements for Shared Savings. It is expected that high-performing RCCOs will be given the opportunity to share with the Department any savings that are generated beyond an agregate reduction of costs of 7% which fully covers the costs of the program. Savings earned by the RCCO may be used to increase revenues, invest further into the program, or incentivize network partners to achieve greater program efficiencies and improved outcomes. The Dpeartment anticipates working with its partners to establish thresholds up to which savings will be shared, and to formalize the split of savings between the State, the RCCO and the PCMPs. The Shared Savings is unlike the incentive program in that the Department does not envision a 50-50 split between the RCCO and the PCMP.

3. Performance Improvement

The RCCO shall continually monitor and improve its own performance in order to successfully improve the health of its Members and the care its Members receive. The RCCO's Performance Improvement Program, which will be in effect for the duration of the contract period, will guide performance improvement. It includes performance improvement planning, targeted performance improvement activities, and proactive data analysis to effect positive change.

The following diagram illustrates the performance improvement cycle that will be promoted through the implementation of the ACC Program. The RCCO shall play an integral role in this process:



a. Performance Improvement Program. The RCCO shall operate an ongoing aggressive performance improvement program to improve the care of Members and the support the RCCO gives to providers. The ultimate goal is to improve both the health of Members and the experience of Members and providers. It fosters an environment of continuous and rapid-cycle learning, incorporating best practices for administrative processes, evidence-guided clinical care, and the use of proven performance improvement models to positively effect change in the RCCO's own processes and those of its providers. The Performance Improvement Program consists of, at a minimum, these elements:

i. Performance Improvement Plan. The RCCO shall submit a performance improvement plan to the Department annually. It shall describe:
   (1) Health and health care performance improvement goals and objectives, using national standards, the Department's priorities, and the region's needs.
   (2) The methods the RCCO will employ to achieve the stated goals.
   (3) At least two targeted performance improvement activities, including the rationale for choosing those and the plan for addressing them.
   (4) Feedback and complaints received from Members, providers, and community partners, as well as the views and advice provided by the RCCO Performance Improvement Advisory Committee.

b. Proactive Analysis and Application of Data. The RCCO shall have access to several sources of data in order to analyze program performance and measure success. The SDAC will do the majority of data compilation and analytics, but the RCCO is required to have the expertise in data management and analysis necessary to manage its Members wisely and easily measure success. The RCCO shall use all available data, including those provided by the SDAC, claims data, prior authorization systems, registry data, and data available through national data collection initiatives.

4. Continuous Feedback and Innovation

In addition to the performance improvement program described above, the RCCO shall be part of a formal advisory committee structure outlined below. The advisory committees will provide a structure for ensuring collaboration among key players, and give Members and providers a forum for providing input into the program. The advisory committees promote the principles of continuous performance improvement, foster an environment of constant learning, allow for the free exchange of ideas regarding opportunities to improve ACC Program business processes, and ensure that Department policies are based on sound clinical input and evidence-guided practices. Designed to have cross-representation from several entities that perform functions essential to the success of the ACC Program, the advisory committees will encourage communication, interaction and the sharing of best practices and lessons learned across entities.

RCCO leadership shall participate in the following advisory committees and perform the following roles:

a. RCCO Performance Improvement Advisory Committee. The RCCO shall create an advisory committee devoted to allowing a provider and Member voice into the ACC Program in the region. This includes oversight of and input into the RCCO's performance improvement program, as well as input into the overall administration of the ACC Program within the region. The committee shall:

   i. Be directed and chaired by RCCO leadership.

   ii. Have a formal membership and governance structure.

   iii. Have committee membership that is representative of the diverse population in the region and include representation of at least the following:

      (1) ACC Members

      (2) Families

      (3) Advocates

      (4) PCMP Network

      (5) Other Medicaid Providers

      (6) Behavioral Health Community

      (7) Community Organizations

   iv. Have regularly scheduled meetings no less than quarterly. Meetings shall be open to the public and minutes shall be posted on the RCCO's website following each meeting.

b. ACC Program Improvement Advisory Committee. This committee shall be directed and chaired by the Department and include representation from each RCCO in the state, the SDAC, the utilization management contractor and the provider and Member communities. The committee shall provide guidance and make recommendations to help improve health outcomes, access, cost and Client and provider experience in the

ACC Program.

The Department's intent is to move toward aligning payment for ACC Program operational services with Member-specific costs, such as risk adjustment. The RCCOs shall collaborate with the Department and other committee members on developing a risk-adjusted methodology for future PMPM payments beyond the Expansion Phase.

c. Medical Management Oversight Advisory Committee. This committee shall be directed and chaired by the Department's utilization management contractor and will include representation from each RCCO, the SDAC, the Department, clinical experts and the provider community. The committee will provide policy guidance and make other recommendations regarding medical management for the ACC Program and Colorado Medicaid overall.

d. SDAC Operations Advisory Committee. This committee shall be directed and chaired by the SDAC. It shall include representation from each RCCO and other key players. The committee will give its members the opportunity to provide the SDAC with feedback about its data collection and reporting interfaces and the usefulness of the data. It will also make recommendations regarding operational improvements, the Web Portal provided by the SDAC, and any other data and analytics activities of the SDAC.

OFFEROR'S RESPONSE:

The Offeror's proposal shall include a description of how the Offeror intends to meet all of the requirements above as well as its approach to adjusting strategies to maintain accountability for achieving the program goals. This description shall specifically include:

1. **The Offeror's approach to ensuring quality health care for Members while managing costs to achieve budget neutrality in a relatively short period of time by the end of the Initial Phase. Describe the Offeror's capability to apply data as a tool to guide performance improvement planning and measurement of success.**

2. **The Offeror's capacity to manage a broad-based performance improvement program that incorporates input from and promotes the involvement of providers, consumers, and community partners, and a discussion of the Offeror's ability to act upon and be responsive to stakeholder feedback regarding performance improvement programming.**

3. **The Offeror's plans for ensuring continuous feedback and innovation through the use of the advisory committee structure and stakeholder participation. Include a detailed plan for forming the RCCO Performance Improvement Committee, a description of the membership and governance structure, and a plan for recruiting committee members to represent key stakeholder groups.**

4. **Provide a positive statement that the Offeror will collaborate with the Department and other ACC Program Improvement Advisory Committee members on**

developing a risk-adjusted methodology for future PMPM payments beyond the Expansion Phase.

G. PROGRAM REPORTING

Reports are an essential part of the ACC Program. They allow the partners and stakeholders to communicate key information and track progress towards the ACC Program's ultimate goal of improving health outcomes and containing costs.

While most of the ACC Program reports will be generated by the SDAC, this section describes the two sets of reports that are required of the RCCO on a regular basis: administrative reports and performance reports. In cases where the Department provides a report template, the RCCO shall follow the template and the accompanying instructions. At its discretion, the Department may verify reported information through fact-checking, audits of reported data, requests for additional information, or site visits.

RCCOs shall be responsible for the following reports**:**

1. Administrative Reports

a. Network Report.

i. The RCCO shall submit a network report at the end of each quarter, 30 days after the end of the reporting quarter.

ii. The report shall contain the total number of providers by type of provider and county (including, but limited to, PCMPs, specialists, and hospitals), the number accepting new Clients, and how the provider network meets the needs of the Member population. In addition, the report submitted at the beginning of the fiscal year should include a summary of the challenges and opportunities for improving the provider network, the unmet needs in the network, and strategies for meeting the unmet needs.

b. Key Staff Changes. The RCCO shall report in writing any changes in key staff. The RCCO shall report the following:

i. Vacancies of key staff, the interim plan for covering the vacant position's responsibilities, and the plan for filling the vacancy.

ii. Hiring of new key staff, within five business days after a candidate has been approved to fill a key staff vacancy, or five business days prior to the candidate's start date, whichever occurs first. Whenever key staff or their contact information change, the RCCO shall provide the Department with an updated organizational chart with e-mail addresses and phone numbers.

c. Program Integrity. To ensure ACC Program integrity, the RCCO shall immediately report any suspicion or knowledge of fraud and abuse, including but not limited to the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent.

i. The RCCO shall report possible instances of provider Medicaid fraud to the Department immediately upon receipt of information, following up with a detailed referral in writing within 10 business days. The referral shall include specific background information, the name of the provider and a description of how the RCCO became knowledgeable about the occurrence.

ii. The RCCO shall report possible instances of Member fraud (such as document falsification) to the county department of human/social services in the Member's county of residence immediately, following up in writing within 10 business days.

2. Performance Reports

The RCCO shall submit reports reflecting its performance measurement and improvement activities as listed below. The Department may, at its discretion, verify reported information through any appropriate means, including fact-checking, auditing reported data, requesting additional information, and performing site visits.

a. Performance Measures and Activities. Every quarter, the RCCO shall submit reports that show performance on the measures included in the performance improvement plan. The RCCO shall include in this report performance during the current quarter, performance from the previous four quarters, cumulative performance during the previous 12 months to date, and a summary of performance improvement activities, both completed and in process, as well as activities scheduled for the next quarter. The RCCO shall cooperate with the SDAC as necessary to report on these measures.

b. Stakeholder Feedback Report. Each quarter, the RCCO shall submit a report summarizing the feedback received from Members and stakeholders through the advisory committee meetings, or any other vehicle. In the report, the RCCO shall draw attention to trends and themes in feedback, to determine if there are overarching issues to address or system-wide problems to solve.

c. Management Report. Every quarter, the RCCO shall submit a dashboard that describes its performance on health outcomes and cost containment measures. Of key importance to the Department are measures that fall into these categories:

i. Health outcomes. Measures in this category address specific health outcomes. For example, measuring progress in the Department's priority areas of caries, depression, obesity, and tobacco use.

ii. Affordability. Measures in this category address cost issues. For example, expenditures for RCCO Members on durable medical equipment.

iii. Access to care. Measures in this category address the ability of Members to find and use services. For example, the number of Members in special populations

able to accesss needed care within a certain distance from home or certain period of time.

iv. Experience. Measures in this category address the experience of stakeholders, such Members and providers, with the program.

OFFEROR'S RESPONSE:

The Offeror shall describe its ability to select and integrate relevant information from the SDAC, the RCCO, stakeholders and other sources as described above, and create reports that provide an accurate picture of the RCCO's status and clear direction on the RCCO's next steps. The Offeror shall address the requirements above as well as the following:

1. **Describe Offeror's strategy for identifying and reporting relevant information about the network, including the number of providers by type of provider and county, the number accepting new Clients, and how the provider network meets the needs of the Member population.**

2. **Describe how the Offeror plans to aggregate, report, and analyze stakeholder feedback.**

3. **Describe the Offeror's strategies for identifying, collecting, summarizing and analyzing performance data on health outcomes, affordability, Member access to care, and Member experience to inform future plans and actions.**

H. COMPENSATION

1. Program Funding

The Colorado General Assembly authorized a maximum of $20 PMPM for the operations of the ACC Program, which will cover the services of the SDAC, RCCOs and PCMPs as well as incentive payments to be shared by the RCCOs and the PCMPs. Of the $20, $17 will be used to fund RCCO PMPM and incentive payments as well as the PCMP PMPM and incentive payments. All PCMP PMPM and incentive payments will be made by the Department directly to participating PCMPs.

The effective operation and success of the ACC Program is reliant on several interdependent relationships and expectations. The RCCO is ultimately accountable for the performance of the region and its participating PCMPs. In order to perform some RCCO functions outlined in the Statement of Work, the RCCOs must have an understanding of the overall program funding and Department payments made directly to participating PCMPs. Therefore, this section addresses payments that may be earned by the RCCOs as well as the PCMPs.

There is a budgetary limitation of $13 for PMPM payments to RCCOs for the Initial Phase. There is a budgetary limitation of $12 PMPM for the RCCOs in the Expansion Phase with the opportunity to earn incentive payments up to an additional $1 PMPM for

meeting identified utilization and outcomes targets. Price proposals exceeding the budgetary limitations shall be disqualified.

a. RCCO PMPM and Incentive Payments.

i. RCCO PMPM Payments. Payments will be made monthly to RCCOs based on the number of active Members enrolled in the RCCO on the first day of each month. PMPM payments will not be made during the Start-Up Phase before Members are enrolled in the RCCO and the "go live" date has occurred. Payments will be calculated based on enrollments entered in the claims payment system. Payments will be made on or before the 20th business day of the month.

ii. Incentive Payment Pilot. During the Initial Phase, incentive payments will not be made to the RCCO or PCMPs. The Department will pilot an incentive payment program during this period. This will allow the program to test the incentive program calculations and anticipate future payment projections. Nonetheless, performance on easy-to-calculate key utilization targets (described in Section V.H.2) will be measured and reported to the RCCO and PCMPs to aid in adjusting strategies to improve performance. During the Initial Phase, incentive calculations will be piloted based on performance with regard to the targeted measures and be used as a proxy for whether the RCCO and PCMPs are making progress toward the cost management goal. During the Expansion Phase, the incentive payment amount may be earned based on performance.

iii. Starting in July 2011 (the first full quarter after reaching 60,000 enrollments program-wide) through June 30, 2012 the SDAC will provide monthly data to the RCCO that shows the RCCO's progress on each utilization measure (see Section V.H.2), as well as each PCMP's progress on each measure compared to the RCCO as a whole. The SDAC performance data will provide an estimate of what the RCCOs incentive payment amount would be if the program was fully operational. This feedback will allow the RCCO and its PCMPs to make adjustments in their activities as they strive for improved performance. In order to ensure complete data, taking into consideration the claim submission cycle and lag, measurement of regional performance and proxy calculations will be based on the most recent 90-day period for which complete claims data is available.

iv. RCCO Incentive Payments. Beginning in the Expansion Phase, a total of $2 of the $17 PMPM is designated for the incentive program to be available equally for the RCCO and the PCMPs. During the Expansion Phase, the budget limitation for the base PMPM is reduced; however, the incentive program will allow quarterly incentive payments to be earned for reaching performance goals. Performance will be measured on a regional basis, although the SDAC will provide monthly calculations on the PCMP level as well. Like the regular monthly PMPM payments, these incentive PMPM payments are based on actively enrolled Members during the measurement period.

v. Starting in July 2012, the Expansion Phase, the incentive program will become operational. During the first year of the Expansion Phase, the incentive program will be based on performance against the utilization measures. The RCCO may earn up to $1 PMPM for meeting or exceeding performance targets for the idenfied measures. In order to ensure complete data, taking into consideration the claim submission cycle and lag, measurement of regional performance and incentive payment calculations will be based on the most recent 90-day period for which complete claims data is available. For more information on the performance measures and the performance targets see the table in Section V.H.2. Performance on the utilization targets will be calculated on a regional basis for the RCCO's network as a whole, not at the individual PCMP or PCMP Practice-level.

vi. The RCCO may review the SDAC's incentive payment calculations and provide comments to the SDAC about possible errors. The RCCO shall ensure that all eligible PCMPs are included in the SDAC's calculations for PCMP incentives. The SDAC may recalculate the incentive payments if there is good cause. The Department will approve payments. Once the incentive payments have been approved by the Department, the amounts shall be final. Payments will be made within 30 days of the final determination of the amount due.

vii. If a RCCO chooses to develop its own pay-for-performance program that focuses on rewarding network providers' efforts to improve health outcomes for ACC Program Members in addition to the incentives offered by the Department described here, then the RCCO will be responsible for ensuring that the pay-for-performance program complies with federal and state requirements.

b. <u>PCMP PMPM and Incentive Payments.</u>

i. PCMP PMPM Payments.

(1) To compensate PCMPs for serving as a true Medical Home for Members, the PCMPs will receive a $4 PMPM payment during the Initial Phase based on the number of active Members enrolled with the RCCO and linked to the PCMP at either the PCMP Practice or individual level. The PCMPs will receive a $3 PMPM payment during the Expansion Phase with the opportunity to earn up to an additional $1 PMPM for meeting identified utilization and outcome targets. In the case of rendering providers who are employed by a clinic, FQHC, RHC or other group practice, the payment will be made to the entity (clinic, FQHC, RHC or other group practice) enrolled with the Medicaid program.

(2) Payments will be calculated by the Department based on the linkages identified in the claims payment system. Payment will be made through the claims payment system directly to the Medicaid enrolled provider/entity on or before the 20th business day of the month.

(3) During the Start-Up Phase, PCMP PMPM payments will begin the second

month following a Member's enrollment into RCCO, to allow the RCCO 30 days to link each Member with a PCMP.

(4) PCMP practices certified by the Medicaid and CHP+ Medical Homes for Children Program will receive pay-for-performance under that program for children from the Medical Homes for Children Program enrolled in the ACC Program through June 30, 2012, subject to funds being appropriated, budgeted and made available for this purpose. These Clients may be enrolled in the ACC Program. However, payment for these Clients will not also be made to the PCMP under the ACC Program.

ii. PCMP Incentive Payments. Because the PCMPs will play an equally important role in regional performance, incentive PMPM payments will be shared equally between the RCCO and the PCMPs. Beginning in the Expansion Phase, the PCMPs will have the opportunity to earn up to a $1 PMPM incentive payment based on regional performance.

2. Performance Measures

a. Listed below are three utilization measures and the performance targets that will be used as the basis for measuring performance against regional baselines during the incentive program pilot in the Initial Phase and the first year of the Expansion Phase.

b. In the first year of the Expansion Phase after completion of the pilot, the RCCOs and PCMPs will be responsible for attainment of utilization targets in order to receive the any incentive payments.

c. Following the first year of the Expansion Phase, the RCCO and its PCMPs will be responsible for attainment of health improvement goals in addition to cost containment. The Department, in consultation with the RCCOs and the SDAC, will establish both the cost and health measures used to determine incentive payments. The Department will identify additional performance measurement areas and targets to improve program effectiveness during the performance period of the contract. The Department reserves the right to modify the performance measurement areas and targets, in consultation with the RCCO, by amendment to the contract. The RCCO agrees to negotiate in good faith any required contract amendment.

Initial Measurement Areas:

Measurement Area	Performance Target	Total Incentive Payment Amount
Emergency Room Visits per 1,000 full time enrollees (FTEs)	Percentage improvement compared to RCCO's own regional FFS baseline for FY10 (or most recently available 12 month period). Targets and baselines will be developed using historical data. The SDAC will establish a	Level 1: 66% of full amount Level 2: 100% of full amount The full amount available for this measure for the RCCO is $0.33 PMPM and $0.33 PMPM for the PCMPs.

	RCCO-specific baseline using the actual fiscal year FFS experience from the previous year's data. Level 1 Target: Utilization below baseline, but shows less than 5.0% improvement Level 2 Target: Baseline utilization minus 5.0% or more	
Hospital Re-admissions per 1,000 FTEs	Percentage improvement compared to RCCO's own regional FFS baseline for FY10 (or most recently available 12 month period). Targets and baselines will be developed using historical data. The SDAC will establish a RCCO-specific baseline using the actual fiscal year FFS experience from the previous year's data. Level 1 Target: Utilization equal to or below baseline, but shows less than 5.0% improvement Level 2 Target: Baseline utilization minus 5.0% or more.	Level 1: 66% of full amount Level 2: 100% of full amount The full amount available for this measure for the RCCO is $0.33 PMPM and $0.33 PMPM for the PCMPs.
Outpatient Service Utilization per 1,000 FTEs MRI, CT scans, and X-ray tests per 1,000 FTEs	Percentage improvement compared to RCCO's own regional per-FTE utilization of MRIs, CT scans, and X-rays FFS baseline for FY10 (or most recently available 12 month period) Level 1 Target: Utilization equal to or below baseline, but shows less than 5.0% improvement Level 2 Target: Baseline utilization minus 5.0% or more	Level 1: 66% of full amount Level 2: 100% of full amount The full amount available for this measure for the RCCO is $0.33 PMPM and $0.33 PMPM for the PCMPs.

3. Shared Savings

The Department and RCCO will work together to realize the Department's vision of surpassing budget neutrality to achieving savings. Effective care coordination, reduction of duplicative services, promoting healthy lifestyles and appropriate utilization, coupled with the availability of claims data for providers to use in decision-making and a full-spectrum network with common goals will result in efficiencies and savings beyond the budget neutrality targets. By allowing the RCCO and PCMP to share in the savings beyond budget neutrality, the Department hopes to encourage collaboration and improved performance. The opportunity to share savings with the Department will give the RCCOs an opportunity to increase their revenues and invest further in the program, or incentivize their partners and community. While this element of the ACC Program is still in

development, the Department is committed toward establishing a Shared Savings component.

Examples of such Shared Savings calculations could include annually comparing the actual ACC Program performance, on a per-capita cost basis, to a risk-adjusted FFS control group and/or cost reduction realized versus projected costs for the enrolled ACC Program population.

Funding will be available no sooner than the State Fiscal year 2011-12, which starts July 1, 2011. The Department may add Shared Savings components to the contracts by contract amendment.

OFFEROR'S RESPONSE:
The Offeror's proposal shall:

1. **Provide a positive statement of the Offeror's willingness to work with the Department to modify the performance measures to improve program effectiveness and to negotiate in good faith any required contract amendment.**

2. **Describe any proposed Member or provider incentive plans the Offeror may implement.**

I. CONTRACT START-UP PROCESS

1. Implementation of a Contract Resulting from this RFP

a. Start-Up Phase. The Start-Up Phase shall be from the final execution of the contract until the region's "go-live" date. During the Start-Up Phase, the RCCO shall prepare to perform the services required under the terms of the contract. Upon final execution of the contract, the Department and the RCCO shall immediately collaborate to:

   i. Define project management and reporting standards;

   ii. Establish communication protocols between the RCCO and the Department;

   iii. Establish an implementation plan that includes the schedule for key activities and milestones in both the Start-Up and Initial Phases;

   iv. Define expectations for content and format of contract deliverables; and

   v. Initiate the Readiness Review described in Section V.I.2.

b. Start-Up Plan. No more than 30 days following execution of the contract, the RCCO shall submit a Start-Up Plan that includes the following components:

   i. Human resource and staffing plan

   ii. Customer service plan

   iii. Website development plan

iv. Network development plan;

v. Performance management plan

vi. Completed RCCO-specific Member Handbook insert

vii. Provider orientation and training plan

The RCCO shall provide the Department with verbal and written Start-Up Plan updates and shall cooperate and communicate with the Department to resolve implementation issues to the Department's satisfaction.

2. Operational Readiness Review

Prior to and subsequent to the first Member enrollment, the RCCO shall cooperate with the Department to assess the RCCO's readiness and ability to provide services to Members and to resolve any identified operational deficiencies. The contractor may not operate as a RCCO ("go live") until the Department determines it is ready to do so. Upon Department request, the RCCO shall develop and implement a corrective action plan in response to deficiencies identified during the readiness review. At a minimum, the RCCO shall cooperate with Department to review the following areas:

a. Network sufficiency and management including reviews of subcontracts

b. Adequacy of staffing

c. Customer service

d. Performance management

e. Information processing and system testing

f. Provider support system

g. Care coordination systems

OFFEROR'S RESPONSE:
The Offeror's proposal shall discuss how the Offeror will enable a smooth transition into its role as RCCO.

J. TRANSITION AT THE TERMINATION OF THE CONTRACT

In the event that a RCCO is terminated or its contract expires, the RCCO shall provide services through the end of the contract term for which monthly payment has been received prior to the date of contract termination. The RCCO shall provide the Department and/or its designee with all materials and information related to the provider network, Members, and the services provided to those Members, to ensure a smooth transition to a follow-on contractor and uninterrupted services. The RCCO shall notify all network providers and Members who have received services within the past year of the upcoming transition. The notification shall be approved by the Department and shall be developed in conjunction with a follow-on contractor, if applicable.

The RCCO shall submit for approval a detailed plan for the transition of its Members and provider network to a follow-on contractor, including the schedule for key activities and milestones 60 days prior to the end of the contract performance period.

The RCCO shall:

1. Make provisions for continuing all network management, care coordination, and administrative services until the transition of all Members is completed and all other requirements of the current contract are satisfied.

2. Designate a person with appropriate training to act as the transition coordinator. The transition coordinator shall interact closely with the Department and the staff from the follow-on contractor to ensure a safe and orderly transition.

3. Provide all reports set forth in this RFP and necessary for the transition process.

4. Notify Subcontractors of contract termination or expiration as directed by the Department.

5. Notify all Members that the RCCO will no longer serve as the Member's RCCO. The RCCO shall be responsible for all costs associated with this notification. The notification is subject to Department approval.

6. Notify each PCMP in writing that the RCCO's contract with the Department has ended. The written notice shall include the contract end date and shall explain to the PCMP how the provider can continue participating in the ACC Program. The RCCO shall be responsible for all costs associated with this notification. The notification is subject to Department approval.

7. Cooperate with a follow-on RCCO organization during transition period including, at minimum, sharing and transferring Member information and records. The Department will notify the RCCO with specific instructions and required actions at the time of transfer.

8. Return any funds advanced to the RCCO for service for periods after the contract end date to the Department within 30 calendar days of the expiration or termination of the contract.

9. Provide the Department, in a format prescribed and approved by the Department:
   a. A list of PCMPs
   b. A list of Members

OFFEROR'S RESPONSE:

The Offeror's proposal shall discuss how the Offeror will facilitate a smooth transition upon termination or expiration of the contract.

VI. OFFEROR'S RESPONSE FORMAT

A. GENERAL INSTRUCTIONS

The Offeror's proposal must describe how the Offeror proposes to meet the requirements in the RFP. Each proposal shall describe a comprehensive, quality package of services and programs the Offeror agrees to provide, and demonstrate the Offeror's ability to partner with the Department to meet its goals related to the ACC Program. The Offeror's response must meet all requirements of and respond to all requests for information set forth in this RFP. Failure to meet all requirements or to respond to all requests for information may result in the rejection of the Offeror's proposal.

The Department will select a Contractor for each of the seven regions. Offerors may propose to provide services in one or more regions. A separate, complete, and unlinked proposal must be submitted for each region. If any element of a proposal for one region is linked to a proposal for another region, the Offeror's proposal may be rejected.

The Offeror is required to submit one hard copy original, clearly marked, nine exact hard copies, clearly marked with the number of the copy, and an exact electronic copy on CD with each hard copy (10 total) of the Technical Proposal for each region for which it is submitting a proposal. In addition, the Offeror is required to submit in a separate binder one hard copy original, clearly marked, nine exact copies, clearly marked with the number of the copy, and an exact electronic copy on a separate CDs with each hard copy (10 total) of the Price Proposal for each region proposed. Electronic copies of both the Technical and the Price proposals on CD must be created with Microsoft Word or Excel, but may be submitted in Adobe PDF to ensure format integrity.

The Offeror shall submit each hard copy of the proposal in a pair of three-ring binders, which allows the Department to easily incorporate updated pages into the original proposal. The official name of the Offeror's organization, the RFP number, RFP title, and "Original" or "Copy" must appear on the outside of the front cover of each binder. The Technical and Price proposals may be submitted in the same package, but must be in separate binders.

The Technical Proposal binder shall include the following items:

1. Transmittal Letter, with the "State of Colorado Department of Health Care Policy and Financing Request for Proposal Signature Page" (the "RFP Signature Page" - see Attachment F) and W-9 (see Attachment M) attached.
2. Executive Summary.
3. Table of Contents. The Table of Contents shall list each major section of the proposal, which corresponds to the sections of the RFP.
4. Technical Proposal. Number all pages of the Technical Proposal consecutively from start to finish.
5. Appended materials, if any.

The Cost Proposal binder shall include the following items:

1. Prices proposed.
2. Budgets.
3. Financial Statements

The Price Proposal shall be numbered consecutively for all pages from start to finish (not required for financial statements).

All proposals must be received by the State of Colorado, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 not later than 3:00 PM (MT) on Friday, October 22, 2010.

The Technical and Price Proposals must be submitted to the Department in a sealed package, with the following information clearly labeled on the outside of the package:

> OFFEROR'S NAME
>
> RFP #HCPFKQ1102RCCO, Regional Care Collaborative Organizations for the Accountable Care Collaborative Program
>
> PROPOSALS DUE: Friday, October 22, 2010 at 3:00 PM (MT)

Offerors must provide all information requested in the proposal. Proposals shall:

1. Use standard 8 ½ by 11- inch paper;
2. Use 12-point font;
3. 1 inch margins; and
4. Include tabs in that are keyed to the Table of Contents to separate each major section of the Technical and Cost proposals.

Offerors shall adhere to the Department's required proposal format and required content. Failure to adhere to these requirements may be cause for a proposal to be rejected.

No reference shall be made to any pricing information or elements of cost within the Transmittal Letter, Executive Summary or the Technical Proposal. If any element of pricing or cost is referred to in the Transmittal Letter, Executive Summary or Technical Proposal, the Offeror's proposal may be rejected.

B. TRANSMITTAL LETTER - PAGE LIMIT: FOUR PAGES

The Transmittal Letter shall be brief and signed by an individual authorized to commit the Offeror to the services and compliance with requirements and fees stated in the Offeror's proposal, for the initial contract period and renewal years. The Transmittal Letter shall not exceed four pages.

The Offeror shall submit a Transmittal Letter on its official business letterhead. The Transmittal Letter shall address the following required provisions:

1. The name, title, email address, mailing address and telephone number of the individual(s) authorized to bind the Offeror to the provisions of the RFP and proposal, and to answer questions concerning the proposal.

2. Identify all materials and enclosures being forwarded as a response to this RFP.

3. Positively states the Offeror's willingness to comply with all requirements described in the RFP, general concept requirements and other terms and conditions specified in this RFP.

4. Positively states that by submitting a proposal, the Offeror affirms its willingness to enter into a contract substantially similar to the terms to the Draft Contract, published with this RFP as Attachment E, and indicates the location in the proposal of any requested modifications to Attachment E.

5. States that the submitted proposal shall remain a firm offer for one hundred eighty (180) calendar days after the proposal due date or until the Contract is fully executed, whichever comes first.

6. Offerors must be legal entities at the time they submit their proposal. Describe the Offeror's form of business organization (i.e. partnership, non-profit corporation, Colorado Corporation, Non-Colorado Corporation, etc.) and its home state. Non-Colorado corporations must register with the Colorado Secretary of State as a foreign corporation to conduct business in Colorado. Any foreign corporation, limited liability company, or limited liability partnership must affirm that it currently has a Certificate of Good Standing or Certificate of Existence to do business in Colorado. If the Offeror is a partnership, name the partners, and describe the form of business organization of each partner.

7. If subcontractors will be used for performance of services, identification for each subcontractor and the services that will be provided by each subcontractor.

8. Discloses all current or pending contracts with the State of Colorado and all bids or proposals submitted to the State of Colorado but not yet awarded.

9. Acknowledges the number of modifications to this RFP received.

10. Acknowledges that submission of a proposal in response to this RFP will preclude consideration for award of the services that will be requested by the Statewide Data and Analytics RFP.

11. Identifies all actual, apparent or potential conflicts of interest related to the services described in this RFP and any resultant contract. The conflicts of interest may be personal or organizational. If an actual, apparent or potential conflict of interest exists, include a plan to

mitigate the conflict of interest. If a conflict of interest cannot be mitigated or resolved, the proposal may be rejected.

12. Acknowledge that by submitting a proposal in response to this RFP, the Offeror is providing the certification described in Section 2.13, Debarment and Suspension. If the Offeror is unable to certify to any of the statements in this certification, provide an explanation as an attachment to the transmittal letter. This explanation is exempt from page limitations on the Technical Proposal. The inability of the Offeror to provide the certification will not necessarily result in disqualification of the Offeror. The explanation will be considered in connection with the Department's determination whether to award a contract to Offeror.

After the Transmittal Letter, the Offeror shall include the RFP Signature Page (Attachment F), signed in ink by the Offeror or an officer of the Offeror who is legally authorized to bind the Offeror to the proposal. An original signature must be present in the binder labeled "Original". The Offeror shall include a completed W-9 form (Attachment M) after the RFP Signature Page. (NOTE: The RFP Signature Page and W-9 form will not be counted as part of the four (4) page limit for the Transmittal Letter.)

C. EXECUTIVE SUMMARY - PAGE LIMIT: SIX PAGES

The Offeror shall include an Executive Summary as part of the Technical Proposal. The Executive Summary must be factual, brief and cover the core aspects of the proposed program. The Executive Summary shall not exceed six (6) pages.

D. TECHNICAL PROPOSAL - PAGE LIMIT: 175 PAGES

The page limit above includes all appendices, exhibits or attachments, but does not include the Transmittal Letter and Executive Summary.

The Technical Proposal for each region shall present a full and complete description of the qualifications of the Offeror to carry out the requirements set forth in this RFP, as well as the approach and methods the Offeror proposes to use in meeting the requirements and completing the work for each region. Each proposal shall describe a comprehensive quality package of services and programs the Offeror agrees to provide and demonstrate the Offeror's ability as a primary care case management entity and to partner with the Department to meet the goals of the ACC program.

The Offeror's Technical Proposal must contain all of the information requested in Sections IV and V under "Offeror's Response" (in bold font). To aid evaluators in reviewing proposals, Offeror shall first repeat the language from the RFP that describes which section of the RFP, including the RFP section number the Offeror is responding to (e.g. "Section V.B, Membership and Enrollment, item 1"), followed by the Offeror's response to that requirement.

The Offeror shall not assume that there will be an opportunity for revisions of proposals. Therefore, each proposal shall contain the Offeror's best terms from a price and technical standpoint.

The Offeror is cautioned to ensure that its proposal adequately describes its proposed program and demonstrates an understanding of the requirements. The proposal should be succinct, self-explanatory and well organized so that reviewers can understand the process that will be used to complete the requirements of this RFP. The Department does not encourage excessive responses and may disqualify proposals that exceed the page limit. Tabular or graphical presentations may be incorporated in the text of the proposal response or separate attachments. However, evaluators cannot be expected to comprehend all material in attachments whose content and relevance to the proposal are not clearly stated.

The Technical Proposal shall not exceed 175 pages, including all appendices, exhibits or attachments. Standard commercial brochures or Member handbooks that are attached as appendices, exhibits or attachments will be counted against page limitations.

No reference shall be made to any pricing information or elements of cost within the Transmittal Letter, Executive Summary or the Technical Proposal. If any element of pricing or cost is referred to in the Transmittal Letter, Executive Summary or Technical Proposal, the Offeror's proposal may be rejected.

E. PRICE PROPOSAL – NO PAGE LIMIT

Compensation. The Offeror shall submit two prices in its price proposal. The first price is a per member per month (PMPM) amount which will be valid for the Initial Phase. There is a budget limitation of $13 PMPM for the Initial Phase. The second price is a per member per month (PMPM) amount which will be valid for each year of the Expansion Phase. There is a budget limitation of $12 PMPM for the Expansion Phase. A price proposal that exceeds the budget limitation shall be disqualified.

The Price Proposal must contain a statement that the Offeror has the financial strength to maintain this contract.

Budget. The price proposal shall include two program budgets. The first budget is for the Initial Phase of the contract. The second budget is a yearly budget for the Expansion Phase. The program budgets shall include expected expenditures in sufficient detail to determine the cost of providing the services described in the Offeror's proposal. The budgets shall be submitted in the template format provided in Attachment N of this RFP, and shall include both a summary and a descriptive narrative.

Financial Information. Include as an attachment to the Price Proposal true copies of the Offeror's most recent audited annual financial statements. These statements must include a balance sheet and revenue statements for a reasonable number of previous years. The Offeror must submit one of the following (in order of preference):

1. An audited financial statement; or
2. A financial statement reviewed by a certified public accountant; or
3. A third-party prepared financial statement if an audited or reviewed statement is not available; or

4. Another financial statement prepared in the routine course of the Offeror's business.

The statements must have been prepared by a Certified Public Accountant and meet Generally Accepted Accounting Principle standards.

If the Offeror is a new entity, include the information for the entities that formed the new organization. This information will be used to assist the Department in making its determination of successful Offeror responsibility in accordance with C.R.S. 24-103-401.

VII. PROPOSAL EVALUATION

A. EVALUATION PROCESS

The evaluation of proposals will result in a recommendation for award of one contract under this RFP for each of the seven regions. The award will be made to the Offerors whose proposals, conforming to the RFP, will be most advantageous to the State of Colorado, price and other factors considered.

The Department will conduct a comprehensive, thorough, complete and impartial evaluation of each proposal received. First, all proposals will be reviewed by the Department's Contracts and Purchasing Section for acceptance. The Department's Contracts and Purchasing Section will be responsible for ensuring that: 1) the Offeror's proposal complied with the due date and time; 2) the Offeror's "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" meets requirements; 3) the Offeror included the appropriate number of proposal copies; and 4) the Offeror was registered with the State of Colorado's BIDS website prior to the due date and time.

Proposals will then be evaluated by an evaluation committee to determine whether the mandatory minimum requirements in Section IV.A have been met. The Technical and Price Proposals that meet the mandatory minimum requirements will be evaluated by the evaluation committee using the evaluation criteria listed below. Scores from 0 to 5 will be assigned. The score given for each criterion will be based on the evaluators' assessment of the response, how the response meets the requirements of the RFP, and whether required statements and submissions were provided. Scores for all evaluators will be multiplied by the weights stated in the table below, which reflect the relative importance of the criteria, to determine the number of points.

The Evaluation Committee may check client references as part of the evaluation process. Reference checks will not be limited to specific references cited in the proposal but may include others.

The evaluation committee may, if it deems necessary, request clarifications, conduct discussions or oral presentations, or request best and final offers; however, it may proceed to an award recommendation without any of these activities. Offerors selected to participate in these activities would be those which, based on the scores, are reasonably likely to be selected for

award. The evaluation committee may adjust its scoring based on the results of such activities, if any. However, proposals may be reviewed and determinations made without such activities, and Offerors should be aware that the opportunity for further explanation might not exist. Therefore, it is important that proposals are complete and favorable. The Offeror shall not assume that there will be an opportunity for revisions of proposals. Therefore, each proposal shall contain the Offeror's best terms from a price and technical standpoint.

The Evaluation Committee will then make an award recommendation subject to the final approval of the Department's Procurement Director. Upon review and final approval of the Evaluation Committee's recommendation for award, the Department's Procurement Director will issue a "Notice of Intent to Make an Award" letter that will be sent to all Offerors, announcing the Department's intent to make an award to the selected Offeror. At approximately the same time, a notification of the award is published on the Colorado BIDS website.

Failure of a proposal to comply with the requirements of this RFP may result in the proposal being disqualified as a non-responsive proposal.

B. PROPOSAL EVALUATION CRITERIA

The Evaluation Committee will use the following criteria in evaluating the proposals and recommending an award:

MANDATORY MINIMUM REQUIREMENTS	Met/Not Met
1. Meets the definition of a PCCM as set forth in 42 CFR 438.2.	
2. Minimum of three years of Medicaid experience within the last five years.	
3. Minimum of three years of experience coordinating and delivering or arranging for the delivery of comprehensive health care services spanning both the inpatient and outpatient continuum of care. Includes experience with at least two of the following: physical health, behavioral health, oral health and specialty care.	
TECHNICAL PROPOSAL CRITERIA	Weights
1. Experience and Organization	90
2. Membership and Enrollment	60
3. Network and Regional Strategy	90
4. Provider Support	90
5. Medical Management and Care Coordination	90
6. Accountability	90
7. Program Reporting	30
8. Compensation	15

9. Contract Start-Up Process	15
10. Transition at the Termination of the Contract	10
PRICE PROPOSAL	Weights
1. Price	100
2. Budget	50

VIII. ATTACHMENTS

Attachments are provided as separate documents on the BIDS website.

Colorado Department of Health Care Policy and Financing

Request for Proposals
RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
for the Accountable Care Collaborative Program

Attachment A

Definitions

Final

Attachment A: Definitions

The following words have been defined for the purpose of this RFP.

Accountable Care Collaborative (ACC) Program is a program designed to affordably optimize Client health, functioning and self-sufficiency. The primary goals of the ACC Program are to improve Medicaid Client health outcomes and control costs. Regional Care Collaborative Organizations (RCCOs), a Statewide Data and Analytics Contractor (SDAC), and Primary Care Medical Providers (PCMPs) that will serve as Medical Homes will work together in collaboration with ACC Program Members and other Medicaid providers to optimize the delivery of outcomes-based, cost-effective health care services.

Accountable Care Organization (ACO) is an organization that accepts accountability for the total cost of care received by a population and encourages providers to coordinate care.

Attribution is the methodology used by the SDAC to match existing Colorado Medicaid Clients that have an existing primary care relationship to create an enrollment record into the ACC Program. The purpose is to preserve existing primary care relationships, when they exist, in assigning an ACC Member to their Medical Home.

Choice Counseling is an Enrollment Broker process that provides Clients with information about their Colorado Medicaid enrollment choices. Passive Enrollment rules allow a 30-day "opt out" period during which the Client can to make an active choice as of whether or not he/she wishes to be enrolled in the ACC Program. Clients that do not opt out of participation in the ACC Program will be enrolled with the RCCO responsible for the region in which they live.

Client is an individual eligible for and enrolled in the Colorado Medicaid program.

Colorado Health Care Affordability Act Expansion Populations are those populations that will be covered by Medicaid as a result of passage of the Colorado Health Care Affordability Act, HB09-1293, which was signed by Governor Ritter on April 21, 2009. The Act authorizes the Department to collect a hospital provider fee and will expand health care coverage to more than 100,000 Coloradans. When fully implemented, an estimated $600 million will be collected to be matched by $600 million federal dollars for a total of $1.2 billion annually. These populations include parents of Medicaid children with income up to 100% of the federal poverty level (FPL); previously ineligible disabled individuals now able to "buy in" to existing programs; and Adults without Dependent Children (AwDC) with income up to 100% of the FPL.

Colorado Regional Health Information Organization (CORHIO) is a non-profit organization in Colorado that serves consumers, employers, doctors, hospitals, nursing homes, pharmacies, home health agencies, health plans and local health information exchanges to support the improvement of the health of Coloradans through the use of health information technology. CORHIO provides collaboration/convening services to communities and offers secure and confidential technical services where needed.

Community-Centered Board (CCB) is a private non-profit organization designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Department of Health Care Policy and Financing (the Department) is the state agency that administers the Medicaid and Child Health Plan *Plus* programs as well as a variety of other programs for Colorado's low-income families, the elderly and people with disabilities. The mission of the Department is to improve access to cost-effective, quality health care services for Coloradans.

Enrollment Broker is the entity contracted by the Department to provide information to all Clients in an unbiased manner about Colorado Medicaid enrollment options, and to advise the Clients on what to consider when making a choice to enroll into a health care option.

Essential Community Providers (ECPs) are the health care providers that have demonstrated a commitment to, and historically served, medically needy or medically indigent populations. These groups also make up a significant portion of its patient population. Functioning as a sole community provider, the ECP serves medically indigent patients within its medical capability, and waives charges, or charges for services on a sliding scale based on income, and does not restrict access or services because of a person's financial limitations.

Expansion Phase is the phase of the ACC Program that begins July 1, 2012, provided initial program goals have been met and authorization is given to expand. The Department envisions that eligible Medicaid Clients (not currently enrolled in a managed care program) will be enrolled as Members in the ACC Program.

Fee-For-Service (FFS) is a provider payment mechanism where providers are reimbursed a fee for each service they provide such as an office visit, test, procedure, or other health care service.

Focus Communities are those communities where the RCCO has identified excellent systems of care, where there is an opportunity to promote best practices and reduce unnecessary variation in care, and where there are especially strong connections between health provider and community resources, thereby reducing the overall cost of care and improving the health and functioning of the Members. Initial ACC Program enrollment is to be directed to these communities within each RCCO.

Health Insurance Portability and Accountability Act (**HIPAA)** is a federal law designed to provide privacy and security standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Developed by the U.S. Department of Health and Human Services, these standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country.

Health Information Technology (HIT) is an electronic system that allows for comprehensive management of medical information and the secure exchange of health care data and records.

Informatics also known as **Health Informatics** is the intersection of information science, computer science, and health care. It deals with the resources, devices, and methods required to optimize the acquisition, storage, retrieval, and use of information in health care systems and delivery. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems.

Initial Phase is the period of the ACC Program that extends from the region's "go-live" date (Either April 1, 2011 or June 1, 2011) through June 30, 2012. During the Initial Phase, Member enrollment in the ACC Program will be limited to 60,000 Members statewide.

Marketing is any communication from a contractor to a Medicaid Client who is not enrolled in that contractor's plan or program, that can reasonably be interpreted as intended to influence the Client to enroll in a contractor's plan or program, or either not to enroll in, or to disenroll from, another contractor's plan or program.

Medical Home is the general approach to providing comprehensive primary care that facilitates partnerships between Clients and their personal providers. Medical Homes may allow better access to health care, increase satisfaction with care, and improve health. Throughout the RFP, the term Medical Home is used in a general sense. However, there are several accepted elements of most Medical Home models including improved Client access and care that is coordinated, integrated, whole-person-oriented, culturally competent and outcomes-focused.

Member is any Medicaid Client who is enrolled in the ACC Program.

Passive Enrollment is a voluntary process of enrollment, initiated by proactively enrolling Clients into a specific program and allowing them to opt out of that program. It includes the selection of Clients appropriate for enrollment, notification of Clients selected for enrollment and choice counseling to assist Clients in making a decision regarding enrollment.

Patient-Centered Medical Home is a specific Medical Home model with joint principles developed by several national physician associations.

Per Member Per Month (PMPM) is the capitated payment method that makes a fixed payment per enrollee each month for services regardless of actual number or nature of services provided.

Primary Care Case Manager (PCCM) is a physician, a physician group practice, or entity that that employs or arranges with providers to furnish primary care case management services. The PCCM may also be a physician assistant, nurse practitioner, or certified nurse-midwife. See 42 CFR 438.2.

Primary Care Medical Provider (PCMP) is a primary care provider who serves as a Medical Home for Members. PCMP Practices may be FQHCs, RHCs, clinics or other group practices that provide the majority of a Member's comprehensive primary, preventive and sick care. Individual PCMPs can be physicians with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics or obstetrics and gynecology.

Primary Care Physician Program (PCPP) is Colorado Medicaid's existing Primary Care Case Management program. The ACC Program builds on this program and creates a hybrid model that adds characteristics of an Accountable Care Organization to the Primary Care Case Management system of care.

Regional Care Collaborative Organizations (RCCOs) are the seven regionally-based entities with which the Department intends to contract on a regional basis. The RCCOs will be responsible for accountable care, care that improves the health of Members and controls costs.

Shared Savings also known as "gain-sharing" is the process by which savings realized through implementation of the ACC Program are shared between the Department, RCCOs and participating PCMP providers. Examples of such Shared Savings calculations could include comparing the actual annual regional performance, on a per-capita cost basis, to a risk-adjusted FFS control group and/or measuring the actual cost reductions realized versus projected costs for the enrolled ACC Program population. Shared Savings will not be in place during the Initial Phase. The Department may add Shared Savings components to the contracts by contract amendment.

Single Entry Point (SEP) is a community agency that determines functional eligibility for Medicaid's community-based long-term care programs, provides care planning and case management for Clients in these programs, and makes referrals to other resources. SEP agencies serve Clients by county of residence.

Start-Up Phase is the phase of the ACC Program that extends from contract execution through the region's "go-live" date (either April 1, 2011 or June 1, 2011).

Statewide Data and Analytics Contractor (SDAC) is the entity with which the Department intends to contract to provide data aggregation, analysis and distribution in support of the ACC Program.

Subcontractor is an individual or entity contracted with the RCCO to perform all or part of the Statement of Work covered by the Contract resulting from this RFP, excluding agreement with providers. The written agreements between RCCOs and providers participating as PCMPs are not considered Subcontracts. The terms Subcontractor and Subcontractors mean Subcontractor(s) in any tier.

Colorado Department of Health Care Policy and Financing

RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
For The Accountable Care Collaborative Program

Attachment B

Administrative Information Document

Final

ADMINISTRATIVE INFORMATION

TABLE OF CONTENTS

ADMINISTRATIVE INFORMATION

A. INQUIRIES

Unless otherwise noted, prospective offerors may make written, faxed, or e-mail inquiries concerning this RFP to obtain clarification of requirements. E-mail is the preferred method for vendors to submit inquiries. No inquiries will be accepted after the date and time indicated in the Schedule of Activities in the RFP document.

E-mail, mail, or fax all inquiries to:

E-mail: Katherine.quinby@state.co.us

Katherine Quinby
State of Colorado
Department of Health Care Policy and Financing
Contracts and Purchasing Section
1570 Grant Street
Denver, CO 80203

Fax number: (303) 866-4411, ATTN: Katherine Quinby

Clearly identify your inquiries with the RFP number and title: RFP # HCPFKQ1102RCCO, Regional Care Collaborative Organizations for the Accountable Care Collaborative Program. Responses to prospective Offerors' inquiries will be published as an RFP modification on the State of Colorado BIDS web page in a timely manner.

B. MODIFICATION OR WITHDRAWAL OF PROPOSALS

Proposals may be modified or withdrawn by the Offeror prior to the established due date and time.

C. PROPOSAL SUBMISSION

Proposals must be received on or before the due date and time (Proposal Submission Deadline) indicated in the Schedule of Activities in the RFP document. Late proposals will not be accepted. It is the responsibility of the Offeror to ensure that its proposal is received by the Department of Health Care Policy and Financing (HCPF), Contracts and Purchasing Section (CPS), at the location listed below on or before the due date and time. Offerors mailing their proposals shall allow sufficient mail delivery time to ensure receipt of their proposals by the time specified. The proposal package shall be delivered or sent by mail to:

State of Colorado
Department of Health Care Policy and Financing
Contracts and Purchasing Section
1570 Grant Street

Denver, CO 80203

The "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" MUST be signed in ink by the Offeror or an officer of the Offeror legally authorized to bind the Offeror to the proposal. **Proposals that are determined to be at variance with this requirement may not be accepted**.

See the Proposal Requirements section in the RFP document for the number of copies of the proposal that must be submitted.

Proposals must be submitted and sealed in a package showing the following information clearly on the outside of the package:

- OFFEROR'S NAME
- RFP # HCPFKQ1102RCCO, Regional Care Collaborative Organizations for the Accountable Care Collaborative Program.
- PROPOSAL DUE: Friday, October 22, 2010, at 3:00 PM (MST).

The RFP document may contain additional instructions regarding packaging of proposals, such as requiring separation of Technical Proposals from Price Proposals.

You are encouraged to submit proposals on recycled, and recyclable, non-glossy paper.

For its proposal to be considered, an Offeror must be registered with the State of Colorado's BIDS website (www.gssa.state.co.us/VenSols) by the proposal submission due date and time.

D. ADDENDUM OR SUPPLEMENT TO REQUEST FOR PROPOSAL

In the event that it becomes necessary to revise any part of this RFP, a modification will be published on the BIDS website at www.gssa.state.co.us/VenSols. **It shall be the responsibility of the Offerors to regularly monitor the BIDS website for any such postings. Failure to retrieve such modifications, and include their provisions in your proposal, may result in your proposal being disqualified.**

E. ORAL PRESENTATIONS/SITE VISITS

Offerors may be asked to make oral presentations or to make their facilities available for a site inspection by the evaluation committee. Such presentations and/or site visits will be at the Offeror's expense.

F. PROTESTED SOLICITATIONS AND AWARDS

Any actual or prospective Offeror or contractor who is aggrieved in connection with the solicitation or award of a contract may protest to: Katherine Quinby, Procurement Director, State of Colorado Department of Health Care Policy and Financing, Contracts and Purchasing

Section, 1570 Grant Street, Denver, CO 80203-1818. The protest shall be submitted in writing within seven working days after such aggrieved person knows, or should have known, of the facts giving rise thereto. (Reference: C.R.S. Title 24, Article 109.)

G. CONFIDENTIAL/PROPRIETARY INFORMATION

Any restrictions on the use or inspection of material contained within the proposal shall be requested prior to the submission of the proposal itself. Requests for confidentiality shall be submitted in writing to the Katherine Quinby, Procurement Director, Contracts and Purchasing Section, by the Offeror *prior to* the proposal submission date. The Offeror must state specifically which materials it is requesting to be considered confidential/proprietary with an explanation of the reasons that the materials are considered confidential/proprietary under the Colorado Open Records Act, C.R.S. Title 24, Article 72, Part 2, as amended. The Contracts and Purchasing Section will inform the Offeror in writing which portions of the confidentiality/proprietary request will be honored and which will not.

If a request is granted confidential/proprietary information must be clearly identified, marked and the Offeror shall submit the information segregated from the rest of the proposal in a separate package. Co-mingling of confidential/proprietary and other information is NOT acceptable.

Neither a proposal in its entirety nor the proposal price information will be considered confidential and/or proprietary. Any information that will be included in any contract resulting from the RFP cannot be considered confidential.

After award, the offers shall be open to public inspection pursuant to the Colorado Open Records Act, subject to any continued prohibition on the disclosure of confidential data.

H. RFP RESPONSE MATERIAL OWNERSHIP

All products and materials submitted in response to this RFP becomes the property of the State of Colorado at the established opening date and time, unless otherwise noted in the RFP. Proposals may be reviewed by any person after the "Notice of Intent to Make an Award" letter has been issued, subject to the terms of C.R.S. Title 24, Article 72, Part 2, as amended.

I. PROPOSAL PRICES

Estimated proposal prices are not acceptable. Best and final offers may be considered, at the Department's option, in determining the apparent successful Offeror. Proposals shall be firm for a period of not less than one hundred eighty (180) calendar days.

J. PUBLIC OPENING OF PROPOSALS

On the date and time shown on the "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page," the Contracts and Purchasing Section will conduct, at the delivery location identified under Section C, Proposal Submission, above, a

public opening of proposals. The public opening will only disclose the names of all Offerors who have submitted a proposal in response to the RFP. Information on costs and qualifications will be available from the Contracts and Purchasing Section following issuance of a "Notice of Intent to Make an Award" letter.

K. EVALUATION

The evaluation of proposals will result in a recommendation for an award of a contract under this RFP. The award will be made to the Offeror (or Offerors, if multiple awards are anticipated by the RFP) whose proposal(s), conforming to the RFP, will be most advantageous to the State of Colorado, price and other factors considered.

The State of Colorado will conduct a comprehensive, fair and impartial evaluation of each proposal received. First, all proposals will be submitted to the Contracts and Purchasing Section for acceptance. The Contracts and Purchasing Section will be responsible for ensuring that:

- The Offeror's proposal complied with the due date and time;
- The Offeror's "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" meets requirements;
- The Offeror included the appropriate number of proposal copies; and
- The Offeror was registered with the State of Colorado's BIDS website prior to the due date and time.

Evaluation Process

The Department plans an intensive, thorough, complete and fair evaluation process. Proposals will be evaluated by a committee using the evaluation criteria listed in the RFP; the criteria will include the proposed price or cost. Committee members will be selected who do not have a conflict of interest regarding this solicitation. The committee will be responsible for the evaluation process, which will include the following steps:

- Review proposals for any conditions that may disqualify an Offeror and to ensure that required terms and conditions have been met.
- Review proposal content, contact references (if required), and assign a preliminary score to each criterion for each proposal.
- Determine whether any Offerors will be invited to participate in discussions with the committee. Such Offerors would be those who, based on preliminary scores, are reasonably susceptible of being selected for the award. However, proposals may be reviewed and determinations made without such discussion and Offerors should be aware that the opportunity for further explanation might not exist. Therefore, it is important that proposals are complete.
- Oral presentations, if the committee requires, for invited Offerors to demonstrate their proposed service.
- Adjust of points or ratings, as necessary.
- Best and final offers (which may take place at the State's option).
- Make final award recommendation to the Contracts and Purchasing Section.

L. AWARD

Upon review and approval of the evaluation committee's recommendation for award, the Contracts and Purchasing Section will issue a "Notice of Intent to Make an Award" letter that will be sent (usually via fax) to all Offerors, announcing the Department's intent to make an award to the selected Offeror. At approximately the same time, the intent to award is also published on the Colorado BIDS website. Should a contract not be completed and executed by the parties, through no fault of the Department, on or before the estimated "Contract Finalized" date shown in the RFP's Schedule of Activities, the Department at its sole discretion may elect to cancel the "Notice of Intent to Make an Award" notice and make the award to the next most advantageous Offeror.

M. BINDING OFFER

A proposal submitted in response to this RFP shall constitute a binding offer. Acknowledgment of this condition shall be indicated by the signature on the "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" of the Offeror or an officer of the Offeror legally authorized to execute contractual obligations. By submitting a proposal the Offeror affirms its acceptance of the terms and requirements of this RFP, including its attachments and exhibits, without exception, deletion, or qualification - and without making its offer contingent.

N. PROPOSAL CONTENT ACCEPTANCE

The contents of the proposal (including persons specified to implement the project) of the successful Offeror will become contractual obligations if acquisition action ensues. Failure of the successful Offeror to accept these obligations in a contract, purchase document, delivery order or similar acquisition instrument may result in cancellation of the award and such Offeror may be removed from consideration for future solicitations.

O. CONTRACT TERMS

Included with this RFP's attachments is a draft contract, as Attachment E. By submitting a proposal, the Offeror affirms its willingness to enter into a contract containing substantially similar terms and conditions to the draft contract, and the requirements of the RFP without exception, deletion, qualification or contingency.

P. RFP CANCELLATION

The Department reserves the right to cancel this Request for Proposal at any time, without penalty.

Q. PROPOSAL AND PRE-CONTRACT COSTS

The Department is not liable for any costs incurred by Offerors prior to issuance of a legally

executed contract or procurement document. No property interest of any nature shall occur until a contract is awarded and signed by all concerned parties.

R. PROPOSAL REJECTION

The Department reserves the right to reject any or all proposals, to waive informalities and minor irregularities in proposals received, and to accept any portion of a proposal or all items proposed if deemed in the best interests of the State.

S. VENDOR IDENTIFICATION

The tax identification number provided must be that of the Offeror responding to the RFP. The Offeror must be a legal entity with the legal right to contract.

T. NEWS RELEASES

News releases pertaining to this RFP shall NOT be made prior to execution of the contract without prior written approval by the Department.

U. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION

1. By submission of this proposal each Offeror certifies, and in the case of a joint proposal each party thereto certifies as to its own organization, that in connection with this procurement:

    (a) The prices in this proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other Offeror or with any competitor;
    (b) Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to opening, directly or indirectly to any other Offeror or to any competitor; and
    (c) No attempt has been made or will be made by the Offeror to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

2. Each person signing the "State of Colorado, Department of Health Care Policy and Financing, Request for Proposal Signature Page" of this proposal certifies that:

    (a) She/he is the person in the Offeror's organization responsible within that organization for the decision as to the prices being offered herein and that she/he has not participated, and will not participate, in any action contrary to (1)(a) through (1)(c) above; or she/he is not the person in the Offeror's organization responsible within that organization for the decision as to the prices being offered herein but that she/he has been authorized in writing to act as agent for the persons responsible for such decision in certifying that such persons have not participated, and will not participate, in any action contrary to (1)(a) through (1)(c) above, and as their agent does hereby so certify;

and she/he has not participated, and will not participate, in any action contrary to (1)(a) through (1)(c) above.

3. A proposal will not be considered for award where (1)(a), (1)(c), or (2) above has been deleted or modified. Where (1)(b) above has been deleted or modified, the proposal will not be considered for award unless the Offeror furnishes with the proposal a signed statement which sets forth in detail the circumstances of the disclosure and the head of the agency, or her/his designee, determines that such disclosure was not made for the purpose of restricting competition.

V. CONFLICTS OF INTEREST

The holding of public office or employment is a public trust. A public officer or employee whose conduct departs from his fiduciary duty is liable to the people of the State. Rules of conduct for public officers and state employees:

1. Proof beyond a reasonable doubt of commission of any act enumerated in this section is proof that the actor has breached his fiduciary duty.

2. A public officer or a state employee shall not:

   (a) Engage in a substantial financial transaction for her/his private business purposes with a person whom she/he inspects, regulates, or supervises in the course of his official duties;
   (b) Assist any person for a fee or other compensation in obtaining any contract, claim, license, or other economic benefit from her/his agency;
   (c) Assist any person for a contingent fee in obtaining any contract, claim, license, or other economic benefit from any state agency; or
   (d) Perform an official act directly and substantially affecting its economic benefit a business or other undertaking in which she/he either has a substantial financial interest or is engaged as counsel, consultant, representative, or agent.
   (e) Serve on the Board of any entity without disclosure to the entity, the Secretary of State, and his/her employer.

3. A head of a principal department or a member of a quasi-judicial or rule-making agency may perform an official act notwithstanding paragraph (d) of subsection (2) of this section if her/his participation is necessary to the administration of a statute and if she/he complies with the voluntary disclosure procedures under C.R.S. 24-18-110.

4. Paragraph (c) of subsection (2) of this section does not apply to a member of a board, commission, council, or committee if she/he complies with the voluntary disclosure procedures under C.R.S. 24-18-110 and if she/he is not a full-time state employee.
   Reference C.R.S. 24-18-108, as amended.

W. TAXES

The State of Colorado, as purchaser, is exempt from all federal excise taxes under Chapter 32 of the Internal Revenue Code (Registration No. 84-730123K) and from all state and local government use taxes (C.R.S. 39-26-704). The Colorado State and Local Sales Tax Exemption Number is 98-01159-0000. Seller is hereby notified that when materials are purchased in certain political sub-divisions (for example in the City of Denver) the seller may be required to pay sales tax even though the ultimate product or service is provided to the State of Colorado. This sales tax will not be reimbursed by the State.

Colorado Department of Health Care Policy and Financing

Request for Proposals
RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
for the Accountable Care Collaborative Program

Attachment C

Data Set

Final

Attachment C: Data Set

The Department will make available a limited data set from Medicaid claims data for Fiscal Years 2007, 2008 and 2009 to Offerors which have submitted a Letter of Intent to Propose and executed a Confidentiality Agreement. See Paragraph II.I in the RFP for instructions.

The sole purpose of the limited data set is to provide information to Offerors on Colorado Medicaid, its claims and eligibility groups, and the costs associated with them. Offerors are not permitted to copy the data or use it for any other purpose. This is a limited data set under HIPAA; there is client-level data but no actual client identifiers, with the exception of a masked ID number for matching claims to clients. The data set is solely for the use of the Offeror, and may only be used to inform the response to this RFP.

Data Format

The data will be available as a zip file-encrypted two-disc CD set. Historical claims data will be provided by fiscal quarter, in a tab-delimited text file format. Eligibility data will be provided by fiscal year, in a tab-delimited text file format. Field names for all files and a limited data dictionary are also included in the package.

Data Available

The CDs contain comprehensive claims data for Fiscal Years 2007, 2008 and 2009. The data set includes detail level, de-identified fee-for-service physical health claims with dates of service in FY2007, FY2008, and FY2009. This includes all paid amounts, diagnoses, procedures, provider types, and claim types (including pharmacy claims). The data set also includes de-identified monthly eligibility and enrollment details for clients with eligibility in FY2007, FY2008, and FY2009.

- FFS diagnosis codes
- FFS procedure codes
- Client eligibility category
- County of residence
- Client race
- Claim type (inpatient, outpatient, transportation, physician service, etc.)
- Provider type
- Drug type (for pharmacy claims)

Colorado Department of Health Care Policy and Financing

Request for Proposals
RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
for the Accountable Care Collaborative Program

Attachment D

Map of Regions and Associated Counties

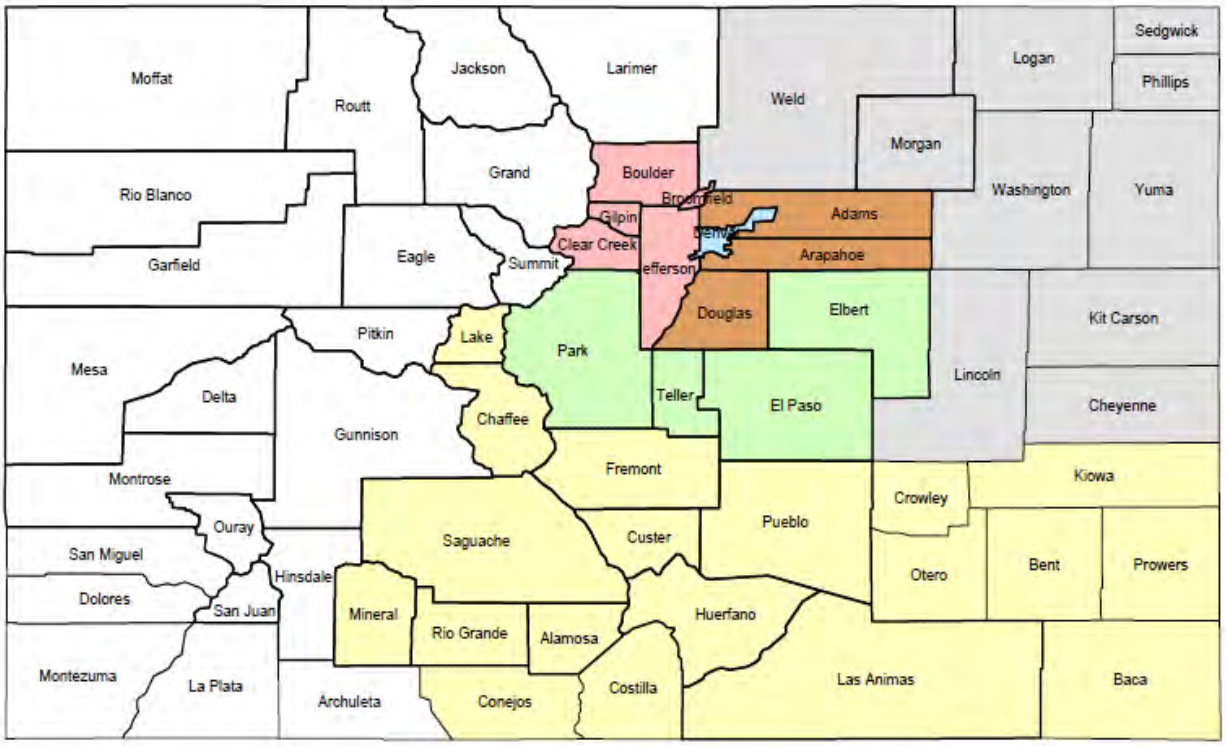
Final

Attachment D: Map of Regions and Associated Counties

Client Caseloads by RCCO Region

Region 1	76,390
Region 2	41,482
Region 3	123,972
Region 4	64,386
Region 5	93,318
Region 6	60,089
Region 7	66,113

Source for all caseload data provided is the MMIS data warehouse table Client Monthly Reports Data. This table is consistent with the REX01/COLD (MARS)R-474701 report which is the source of official Health Care Policy & Financing (HCPF) caseload numbers.



Client Caseloads include all Medicaid clients with at least one day of eligibility during the month of June 2010. Client duplication may occur due to client movement between counties.

Associated Counties

REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7
ARCHULETA	CHEYENNE	ADAMS	ALAMOSA	DENVER	BOULDER	EL PASO
DELTA	KIT CARSON	ARAPAHOE	BACA		BROOMFIELD	ELBERT
DOLORES	LINCOLN	DOUGLAS	BENT		CLEAR CREEK	PARK
EAGLE	LOGAN		CHAFFEE		GILPIN	TELLER
GARFIELD	MORGAN		CONEJOS		JEFFERSON	
GRAND	PHILLIPS		COSTILLA			
GUNNISON	SEDGWICK		CROWLEY			
HINSDALE	WASHINGTON		CUSTER			
JACKSON	WELD		FREMONT			
LA PLATA	YUMA		HUERFANO			
LARIMER			KIOWA			
MESA			LAKE			
MOFFAT			LAS ANIMAS			
MONTEZUMA			MINERAL			
MONTROSE			OTERO			
OURAY			PROWERS			
PITKIN			PUEBLO			
RIO BLANCO			RIO GRANDE			
ROUTT			SAGUACHE			
SAN JUAN						
SAN MIGUEL						
SUMMIT						

Colorado Department of Health Care Policy and Financing

Request for Proposals
RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
for the Accountable Care Collaborative Program

Attachment E

Draft Contract

Final

Contract Routing Number _____

STATE OF COLORADO
Department of Health Care Policy and Financing
Contract with
Insert Contractor's Full Legal Name
For Regional Care Collaborative Organization

TABLE OF CONTENTS

1. PARTIES

This Contract (hereinafter called "Contract") is entered into by and between Insert Legal Name of Contractor and address (hereinafter called "Contractor"), and the STATE OF COLORADO acting by and through the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 (hereinafter called the "State" or "Department"). Contractor and the State hereby agree to the following terms and conditions.

2. EFFECTIVE DATE AND NOTICE OF NONLIABILITY

This Contract shall not be effective or enforceable until it is approved and signed by the Colorado State Controller or designee (hereinafter called the "Effective Date"). The State shall not be liable to pay or reimburse Contractor for any performance hereunder including, but not limited to, costs or expenses incurred, or be bound by any provision hereof prior to the Effective Date.

3. RECITALS

A. Authority, Appropriation, and Approval

Authority to enter into this Contract exists in Insert statutory or other legal authority and funds have been budgeted, appropriated and otherwise made available pursuant to Insert statutory or other legal authority and a sufficient unencumbered balance thereof remains available for payment. Required approvals, clearance and coordination have been accomplished from and with appropriate agencies.

B. Consideration

The Parties acknowledge that the mutual promises and covenants contained herein and other good and valuable consideration are sufficient and adequate to support this Contract.

C. Purpose

The purpose of this Contract is Briefly describe the Contract's purpose. Contractor's offer, submitted in response to RFP Number Insert RFP number was selected by the State.

D. References

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

4. DEFINITIONS

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

A. "Contract" means this Contract, its terms and conditions, attached addenda, exhibits, documents incorporated by reference under the terms of this Contract, and any future modifying agreements, exhibits, attachments or references

incorporated herein pursuant to Colorado State law, Fiscal Rules, and State Controller Policies.

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

HIPAA Business Associate Addendum
Exhibit A, Statement of Work.

C. **"**Goods" means tangible material acquired, produced, or delivered by Contractor either separately or in conjunction with the Services Contractor renders hereunder.

D. "Party" means the State or Contractor and Parties means both the State and Contractor.

E. "Review" means examining Contractor's Work to ensure that it is adequate, accurate, correct and in accordance with the standards described in this Contract.

F. "Services" means the required services to be performed by Contractor pursuant to this Contract.

G. "Subcontractor" means third parties, if any, engaged by Contractor to aid in performance of its obligations.

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

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

5. TERM AND EARLY TERMINATION

A. Initial Term-Work Commencement

The Parties' respective performances under this Contract shall commence on the later of either the Effective Date or Insert Month Day, Year. This Contract shall expire on Insert Month Day, Year, unless sooner terminated or further extended as specified elsewhere herein.

B. Two Month Extension

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

C. Extension Amendments

The State may require continued performance for a period of one year at the same rates and same terms specified in the Contract, unless modified by the extension amendment. Such extension shall be made by contract amendment. An extension amendment is not effective until approved and signed by the Colorado State Controller or an authorized designee. The extended contract shall be considered to include this renewal provision. The total duration of this Contract, including any extension amendments under this clause, shall not exceed Insert number of years years.

6. STATEMENT OF WORK

A. Completion

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

B. Goods and Services

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

C. Independent Contractor

All persons employed by Contractor or Subcontractors to perform Work under this Contract shall be Contractor's or Subcontractors' employee(s) for all purposes hereunder and shall not be employees of the State for any purpose as a result of this Contract.

7. PAYMENTS TO CONTRACTOR

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

A. Maximum Amount

The maximum amount payable under this Contract to Contractor by the State for Work performed in each State fiscal year is:

State Fiscal Year Insert FY (xx-xx)	$Insert maximum amount

B. Payment

Payment pursuant to this Contract will be made as earned. Any advance payments allowed under this Contract shall comply with State Fiscal Rules and be made in accordance with the provisions of this Contract. Contractor shall initiate any payment requests by submitting invoices to the State in the form and manner prescribed by the State.

C. Interest

The State shall fully pay each invoice within forty-five (45) days of receipt thereof if the amount invoiced represents peformance by Contractor previously accepted by the State. Uncontested amounts not paid by the State within forty-five (45) days shall bear interest on the unpaid balance beginning on the forty-sixth (46^{th}) day at a rate not to exceed one percent (1%) per month until paid in full; provided, however, that interest shall not accrue on unpaid amounts that are subject to a good faith dispute. Contractor shall invoice the State separately for accrued interest on delinquent amounts. The billing shall reference the delinquent payment, the number of days' interest to be paid and the interest rate.

D. Available Funds-Contingency-Termination

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

E. Erroneous Payments

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

8. REPORTING – NOTIFICATION

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

A. Quarterly Reports

Unless otherwise provided, in contracts having a performance term longer than three (3) months, the Contractor shall submit, on a quarterly basis, a written program report specifying progress made for each activity identified in the Contractor's duties and obligations. Such written analysis shall be in accordance with the procedures developed and prescribed by the State. Required reports shall be submitted to the State not later than the end of each calendar quarter, or at such time as otherwise specified.

B. Litigation Reporting

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

C. Noncompliance

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

9. CONTRACTOR RECORDS

A. Maintenance

Contractor shall make, keep, maintain, and allow inspection and monitoring by the State of a complete file of all records, documents, communications, notes and other written materials, electronic media files and electronic communications,

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

B. Inspection

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

C. Monitoring

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

D. Final Audit Report

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

10. CONFIDENTIAL INFORMATION

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

A. Confidentiality

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

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

i. Federal Law and Regulations

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

ii. Business Associate Contract

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

iii. Confidentiality of Records

Whether or not an Addendum is attached to this Contract, the Contractor shall protect the confidentiality of all records and other materials containing personally identifying information that are maintained in

accordance with the Contract and comply with HIPAA rules and regulations. Except as provided by law, no information in possession of the Contractor about any individual constituent shall be disclosed in a form including identifying information without the prior written consent of the person in interest, a minor's parent, or guardian. The Contractor shall have written policies governing access to, duplication and dissemination of, all such information. The Contractor shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. The Contractor shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the federal Health Insurance Portability and Accountability Act of 1996.

C. Notification

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

D. Use, Security, and Retention

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

E. Disclosure-Liability

Disclosure of State records or other confidential information by Contractor for any reason may be cause for legal action by third parties against Contractor, the State or their respective agents. Contractor shall indemnify, save, and hold harmless the State, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees and related costs, incurred as a result of any act or omission by Contractor, or its employees, agents, Subcontractors, or assignees pursuant to this **§ 10.**

11. CONFLICTS OF INTEREST

A. Contractor shall not engage in any business or personal activities or practices or

maintain any relationships which conflict in any way with the full performance of Contractor's obligations hereunder. Contractor acknowledges that with respect to this Contract, even the appearance of a conflict of interest is harmful to the State's interests. Absent the State's prior written approval, Contractor shall refrain from any practices, activities or relationships that reasonably appear to be in conflict with the full performance of Contractor's obligations to the State hereunder. If a conflict or appearance exists, or if Contractor is uncertain whether a conflict or the appearance of a conflict of interest exists, Contractor shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the apparent conflict constitutes a breach of this Contract.

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

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

12. REPRESENTATIONS AND WARRANTIES

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

A. Standard and Manner of Performance

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

B. Legal Authority – Contractor Signatory

Contractor warrants that it possesses the legal authority to enter into this Contract and that it has taken all actions required by its procedures, and bylaws, and/or

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

C. Licenses, Permits, Etc.

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

13. INSURANCE

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

A. Contractor

i. Public Entities

If Contractor is a "public entity" within the meaning of the Colorado Governmental Immunity Act, CRS §24-10-101, *et seq*., as amended (the "GIA"), then Contractor shall maintain at all times during the term of this Contract such liability insurance, by commercial policy or self-insurance, as is necessary to meet its liabilities under the GIA. Contractor shall show proof of such insurance satisfactory to the State, if requested by the State. Contractor shall require each contract with a Subcontractor that is a public

entity, to include the insurance requirements necessary to meet such Subcontractor's liabilities under the GIA.

ii. Non-Public Entities

If Contractor is not a "public entity" within the meaning of the GIA, Contractor shall obtain and maintain during the term of this Contract insurance coverage and policies meeting the requirements set forth in **§ 13.B**.

B. Contractors – Subcontractors

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

i. Worker's Compensation

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

ii. General Liability

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

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

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

iii. Automobile Liability

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

iv. Additional Insured

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 hereunder.

v. Primacy of Coverage

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

vi. Cancellation

The above insurance policies shall include provisions preventing cancellation or non-renewal without at least thirty (30) days prior notice to Contractor and the State by certified mail and in accordance with **§ 16**.

vii. Subrogation Waiver

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

C. Certificates

Contractor and all Subcontractors shall provide certificates showing insurance coverage required hereunder to the State within seven (7) business days of the Effective Date of this Contract. No later than fifteen (15) days prior to the expiration date of any such coverage, Contractor and each Subcontractor shall deliver to the State or Contractor certificates of insurance evidencing renewals thereof. In addition, upon request by the State at any other time during the term of this Contract or any subcontract, Contractor and each Subcontractor shall, within ten (10) days of such request, supply to the State evidence satisfactory to the State of compliance with the provisions of this **§ 13**.

14. BREACH

A. Defined

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

B. Notice and Cure Period

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

15. REMEDIES

A. Termination for Cause and/or Breach

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

i. Obligations and Rights

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

expiration of this Contract. At the sole discretion of the State, Contractor shall assign to the State all of Contractor's right, title, and interest under such terminated orders or subcontracts. Upon termination, Contractor shall take timely, reasonable and necessary action to protect and preserve property in the possession of Contractor in which the State has an interest. All materials owned by the State in the possession of Contractor shall be immediately returned to the State. All Work Product, at the option of the State, shall be delivered by Contractor to the State and shall become the State's property. The Contractor shall be obligated to return any payment advanced under the provisions of this Contract.

ii. Payments

The State shall reimburse Contractor only for accepted performance up to the effective date of the termination. If, after termination by the State, it is determined that Contractor was not in breach or that Contractor's action or inaction was excusable, such termination shall be treated as a termination in the public interest and the rights and obligations of the Parties shall be the same as if this Contract had been terminated in the public interest, as described herein.

iii. Damages and Withholding

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

B. Early Termination in the Public Interest

The State is entering into this Contract for the purpose of carrying out the public policy of the State of Colorado, as determined by its Governor, General Assembly, and/or courts. If this Contract ceases to further the public policy of the State, the State, in its sole discretion, may terminate this Contract, in whole or in part. Exercise by the State of this right shall not constitute a breach of the State's obligations hereunder. This subsection shall not apply to a termination of this Contract by the State for cause or breach by Contractor, which shall be governed by **§ 15.A** or as otherwise specifically provided for herein.

i. Method and Content

The State shall notify Contractor of such termination in accordance with **§16.** The notice shall specify the effective date of the termination, which shall be at least twenty (20) days, and whether it affects all or a portion of this Contract.

ii. Obligations and Rights

Upon receipt of a termination notice, Contractor shall be subject to and comply with the same obligations and rights set forth in **§ 15.A.i**.

iii. Payments

If this Contract is terminated by the State pursuant to this **§ 15.B**, Contractor shall be paid an amount which bears the same ratio to the total reimbursement under this Contract as Contractor's obligations that were satisfactorily performed bear to the total obligations set forth in this Contract, less payments previously made. Additionally, if this Contract is less than 60% completed upon the effective date of such termination, the State may reimburse Contractor for a portion of actual out-of-pocket expenses (not otherwise reimbursed under this Contract) incurred by Contractor prior to the effective date of the termination in the public interest which are directly attributable to the uncompleted portion of Contractor's obligations hereunder; provided that the sum of any and all reimbursement shall not exceed the maximum amount payable to Contractor hereunder.

C. Remedies

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

i. Suspend Performance

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

ii. Withhold Payment

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

iii. Deny/Reduce Payment

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

iv. Removal

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

v. Intellectual Property

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

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

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

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

16. NOTICES AND REPRESENTATIVES

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

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

For the State:

Name and Title
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203
Email

For the Contractor:

Name and Title
Company Name
Address 1
Address 2
City, State Zip Code
Email

17. RIGHTS IN DATA, DOCUMENTS, AND COMPUTER SOFTWARE

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

18. GOVERNMENTAL IMMUNITY

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

19. NOT USED

20. GENERAL PROVISIONS

A. Assignment and Subcontracts

Contractor's rights and obligations hereunder are personal and may not be transferred, assigned or subcontracted without the prior, written consent of the State. Any attempt at assignment, transfer or subcontracting without such consent shall be void. All assignments, subcontracts, or Subcontractors are subject to all

of the provisions hereof. Contractor shall be solely responsible for all of the Work performed under this Contract, regardless of whether Subcontractors are used and for all aspects of subcontracting arrangements and performance. Copies of any and all subcontracts entered into by Contractor to perform its obligations hereunder shall be in writing and submitted to the State upon request. Any and all subcontracts entered into by Contractor related to its performance hereunder shall require the Subcontractor to perform in accordance with the terms and conditions of this Contract and to comply with all applicable federal and state laws. Any and all subcontracts shall include a provision that such subcontracts are governed by the laws of the State of Colorado.

B. Binding Effect

Except as otherwise provided in **§20.A**, all provisions herein contained, including the benefits and burdens, shall extend to and be binding upon the Parties' respective heirs, legal representatives, successors, and assigns.

C. Captions

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

D. Counterparts

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

E. Entire Understanding

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

F. Indemnification

Contractor shall indemnify, save, and hold harmless the State, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees and related costs, incurred as a result of any act or omission by Contractor, or its employees, agents, Subcontractors, or assignees pursuant to the terms of this Contract; however, the provisions hereof shall not be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions, of the Colorado Governmental Immunity Act, CRS §24-10-101 *et seq.*, or the Federal Tort Claims Act, 28 U.S.C. 2671 et seq., as applicable, as now or hereafter amended.

G. Jurisdiction and Venue

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

H. Modification

i. By the Parties

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

ii. By Operation of Law

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

I. Order of Precedence

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

i. Colorado Special Provisions
ii. HIPAA Business Associate Addendum
iii. The provisions of the main body of this Contract
iv. Exhibit A, Statement of Work

J. Severability

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

K. Survival of Certain Contract Terms

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

L. Taxes

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

M. Third Party Beneficiaries

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

N. Waiver

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

21. ADDITIONAL GENERAL PROVISIONS

A. Compliance With Applicable Law

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

Age Discrimination Act of 1975, as amended	42 U.S.C. 6101, *et seq.*

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

State laws include:

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

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

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

conditions, in performance of Work under this Contract.

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

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

B. Federal Audit Provisions

Office of Management and Budget (OMB) Circular No. A-133 Audits of States, Local Governments, and Non-Profit Organizations defines audit requirements under the Single Audit Act of 1996 (Public Law 104-156). All state and local governments and non-profit organizations expending $500,000 or more from all sources (direct or from pass-through entities) are required to comply with the provisions of Circular No. A-133. The Circular also requires pass-through entities to monitor the activities of subrecipients and ensure that subrecipients meet the audit requirements. To identify its pass-through responsibilities, the State of Colorado requires all subrecipients to notify the State when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.

C. Debarment and Suspension

i. If this is a covered transaction or the Contract amount exceeds $100,000, the Contractor certifies to the best of its knowledge and belief that it and its principals and Subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency.

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

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

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

v. The Contractor agrees that it will include this certification in all lower tier covered transactions and subcontracts that exceed $100,000.

D. Force Majeure

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

E. Disputes

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

F. Lobbying

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

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

ii. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an office or employee of any agency, a Member of Congress, an office or employee

of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative Contract, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

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

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

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SPECIAL PROVISIONS

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

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

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

3. **GOVERNMENTAL IMMUNITY**. No term or condition of this contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, of the Colorado Governmental Immunity Act, CRS §24-10-101 et seq., or the Federal Tort Claims Act, 28 U.S.C. §§1346(b) and 2671 et seq., as applicable now or hereafter amended.

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

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

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

7. **BINDING ARBITRATION PROHIBITED.** The State of Colorado does not agree to binding arbitration by any extra-judicial body or person. Any provision to the contrary in this contact or incorporated herein by reference shall be null and void.

8. **SOFTWARE PIRACY PROHIBITION. Governor's Executive Order D 002 00**. State or other public funds payable under this contract shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Contractor hereby certifies and warrants that, during the term of this contract and any extensions, Contractor has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Contractor is in violation of this provision, the State may exercise any remedy available at law or in equity or under this contract, including, without limitation, immediate termination of this contract and any remedy consistent with federal copyright laws or applicable licensing restrictions.

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

10. **VENDOR OFFSET**. **CRS §§24-30-202 (1) and 24-30-202.4**. [***Not Applicable to intergovernmental agreements***] Subject to CRS §24-30-202.4 (3.5), the State Controller may withhold payment under the State's vendor offset intercept system for debts owed to State agencies for: **(a)** unpaid child support debts or child support arrearages; **(b)** unpaid balances of tax, accrued interest, or other charges specified in CRS §39-21-101, et seq.; **(c)** unpaid loans due to the Student Loan Division of the Department of Higher Education; **(d)** amounts required to be paid to the Unemployment Compensation Fund; and **(e)** other unpaid debts owing to the State as a result of final agency determination or judicial action.

SPECIAL PROVISIONS

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

11. PUBLIC CONTRACTS FOR SERVICES. **CRS §8-17.5-101**. [***Not Applicable to agreements relating to the offer, issuance, or sale of securities, investment advisory services or fund management services, sponsored projects, intergovernmental agreements, or information technology services or products and services***] Contractor certifies, warrants, and agrees that it does not knowingly employ or contract with an illegal alien who will perform work under this contract and will confirm the employment eligibility of all employees who are newly hired for employment in the United States to perform work under this contract, through participation in the E-Verify Program or the Department program established pursuant to CRS §8-17.5-102(5)(c), Contractor shall not knowingly employ or contract with an illegal alien to perform work under this contract or enter into a contract with a subcontractor that fails to certify to Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this contract. Contractor **(a)** shall not use E-Verify Program or Department program procedures to undertake pre-employment screening of job applicants while this contract is being performed, **(b)** shall notify the subcontractor and the contracting State agency within three days if Contractor has actual knowledge that a subcontractor is employing or contracting with an illegal alien for work under this contract, **(c)** shall terminate the subcontract if a subcontractor does not stop employing or contracting with the illegal alien within three days of receiving the notice, and **(d)** shall comply with reasonable requests made in the course of an investigation, undertaken pursuant to CRS §8-17.5-102(5), by the Colorado Department of Labor and Employment. If Contractor participates in the Department program, Contractor shall deliver to the contracting State agency, Institution of Higher Education or political subdivision a written, notarized affirmation, affirming that Contractor has examined the legal work status of such employee, and shall comply with all of the other requirements of the Department program. If Contractor fails to comply with any requirement of this provision or CRS §8-17.5-101 et seq., the contracting State agency, institution of higher education or political subdivision may terminate this contract for breach and, if so terminated, Contractor shall be liable for damages.

12. PUBLIC CONTRACTS WITH NATURAL PERSONS. CRS §24-76.5-101. Contractor, if a natural person eighteen (18) years of age or older, hereby swears and affirms under penalty of perjury that he or she **(a)** is a citizen or otherwise lawfully present in the United States pursuant to federal law, **(b)** shall comply with the provisions of CRS §24-76.5-101 et seq., and **(c)** has produced one form of identification required by CRS §24-76.5-103 prior to the effective date of this contract.

Contract Routing Number xxxx-xxxx

THE PARTIES HERETO HAVE EXECUTED THIS CONTRACT

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

CONTRACTOR:

Legal Name of Contracting Entity

By: Signature of Authorized Officer

Printed Name of Authorized Officer

Printed Title of Authorized Officer

Date:

STATE OF COLORADO:
Bill Ritter, Jr., Governor

By:
Joan Henneberry, Executive Director
Department of Health Care Policy and Financing

Date:

LEGAL REVIEW:
John W. Suthers, Attorney General

By:

Date:

ALL CONTRACTS REQUIRE APPROVAL BY THE STATE CONTROLLER

CRS §24-30-202 requires the State Controller to approve all State Contracts. This Contract is not valid until signed and dated below by the State Controller or delegate. Contractor is not authorized to begin performance until such time. If Contractor begins performing prior thereto, the State of Colorado is not obligated to pay Contractor for such performance or for any goods and/or services provided hereunder.

STATE CONTROLLER:

David J. McDermott, CPA

By:

Date:

HIPAA BUSINESS ASSOCIATE ADDENDUM

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

RECITALS

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

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

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

The parties agree as follows:

1. Definitions.

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

b. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be

used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

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

2. Obligations of Associate.

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

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

c. Appropriate Safeguards. Associate shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information other than as permitted by this Contract. Associate shall comply with the requirements of the Security Rules, 164.308, 164.310, 164.312, and 164.316. Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate's operations and the nature and scope of its activities.

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

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

f. Access to Protected Information. Associate shall make Protected Information maintained by Associate or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) business days of a request by CE to enable CE to fulfill its obligations to permit individual access to PHI under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524.

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

h. Accounting Rights. Within ten (10) business days of notice by CE of a request for an accounting of disclosures of Protected Information, Associate and its agents or subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528. As set forth in, and as limited by, 45 C.F.R. Section 164.528, Associate shall not provide an accounting to CE of disclosures: (i) to carry out treatment, payment or health care operations, as set forth in 45 C.F.R. Section 164.506; (ii) to individuals of Protected Information about them as set forth in 45 C.F.R. Section 164.502; (iii) pursuant to an authorization as provided in 45 C.F.R. Section 164.508; (iv) to persons involved in the individual's care or other notification purposes as set forth in 45 C.F.R. Section 164.510; (v) for national security or intelligence purposes as set forth in 45 C.F.R. Section 164.512(k)(2); (vi) to correctional institutions or law enforcement officials as set fort in 45 C.F.R. Section 164.512(k)(5); (vii) incident to a use or disclosure otherwise permitted by the Privacy Rule; (viii) as part of a limited data set under 45 C.F.R. Section 164.514(e); or (ix) disclosures prior to April 14, 2003. Associate agrees to implement a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years prior to the

request, but not before the compliance date of the Privacy Rule. At a minimum, such information shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to Associate or its agents or subcontractors, Associate shall within five (5) business days of the receipt of the request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. Associate shall not disclose any Protected Information except as set forth in Section 2(b) of this Addendum.

i. Governmental Access to Records. Associate shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), in a time and manner designated by the Secretary, for purposes of determining CE's compliance with the Privacy Rule. Associate shall provide to CE a copy of any Protected Information that Associate provides to the Secretary concurrently with providing such Protected Information to the Secretary.

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

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

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

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

n. Notification of Breach. During the term of this Contract, Associate shall notify CE within two (2) business days of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Such notice shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed to

have been accessed, acquired or disclosed during the breach. Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

o. Audits, Inspections and Enforcement. Within ten (10) business days of a written request by CE, Associate and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Addendum for the purpose of determining whether Associate has complied with this Addendum; provided, however, that: (i) Associate and CE shall mutually agree in advance upon the scope, timing and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of Associate to which CE has access during the course of such inspection; and (iii) CE shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested by Associate. The fact that CE inspects, or fails to inspect, or has the right to inspect, Associate's facilities, systems, books, records, agreements, policies and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Contract.

p. Safeguards During Transmission. Associate shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of Protected Information transmitted to CE pursuant to the Contract, in accordance with the standards and requirements of the Privacy Rule, until such Protected Information is received by CE, and in accordance with any specifications set forth in Attachment A.

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

3. Obligations of CE.

a. Safeguards During Transmission. CE shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Associate pursuant to this Contract, in accordance with the standards and requirements of the Privacy Rule, until such PHI is received by Associate, and in accordance with any specifications set forth in Attachment A.

b. Notice of Changes. CE shall provide Associate with a copy of its notice of privacy practices produced in accordance with 45 C.F.R. Section 164.520, as well as any subsequent changes or limitation(s) to such notice, to the extent such changes or limitation(s)

may effect Associate's use or disclosure of Protected Information. CE shall provide Associate with any changes in, or revocation of, permission to use or disclose Protected Information, to the extent it may affect Associate's permitted use or disclosure of PHI, CE shall notify Associate of any restriction on the use or disclosure of Protected Information that CE has agreed to in accordance with 45 C.F.R. Section 164.522. CE may effectuate any and all such notices of non-private information via posting on CE's web site. Associate shall review CE's designated web site for notice of changes to CE's HIPAA privacy policies and practices on the last day of each calendar quarter.

4. Termination.

a. Material Breach. In addition to any other provisions in the Contract regarding breach, a breach by Associate of any provision of this Addendum, as determined by CE, shall constitute a material breach of this Contract and shall provide grounds for immediate termination of this Contract by CE pursuant to the provisions of the Contract covering termination for cause, if any. If the Contract contains no express provisions regarding termination for cause, the following terms and conditions shall apply:

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

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

(3) Compensation. Payment for completed supplies delivered and accepted by CE shall be at the Contract price. In the event of a material breach under paragraph 4(a), CE may withhold amounts due Associate as CE deems necessary to protect CE against loss from third party claims of improper use or disclosure and to reimburse CE for the excess costs incurred in procuring similar goods and services elsewhere.

(4) Erroneous Termination for Default. If after such termination it is determined, for any reason, that Associate was not in default, or that Associate's action/inaction was excusable, such termination shall be treated as a termination for the public interest, and the rights and obligations of the parties shall be the same as if this Contract had been terminated for the public interest, as described in this Contract.

b. Reasonable Steps to Cure Breach. If CE knows of a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum or another arrangement and does not terminate this Contract pursuant to Section 4(a), then CE shall take reasonable steps to cure such breach or end such violation, as applicable. If CE's efforts to cure such breach or end such violation are unsuccessful, CE shall either (i) terminate the Contract, if feasible or (ii) if termination of this

Contract is not feasible, CE shall report Associate's breach or violation to the Secretary of the Department of Health and Human Services.

c. Judicial or Administrative Proceedings. Either party may terminate the Contract, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

d. Effect of Termination.

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

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

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

6. No Waiver of Immunity. No term or condition of this Contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protection, or other provisions of the Colorado Governmental Immunity Act, CRS 24-10-100 *et seq*. or the Federal Tort Claims Act, 28 U.S.C. 2671 *et seq*. as applicable, as now in effect or hereafter amended.

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

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

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

10. Amendment.

a. Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of this Addendum may re required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the Privacy Rule, the Final HIPAA Security Regulations at 68 Fed. Reg. 8334 (Feb 20, 2003), 45 C.F.R. § 164.314 and other applicable laws relating to the security or privacy of PHI. The parties understand and agree that CE must receive satisfactory written assurance from Associate that Associate will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the Privacy Rule or other applicable laws. CE may terminate this Contract upon thirty (30) days written notice in the event (i) Associate does not promptly enter into negotiations to amend this Contract when requested by CE pursuant to this Section or (ii) Associate does not enter into an amendment to this Contract providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the Privacy Rule.

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

11. Assistance in Litigation or Administrative Proceedings. Associate shall make itself, and any subcontractors, employees or agents assisting Associate in the performance of its obligations under the Contract, available to CE, at no cost to CE, up to a maximum of thirty (30) hours, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of HIPAA, the Privacy Rule or other laws relating to security and privacy or PHI, except where Associate or its subcontractor, employee or agent is a named adverse party.

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

13. Interpretation and Order of Precedence. The provisions of this Addendum shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Addendum. Together, the Contract and This Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA and the Privacy Rule. The parties agree that

any ambiguity in this Contract shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the Privacy Rule. This Contract supersedes and replaces any previous separately executed HIPAA addendum between the parties.

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

15. Representatives and Notice.

a. Representatives. For the purpose of the Contract, the individuals identified elsewhere in this Contract shall be the representatives of the respective parties. If no representatives are identified in the Contract, the individuals listed below are hereby designated as the parties' respective representatives for purposes of this Contract. Either party may from time to time designate in writing new or substitute representatives.

b. Notices. All required notices shall be in writing and shall be hand delivered or given by certified or registered mail to the representatives at the addresses set forth below.

State/Covered Entity Representative:

Name:	Insert Name
Title:	Insert Title
Department:	Department of Health Care Policy and Financing
Address:	1570 Grant Street, Denver, CO 80203

Contractor/Business Associate Representative:

Name:	Insert Name
Title:	Insert Title
Company:	Insert Name of Company
Address:	Insert Address

ATTACHMENT A

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

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

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

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

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

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

6. Additional Terms. *Section may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signature of PHI, authentication, additional security or privacy specifications, de-identification/re-identification of data, etc.*:

Contract Routing No. _____

EXHIBIT A
STATEMENT OF WORK

Colorado Department of Health Care Policy and Financing

RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
For The Accountable Care Collaborative Program

Attachment F

RFP Signature Page

Final

STATE OF COLORADO
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR PROPOSALS
SIGNATURE PAGE

DATE:	August 20, 2010
RFP NUMBER:	HCPFKQ1102RCCO
DIRECT INQUIRIES TO:	Katherine Quinby
PHONE:	303-866-4940
E-MAIL:	katherine.quinby@state.co.us

DELIVER PROPOSAL TO:
Department of Health Care Policy and Financing
Contracts and Purchasing Section
1570 Grant Street
Denver, Colorado 80203-1818
RFP # HCPFKQ1102RCCO

DUE DATE/TIME: Friday, October 22, 2010 at 3:00 PM (MT)

Proposals properly marked as to OFFEROR'S NAME, RFP NUMBER, DUE DATE and TIME of opening, subject to the conditions of the RFP documents, will be accepted at the address listed above on or prior to the DUE DATE and TIME listed above. In the event that the DUE DATE and TIME are revised via an RFP Modification, the modified DUE DATE and TIME shall take precedence over the DUE DATE and TIME listed above. All proposals shall be quoted F.O.B. Destination, unless otherwise specified in the RFP documents, to the delivery location listed above.

REQUEST FOR PROPOSALS

NUMBER: **HCPFKQ1102RCCO**

TITLE: **REGIONAL CARE COLLABORATIVE ORGANIZATIONS FOR THE ACCOUNTALBE CARE COLLABORATIVE PROGRAM**

AGENCY: **DEPARTMENT OF HEALTH CARE POLICY AND FINANCING**

SEE ATTACHED PAGES FOR TERMS AND CONDITIONS AND PROPOSAL REQUIREMENTS.

IMPORTANT: Proposals submitted in response to the RFP **MUST** be accompanied by this "Signature Page".

Offerors should read the entire RFP document before submitting a proposal.
Offerors must be registered with Colorado BIDS by the proposal submission due date and time.

PROPOSALS MUST BE SIGNED IN INK

TYPED OR PRINTED SIGNATURE

Handwritten signature by Officer or Agent who is legally authorized to execute contractual obligations for Offeror.

TITLE

DATE

CONFIRMATIONS

____ **Confirm that you are aware that the award notice will be published on BIDS.**

____ **Confirm that your company is registered with Colorado BIDS.**

____ **State the number of Modifications you have obtained from the State's BIDS website.**

TERMS: _____
Payment terms of less than 30 calendar days will not be considered.

Pricing shall be effective for 180 days after due date.

FULL LEGAL NAME OF OFFEROR:

_____

_____

ADDRESS: _____

_____

_____

_____ **ZIP:** _____

PHONE: _____

FAX: _____

E-MAIL: _____

FEIN OR SSN: _____
Enter your FEIN or SSN as registered on Colorado BIDS

RETURN THIS PAGE WITH YOUR PROPOSAL

Colorado Department of Health Care Policy and Financing

Request for Proposals
RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
for the Accountable Care Collaborative Program

Attachment G

Medicaid and CHP+
Medical Homes for Children

Attachment G: Medicaid and CHP+ Medical Homes for Children

Background Information:

Senate Bill 07-130 (SB 07-130), Medical Homes for Children, defines a medical home as a qualified medical specialty, developmental, therapeutic, or mental health care practice that ensures access to and coordination of all medically-related services to a child. This allows any provider to be a medical home as long as they accept and fulfill the responsibility of assuring the child accesses preventative medical care from a physician or clinic, as well as the services of a dentist, based on the periodicity schedule set forth by the Department and the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program. The Department must verifiably ensure providers are meeting the Colorado Medical Home Standards.

Included in the bill are the following services:

- Health maintenance and preventive care;
- Health education;
- Acute and chronic illness care;
- Coordination of medications, specialists, and therapies;
- Provider participation in hospital care; and
- 24-hour telephone care.

In a medical home, the child or youth, his or her family, primary care physician, and/or other health professionals develop a trusting partnership based on mutual responsibility and respect for each other's expertise. Together, families, health care professionals and community service providers identify and access all medical and non-medical services needed to help the child and family. The goal of SB 07-130 is that all children enrolled in Medicaid and the Children's Basic Health Plan (CBHP) receives comprehensive health care in a medical home and are satisfied with the level of care given as well as feeling valued as a central part of the health care team.

The Department maintains strong, active partnerships with parents, youth, health care providers, health care strategists, advocates, managed care entities, other community stakeholders as well as the Colorado Department of Public Health and Environment (CDPHE). Colorado is recognized as a national leader in medical homes and presented this program to White House staff in September of 2009.

As of this date, 146,000 Medicaid children and 69,369 CBHP children - for a total of 216,000 - are attached to a medical home.

Medical Home Program for Medicaid Children:

Medical Home for children is an easier approach to QI/QA because it has more emphasis on patient and parent satisfaction rather than a chronic care model. It is based on the EPSDT wellness model as approximately 85% of children are well and only need a check up for preventative care. The other 15% may have chronic conditions that can benefit from medical case management or care coordination as provided to adults in the Patient Centered Medical Home model, but does not need to be provided in an EMR controlled and structured way. The model for children also focuses on the inclusion of the family in treatment and in the customer service focus of the practice, as most children come attached to a family of some sort. Certification is completed by using the Medical Home Index (McAllister and Cooley) rather than by NCQA standards. Certification comes with recognition and a pay for performance rate. The Pay for Performance rate is based on well care visit and cannot be earned for seeing a child only for sick care.

The Department works collaboratively with the Colorado Children's Healthcare Access Program (CCHAP) and Family Voices Colorado as active partners in the Medical Homes for Children Program.

CCHAP is a non-profit organization whose mission is to provide support services for children, families, and primary care practices to enable and encourage the practices to devote at least ten (10) percent of the practice to establishing a medical home for Medicaid and CHP+ children. The long-term goal is to develop a model that will increase the EPSDT participation rates in Colorado by enhancing support systems and reimbursement to primary care practices and facilitate a coordinated and integrated system of care. CCHAP currently provides 14 practice supports to providers and clinics as well as Quality Assurance assistance and practice transformation assistance. They also provide a practice managers support meeting every month as well as a monthly newsletter.

Family Voices Colorado (FVCo) represents the parent and families component of Medical Homes for Children and has been involved in the medical home process since 2000. FVCo also works with the Department to provide staffing for Medical Home Technical Assistance and provider recruitment and retention. Technical Assistance staff work directly with providers to complete the Medical Home Index (MHI). The MHI measures parent and family satisfaction with their provider as well as their feelings about culturally competency and being heard and valued by the provider or clinic.

In conjunction with the Department, CCHAP and FVCo provide a statewide provider helpline staffed by parents and professionals. This line is available to providers and clinic staff 8:00 a.m to 5:00 p.m., Monday through Friday, to help them locate any medical or non-medical assistance within their community, state or nationally. They also act as the first level of advocacy for patients having problems accessing services or working with private insurance companies.

Program Results

Overall, the evaluators found the children in the medical home practices had lower median reimbursed medical costs than non-Medical Home children in the Denver Metro area ($785 vs. $1,001, $p<0.0001$) and in El Paso County ($1,044 vs. $1,201, $p<0.001$).

The difference in median reimbursed medical costs was more pronounced between Medical Home and Non Medical Home children if the child also had a chronic condition (Denver Metro Area: $2,275 vs. $3,404, $p<0.0001$) and in El Paso County: ($1,044 vs. $2,988, $p<0.0001$).

The Department also saw an increase in the EPSDT program screening rates reported to The Centers for Medicare and Medicaid Services (CMS) on April 1 of each year. Due to the efforts in the Medical Homes for Children program, Colorado has increased the EPSDT Screening and Referral rates as follows:

Federal Fiscal Year	Screening Ratio	Total Eligibles Referred for Corrective Treatment	Total Eligibles Receiving Dental Services*
FFY 06/07	69%	188,135	121,642
FFY 07/08	71%	201,581	132,097
FFY 08/09	73%	249,023	161,394

*Colorado has 17 counties without a participating dental provider.

Also, by teaming with the Assuring Better Child Development (ABCD) program, the Department has been able to increase standardized developmental screenings by 7,000 percent since 2007. These screenings increased the appropriate referrals to Early Intervention Colorado (EI) services:

1. Between October 1, 2007 and March 31, 2008, 532 or twenty-one percent (21%) of the 2573 total referrals made to EI Colorado were from PCP's.
2. Between October 1, 2008 and March 31, 2009, 863 or twenty-nine percent (29%) of the 3005 total referrals to EI Colorado were from PCP's.
3. Of the overall increase in referrals, seventy-six percent (76%) can be attributed to referrals made by primary health care providers.
4. Sixty-five percent (65%) of the increases in PCP referrals were as a result of the ABCD training and technical assistance offered to communities.

Colorado has also included the need for medial homes within the Early Childhood Framework. By including this work in the framework documents, the medical home approach is disseminated at the local level through grant-funded projects aimed at children eligible for early childhood services.

Medical Home Program for Child Health Plan *Plus* Members:

CHP+ participating health plans are the foundation for medical home, as they possess the infrastructure to support the medical home model. In SFY 2009, each of the participating plans, as well as the State Managed Care Network, received funding in order to enhance their medical home infrastructures, and support the medical home framework in various communities.

Plans combined their efforts to perform provider needs assessments and trainings, as well as outreach to members to schedule appointments with medical home providers. Members who have not received annual and/or preventive visits are being tracked and sent notices reminding them to schedule these appointments.

Providers are encouraged to have open scheduling to accommodate same day appointments, and each plan is using some form of the "secret shopper" method to determine whether providers are fulfilling medical home standards.

Under direction from the Department, all participating CHP+ plans are providing incentive payments of up to $21 for primary care physicians and obstetric providers that are seeing members for annual well visits in the age ranges of 0-15 months and 12-17 years of age. These well-visits are a vital piece of medical home because they bring the member into a practice that is a medical home model. 12,626 Incentive visits have been reported and $210,078 in incentive payments have been made to providers for the July – December 2009 time period.

The participating plans are expect to continue provider medical home education and training around the eleven (11) medical home standards.

Conclusion:

No matter the terminology describing the medical home approach - Family Medical Home, Health Care Home, Primary Care Medical Home or Patient Centered Medical Home – Colorado keeps the family and patient at the center of the discussions.

The Department is encouraged by the potential savings to the state and the increased family-centered care of children who are eligible for a medical home. The apparent improved health care outcomes for a child linked to a medical home also demonstrate the potential for a fully implemented medical home model. The Department believes the components of SB 07-130 are resulting in more efficient operations, increased provider retention, improved access to health care services, and better quality outcomes for those served under Medicaid and CHP+. The Department truly believes that a Family Centered Medical Home is effective clinical care. The sum of public health coverage, the use of primary health services, and the follow up for medically necessary services and other non-medical services results in healthy child development and bodes well for the future of Colorado.

Guiding principles and standards for Medical Homes and the Colorado Framework can be found on the following pages.

GOALS

Children have high quality early learning supports and environments and comprehensive health care.

Families have meaningful community and parenting supports.

Early childhood professionals have the knowledge, skills, and supports to work effectively with and on behalf of families and children.

all children are valued, healthy, and thriving

outcomes

	EARLY LEARNING	FAMILY SUPPORT AND PARENT EDUCATION	SOCIAL, EMOTIONAL, AND MENTAL HEALTH	HEALTH
ACCESS OUTCOMES	• Increased availability of formal education and professional development opportunities for early childhood professionals related to early learning standards. • Increased access to high quality early learning, birth through third grade.	• Increased availability and family use of high quality parenting/child development information, services, and supports. • Increased parent engagement and leadership at program, community, and policy levels.	• Increased availability and use of high quality social, emotional, and mental health training and support. • Increased number of supportive and nurturing environments that promote children's healthy social and emotional development.	• Increased access to preventive oral and medical health care. • Increased number of children covered by consistent health insurance.
QUALITY OUTCOMES	• Increased number of children meeting developmental milestones to promote school readiness. • Increased number of programs that are accredited and/or quality rated. • Increased number of schools that have leadership and educational environments that support young children's success. • Increased availability of community resources and support networks for early childhood practitioners, professionals, and programs.	• Increased number of children who live in safe, stable, and supportive families. • Improved family and community knowledge and skills to support children's health and development. • Increased family ability to identify and select high quality early childhood services and supports.	• Increased number of environments, including early learning settings, providing early identification and mental health consultation. • Improved knowledge and practice of nurturing behaviors among families and early childhood professionals.	• Increased number of children who receive a Medical Home approach. • Increased number of children who are fully immunized. • Increased knowledge of the importance of health and wellness (including nutrition, physical activity, medical, oral, and mental health).
EQUITY OUTCOMES	• Increased number of children with special needs who receive consistent early learning services and supports. • Decreased gaps in school readiness and academic achievement between populations of children.	• Increased availability and use of family literacy services and supports. • Increased availability of resources and supports, including financial and legal, to promote family self-sufficiency. • Increased coordination of services and supports for families and children who are at-risk or have special needs.	• Increased number of mental health services for children with persistent, serious challenging behaviors. • Decreased number of out-of-home placements of children.	• Increased percentage of primary care physicians and dentists who accept Medicaid and Child Health Plan Plus. • Increased percentage of women giving birth with timely, appropriate prenatal care. • Decreased number of underinsured children.

STRATEGIES FOR ACTION

EARLY LEARNING	FAMILY SUPPORT AND PARENT EDUCATION	SOCIAL, EMOTIONAL, AND MENTAL HEALTH	HEALTH
• Develop and support use of early learning standards by families, programs, and professionals. • Evaluate and recognize high quality programs with a comprehensive rating and reimbursement system. • Develop, promote, and support high quality professional development and formal education for adults who work with young children. • Monitor children's learning and development through screening and on-going assessments. • Improve financial sustainability and governing efficiency of early learning programs and infrastructure.	• Strengthen coordinated efforts of public and private stakeholders to meet the needs of children and families. • Strengthen and support family leadership through effective training models. • Provide tools and information to families to strengthen their own engagement and involvement in their children's lives. • Provide information to families to facilitate connection to services and supports.	• Promote caregivers' knowledge of the social, emotional, and mental health of young children. • Provide early childhood professionals with effective practices that promote children's social-emotional development and mental health. • Strengthen and support community-based mental health services that identify and serve young children.	• Enroll more children in health insurance programs. • Promote and support use of standards for a Medical Home approach (including medical, oral, and mental health, as well as developmental, vision, and hearing screening and services). • Strengthen coordinated efforts of public and private stakeholders to support health and wellness.

FOUNDATIONS

Build and Support Partnerships | Fund and Invest | Change Policy | Build Public Engagement | Share Accountability | Generate Education and Leadership Opportunities

EARLY CHILDHOOD COLORADO PROVIDES A FRAMEWORK THAT:

- Recognizes the needs of the whole child and family.
- Communicates the vision for comprehensive early childhood work.
- Focuses on specific measurable outcomes.
- Guides, organizes, and focuses the actions and accountability of public and private stakeholders.

THIS WORK IS GUIDED BY THE FOLLOWING PRINCIPLES:

- Be child-focused and family-centered.
- Recognize and respond to variations in cultures, languages, and abilities.
- Use data to inform decisions.
- Build on strengths of communities and families.
- Focus on children from birth to age 8.
- Promote partnerships.
- Act at state, local, and statewide levels.

For more information contact Early.ChildhoodTeam@capitol.state.co.us.

COLORADO MEDICAL HOME STANDARDS

GUIDING PRINCIPLES AND ASSURANCES

A MEDICAL HOME IS A CONCEPT OF QUALITY HEALTH CARE.

5 GUIDING PRINCIPLES

1. THE STANDARDS ARE A FRAMEWORK FOR CONTINUOUS QUALITY IMPROVEMENT.
2. THE STANDARDS ARE MEANT TO DESCRIBE COLORADO'S GOALS FOR QUALITY HEALTH CARE FOR ALL CHILDREN, THEY ARE NOT MEANT TO BE PUNITIVE OR PRESCRIPTIVE.
3. THE STANDARDS, BASED ON THE NATIONAL COMPONENTS OF A MEDICAL HOME, WERE DEVELOPED IN COLLABORATION WITH MULTIPLE COLORADO STAKEHOLDERS, INCLUDING: PHYSICAL AND BEHAVIORAL HEALTH CARE PROVIDERS & PHYSICIANS, FAMILY MEMBERS, COMMUNITY ADVOCATES AND EVALUATORS, AND ARE ALIGNED WITH ESTABLISHED NATIONAL STANDARDS.
4. THE STANDARDS ARE A WAY TO ACKNOWLEDGE GOOD PRACTICE WHILE PROVIDING A SHARED VISION AND COMMON LANGUAGE FOR A QUALITY SYSTEM OF CARE FOR ALL CHILDREN IN COLORADO.
5. THE STANDARDS PROVIDE A MEANS FOR EVALUATION TO ESTABLISH STATE, PAYER, FAMILY, AND PRACTICE ACCOUNTABILITY.

5 ASSURANCES

1. THE COLORADO MEDICAL HOME INITIATIVE WILL CONTINUE TO PROVIDE A PLATFORM WHEREBY STAKEHOLDERS' INPUT IS ENCOURAGED, VALUED AND INCORPORATED.
2. PROVIDERS WHO CHOOSE TO BE ACKNOWLEDGED AS PROVIDING A MEDICAL HOME APPROACH WILL BE OFFERED RESOURCES AND SUPPORT.
3. THE TERM 'PROVIDER' IS INTENDED TO BE INCLUSIVE OF BEHAVIORAL, ORAL AND PHYSICAL HEALTH CARE PROVIDERS AND SPECIALISTS.
4. DEVELOPMENT AND REFINEMENT OF THESE STANDARDS IS ONLY THE *FIRST* STEP IN THE PROCESS OF IMPLEMENTATION.
5. MEDICAID PROVIDERS CAN CHOOSE TO BE ACKNOWLEDGED AS MEDICAL HOME PROVIDERS ON A VOLUNTARY BASIS.

The standards, guiding principles and assurances were developed in a joint effort by the Colorado Department of Public Health and Environment and the Colorado Department of Health Care Policy and Financing.

For more information, please contact:

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Colorado Department of Public Health and Environment

Colorado Department of Health Care Policy and Financing

COLORADO MEDICAL HOME STANDARDS

STANDARDS

Standard	Statutory Link*	Zoomerang Survey Response
1. Provides 24 hour 7 day access to a provider or trained triage service.	**Accessible Family Centered Comprehensive Culturally Competent Compassionate Coordinated Continuous Community based**	**89% of respondents agreed with this standard.**
2. Child/family has a personal provider or team familiar with their child's health history.	**Accessible Family Centered Culturally Competent Coordinated Continuous**	**96% of respondents agreed with this standard.**
3. Appointments are based on condition (acute, chronic, well or diagnostic) and provider can accommodate same day scheduling when needed.	**Accessible Family Centered Compassionate**	**96% of respondents agreed with this standard.**
4. A system is in place for children and families to obtain information and referrals about insurance, community resources, non-medical services, education and transition to adult providers.	**Family Centered Comprehensive Culturally Competent Compassionate Coordinated Continuous Community based**	**95% of respondents agreed with this standard.**
5. Provider and office staff communicates in a way that is family centered and encourages the family to be a partner in health care decision making.	**Accessible Family Centered Culturally Competent Compassionate**	**94% of respondents agreed with this standard.**
6. Provider and office staff demonstrate cultural competency.	**Accessible Family Centered Culturally Competent Compassionate Community based**	**89% of respondents agreed with this standard.**
7. The designated Medical Home takes the primary responsibility for care coordination.	**Family Centered Comprehensive Coordinated Continuous**	**92% of respondents agreed with this standard.**

COLORADO MEDICAL HOME STANDARDS

STANDARDS

Standard	Statutory Link*	Zoomerang Survey Response
8. Age appropriate preventive care and screening are provided or coordinated by the provider on a timely basis.	**Accessible Comprehensive Coordinated Continuous Community based**	**94% of respondents agreed with this standard.**
9. The designated Medical Home adopts and implements evidence-based diagnosis and treatment guidelines.	**Comprehensive Coordinated Continuous Community based**	**92% of respondents agreed with this standard.**
10. The child's medical records are up to date and comprehensive, and upon the family's authorization, records may be shared with other providers or agencies.	**Accessible Family Centered Comprehensive Coordinated Continuous Community based**	**96% of respondents agreed with this standard.**
11. The Medical Home has a continuous quality improvement plan that references Medical Home standards and elements.	**Accessible Family Centered Comprehensive Culturally Competent Compassionate Coordinated Continuous Community based**	**Recommended by the Evaluation Taskforce**

* Recommendations were developed based on the original medical home model as described by Carl Cooley, MD as well as the statutory language found in C.R.S. 25.5-1-103. Colorado Revised Statute requires that a medical home to "verifiably ensures continuous, accessible, and comprehensive access to and coordination of community based medical care, oral health care and related services for a child…All medical homes shall ensure the following: health maintenance and preventive care; anticipatory guidance and health education; acute and chronic illness care; coordination of medications, specialists, and therapies; provider participation in hospital care; and twenty-four hour telephone care."

Standard	Accessible	Family Centered	Comprehensive	Culturally Competent	Compassionate	Coordinated	Continuous	Community Based
1. 24 hour 7 day access to a provider or trained triage service.	X	X	X	X	X	X	X	X
2. Child/family has a personal provider or team familiar with their child's health history.	X	X		X		X	X	
3. Appointments are based on condition (acute, chronic, well or diagnostic) and provider can accommodate same day scheduling when needed.	X	X			X			
4. A system is in place for families to obtain information and referrals about insurance, community resources, non medical services, education and transition to adult providers.		X	X	X	X	X	X	X
5. Provider and office staff communicates in a way that is family centered and encourages the family to be a partner in health care decision making.		X		X	X			
6. Provider and office staff demonstrate cultural competency	X	X		X	X			X
7. The Medical Home takes the primary responsibility for care coordination.		X	X			X	X	
8. Age appropriate preventive care and screening are provided or coordinated by the provider on a timely basis.			X			X	X	X
9. The designated Medical Home adopts and implements evidence-based diagnosis and treatment guidelines.			X			X		
10. The child's medical records are up to date and comprehensive, and upon the family's authorization, records may be shared with other providers or agencies.	X	X	X			X	X	X
11. A Medical Home has a continuous quality improvement plan that references Medical Home standards and elements.	X	X	X	X	X	X	X	X

Colorado Department of Health Care Policy and Financing

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Regional Care Collaborative Organizations
for the Accountable Care Collaborative Program

Attachment H

PCMP Requirements

Final

Attachment H: PCMP Requirements

In order to enter into a written agreement as a Primary Care Medical Provider (PCMP) in the Accountable Care Collaborative (ACC) Program, the Regional Care Collaborative Organization (RCCO) shall ensure that the following criteria are met:

A PCMP Practice shall:

1. Be an enrolled Colorado Medicaid provider.

2. Be either:
   a. Certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program, **or**
   b. An FQHC, RHC, clinic, or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

3. Act as the dedicated source of primary care for Members and be capable of delivering the majority of the Members' comprehensive primary, preventive, and sick medical care.

4. Be committed to the following principles of the Medical Home model:
   a. The care provided is:
      i. Member/family-centered;
      ii. Whole-person oriented and comprehensive;
      iii. Coordinated and integrated;
      iv. Provided in partnership with the Member and promotes Member self-management;
      v. Outcomes-focused;
      vi. Consistently provided by the same provider as often as possible so a trusting relationship can develop; and
      vii. Provided in a culturally competent and linguistically sensitive manner.

   b. The PCMP Practice is:
      i. Accessible, aiming to meet high access-to-care standards such as:
         (1) 24/7 phone coverage with access to a clinician that can triage;
         (2) Extended daytime and weekend hours;
         (3) Appointment scheduling within 48 hours for urgent care, 10 days for symptomatic, non-urgent care and 45 days for non-symptomatic routine care; and
         (4) Short waiting times in reception area.

ii. Committed to operational and fiscal efficiency.

iii. Able and willing to coordinate with the RCCO on medical management, care coordination, and case management of Members.

iii. Committed to initiating and tracking continuous performance and process improvement activities, such as improving tracking and follow-up on diagnostic tests, improving care transitions, and improving care coordination with specialists and other Medicaid providers, etc.

iv. Willing to use proven practice and process improvement tools (assessments, visit agendas, screenings, Member self-management tools and plans, etc.).

v. Willing to spend the time to teach Members about their health conditions and the appropriate use of the health care system as well as inspire confidence and empowerment in Members' health care ownership.

vi. Focused on fostering a culture of constant improvement and continuous learning.

vii. Willing to accept accountability for outcomes and the Member/family experience.

viii. Able to give Members and designated family members easy access to their medical records when requested.

iv. Committed to working as a partner with the RCCO in providing the highest level of care to Members. This commitment includes data-sharing, access to medical records when requested, cooperation on referrals, participation in performance improvement activities and initiatives, willingness to give feedback and potentially participate on committees and provide clinical expertise, and use the data available to the practice to better manage Members and their health needs.

Each individual PCMP or Pod shall:

1. Be an enrolled Colorado Medicaid provider.

2. Be either:
   a. Certified by the Department as a provider in the Medicaid and CHP+ Medical Homes for Children program, **or**
   b. An individual physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

3. Act as the dedicated primary care provider for Members and be capable of delivering the majority of the Members' comprehensive primary, preventive, and sick medical care.

4. Be committed to the principles of the Medical Home model described in Item #4 above.

Colorado Department of Health Care Policy and Financing

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Attachment I

Eligibility Groups and Regional Caseload Overview

Final

Attachment I: Eligibility Groups and Regional Caseload Overview (report as of 6/30/2010)

Eligibility Group	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Total
OAP-A: Individuals age 65 and over who are eligible for Old Age Pension cash state supplement.	5,285	3,049	8,399	5,859	7,854	5,235	3,219	**38,900**
OAP-B-SSI: Individuals age 60 to 64 who are eligible for SSI and Old Age Pension cash state supplement.	1,047	512	1,156	1,371	1,542	926	772	**7,326**
AND/AB-SSI: Disabled adult children; disabled widow/ers; former SSI recipients; those in long-term care; those eligible to receive Home and Community-Based Services.	7,341	3,499	10,577	9,043	9,257	7,133	7,643	**54,493**
AFDC/CWP Adults: Medical assistance provided to families.	14,134	7,123	20,556	12,278	15,348	10,560	13,214	**93,213**
AFDC/CWP Children: Medical assistance provided to families.	23,935	13,697	41,153	19,866	35,028	18,408	21,639	**173,726**
Foster Care	2,618	1,516	4,360	1,983	2,696	2,450	3,055	**18,678**
BC Women: Qualified pregnant women.	1,367	634	1,770	817	829	886	1,045	**7,348**
BC Children: Infants born to mothers on Medicaid at the time of birth.	17,327	9,997	32,175	10,435	16,374	12,109	13,632	**112,049**
Non-Citizens (Emergency Medicaid)	532	234	1,116	77	938	327	298	**3,522**

Eligibility Group	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Total
QMB: Individuals who have income at or below the percentage of federal poverty level for the family size as mandated by federal regulations. Individual must also be eligible for Medicare Part A.	1,844	816	1,820	1,775	2,398	1,348	1,067	**11,068**
SLMB: Individuals who have income between 100-120% of the federal poverty level who are entitled to Medicare Part A.	960	405	890	882	1,054	707	529	**5,427**
Total for All Eligibility Groups	**76,390**	**41,482**	**123,972**	**64,386**	**93,318**	**60,089**	**66,113**	**525,750**

The eligibility group "BCCP-Women Breast and Cervical Cancer" is not reported due to the low numbers of clients in every region. As of the end of the reporting month, the total client count for this eligibility group is 466.

Source: Colorado Medicaid MMIS data warehouse, the source of official Health Care Policy and Financing caseload numbers.

Colorado Department of Health Care Policy and Financing

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Regional Care Collaborative Organizations
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Attachment J

Provider Types

Final

Attachment J: Provider Types

Value Code	Code Description
	NO DATA
01	GENERAL HOSPITAL
02	MENTAL HOSPITAL
04	DENTIST
05	PHYSICIAN
06	PODIATRIST
07	OPTOMETRIST
08	OPTICIAN
09	PHARMACY
10	HOME HEALTH
11	CASE MANAGER
12	INDEPENDENT LABORATORY
13	AMBULANCE
14	SUPPLY
16	CLINIC
17	PHYSICAL THERAPIST
18	QMB BENEFITS ONLY
19	AUDIOLOGIST
20	SKILLED NURSING
21	INTERMEDIATE NURSING
22	NURSE MID-WIFE
23	HMO
24	NON-PHYSICIAN PRACTITIONER
25	NON-PHYSICIAN PRACTITIONER GRP
26	OSTEOPATH
27	SPEECH THERAPIST
28	OCCUPATIONAL THERAPIST
29	FAMILY PLANNING
30	PSYCHIATRIC RES TREATMENT FAC
31	MENTL HLTH ASSESS AND SVC AGCY
32	FEDLLY QUALIFIED HEALTH CENTER
33	DIALYSIS CENTER
34	HCBS-EBD/BI/MI/CWA/PWA
35	COMMUNITY MNTL HLTH CENTER
36	HCBS-DD HCBS-CHRP
37	PSYCHOLOGIST
38	MA PSYCHOLOGIST
39	PHYSICIAN ASSISTANT

Value Code	Code Description
40	CRNA
41	FAMILY/PEDIATRIC NURSE PRACT
44	AMBULATORY SURGICAL CENTER
45	RURAL HEALTH CLINIC
46	DEVELOPMENT EVALUATION CLINIC
47	DENTAL CLINIC
48	REHABILITAYION AGENCY
49	X-RAY FACILITY
50	HOSPICE
51	SCHOOL BASED CLINIC-DISTRICT
52	THERAPEUTIC RES CHILD CARE FAC
53	BILLING AGENT
54	NURSING FACI OXYGEN SUPPLIER
55	MEDICARE BUY IN
56	HEALTH INSURANCE BUY IN

Colorado Department of Health Care Policy and Financing

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Regional Care Collaborative Organizations
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Attachment K

Regional Overview of Selected Provider Types

Final

Attachment K: Regional Overview of Selected Provider Types

Medicaid Physicians by Primary Care Specialty Status & Federally Qualified Health Centers / Rural Health Centers

Physicians in this table are categorized as follows:

1. Primary Care Physician Specialty includes physicians identified with any of the following specialties: Family Practice, General Practice, Internal Medicine, Obstetrics and/or Gynecology, Pediatrics, and Geriatrics
2. Physicians without a d esignated specialty may or may not be primary care physicians
3. Physicians with a specialty not included in the primary care physician specialty list are considered non-PCPs

RCCO Region	Total Physicians & FQHCs/RHCs	Primary Care Physician Specialty	Specialty Not Available	Non-Primary Care Physicians	FQHCs/RHCs
Region 1	1852	773	404	658	17
Region 2	450	195	82	153	20
Region 3	2155	820	667	660	8
Region 4	724	274	173	252	25
Region 5	3740	1594	725	1392	29
Region 6	1687	755	347	575	10
Region 7	1020	387	220	411	2
Total	11628	4798	2618	4101	111

Source: Department of Health Care Policy & Financing Data Warehouse, Provider and Provider Specialty Tables; 8/5/2010
Provider Types 05 (Physician), 32 (Federally Qualified Health Center), and 45 (Rural Health Center)
Enrollment Status Codes 60 (Active), 61 (Active Reinstated), and 62 (Active Do Not Pay)
PCP Specialties: Family Practice (77), General Practice (01), Internal Medicine (15), Obstetrics and/or Gynecology (53, 46, 47), Pediatrics (16), and Geriatrics (43)

Medicaid Physicians by Primary Care Specialty Status
& Federally Qualified Health Centers / Rural Health Centers
By RCCO Region and County

RCCO Region	County	Total Physicians & FQHCs/RHCs	Primary Care Physician Specialty	Specialty Not Available	Non-Primary Care Physicians	FQHCs/RHCs
Region 1		**1,852**	**773**	**404**	**658**	**17**
	ARCHULETA	14	9	4	1	
	DELTA	59	29	19	10	1
	DOLORES	1				1
	EAGLE	90	37	24	29	
	GARFIELD	111	49	30	30	2
	GRAND	13	7	6		
	GUNNISON	18	10	4	4	
	HINSDALE	2	1			1
	JACKSON	3		1	1	1
	LA PLATA	180	72	26	81	1
	LARIMER	595	260	114	219	2
	MESA	380	130	86	164	
	MOFFAT	16	6	2	7	1
	MONTEZUMA	51	20	12	16	3
	MONTROSE	86	30	20	35	1
	OURAY	5	3	2		
	PITKIN	41	14	7	20	
	RIO BLANCO	9	7	1		1
	ROUTT	54	25	12	17	
	SAN JUAN	68	35	22	11	
	SAN MIGUEL	13	6	1	4	2
	SUMMIT	43	23	11	9	
Region 2		**450**	**195**	**82**	**153**	**20**
	CHEYENNE	3	2			1
	KIT CARSON	10	5	2		3
	LINCOLN	9	4	2	1	2
	LOGAN	41	18	9	12	2
	MORGAN	49	24	8	13	4
	PHILLIPS	8	6	1		1
	SEDGWICK	4	2	1		1
	WASHINGTON	2	1			1
	WELD	309	127	53	125	4
	YUMA	15	6	6	2	1
Region 3		**2,155**	**820**	**667**	**660**	**8**
	ADAMS	752	252	331	164	5
	ARAPAHOE	1212	478	276	455	3
	DOUGLAS	191	90	60	41	

RCCO Region	County	Total Physicians & FQHCs/RHCs	Primary Care Physician Specialty	Specialty Not Available	Non-Primary Care Physicians	FQHCs/RHCs
Region 4		**724**	**274**	**173**	**252**	**25**
	ALAMOSA	71	21	24	25	1
	BACA	8	1	2	3	2
	BENT	2	1			1
	CHAFFEE	32	17	3	10	2
	CONEJOS	12	6	5		1
	CROWLEY	1				1
	CUSTER	3	1		1	1
	FREMONT	55	23	14	12	6
	HUERFANO	11	6	2	3	
	KIOWA	1				1
	LAKE	4	2	1	1	
	LAS ANIMAS	27	12	8	5	2
	MINERAL	1	1			
	OTERO	29	12	7	9	1
	PROWERS	50	12	19	15	4
	PUEBLO	401	153	82	165	1
	RIO GRANDE	13	6	4	2	1
	SAGUACHE	3		2	1	
Region 5		**3740**	**1594**	**725**	**1392**	**29**
	DENVER	3740	1594	725	1392	29
Region 6		**1687**	**755**	**347**	**575**	**10**
	BOULDER	791	363	158	267	3
	BROOMFIELD	30	21	5	4	
	CLEAR CREEK	2	2			
	GILPIN	2	1			1
	JEFFERSON	862	368	184	304	6
Region 7		**1020**	**387**	**220**	**411**	**2**
	EL PASO	1005	378	217	408	2
	ELBERT	1	1			
	PARK	4	1		3	
	TELLER	10	7	3		

Source: Department of Health Care Policy & Financing Data Warehouse, Provider and Provider Specialty Tables; 8/5/2010
Provider Types 05 (Physician), 32 (Federally Qualified Health Center), and 45 (Rural Health Center)
Enrollment Status Codes 60 (Active), 61 (Active Reinstated), and 62 (Active Do Not Pay)
PCP Specialties: Family Practice (77), General Practice (01), Internal Medicine (15), Obstetrics and/or Gynecology (53, 46, 47), Pediatrics (16), and Geriatrics (43)

Federally Qualified Health Centers & Rural Health Centers by RCCO Region and County

RCCO Region	County	Provider Name
Region 1		
	DELTA	SURFACE CREEK FAMILY PRACT
	DOLORES	COMMUNITY HEALTH CLINIC
	GARFIELD	BATTLEMENT MESA MEDICAL CENTER
	GARFIELD	GRAND RIVER PRIMARY CARE
	HINSDALE	LAKE CITY AREA MEDICAL CENTER
	JACKSON	NORTH PARK MEDICAL CLINIC, INC
	LA PLATA	SOUTHERN COLORADO UTE SERVICE UNIT
	LARIMER	PLAN DE SALUD DEL VALLE
	LARIMER	SALUD FAMILY HEALTH CENTERS
	MOFFAT	NORTHWEST COLORADO COMMUNITY HEALTH
	MONTEZUMA	DOLORES MEDICAL CENTER DC
	MONTEZUMA	SOUTHERN CO UTE SERVICE
	MONTEZUMA	SOUTHWEST MEMORIAL PRIMARY CARE
	MONTROSE	OLATHE MEDICAL CENTER
	RIO BLANCO	MEEKER FAMILY HEALTH CENTER
	SAN MIGUEL	TMC PRIMARY CARE
	SAN MIGUEL	UNCOMPAHGRE COMBINED CLINIC
Region 2		
	CHEYENNE	PRAIRIE VIEW RHC
	KIT CARSON	PARKE HEALTH CENTER
	KIT CARSON	PLAINS MEDICAL CENTER
	KIT CARSON	STRATTON MEDICAL CLINIC
	LINCOLN	PLAINS MEDICAL CENTER
	LOGAN	FAMILY CARE CLINIC
	LOGAN	SALUD FAMILY HEALTH CENTERS
	MORGAN	BRUSH FAMILY MEDICINE
	MORGAN	COLORADO PLAINS CLINIC WIGGINS
	MORGAN	FORT MORGAN PEDIATRIC CLINIC PC
	MORGAN	PLAN DE SALUD DEL VALLE
	PHILLIPS	FAMILY PRACTICE OF HOLYOKE
	SEDGWICK	SEDGWICK COUNTY MEM HOSP
	WASHINGTON	WASHINGTON COUNTY CLINIC
	WELD	PLAN DE SALUD DEL VALLE
	WELD	SALUD FAMILY HEALTH CENTERS
	WELD	SUNRISE COMM HEALTH CNTR
	YUMA	YUMA CLINIC

RCCO Region	County	Provider Name
Region 3		
	ADAMS	CLINICA CAMPESINA
	ADAMS	CLINICA CAMPESINA FAMILY HEALTH
	ADAMS	METRO COMMUNITY PROVIDER NETWORK IN
	ADAMS	PLAINS MEDICAL CENTER
	ADAMS	PLAN DE SALUD DEL VALLE
	ARAPAHOE	METRO COMMUNITY PROV NETWORK INC
	ARAPAHOE	METRO COMMUNITY PROVIDER NETWORK IN
Region 4		
	ALAMOSA	VALLEY WIDE HEALTH SYSTEMS INC
	BACA	SOUTHEAST COLORADO PHYSICIANS CLINI
	BACA	WALSH MEDICAL CLINIC
	BENT	BENT COUNTY PUBLIC HEALTH
	CHAFFEE	BUENA VISTA FAMILY PRACTICE
	CHAFFEE	MOUNTAIN MED CNTR OF BUENA
	CONEJOS	CONEJOS COUNTY HOSPITAL CORPORATION
	CROWLEY	CENTENNIAL FAMILY HEALTH CTR LLC
	CUSTER	CUSTER COUNTY MEDICAL CLIN
	FREMONT	BUTTON FAMILY PRACTICE PC
	FREMONT	FLORENCE MEDICAL CENTER, LLC
	FREMONT	HAVENS FAMILY CLINIC
	FREMONT	PEDIATRIC ASSOCIATION OF CANON CTY
	FREMONT	RIVER VALLEY PEDIATRICS
	FREMONT	SABATINI PEDIATRICS PC
	KIOWA	EADS MEDICAL CLINIC
	LAS ANIMAS	MT SAN RAFAEL HOSPITAL CLINIC
	LAS ANIMAS	TRINIDAD FAMILY MEDICAL CENTER
	OTERO	ROCKY FORD FAMILY HEALTH CTR LLC
	PROWERS	HIGH PLAINS COMM HLTH CNTR
	PROWERS	PROWERS MEDICAL GROUP CONVENIENT CA
	PROWERS	PROWERS MEDICAL GROUP HOLLY MEDICAL
	PROWERS	PROWERS MEDICAL GROUP LAMAR MEDICAL
	PUEBLO	PUEBLO COMMUNITY HLTH CNTR
	RIO GRANDE	RIO GRANDE HOSPITAL CLINIC

RCCO Region	County	Provider Name
Region 5		
	DENVER	DENVER HEALTH & HOSP AUTH
	DENVER	DENVER HEALTH DENTAL CLINIC
	DENVER	DENVER HEALTH WOMENS MOBILE SERVICE
	DENVER	DENVER INDIAN HLTH & FAMIL
	DENVER	DENVER SCHOOL BASED HEALTH CENTERS
	DENVER	DEPT OF HLTH & HOSP-LOWRY
	DENVER	DSBHC - KEPNER MIDDLE SCHOOL
	DENVER	DSBHC - KUNSMILLER COMMUNITY SCHOOL
	DENVER	DSBHC - SOUTH HIGH SCHOOL
	DENVER	DSBHC BRUCE RANDOLPH MIDDLE SCHOOL
	DENVER	EASTSIDE DENTAL NEIGHBORHOOD HLTH P
	DENVER	EASTSIDE FHC
	DENVER	FORD ELEMENTARY SCHOOL
	DENVER	JFK HIGH SCHOOL
	DENVER	LA CASA DE SALUD HLTH STAT
	DENVER	LA MARIPOSA FHC
	DENVER	LINCOLN HIGH SCHOOL
	DENVER	MANUAL HIGH SCHOOL
	DENVER	MARTIN LUTHER KING JR MIDDLE SCHOOL
	DENVER	MONTBELLO HEALTH CENTER
	DENVER	MONTBELLO HIGH SCHOOL
	DENVER	NORTH HIGH SCHOOL
	DENVER	PARK HILL FHC
	DENVER	SAM SANDOS WESTSIDE FHC
	DENVER	STOUT STREET CLINIC
	DENVER	VALDEZ ELEMENTARY SCHOOL
	DENVER	WESTSIDE DENTAL NEIGHBORHOOD HLTH
	DENVER	WESTWOOD FHC
Region 6		
	BOULDER	CLINICA CAMPESINA
	BOULDER	PEOPLES CLINIC
	BOULDER	SALUD FAMILY HEALTH CENTERS
	GILPIN	COLUMBINE FAMILY HEALTH CENTER
	JEFFERSON	METRO COMMUNITY PROV NETWORK INC
	JEFFERSON	METRO COMMUNITY PROVIDER NETWORK IN
Region 7		
	EL PASO	EASTERN PLAINS MEDICAL CLINIC
	EL PASO	PEAK VISTA COMMUNITY HEALTH CENTERS

Source: Department of Health Care Policy & Financing Data Warehouse, Provider Table; 8/5/2010
Provider Types 32 (Federally Qualified Health Center) and 45 (Rural Health Center)
Enrollment Status Codes 60 (Active), 61 (Active Reinstated), and 62 (Active Do Not Pay)

Colorado Department of Health Care Policy and Financing

Request for Proposals
RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
for the Accountable Care Collaborative Program

Attachment L

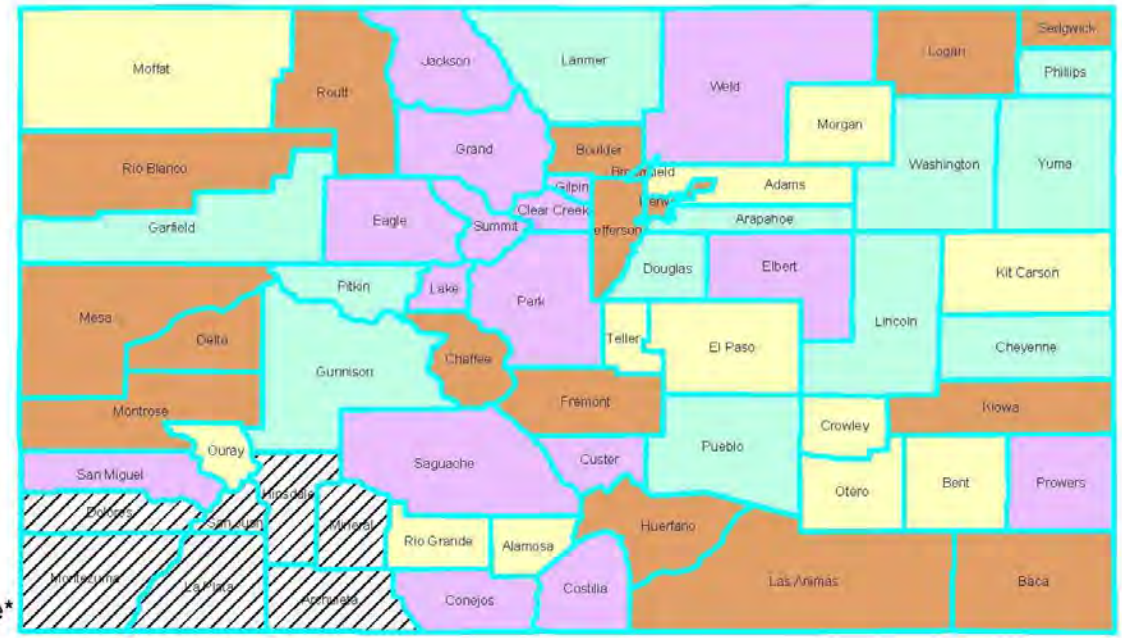
Utilization and Cost Variance Maps

County Name	FTE by County FY 2008-2009	County Population as of July 2008
ADAMS	44,624	434,762
ALAMOSA	2,981	15,903
ARAPAHOE	40,884	562,009
ARCHULETA	7	12,704
BACA	493	4,154
BENT	925	6,163
BOULDER	14,477	298,685
BROOMFIELD	1,971	54,796
CHAFFEE	1,040	17,143
CHEYENNE	160	1,999
CLEAR CREEK	433	9,438
CONEJOS	1,641	8,382
COSTILLA	743	3,501
CROWLEY	633	6,246
CUSTER	272	4,123
DELTA	1,736	31,600
DENVER	42,433	611,509
DOLORES	6	2,014
DOUGLAS	5,568	283,951
EAGLE	1,908	54,044
EL PASO	48,775	597,249
ELBERT	930	23,296
FREMONT	4,890	48,034
GARFIELD	3,659	57,050
GILPIN	234	5,191
GRAND	560	14,620
GUNNISON	652	15,259
HINSDALE	30	866
HUERFANO	1,232	8,079
JACKSON	111	1,440
JEFFERSON	27,968	543,053
KIOWA	105	1,449

County Name	FTE by County FY 2008-2009	County Population as of July 2008
KIT CARSON	756	8,383
LA PLATA	20	50,735
LAKE	646	8,353
LARIMER	18,076	293,937
LAS ANIMAS	2,265	16,639
LINCOLN	544	5,668
LOGAN	2,035	21,705
MESA	5,422	144,440
MINERAL	38	988
MOFFAT	1,138	14,174
MONTEZUMA	30	25,713
MONTROSE	1,714	41,302
MORGAN	3,277	28,594
OTERO	3,635	19,055
OURAY	66	4,703
PARK	765	17,073
PHILLIPS	412	4,595
PITKIN	160	17,101
PROWERS	2,341	13,397
PUEBLO	26,834	157,389
RIO BLANCO	236	6,564
RIO GRANDE	2,273	12,608
ROUTT	668	23,738
SAGUACHE	926	7,080
SAN JUAN	49	567
SAN MIGUEL	156	7,771
SEDGWICK	261	2,542
SUMMIT	939	29,143
TELLER	1,347	22,765
WASHINGTON	352	4,736
WELD	23,792	251,220
YUMA	1,026	10,000

FY 08-09 Total Medicaid Dollars per 1,000 FTE clients

Range: $2,358,121 - $16,885,097
Median: $6,103,417



Legend

Colorado Counties

- Volume too low to include*

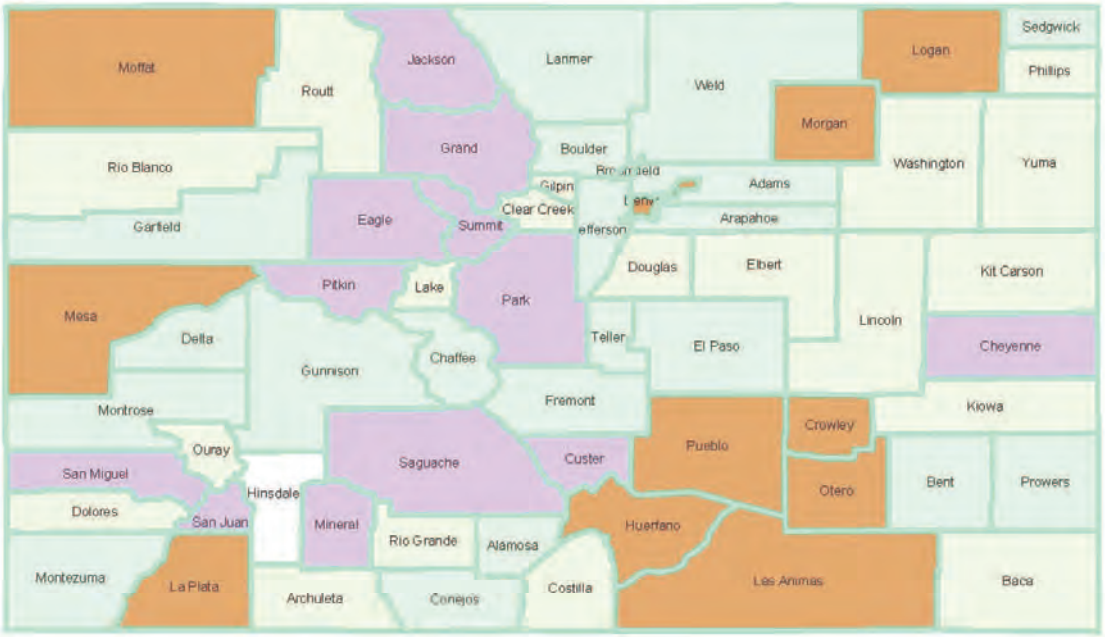
Category

- under $5,000,000
- $5,000,000 - $5,999,999
- $6,000,000 - $6,999,999
- $7,000,000 - $17,000,000

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 ER visits per 1,000 FTE clients

Range: 1,182 - 343
Median: 731



Legend

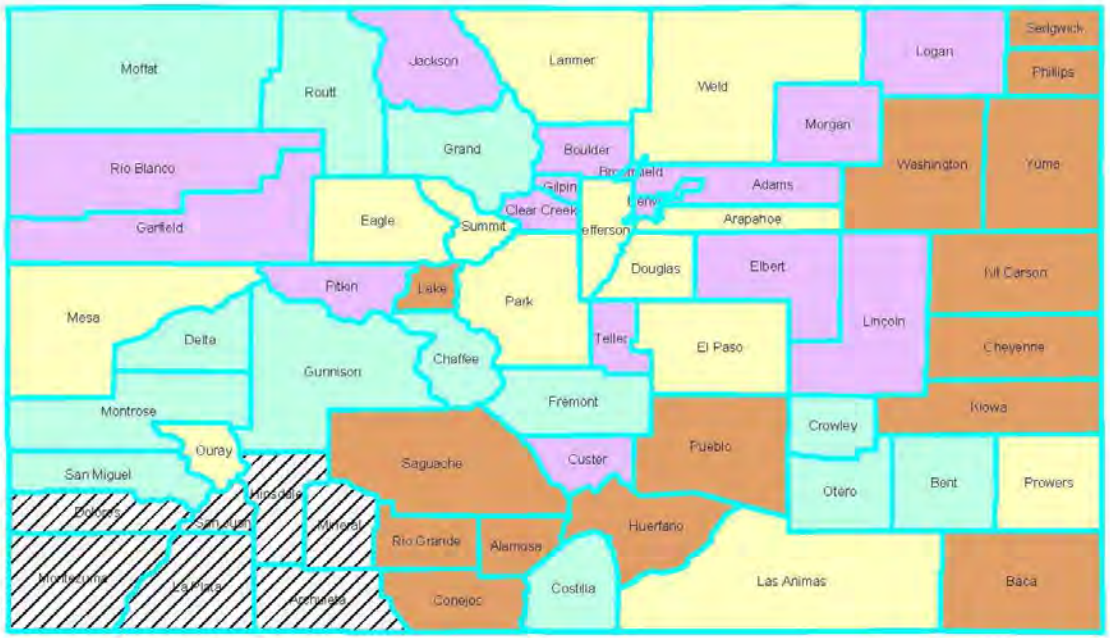
Colorado Counties

Category

- under 343
- 343 - 536
- 537 - 731
- 732 - 955
- 956 - 1182

FY 08-09 Office Visits per 1,000 FTE clients

Range: 1,468 - 7,825
Median: 3,748



Legend

Colorado Counties

Volume too low to include*

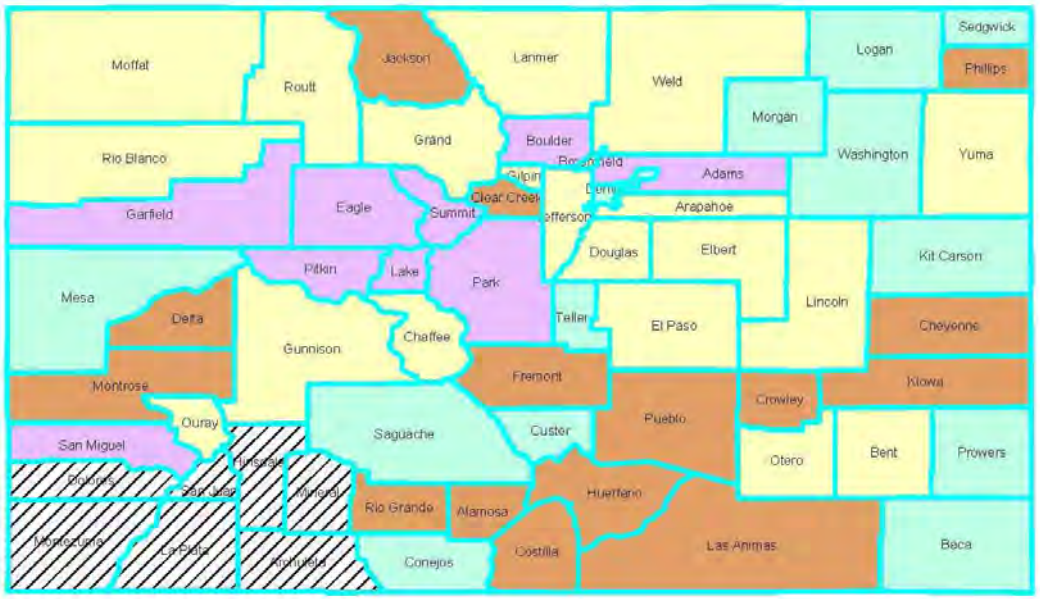
Category

- under 3300
- 3300-3748
- 3749-4499
- 4500-7825

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 CAT scans per 1,000 FTE clients

Range: 159 - 763
Median: 487



Legend

Colorado Counties

- Volume too low to include *

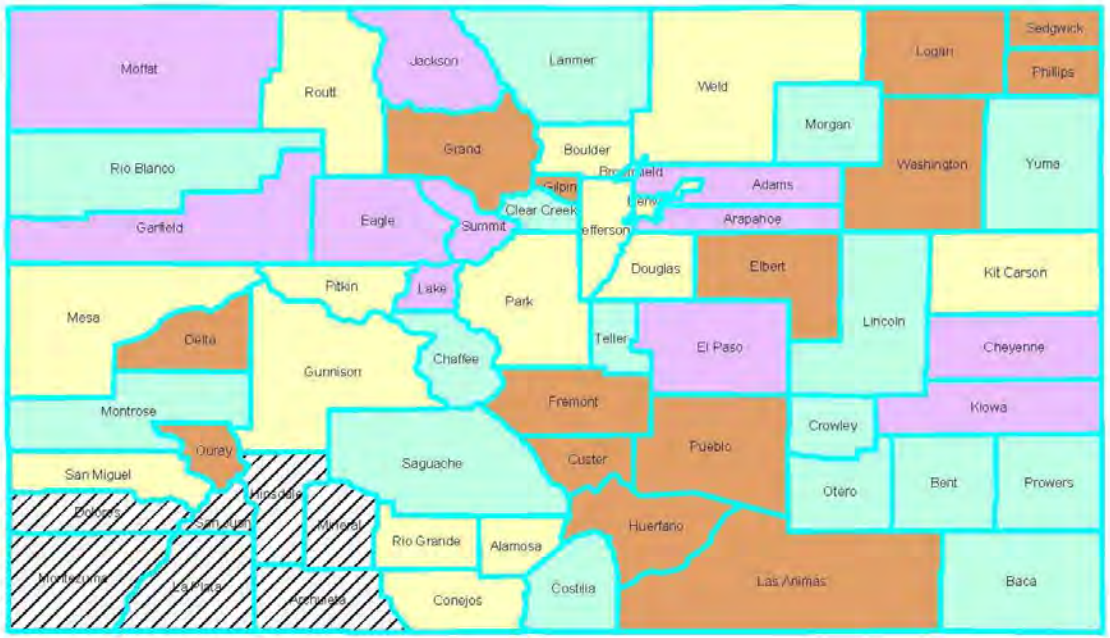
Category

- under 400
- 400 - 487
- 488 - 629
- 630 - 763

*Refers to counties which either have two few clients or too few services for comparison

FY 08-09 MRI scans per 1,000 FTE clients

Range: 24- 193
Median: 103



Legend

Colorado Counties

Volume too low to include*

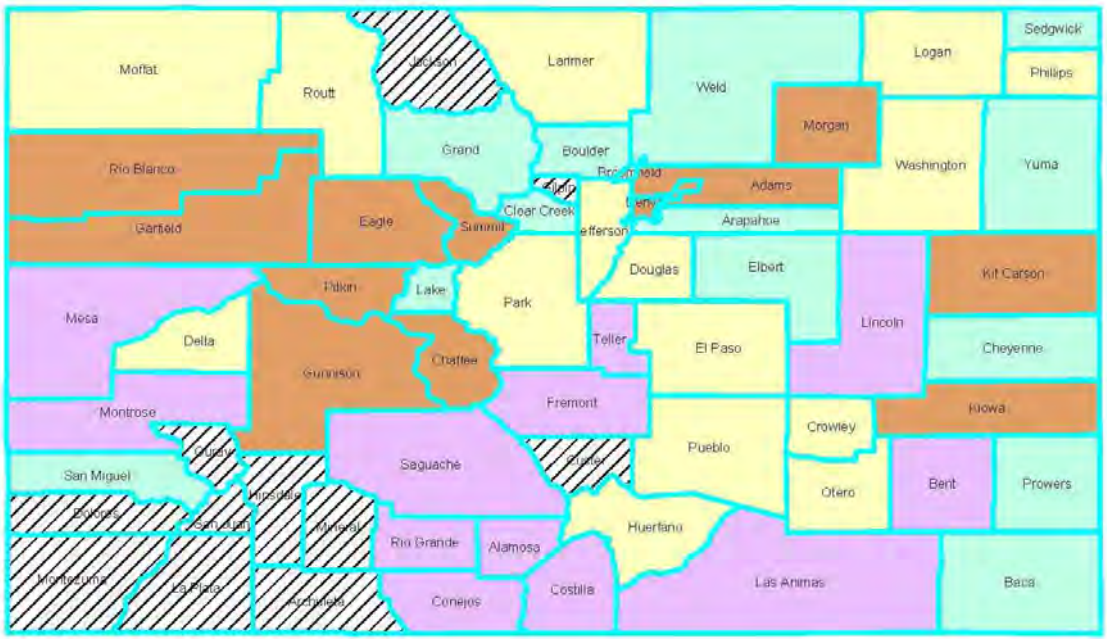
Category

- under 80
- 80 -102
- 103 -119
- 120 -193

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 Complicated Cesarean sections per 1,000 FTE clients
Females ages 14 to 45

Range: 3 - 81
Median: 27



Legend

Colorado Counties

Volume to low to include*

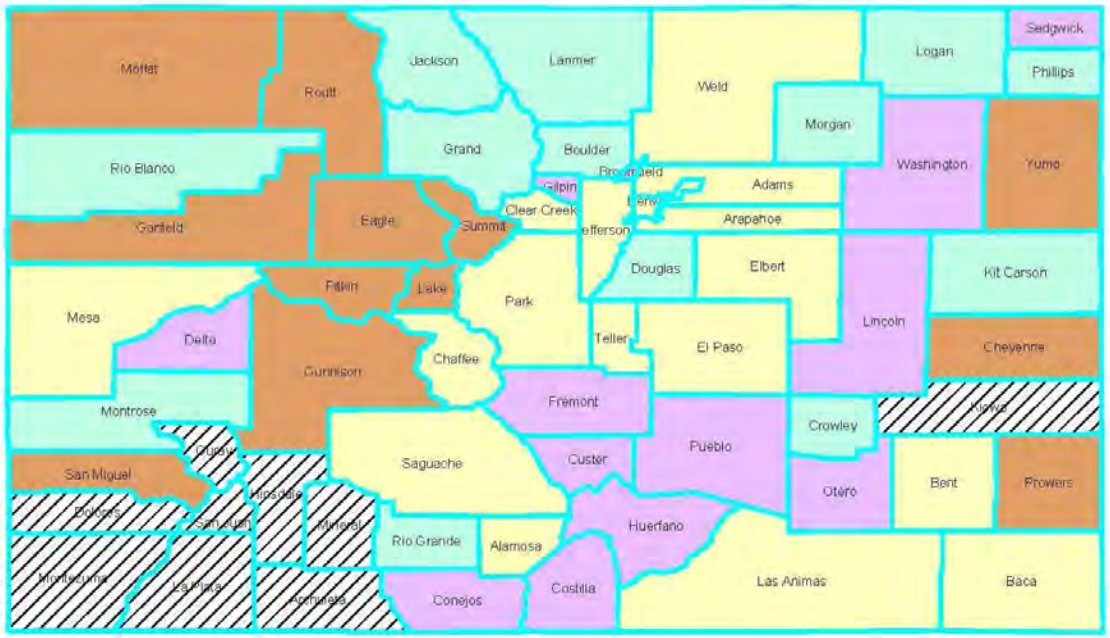
Category

- under 15
- 15-27
- 28-39
- 40-81

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 Uncomplicated Cesarean sections per 1,000 FTE clients
Females ages 14-45

Range: 8 - 205
Median: 39



Legend

Colorado Counties

Volume too low to include*

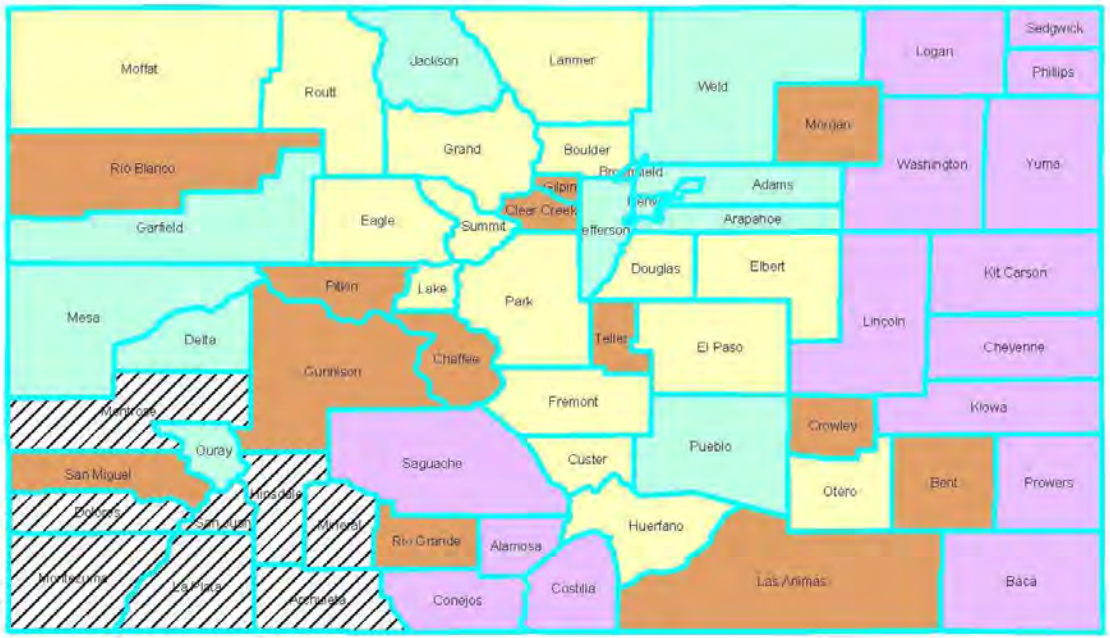
Category

- under 27
- 27-39
- 40-69
- 70-205

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 Total Dental Costs per 1,000 FTE clients

Range: $24,930 - $364,381
Median: $145,362



Legend

Colorado Counties

- Volume too low to include *

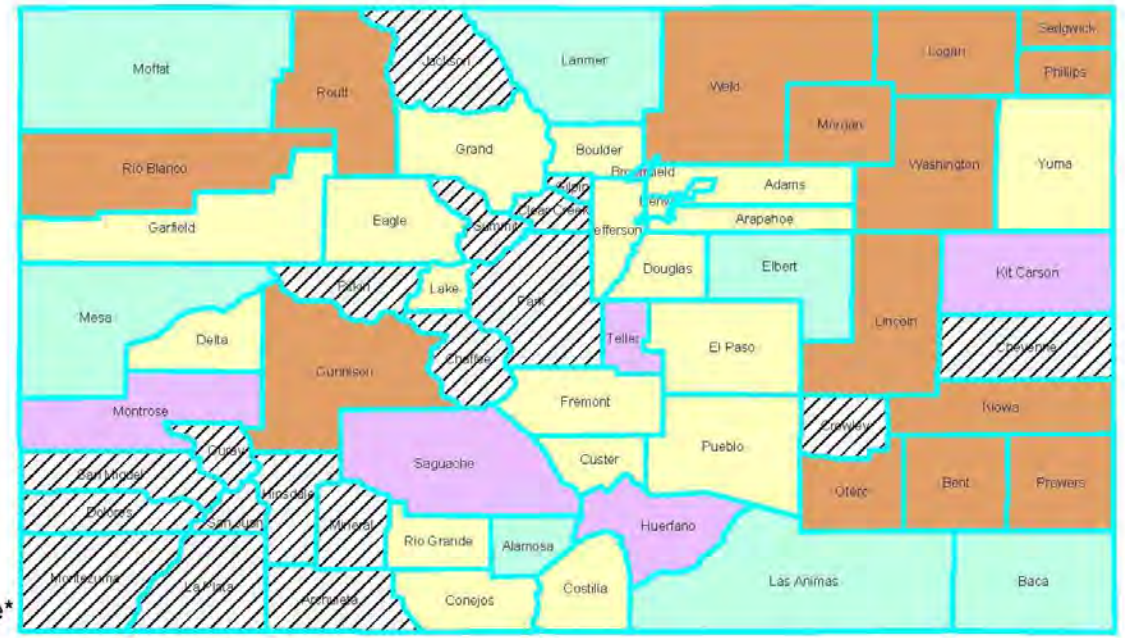
Category

- under $83,134
- $83,135 - $145,362
- $145,363 - $185,031
- $185,032 - $364,381

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 Tonsillectomies per 1,000 FTE clients
Ages 0-9

Range: 6 - 42
Median: 15



Legend

Colorado Counties

Volume too low to include*

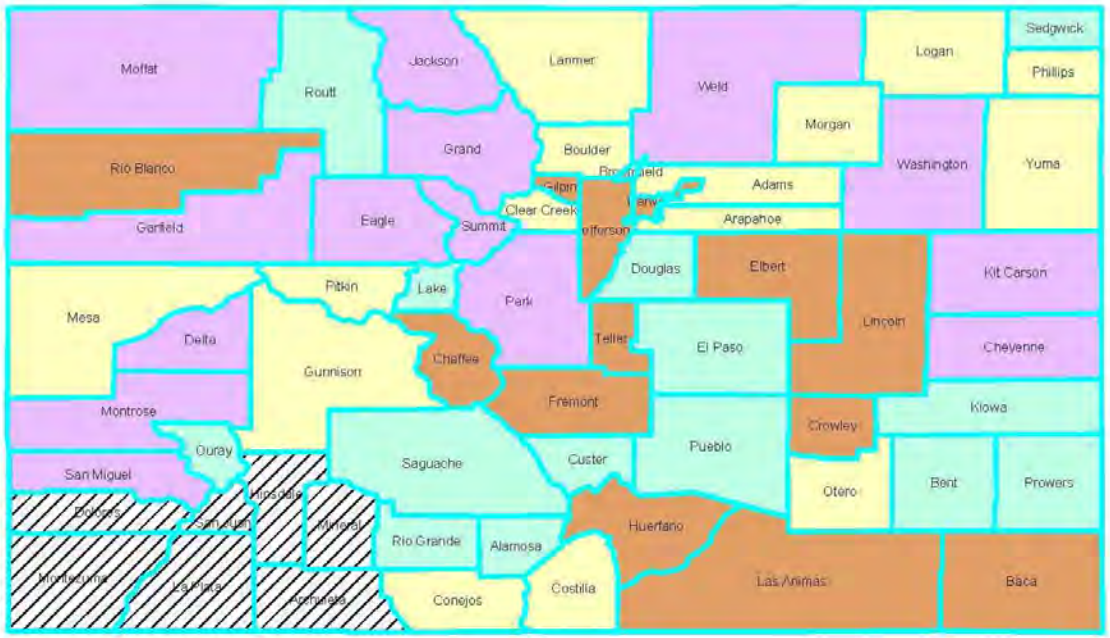
Category

- under 10
- 10-15
- 16-19
- 20-42

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 Cost for equipment and supplies per 1,000 FTE clients

Range: $44,358 - $357,895
Median: $185,080



Legend

Colorado Counties

- Volume too low to include*

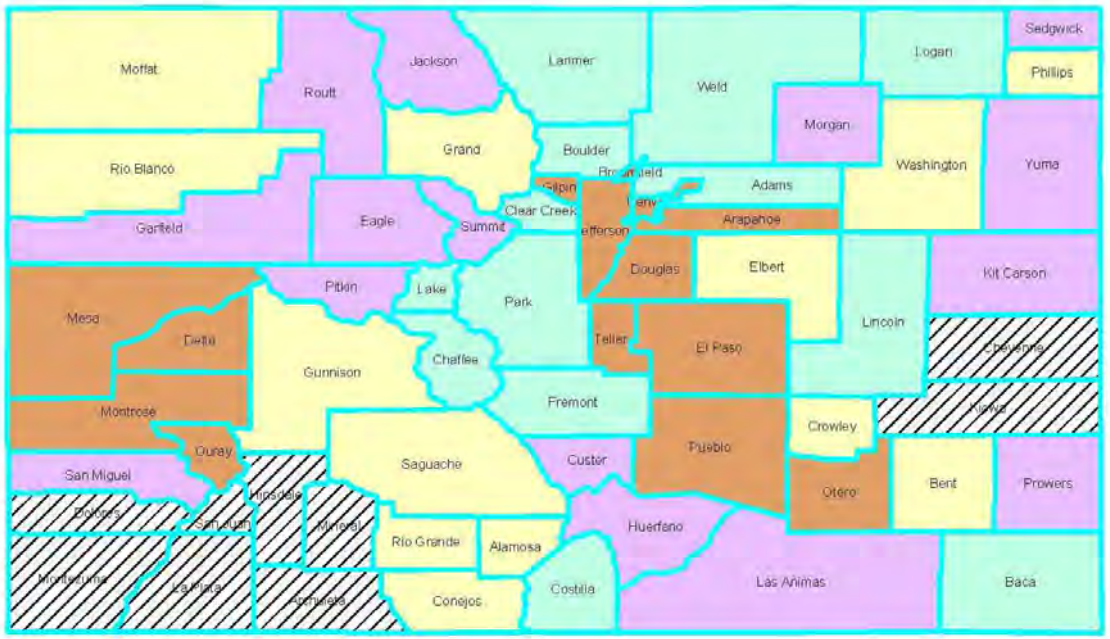
Category

- under $150,000
- $150,000 - $185,080
- $185,081 - $249,999
- $250,000 - $357,895

*Refers to counties which either have too few clients or too few services for comparison

FY 08-09 Home Health Costs per 1,000 FTE clients

Range: $731 - $961,600
Median: $192,333



Legend

Colorado Counties

- Volume too low to include*

Category

- under $100,000
- $100,000 - $192,333
- $192,334 - $424,999
- $425,000 - $961,600

*Refers to counties which either have too few clients or too few services for comparison

Prevention Quality Indicator Analysis (State FY2007-08)

Overall Admission Rate for Acute Indicators

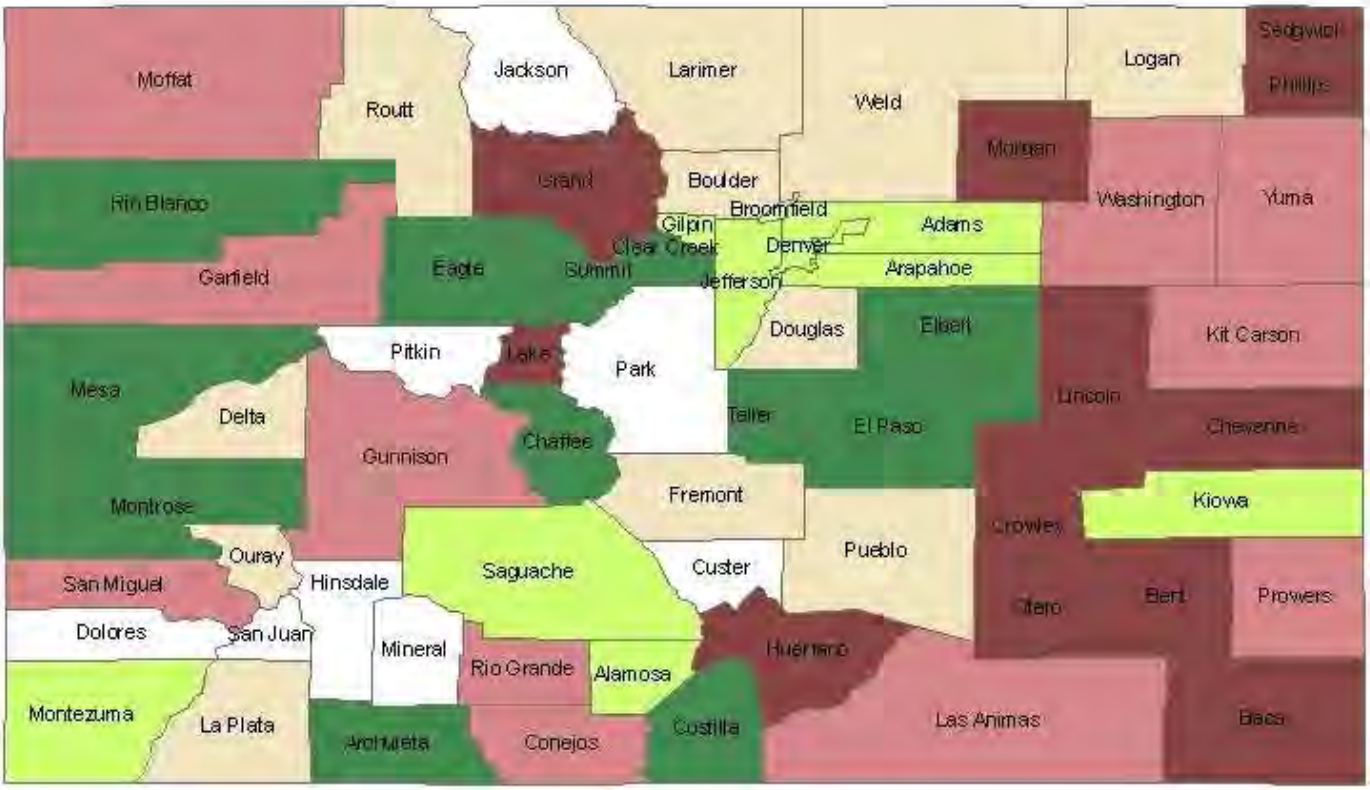
The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for future years. All future years will be grouped based on these categories to determine relative performance.

AHRO National Average (2004): 723 (Includes clients with dual eligibility)

Admissions: 2,339
Statewide Rate: 1,306

Rate per 100,000

- No Rate/Data
- 256 - 1000
- 1001 - 1400
- 1401 - 1700
- 1701 - 3000
- 3001 - 6500



Prevention Quality Indicator Analysis (State FY2008-09)

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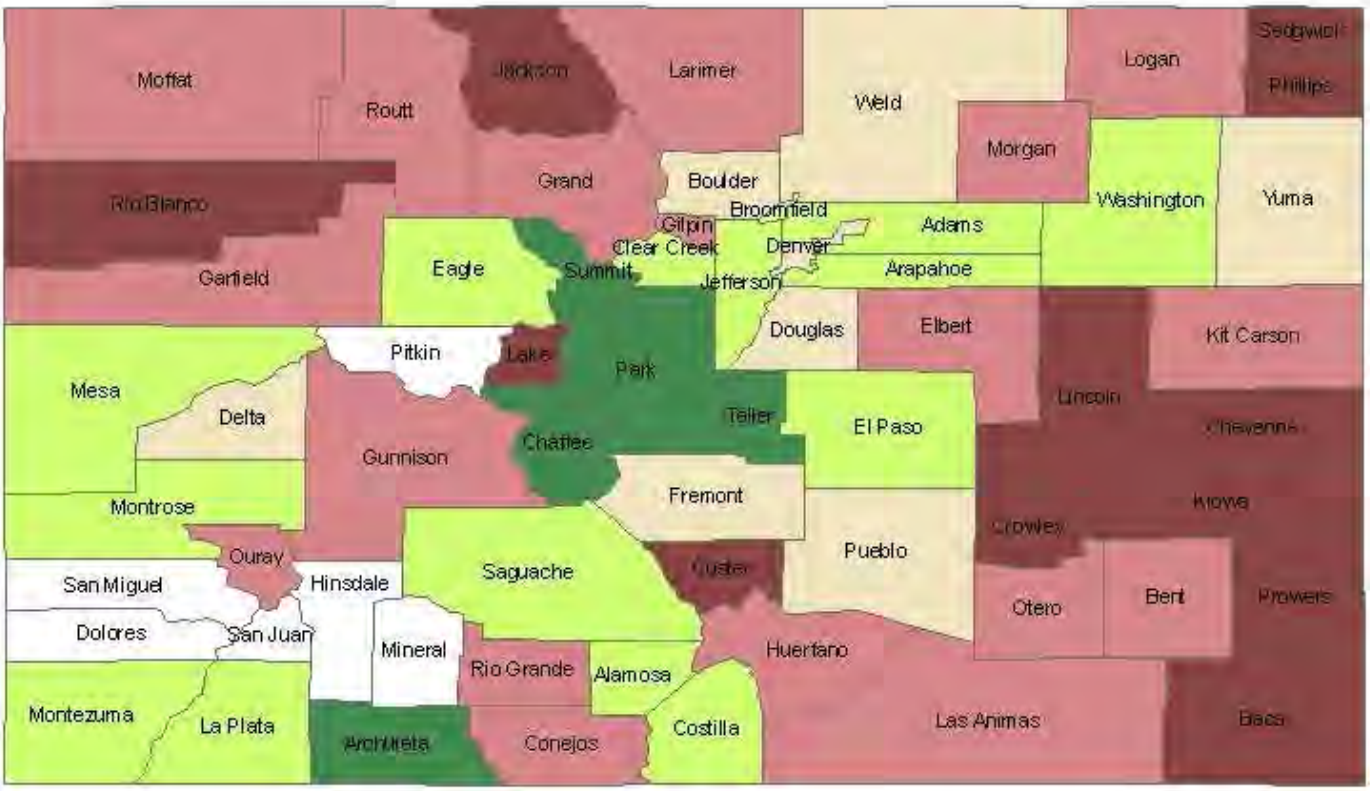
AHRO National Average (2004): 723 (Includes clients with dual eligibility)

Admissions: 2,312
Statewide Rate: 1,468

Rate per 100,000

- No Rate/Data
- 309 - 1000
- 1001 - 1400
- 1401 - 1700
- 1701 - 3000
- 3001 - 6600



Prevention Quality Indicator Analysis
State FY2009-10 through Q3

Overall Admission Rate for Acute Indicators

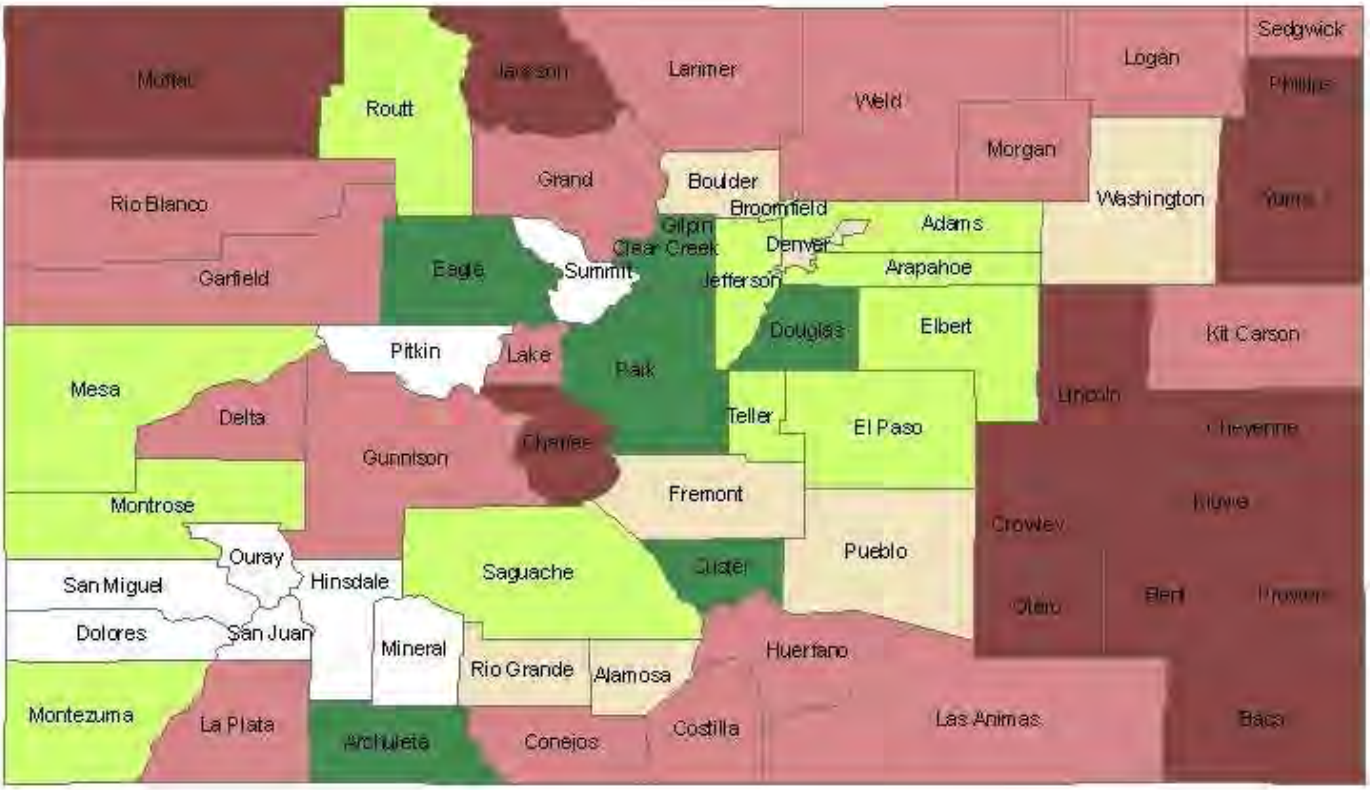
The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for furture years. All future years will be grouped based on these categories to determine relative performance.

AHRQ National Average (2004): 723 (Includes clients with dual eligibility)

Admissions: 2,706
Statewide Rate: 1,583

Rate per 100,000

- No Rate/Data
- 395 - 1000
- 1001 - 1400
- 1401 - 1700
- 1701 - 3000
- 3001 - 8219



Prevention Quality Indicator Analysis (State FY2007-08)

Overall Admission Rate for Chronic Indicators

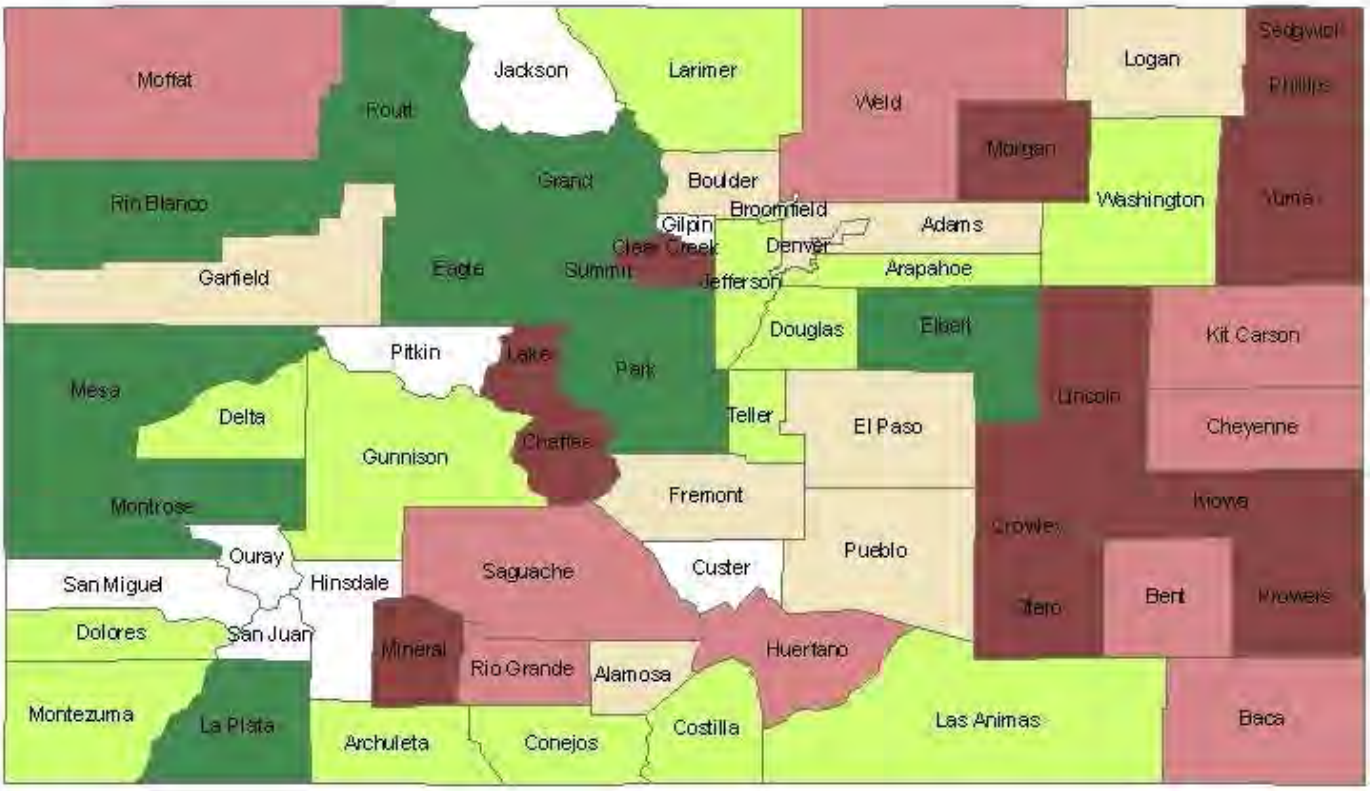
The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for future years. All future years will be grouped based on these categories to determine relative performance.

AHRQ National Average (2004): 1,156 (Includes clients with dual eligibility)

Admissions: 2,696
Statewide Rate: 1,506

Rate per 100,000

- No Rate/Data
- 370 - 1000
- 1001 - 1400
- 1401 - 1800
- 1801 - 2500
- 2501 - 5300



Prevention Quality Indicator Analysis (State FY2008-09)

Overall Admission Rate for Chronic Indicators

The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for furture years. All future years will be grouped based on these categories to determine relative performance.

AHRQ National Average (2004): 1,156 (Includes clients with dual eligibility)

Admissions: 2,905
Statewide Rate: 1,845

Rate per 100,000

- No Rate/Data
- 439 - 1000
- 1001 - 1400
- 1401 - 1800
- 1801 - 2500
- 2501 - 5300

Prevention Quality Indicator Analysis
State FY2009-10 through Q3

Overall Admission Rate for Chronic Indicators

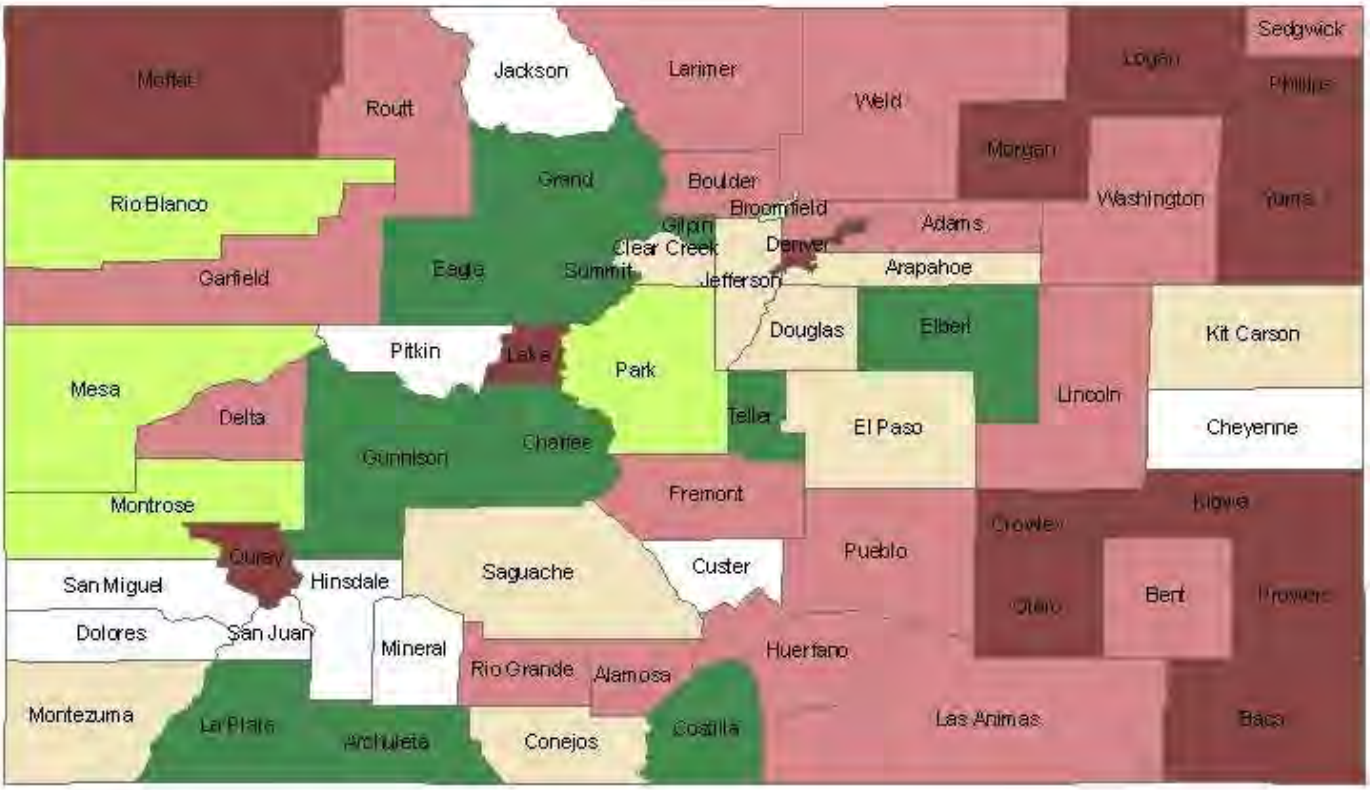
The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for furture years. All future years will be grouped based on these categories to determine relative performance.

AHRQ National Average (2004): 1,156 (Includes clients with dual eligibility)

Admissions: 3,493
Statewide Rate: 2,044

Rate per 100,000

- No Rate/Data
- 193 - 1000
- 1001 - 1400
- 1401 - 1800
- 1801 - 2500
- 2501 - 11364



Prevention Quality Indicator Analysis (State FY2007-08)

Overall Admission Rate for Acute and Chronic Indicators

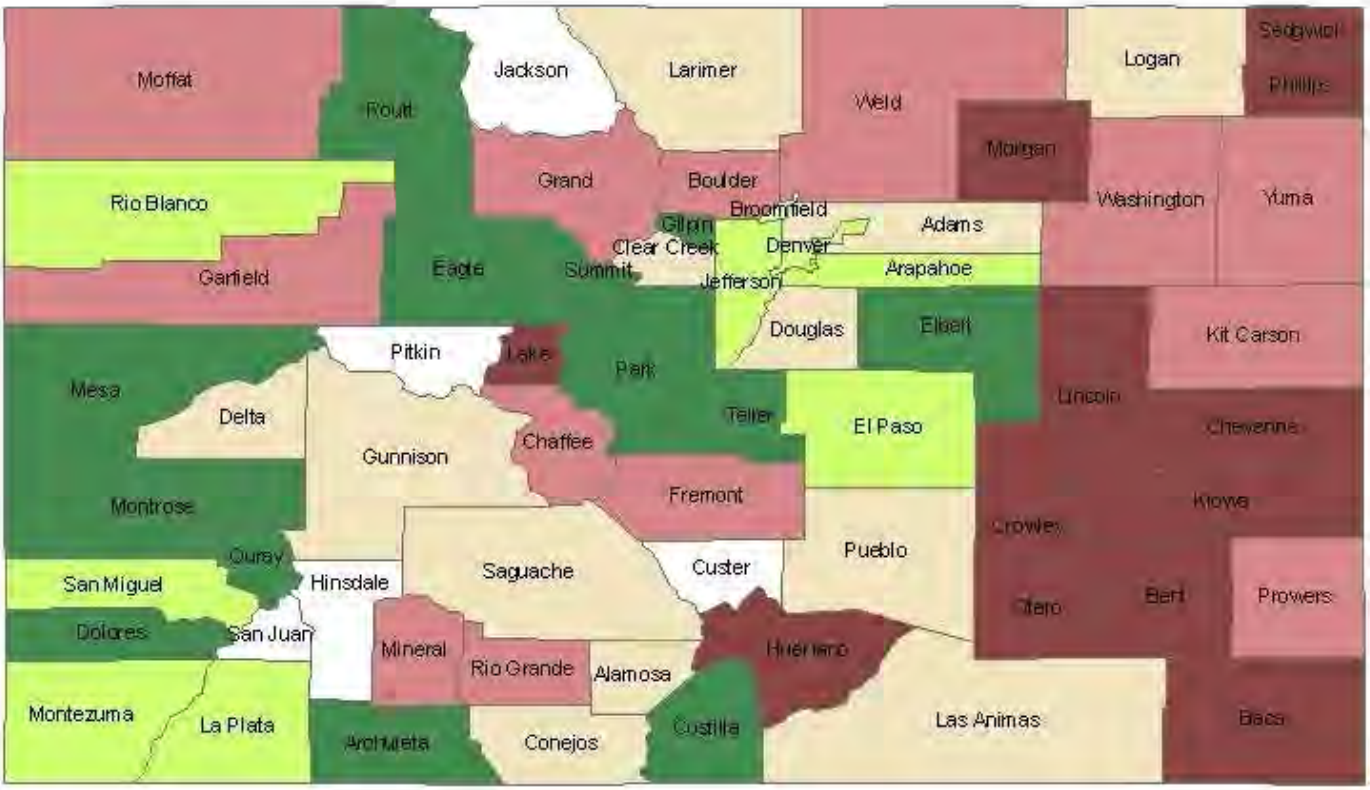
The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for furture years. All future years will be grouped based on these categories to determine relative performance.

AHRQ National Average (2004): 1,879 (Includes clients with dual eligibility)

Admissions: 5,216
Statewide Rate: 2,812

Rate per 100,000

- No Rate/Data
- 632 - 1900
- 1901 - 2700
- 2701 - 3200
- 3201 - 5700
- 5701 - 8800



Prevention Quality Indicator Analysis (State FY2008-09)

Overall Admission Rate for Acute and Chronic Indicators

The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for furture years. All future years will be grouped based on these categories to determine relative performance.

AHRQ National Average (2004): 1,879 (Includes clients with dual eligibility)

Admissions: 5,216
Statewide Rate: 3,313

Rate per 100,000

- No Rate/Data
- 1316 - 1900
- 1901 - 2700
- 2701 - 3200
- 3201 - 5700
- 5701 - 11000

Prevention Quality Indicator Analysis
State FY2009-10 through Q3

Overall Admission Rate for Acute and Chronic Indicators

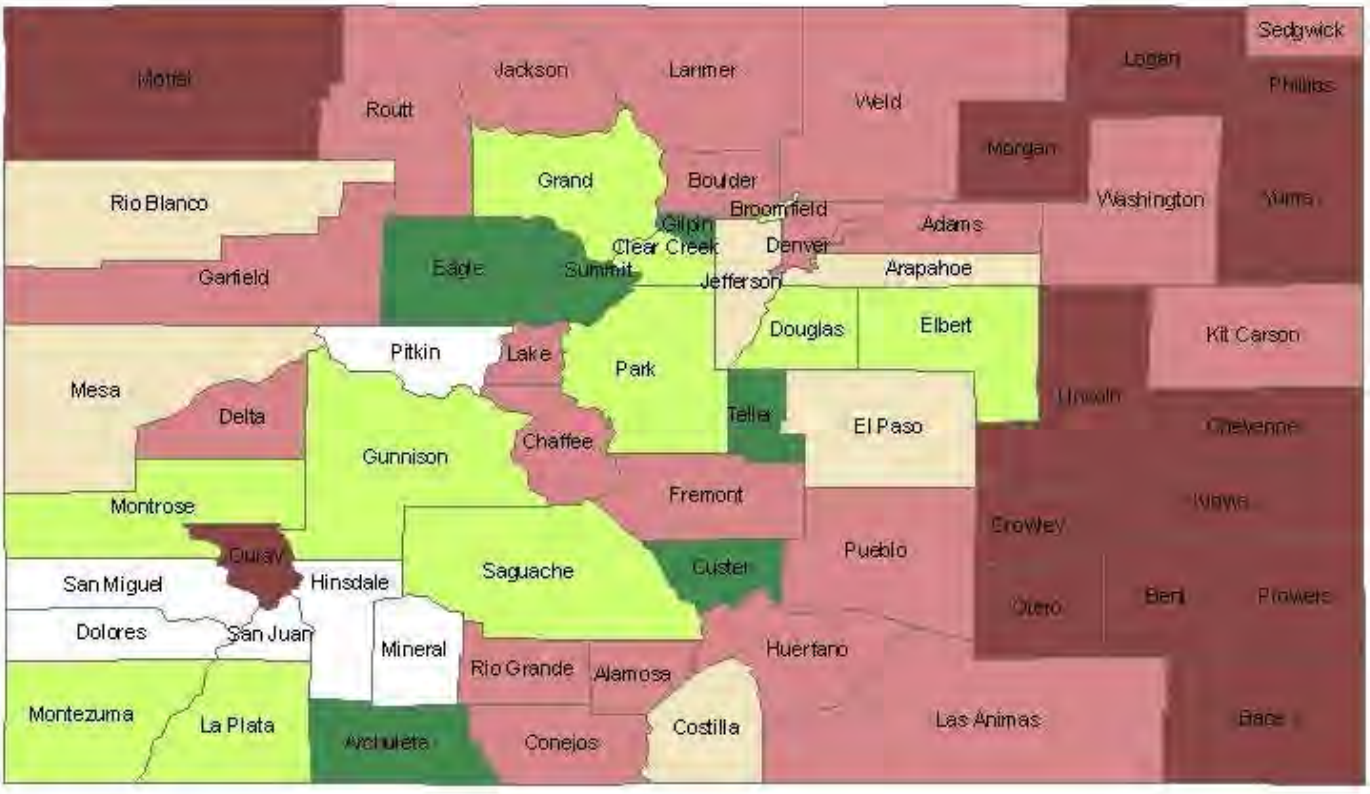
The following maps graphically represent the performance of Colorado counties relative to each other on the quality indicator listed above. Green shades represent counties that fell below the average performance of the state with darker green having the fewest admissions. Red shades represent counties that scored above average. All numbers are rates per 100,000 individuals. The analysis was based on a 5 quantile system and then rounded to the nearest 100. This was based on the State FY2007-08 data to create a baseline for furture years. All future years will be grouped based on these categories to determine relative performance.

AHRQ National Average (2004): 1,879 (Includes clients with dual eligibility)

Admissions: 6,199
Statewide Rate: 3,628

Rate per 100,000

- No Rate/Data
- 690 - 1900
- 1901 - 2700
- 2701 - 3200
- 3201 - 5700
- 5701 - 13793



Colorado Department of Health Care Policy and Financing

RFP # HCPFKQ1102RCCO

Regional Care Collaborative Organizations
For The Accountable Care Collaborative Program

Attachment M

W-9 Form

Substitute Form
W-9

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER (TIN) VERIFICATION

State of Colorado
Do NOT send to IRS

PRINT OR TYPE

RETURN TO ADDRESS BELOW

Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON IRS OR SOCIAL SECURITY ADMINISTRATION RECORDS)
DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPIETORSHIP ON THIS LINE - See Reverse for Important Information

Trade Name -- complete only if doing business as (D/B/A)

Remit Address

Purchase Order Address -- Optional

PART II See Part II Instructions on Back of Form

Check legal entity type and enter 9 digit Taxpayer Identification Number (TIN) below:
(SSN = Social Security Number EIN = Employer Identification Number)

Do Not enter an SSN or EIN that was not assigned to the legal name entered above

☐ Individual (Individual's SSN) ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___
NOTE: If no name is circled on a Joint Account when there is more that one name, the number will be considered to be that of the first name listed.

☐ Sole Proprietorship (Owner's SSN or Business EIN) SSN ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___
Note: Enter both the owner's SSN and the business EIN (if you are required to have one) EIN ___ ___ -- ___ ___ ___ ___ ___ ___ ___

☐ Partnership ☐ General ☐ Limited (Partnership'S EIN) ___ ___ -- ___ ___ ___ ___ ___ ___ ___

☐ Estate/Trust (Legal Entity's EIN) ___ ___ -- ___ ___ ___ ___ ___ ___ ___
NOTE: Do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title. List and circle the name of the legal trust, estate, or pension trust.

☐ Other > (Entity's EIN) ___ ___ -- ___ ___ ___ ___ ___ ___ ___
Limited Liability Company, Joint Venture, Club, etc.

☐ Corporation Do you provide medical services? ☐ Yes ☐ No (Corp's EIN) ___ ___ -- ___ ___ ___ ___ ___ ___ ___
Includes corporations providing medical billing services

☐ Government (or Government Operated) Entity (Entity's EIN) ___ ___ -- ___ ___ ___ ___ ___ ___ ___

☐ Organization Exempt from Tax under Section 501(a) (Org's EIN) ___ ___ -- ___ ___ ___ ___ ___ ___ ___
Do you provide medical services? ☐ Yes ☐ No

☐ Check Here if you do not have a SSN or EIN, but have applied for one. See reverse for information on *How to Obtain A TIN*
Licensed Real Estate Broker? ☐ Yes ☐ No

Under Penalties of Perjury, I certify that:

(1) The number listed on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition or abandonment of secure property, contribution to an individual retirement arrangement (IRA), and payment other than interest and dividends).

CERTIFICATION INSTRUCTIONS -- You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return. (See Signing the Certification on the reverse of this form.)

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING.

NAME (Print or Type) _____ TITLE (Print or Type) _____

AUTHORIZED SIGNATURE _____ DATE _____ PHONE (_____) _____

DO NOT WRITE BELOW THIS LINE **RETURN BOTH COPIES TO ADDRESS ABOVE**

AGENCY USE ONLY

Agency ____ ____ ____ Approved by _____ Date _____

1099: Yes ____ No ____ Action Completed by _____ Date _____

VENDOR: Addition ____ Change ____

SUBSTITUTE FORM 1099 INSTRUCTIONS

PART I

NAME AND TAX IDENTIFICATION NUMBER (TIN)

INDIVIDUAL: Enter First and Last name EXACTLY as it appears on your Social Security Card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name and both the last name shown on your social security card and your new last name (IN THAT ORDER). For your TIN, enter your Social Security Number (SSN).

SOLE PROPRIETORSHIPS: Enter the owner's name on the first line; on the second name line you may enter the business name. YOU MAY NOT ENTER ONLY THE BUSINESS NAME. For the TIN, enter both the owner's Social Security Number and the Federal Employer Tax Identification Number (EIN) if you are required to have one.

ALL OTHER ENTITY'S: Enter the name of the owner of the EIN or SSN exactly as originally registered with the IRS. The correct TIN is the Employer Identification Number (EIN).

DO NOT ENTER AN SSN OR EIN THAT WAS NOT ASSIGNED TO THE LEGAL NAME OF THIS FORM

HOW TO OBTAIN A TIN

If you do not have a TIN, you should apply for one immediately. To apply for the number, obtain Form SS-05, Application for a Social Security Number Card (for individual), or Form SS-4, Application of Employer Identification Number (for businesses and all other entities), at your local office of the Social Security Administration or the Internal Revenue Service. Complete and file the appropriate form according to its instructions.

To complete Form W-9 if you do not have a TIN, check "Applied For" box in the space indicated in front, sign and date the form, and give it to the requester. For payments that could be subject to backup withholding, you will then have 60 days to obtain a TIN and furnish it to the requester. During the 60-day period, the payments you receive will not be subject to the 31% backup withholding, unless you make a withdrawal. However if the requester does not receive your TIN from you within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN to the requester.

Note: *Writing "Applied For" on the form means that you have already applied for a TIN OR that you intend to apply for one in the near future.*

As soon as you receive your TIN, complete another form W-9, include your new TIN, sign and date the form, and give it to the requester.

PART II

FOR PAYEES EXEMPT FROM BACKUP WITHHOLDING

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding. Enter you correct TIN in Part I, write "Exempt" in Part II, and sign and date the form.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester a completed Form W-8, Certificate of Foreign Status.

PART III

CERTIFICATION

(1) **Interest, Dividends, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts That Were Considered Active During 1983.** - You are not required to sign the certification; however, you may do so. You are required to provide your correct TIN.

(2) **Interest, Dividend, Broker and Barter Exchange Accounts Opened After 1983 and Broker Accounts That Were Considered Inactive During 1983.** - You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item (2) in the certification before signing the form.

(3) **Real Estate Transactions** - You must sign the certification. You may cross out item (2) of the certification if you wish.

(4) **Other Payments** - You are required to furnish your correct TIN, but you are not required to sign the certification unless you have been notified of an incorrect TIN. Other payments include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services, payments to a nonemployee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

(5) **Mortgage Interest Paid by You, Acquisition or Abandonement of Secured Property, or IRA Contribution** - You are required to furnish your correct TIN, but you are not required to sign the certification.

OTHER

Signature - The signature should be an authorized signature, generally the person whose name is on the top line of the form, a partner in the partnership, or an officer of the corporation. For a joint account, only the person whose TIN is shown in LEGAL BUSINESS DESIGNATION should sign the form.

Privacy Act Notice - Section 6109 requires you to furnish your correct taxpayer identificatioon number (TIN) to persons who must file information returns with IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonement of secured property, or contributions you made to an individual retirement arrangement (IRA). IRS uses the numbers for identification purposes and to help verify the accuracy of your tax returns. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 31% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain other penalties may also apply.