EXHIBIT B, STATEMENT OF WORK

1. REGIONAL ACCOUNTABLE ENTITY

1.1. Contractor shall be the Regional Accountable Entity (RAE) for Region #XXX and shall be the Primary Care Case Management Entity (PCCME) and the Prepaid Inpatient Health Plan (PIHP) for Members enrolled with the Contractor.

1.1.1. Region XXX includes XXX Counties.

1.2. Contractor shall conduct the Work in manner that achieves the Accountable Care Collaborative (ACC) mission of improving Member health and reducing costs in the Medicaid Program.

1.2.1. Contractor, as the RAE, shall assist Department in reducing avoidable and unnecessary costs within the Medicaid Program to achieve the goal of supporting the right care, in the right place, at the right time, for the right outcome.

1.3. Contractor shall perform all of the functions described in this Contract in compliance with all pertinent state and federal statutes, regulations, and rules, including Department's 1915(b) waiver for the ACC and any other 1115 waivers as identified by Department.

1.4. Contractor shall be licensed by the Colorado Division of Insurance (CDOI) as either a:

1.4.1. Health Maintenance Organization (HMO) or

1.4.2. Limited Service Licensed Provider Network (LSLPN), as defined by 3 CCR 702-2, Colorado Insurance Regulation 2-1-9.

1.5. Contractor shall administer the program in compliance with the requirements for both a PCCME and a PIHP set forth in 42 C.F.R. § 438.

1.5.1. Contractor shall administer the two managed care authorities as one program that integrates clinical care, operations, management, and data systems.

1.6. Contractor shall have a governing body responsible for oversight of the Contractor's activities in relation to this Contract.

1.6.1. Contractor shall:

1.6.1.1. Select representatives of the Community to join the governing body.

1.6.1.2. Select Members of the governing body in such a way as to minimize any potential or perceived conflicts of interest.

1.6.1.3. Select Members of the governing body so that Network Providers and other contracted or Subcontracted organizations hold no more than 50% of the seats on the governing body in accordance with C.R.S. 25.5-5-402(9)(b).

1.6.1.4. Exclude from the governing body any Network Providers that have ownership in the Contractor organization.

1.6.1.5. Ensure Members of the governing body do not have any control, influence, or decision-making authority in the establishment of provider networks per C.R.S. 25.5-5-402(9)(b).

1.6.1.6. Shall publicly list information on Contractor's website about the governing body, including, but not limited to, the names of the Members of the governing body and their affiliations.

1.7. Contractor shall create a written RAE governance plan that describes how Contractor will protect against any perceived conflict of interest among its governing body from influencing Contractor's activities under this Contract.

1.7.1. Contractor shall include as conflicts of interest any party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is or may be controlled or significantly influenced by a Contractor, including but not limited to:

1.7.1.1. Agents.

1.7.1.2. Managing Employees.

1.7.1.3. Persons with an ownership or controlling interest in the Contractor and their immediate families.

1.7.1.4. Members of the governing body or governing Board.

1.7.1.5. Subcontractors.

1.7.1.6. Wholly owned subsidiaries or suppliers.

1.7.1.7. Parent companies.

1.7.1.8. Sister companies.

1.7.1.9. Holding companies.

1.7.1.10. Other entities controlled or managed by any such entities or persons.

1.7.2. Contractor shall post the RAE Governance Plan publicly on the Contractor's website.

1.7.3. Contractor shall submit the RAE Governance Plan to Department annually for approval.

1.7.3.1. DELIVERABLE: RAE Governance Plan

1.7.3.2. DUE: 30 Calendar Days prior to the Go-Live date, then annually thereafter starting June 1, 2026

1.7.4. Contractor shall submit an updated written RAE Governance Plan to Department and post it when a change is made to the Governance Plan, or a change in governance is discovered by the Contractor.

1.7.4.1. DELIVERABLE: Updated RAE Governance Plan

1.7.4.2. DUE: Within 30 days after the new change in governance is discovered

2. MEMBER ENROLLMENT AND ATTRIBUTION

2.1. Contractor shall understand the Member enrollment, attribution, and assignment processes described in this section.

2.1.1. All full-benefit Medicaid Members will be mandatorily enrolled into the ACC, with the exception of individuals that choose the Program of All-Inclusive Care for the Elderly (PACE).

2.1.2. The following individuals are not full-benefit Medicaid Members and are therefore not eligible for enrollment in the ACC:

2.1.2.1. Qualified Medicare Beneficiary only (QMB-only), except when combined with another eligible full-benefit Program Aid Code for the ACC.

2.1.2.2. Qualified Working Disabled Individuals (QWDI).

2.1.2.3. Qualified Individuals 1 (QI 1).

2.1.2.4. Special Low-Income Medicare Beneficiaries only (SLMB-only), except when combined with another eligible full-benefit Program Aid Code for the ACC.

2.1.2.5. Undocumented immigrants (per 8 U.S.C.A. § 1611).

2.1.2.6. All individuals while determined presumptively eligible for Medicaid.

2.2. Contractor shall verify Medicaid eligibility and enrollment using the Health Insurance Portability and Accountability Act (HIPAA) 834 Benefit Enrollment and Maintenance transaction generated from the Colorado interChange (MMIS). The Colorado Medical Assistance Program Web Portal may also be used to verify Medicaid eligibility and enrollment in the ACC. Department is the final arbiter for all discrepancies between the various systems utilized for verifying eligibility and enrollment.

2.2.1. Contractor shall have systems capable of receiving and processing 834 transactions generated by the Colorado interChange.

2.2.2. Contractor shall ensure that Network Providers supply services only to eligible Medicaid Members. Contractor shall ensure that Network Providers verify the following:

2.2.2.1. The individual receiving services covered under this Contract is Medicaid-eligible on the date of service.

2.2.2.2. Whether Contractor or Department is responsible for reimbursement of the services provided

2.2.2.3. Whether Contractor has authorized a referral or made special arrangements with a provider, when appropriate.

2.3. Department will enroll all Members into the ACC, assign all Members to a RAE, and attribute most Members to a PCMP or an approved integrated care practice.

2.3.1. Department will enroll Members into the ACC on the same day that a Member's Medicaid eligibility notification is received in the Colorado interChange from the Colorado Benefit Management System (CBMS). In alignment with the Member Enrollment Policy, Department may enroll or disenroll Members up to 90 days retroactively. Capitation payments will be reconciled in accord with the updated enrollment date.

2.3.2. Department will assign Members to the Contractor based on the location of the PCMP Practice Site to which the Member is attributed. Department will assign unattributed

Members to the RAE of the region that includes the Member's address. The PCMP attribution effective date will be the same as the RAE assignment date.

2.3.3. Department will assign child welfare involved Members to the RAE in which their case originated in accordance with C.R.S. 25.5-5-402(6)(b).

2.3.4. If the Member loses Medicaid eligibility for two months or less, Department will automatically re-enroll Members with the PCMP and RAE that were in effect at the time of their loss of Medicaid eligibility.

2.4. Contractor shall maintain policies that achieve the state's goal of making a "Colorado for All" by not discriminating against individuals eligible to enroll in the ACC on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs or disability. Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs or disability. Contractor shall not discriminate against Members in enrollment and re-enrollment on the basis of health status or need for health care services.

2.5. Contractor shall accept all eligible Members Department assigns to Contractor in the order in which they are assigned, without restriction. Department will assign Members to a RAE based on Department attribution and assignment policies and procedures.

2.6. Contractor shall understand that Members may select a different PCMP at any time through the Enrollment Broker.

2.6.1. The selection of a different PCMP may result in assignment to a different RAE. Assignment into a different RAE is effectuated on the first day of the month following the month when the selection was made.

2.6.2. Contractor shall develop procedures to transition services when a Member's assignment is changed from one RAE to a different RAE, to ensure that the Member's quality, quantity, and timeliness of RAE support, care coordination and care is not affected during the transition.

2.7. Contractor shall process the attribution and assignment list sent by Department that contains the attribution and assignment information for all Members in the Contractor's region and any additions, deletions, or changes to the existing PCMP selection records.

2.7.1. Contractor shall use Department-developed PCMP-Member fidelity tool or comparable analytics to identify opportunities for Member outreach to increase the fidelity of Members to their attributed PCMP. Contractor shall share information with PCMPs about Member utilization patterns outside of the PCMP practice.

2.7.2. Contractor shall follow up with Members who are seeking frequent care from primary care providers other than the attributed PCMP, including frequent urgent care and ED visits, to identify any barriers to accessing their attributed PCMP and, if appropriate, to assist the Member by strengthening their relationship with their current attributed PCMP or changing their attributed PCMP.

2.7.2.1. Contractor shall assist Members who want to select or change their attributed PCMP by providing a warm handoff to the Enrollment Broker customer contact center.

2.7.3. Contractor shall regularly identify Members in nursing facility and Regional Centers to ensure accurate Member attribution. The Contractor shall work with nursing facilities and Regional Centers as necessary to ensure appropriate Member attribution and, when needed, assist Members in choosing a PCMP.

2.8. Contractor shall work with Department, PCMPs, and Stakeholders to develop policies that support Member accountability for utilization of health services over an extended period of time, such as a provider lock-in policy.

2.9. RAE Reassignment Process

2.9.1. Contractor shall understand that any Member may request reassignment from the RAE serving the Member's PCMP to the RAE serving the Member's county of residence when requested by both the Member and their care coordinator/case manager by submitting a RAE Reassignment Request Form, Exhibit F.

2.9.2. Contractor shall support any Member that is requesting RAE reassignment. Contractor shall share the RAE Reassignment Request form with the requested RAE.

2.9.3. Contractor shall understand that Members considered for reassignment must meet all the following criteria:

2.9.3.1. The Member resides in a RAE geographic region different from the RAE geographic region of the Member's PCMP.

2.9.3.2. The Member is receiving an array of mental health and community support services from a Comprehensive Community Behavioral Health Safety Net Provider.

2.9.3.3. The Member has a current plan of care that includes state plan services, 1915(b)(3) community-based system of care services, or other state resources to support the Member in living in the community, maintaining optimal level of functioning, and achieving recovery.

2.9.3.4. The Member has a history of hospitalization for a mental health condition, utilization of the Colorado Crisis Services system, involvement with the criminal justice system, or other similar indicator of the complexity of the Member's mental health condition within the past 12 months and requires ongoing therapeutic and community-based services in order to live stably in the community.

2.9.4. If approved, a Member's assignment to the new RAE is effective on the first day of the month following the month in which Department approves the request for reassignment. If a request for reassignment comes too late to process the request in the Colorado interchange according to this schedule, the reassignment will occur the first day of the second month following the month in which Department approves the request for reassignment.

2.9.5. Contractor shall comply with and process Department's determination regarding RAE reassignment.

2.9.5.1. Contractor shall develop procedures to transition services to the new RAE to ensure that the Member's quality, quantity, and timeliness of care is not affected during the transition.

3. MEMBER ENGAGEMENT

3.1. Person-and Family-Centered Approach

3.1.1. Contractor shall actively engage Members in their health and well-being by demonstrating the following:

3.1.1.1. Responsiveness to Member and family/caregiver needs by incorporating best practices in communication and cultural responsiveness in service delivery.

3.1.1.2. Utilization of various methods and tools to communicate clearly and concisely.

3.1.1.3. Proactive education promoting the effective utilization of Medicaid benefits and the health care system.

3.1.1.4. Promotion of health and wellness, particularly preventive and healthy behaviors, including but not limited to Colorado state public health initiatives, Department priorities, and Medicaid's CMS Core Measures.

3.1.2. Contractor shall align Member engagement activities with Department's person- and family-centered approach that respects and values individual preferences, strengths, and contributions.

3.1.3. Contractor shall monitor the work and recommendations from Department's Member Experience Advisory Council, which consists of Medicaid and CHP+ Clients, family Members and/or caretakers.

3.2. Cultural Responsiveness

3.2.1. Contractor shall provide and facilitate the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity in compliance with 42 C.F.R. § 438.206(c)(2).

3.2.2. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages. Contractor shall create written materials in English and Spanish or any other prevalent language, as directed by Department or as required by 42 CFR 43810.

3.2.3. Contractor shall provide cultural and disability competency training to Network Providers and Contractor staff regarding:

3.2.3.1. Health care attitudes, values, customs, and beliefs that affect access to and engagement in health care services.

3.2.3.2. The medical risks associated with the Member population's racial, ethnic and socioeconomic conditions.

3.2.4. Contractor shall utilize staff, tools, and resources to support Members whose cultural identity, norms, and practices may affect their access to health care.

3.2.5. Contractor shall provide all information for Members in a manner and format that may be easily understood and is readily accessible by Members.

3.2.5.1. Readily accessible is defined as electronic information and services that comply with modern accessibility standards, such as the Americans with Disabilities Act, Sections 504 and 508 of the Rehabilitation Act, and the most recent Web Content Accessibility Guidelines (WCAG) from W3C.

3.2.6. Contractor shall provide language assistance services as described in 42 C.F.R. § 43810, for all Contractor interactions with Members and for all covered services. Language assistance services include bilingual staff and interpreter services, at no cost to any Member. Language assistance shall be provided at all points of contact, in a timely manner and during all hours of operation. Contractor shall implement appropriate technologies for language assistance services in accordance with evolving best practices in communication.

3.2.6.1. Contractor shall make oral interpretation in all languages and written translation in each prevalent non-English language available at no cost to any Member.

3.2.6.1.1. Contractor shall assure the competence of language assistance provided by interpreters and bilingual staff.

3.2.6.1.2. Contractor shall not use family and friends to provide interpretation services except by request of the Member.

3.2.6.1.3. Contractor shall provide interpreter services for all interactions with Members when there is no Contractor staff person available who speaks a language understood by a Member.

3.2.6.2. Contractor shall notify Members verbally and through written notices regarding the Member's right to receive the following language assistance services, as well as how to access the following language assistance services:

3.2.6.2.1. Oral interpretation for any language. Oral interpretation requirements apply to all non-English languages, not just those that the state identifies as prevalent.

3.2.6.2.2. Written translation in prevalent languages.

3.2.6.2.3. Auxiliary aids and services for Members with disabilities.

3.2.6.3. Contractor shall ensure that language assistance services include the use of auxiliary aids such as TTY/TDY and American Sign Language.

3.2.6.4. Contractor shall ensure that customer service call centers can easily access interpreter or bilingual services.

3.2.6.5. Contractor shall submit a deliverable documenting the provision of language assistance services to Members using a template provided by Department.

3.2.6.5.1. DELIVERABLE: Language Assistance Services Report

3.2.6.5.2. DUE: Annually on September 30

3.2.7. Written Materials for Members

3.2.7.1. Contractor shall ensure that all written materials it creates for distribution to Members meet all noticing requirements of 45 C.F.R. Part 92.

3.2.7.2. Contractor shall ensure that all written materials it creates for distribution to Members are culturally and linguistically appropriate to the recipient.

3.2.7.3. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in the State.

3.2.7.3.1. Contractor shall include taglines in the prevalent non-English languages in the State, and in large print, explaining the availability of written translation or oral interpretation to understand the information provided.

3.2.7.4. Contractor shall notify all Members and potential Members of the availability of alternate formats for information, as required by 42 C.F.R. § 43810 and 45 C.F.R. § 92.8, and how to access such information.

3.2.7.5. Contractor shall write all materials in easy-to-understand language and comply with all applicable requirements of 42 C.F.R. § 43810.

3.2.7.5.1. Contractor shall write all published information provided to Members, to the extent possible, at the sixth-grade level, unless otherwise directed by Department.

3.2.7.5.2. Contractor shall publish all written materials provided to Members using a font size no smaller than 12 point.

3.2.7.6. Contractor shall translate all written information into other non-English languages prevalent in Contractor's Region.

3.2.7.7. Contractor shall ensure that its written materials for Members are available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the needs of Members with disabilities, Members who are visually impaired and Members who have limited reading and/or English proficiency, at no cost.

3.2.7.8. Contractor shall ensure that its written materials for Members include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll-free and TTY/TDY telephone number of Contractor's Member service unit, at no cost.

3.2.7.9. Contractor shall ensure that all written materials for Members have been tested for understanding with representatives of the Member population.

3.3. Member Communication

3.3.1. Contractor shall maintain consistent communication, both proactive and responsive, with Members.

3.3.2. Contractor shall ensure that Member communications adhere to Colorado Medicaid's brand standards.

3.3.2.1. Contractor shall co-brand all written Member communications using the Health First Colorado logo to reduce Member confusion. Communications should strive to clarify the role of the RAE as the administrator of Colorado Medicaid.

3.3.3. Contractor shall maintain, staff, and publish the number for a toll-free telephone line that Members may call for customer service or Care Coordination issues.

3.3.3.1. Contractor's Member call line shall have the capability to receive calls and make outbound calls.

3.3.3.2. Contractor's Member call line shall be open to receive and make calls with sufficient staff to support minimum hours of operations during Business Hours.

3.3.3.3. Contractor's Member call line shall be capable of managing all contacts, including during fluctuations in call volumes.

3.3.3.3.1. During Business Hours, Contractor shall ensure that no more than 5% of calls are abandoned in any consecutive 30-day period. A call shall be considered abandoned if the caller hangs up after that caller has waited in the call queue for 180 seconds or longer.

3.3.3.3.2. In any calendar month, Contractor shall ensure that the average length of time callers wait in the call queue before the call is answered is two minutes or less.

3.3.3.3.3. Contractor shall have no more than five calls during each business week that have a maximum delay of ten minutes or longer, and no calls shall have a maximum delay over 20 minutes.

3.3.3.4. Contractor shall establish and define call types that categorize the common questions or reasons Members call.

3.3.3.4.1. Contractor shall record a call type for each call received by Contractor.

3.3.3.5. Contractor shall create a process to conduct call center Member surveys for Contractor's interactions with Members to assess Member experience and perform continuous quality improvement.

3.3.3.5.1. Contractor's call center Member survey shall measure, at a minimum, all of the following areas:

3.3.3.5.1.1. Overall satisfaction with the services provided by Contractor.

3.3.3.5.1.2. The Member's satisfaction with how Contractor explained their services and the Member's options to the Member.

3.3.3.5.1.3. Member perception of accessibility to Contractor's services, including the telephone system and any other contact methods Contractor uses to communicate.

3.3.3.6. Contractor shall submit a Call Line Statistics Report in a format agreed upon by Department and Contractor that includes, but is not limited to, the following information:

3.3.3.6.1. Average Speed to Answer (ASA) as a monthly overall average

3.3.3.6.2. Voicemails not returned within one business day, in both number and percentage of all voicemails received

3.3.3.6.3. Languages that were interpreted each month and the connection speed to an interpreter

3.3.3.6.4. Results of any Member surveys, including number of surveys sent or offered if not a post-call survey, number of survey responses received, and results of the survey responses.

3.3.3.6.5. Overall totals for call types and subtypes.

3.3.3.6.5.1. DELIVERABLE: Call Line Statistics Report

3.3.3.6.5.2. DUE: Monthly, within 15 calendar days of the last day of the month for which the report covers.

3.3.4. Contractor shall maintain sufficient licenses to connect to Department's Member Contact Center's (MCC) Customer Relationship Management (CRM) system to easily and quickly transfer Members between Contractor and the MCC, and enable Contractor to access and disseminate standardized Member communications using Department's knowledgebase.

3.3.4.1. Department will provide to the Contractor:

3.3.4.1.1. Technical requirement documentation for Department's CRM.

3.3.4.1.2. Systems training and copies of training modules for new hires Contractor may onboard during the contract term.

3.3.4.1.3. A number of licenses for Department's CRM agreed upon by Contractor and Department.

3.3.4.1.4. The same level of data backup used for the entire system.

3.3.4.2. Contractor may use its own CRM system to supplement Department's CRM.

3.3.5. Contractor shall use Member notices developed by Department.

3.3.6. Contractor shall assist any Member who contacts Contractor, including Members not in Contractor's region who need assistance with contacting their PCMP or RAE. Department will provide data to Contractor on all Members for this purpose.

3.3.7. General Member Information Requirements

3.3.7.1. Contractor shall develop electronic and written materials for distribution to newly enrolled and existing Members, with input from Department, in accordance with 42 C.F.R. § 43810 that must include, at a minimum, all of the following:

3.3.7.1.1. Contractor's single toll-free, customer service phone number.

3.3.7.1.2. Contractor's email address.

3.3.7.1.3. Contractor's website address.

3.3.7.1.4. State relay information.

3.3.7.1.5. The basic features of the RAE's managed care functions as a PCCME and PIHP.

3.3.7.1.6. Which populations are subject to mandatory enrollment into the ACC.

3.3.7.1.7. The service area covered by Contractor.

3.3.7.1.8. Medicaid benefits, including State Plan benefits and Capitated Behavioral Health Benefit.

3.3.7.1.9. Any restrictions on the Member's freedom of choice among Network Providers.

3.3.7.1.10. A directory of Network Providers.

3.3.7.1.10.1. DELIVERABLE: Network Directory

3.3.7.1.10.2. DUE: Five days prior to the Operational Start Date.

3.3.7.1.11. The Contractor's obligation to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards defined in Section 5.

3.3.7.1.12. Contractor's responsibilities for coordination of Member care.

3.3.7.1.13. Information about where and how to obtain counseling and referral services that Contractor does not cover because of moral or religious objections.

3.3.7.1.13.1. Contractor shall notify Members when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections at least 30 days prior to the effective date of the policy for any particular service.

3.3.7.1.14. To the extent possible, quality and performance indicators for Contractor, including Member satisfaction.

3.3.8. Member Rights

3.3.8.1. Contractor shall have written policies guaranteeing each Member's right to be treated with respect and due consideration for his or her dignity and privacy.

3.3.8.2. Contractor shall provide information to Members regarding their Member Rights as stated in 42 C.F.R. § 438100 that include, but are not limited to:

3.3.8.2.1. The right to be treated with respect and due consideration for their dignity and privacy.

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

3.3.8.2.3. The right to participate in decisions regarding their health care, including the right to refuse treatment.

3.3.8.2.4. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

3.3.8.2.5. The right to request and receive a copy of their medical records and request that they be amended or corrected.

3.3.8.2.6. The right to obtain available and accessible services under the Contract.

3.3.8.2.7. Freely exercise their rights with Contractor or its providers treating the Member adversely.

3.3.8.3. Contractor shall post and distribute Member rights to individuals, including but not limited to:

3.3.8.3.1. Members.

3.3.8.3.2. Member's families, legal guardians or caregivers.

3.3.8.3.3. Providers.

3.3.8.3.4. Case workers.

3.3.8.3.5. Stakeholders.

3.3.8.4. Contractor shall have written policies guaranteeing each Member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

3.3.9. Member Handbook

3.3.9.1. Contractor shall collaborate with Department to create a Member Handbook for distribution to newly enrolled and existing Members that meets the requirements of 42 C.F.R. § 43810. The Member Handbook shall include, at a minimum, all of the following:

3.3.9.1.1. Information that enables the Member to understand how to effectively use the Program.

3.3.9.1.2. Information that enables the Member to understand how to select and change their PCMP.

3.3.9.1.3. The amount, duration, and scope of benefits available under the contracts in sufficient detail to ensure that Members understand the benefits to which they are entitled.

3.3.9.1.4. Procedures for obtaining benefits, including any requirements for service authorizations or referrals for specialty care, and for other benefits not furnished by the enrollee's PCMP.

3.3.9.1.5. Extent to which, and how, Members may obtain benefits, including family planning services and supplies from out-of-network Providers.

3.3.9.1.6. Extent to which, and how, after hours and emergency coverage are provided. Contractor shall ensure that this information includes at least the following:

3.3.9.1.6.1. An explanation that an emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child)

in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

3.3.9.1.6.2. An explanation that emergency services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Colorado Medicaid and needed to evaluate or stabilize an emergency medical condition.

3.3.9.1.6.3. An explanation that Post-Stabilization Care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition when Contractor does not respond to a request for pre-approval within one hour, Contractor cannot be contacted, or Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a Managed Care Entity physician is not available for consultation.

3.3.9.1.6.4. A statement that prior authorization is not required for emergency services.

3.3.9.1.6.5. The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent.

3.3.9.1.6.6. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contracts.

3.3.9.1.6.7. A statement that the Member has the right to use any hospital or other setting for emergency care.

3.3.9.1.7. Any restrictions on the Member's freedom of choice among Network Providers.

3.3.9.1.8. A statement that prior authorization is not required to receive services from family planning providers.

3.3.9.1.9. Information about the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and how to access component services if the Member is under the age of 21 and is entitled to the EPSDT benefit.

3.3.9.1.10. Member rights and responsibilities.

3.3.9.1.11. Explanation of access to Member benefits available under the State Plan but not covered under the Contract, including cost sharing, how to request transportation and mileage reimbursement, and how to locate information and updates to the Colorado Prescription Drug List (PDL) program.

3.3.9.1.12. The TOC policies for Members and potential Members.

3.3.9.1.13. Information on how to report suspected fraud or abuse.

3.3.9.1.14. A section with information specific to Contractor's Region.

3.3.9.1.15. Contractor shall submit contact information for inclusion in the Member Handbook to Department.

3.3.9.1.15.1. DELIVERABLE: Colorado Medicaid Member Handbook Contractor contact information.

3.3.9.1.15.2. DUE: Five Business days after the Effective Date.

3.3.9.2. Contractor shall update Contractor's contact information for the Member Handbook and submit it to Department when significant changes occur.

3.3.9.2.1. DELIVERABLE: Updated Colorado Medicaid Member Handbook Contractor contact information

3.3.9.2.2. DUE: 30 calendar days prior to any contact changes taking effect.

3.3.10. Contractor Website

3.3.10.1. Contractor shall develop and maintain a customized and comprehensive website that follows modern principles of optimizing user experience on mobile and personal computer platforms and is navigable by individuals who have low literacy or disabilities, or require language assistance. Contractor shall ensure the website provides online access to general customer service information that includes:

3.3.10.1.1. Contractor's contact information.

3.3.10.1.2. Member rights and handbooks.

3.3.10.1.3. Grievance and Appeal procedures and rights.

3.3.10.1.4. General functions of Contractor.

3.3.10.1.5. Trainings.

3.3.10.1.6. Access to care standards.

3.3.10.1.7. Health First Colorado Nurse Advice Line.

3.3.10.1.8. Colorado Crisis Services information.

3.3.10.1.9. Non-Emergency Medical Transportation benefit information including links for regional providers and instructions for obtaining rides and submitting requests for mileage reimbursement.

3.3.10.2. For PCMPs and behavioral health providers, Contractor shall make information on Contractor's network providers available to Members as a provider directory in electronic form and in paper form upon request.

3.3.10.2.1. Contractor shall ensure that the electronic provider directory is updated no later than 5 calendar days after Contractor receives updated provider information.

3.3.10.2.2. Contractor shall update the paper provider directory at least quarterly as required by 42 CFR 43810(h)(3).

3.3.10.2.3. Contractor shall make the provider directory available on its website in a machine-readable file and format, as specified by the Secretary of Department of Health and Human Services.

3.3.10.2.4. Contractor shall include the following information about Network Providers in the provider directory:

3.3.10.2.4.1. Names, as well as any group affiliations.

3.3.10.2.4.2. Street addresses.

3.3.10.2.4.3. Telephone numbers.

3.3.10.2.4.4. Website URLs, as appropriate.

3.3.10.2.4.5. Specialties, as appropriate.

3.3.10.2.4.6. Whether network providers will accept new Members.

3.3.10.2.4.7. The cultural and linguistic capabilities of network providers, including languages including, but not limited to, American Sign Language (ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

3.3.10.2.4.8. Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

3.3.10.3. Contractor shall provide a link to Department's website on Contractor's website for standardized information such as Member rights and handbooks, as well as a statement that all information is available to Members in paper form upon request.

3.3.10.4. Contractor's website shall include information on Contractor's Member engagement process, such as Member advisory councils.

3.3.10.5. Contractor shall organize the website to allow for easy access of information by Members, family Members, providers, stakeholders and the general public in compliance with the Americans with Disabilities Act (ADA) and the Rehabilitation Act.

3.3.10.6. Contractor shall ensure that web materials are also printer-friendly.

3.3.11. Termination of Provider Agreement

3.3.11.1. Upon termination of a Network Provider's agreement, for any reason, Contractor shall make a good faith effort to give written notice of termination of a Network Provider to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Network Provider. As required in 42 C.F.R. § 438.10(f)(1), notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice. This notification may be made in collaboration with Department in a format that creates the least administrative burden.

3.3.11.1.1. DELIVERABLE: Notice to Members of Network Provider Termination

3.3.11.1.2. DUE: 15 calendar days from the notice of termination.

3.3.12. Information on Grievance and Appeals Process

3.3.12.1. Contractor shall provide information to Members on Grievance, Appeals and State Fair Hearing procedures and timelines, as described in Section 4. The description shall include at least the following:

3.3.12.1.1. A Member's right to file Grievances and Appeals.

3.3.12.1.2. The toll-free number the Member can use to file a Grievance or Appeal by phone.

3.3.12.1.3. Requirements and timeframes for filing a Grievance or Appeal.

3.3.12.1.4. Availability of assistance for filing a Grievance, Appeal, or State Fair Hearing.

3.3.12.1.5. A Member's right to a State Fair Hearing.

3.3.12.1.6. The method for obtaining a State Fair Hearing.

3.3.12.1.7. The rules that govern representation at the State Fair Hearing.

3.3.12.1.8. That benefits will continue, when requested by the Member, if the Member files a timely Appeal or State Fair Hearing request and that if the action is upheld, the Member may be liable for the cost of any continued benefits.

3.3.12.1.9. Any Appeal rights the state makes available to providers to challenge the failure of Contractor to cover a service.

3.3.13. Advance Directives

3.3.13.1. Contractor shall work with Department to improve the process for educating Members on end-of-life planning and care coordination, collective directives and other related end-of-life planning documentation and hosting such information for ease of access by providers and care coordinators.

3.3.13.2. At the time of initial enrollment, Contractor shall provide written information to adult Members with respect to advance directives policies, and include:

3.3.13.2.1. A description of applicable state law.

3.3.13.2.2. Contractor's advance directives policies, including a description of any limitations Contractor places on the implementation of advance directives as a matter of conscience.

3.3.13.2.3. Instructions that complaints concerning noncompliance with advance directives requirements may be filed with the Colorado Department of Public Health and Environment.

3.3.13.2.4. Notice that Members have the right to request and obtain this information at least once per year.

3.3.13.3. In the event of a change in state law, Contractor shall reflect these changes to its advance directives information no later than 90 days after the effective date of the change.

3.3.13.4. Contractor shall maintain written policies and procedures on advance directives for all adults receiving medical care by or through Contractor.

3.3.13.5. Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

3.3.13.6. Contractor shall educate staff concerning its policies and procedures on advance directives.

3.3.14. Other Member information

3.3.14.1. Contractor shall provide other necessary information to Members and their families, as determined by Department. This information shall include, but not be limited to the services provided by Early Periodic Screening, Diagnostic and Treatment (EPSDT) and how to obtain additional information.

3.3.15. Member Material Review Process

3.3.15.1. Contractor shall notify Department at least 30 Business Days prior to Contractor's printing or disseminating any large-scale Member communication initiatives.

3.3.15.2. Contractor shall describe the purpose, frequency, and format of the planned Member communication.

3.3.15.2.1. DELIVERABLE: Notification of large-scale Member communication initiative

3.3.15.2.2. DUE: At least 30 Business Days prior to Contractor printing or disseminating any large-scale Member communication initiatives

3.3.15.3. Contractor shall work with Department to make any suggested changes to the Member communication initiative to align Contractor's communication with Department's communication standards and strategies.

3.3.15.4. Department may review any Member materials used by Contractor and request changes or redrafting of Member materials as Department determines necessary to ensure that the language is easy to understand and that the document aligns with Department standards. Contractor shall make any changes to the Member materials requested by Department. This requirement does not apply to individual correspondence for a specific Member.

3.3.15.5. Contractor shall ensure that all Member materials have been Member-tested and meet the state's accessibility requirements in Section 16, U of the General Provisions.

3.3.16. Electronic Distribution of Federally Required Information

3.3.16.1. In order to electronically distribute information required by 42 C.F.R. § 438.10 to Members, Contractor shall meet all of the following conditions:

3.3.16.1.1. The format is readily accessible and complies with modern accessibility standards such as the Americans with Disabilities Act, Sections 504 and 508 of the Rehabilitation Act, and the latest Web content Accessibility Guidelines (WCAG) by W3C.

3.3.16.1.2. The information is placed in a location on the state or Contractor's website that is prominent and readily accessible.

3.3.16.1.3. The information is provided in an electronic form, which can be electronically retained and printed.

3.3.16.1.4. The information is consistent with the content and language requirements of 42 C.F.R. § 438.10.

3.3.16.1.5. The Member is informed that the information is available in paper form without charge upon request and Contractor provides the information upon request within five Business Days.

3.3.16.2. Contractor shall send an electronic communication at least every six months to all assigned Members providing information on how Members can update their contact information and enrollment information. When possible, this communication should be combined with the Contractor's other communication activities.

3.3.16.2.1. Contractor shall provide assistance to help Members with submitting updated contact information via PEAK at CO.gov/PEAK or in the Health First Colorado mobile application (free and available from Apple and Google Play), depending on Member access to these options.

3.3.16.3. Contractor shall have a Department approved process for outreach to all Members scheduled for renewal, offering to assist them in responding to renewal requests for additional information and submitting necessary renewal forms. Contractor shall use multiple modalities when conducting such outreach, including telephone, email, and text.

3.4. Marketing

3.4.1. Contractor shall not engage in any Marketing Activities, as defined in 42 C.F.R. § 438.104, during the Start-Up Period.

3.4.2. During the Contract phase, Contractor may engage in Marketing Activities at its discretion. Contractor shall not distribute any Marketing materials without Department's review and approval of material.

3.4.3. Contractor shall submit all materials relating to Marketing Activities to Department and shall allow Department and its State Medical Assistance and Services Advisory Council to review any materials Contractor proposes to use for Marketing Activities before distributing the materials. Department may require changes to any materials before Contractor may distribute those materials or may disallow the use of any specific materials in its sole discretion.

3.4.4. Contractor shall specify methods of assuring Department that Marketing, including plans and materials, is accurate and does not mislead, confuse or defraud Members or Department.

3.4.5. Contractor shall distribute the marketing materials to its entire Region as defined by the Contract.

3.4.6. Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

3.4.7. Contractor and any Subcontractors or affiliates shall not, directly or indirectly, engage in email, text, door-to- door, telephone or other cold call marketing activities, including of programs and services not required in the Work.

3.4.8. Contractor may text Members regarding issues with eligibility and provision of Medicaid services as permitted under the Telephone Consumer Protection Act.

3.4.9. Contractor shall not create Marketing materials that contain any assertion or statement, whether written or oral, that the potential Member must enroll with Contractor to obtain benefits or not to lose benefits.

3.4.10. Contractor shall ensure that Marketing materials do not contain any assertion or statement, whether written or oral, that Contractor is endorsed by the Centers for Medicare and Medicaid Services, the federal or state government or similar entity.

3.4.11. Contractor shall only engage in Marketing Activities in compliance with federal and state laws, regulations, policies and procedures.

3.5. Health Needs Survey

3.5.1. Department has developed a Health Needs Survey to be completed by Members as part of the onboarding process to capture some basic information about a Member's individual needs. The Health Needs Survey is a brief set of questions capturing important and time- sensitive health information.

3.5.2. Contractor shall use the results of the Health Needs Survey, provided by Department, to inform Member outreach and Care Coordination activities.

3.5.3. Contractor shall have the capability to process a daily data transfer from Department or its delegate containing responses to Member Health Needs Surveys.

3.5.3.1. Contractor shall review the Member responses to the Health Needs Survey each Business Day to identify Members who may benefit from timely contact and support from the Member's PCMP or RAE.

3.5.3.2. Contractor shall outreach Members who have completed the Health Needs Survey as expeditiously as the Member's reported need requires but not later than three Business Days from the date the Member submitted the Health Needs Survey.

3.5.4. Department reserves the right to adjust the Health Needs Survey during the term of the contract. Contractor shall assist Department in improving this survey and its ability to meet the objectives of the ACC to identify chronic conditions, emerging health risks and opportunities for intervention, health-related social needs, care coordination, and cost control. Contractor shall work with Department to smoothly implement any new tools or aggregate Member information to better meet the objectives of the Needs Survey and the ACC.

3.6. Promotion of Member Health and Wellness

3.6.1. Contractor shall develop programs and materials that complement Department initiatives and other activities to assist Members in effectively utilizing Medicaid benefits and to support Members in becoming proactive participants in their health and well-being.

3.6.2. Contractor shall develop, implement and promote evidenced-based wellness and prevention programs for its Members. Contractor shall seek to promote and provide wellness and prevention programming aligned with similar programs and services promoted by Department such as case management programs for maternity, diabetes, hypertension, asthma, chronic obstructive pulmonary disease (COPD), pediatric wellness and overall health promotion programs, which include tobacco cessation and

behavioral health screenings and follow-up care. Contractor shall also participate in other Colorado public health initiatives at the direction of Department.

3.6.3. Contractor shall provide Members with general health information and provide services to help Members make informed decisions about their health care needs. Contractor shall encourage Members to take an active role in shared decision-making while addressing specific condition management promotion programs.

3.6.4. Member Incentives

3.6.4.1. Contractor shall promote personal responsibility through the use of incentives and care management. Contractor shall reward Members for activities and behaviors that promote good health, health literacy, and Continuity of Care. Department shall review and approve all reward activities proposed by Contractor prior to their implementation.

3.6.4.2. Contractor shall ensure that all incentives are cost-effective and have a linkage to Department's goals for the ACC or value-based payment strategies.

3.6.4.3. For all approved Member Incentive Programs, Contractor shall provide to participating Members cash or other incentives.

3.6.4.3.1. Incentives may include cash, gift cards for specific retailers, vouchers for a farmers' market, contributions to health savings accounts that may be used for health-related purchases or gym Memberships.

3.6.4.3.2. Incentives shall not, in a given fiscal year for any one Member, exceed a total monetary value of $250.00.

3.6.4.4. Contractor shall submit to Department for review and approval all Member Incentive Program plan proposals prior to implementation.

3.6.4.4.1. Contractor shall provide adequate assurances that the Member Incentive Program plan meets Department's criteria for incentive programs and the requirements of the Social Security Act.

3.6.4.5. Contractor shall report to Department, at least annually, the results of any Member Incentive Programs in effect in the prior 12 months, including, but not limited to, the following metrics:

3.6.4.5.1. The incentive(s) offered.

3.6.4.5.2. The number of Members in the program's target population, as determined by Contractor.

3.6.4.5.3. The number of Members who received any incentive payment, and the number who received the maximum amount as a result of participation in the program.

3.6.4.5.4. The total value of the incentive payments.

3.6.4.5.5. An analysis of the statistically relevant results of the program to include percent of engaged participants and progress toward program goals.

3.6.4.5.6. Identification of goals and objectives for the next year, informed by the data.

3.6.4.6. Contractor shall partner with Department to develop and implement at least one Member Healthy Behavior Incentive Program designed to address one of Department's priority areas, including but not limited to:

3.6.4.6.1. Increase the timeliness of prenatal care.

3.6.4.6.2. Address obesity.

3.6.4.6.3. Prevent diabetes.

3.6.4.6.4. Support smoking cessation.

3.6.5. Contractor is encouraged to test and evaluate different Member health promotion and activation strategies, from high-touch, personal interactions to technology-based solutions.

3.6.6. Contractor shall monitor and share lessons learned at the Operational Learning Collaborative.

3.6.7. Contractor shall collaborate with Department on joint initiatives, as appropriate.

3.6.8. Contractor shall submit to Department a Prevention, Wellness, and Member Engagement Report describing the Contractor's activities during the previous six months and strategy for the upcoming six months. The Prevention, Wellness, and Member Engagement Report shall align with the Contractor's Population Management Strategic Plan and shall describe the Contractor's efforts to promote prevention and engage Members in chronic condition and high-risk case management activities.

3.6.8.1. DELIVERABLE: Prevention, Wellness, and Member Engagement Report

3.6.8.2. DUE: Every six months, by December 15 and June 15

4. GRIEVANCES AND APPEALS

4.1. Overview

4.1.1. In accordance with 42 C.F.R. § 438 Subpart F and ten CCR 2505-ten, Section 8.209 of the Medicaid state rules for Managed Care Grievances and Appeals Processes, Contractor shall have a Grievance and Appeal system, as well as processes to collect and track information about them.

4.1.2. Contractor shall remain in compliance with Department's procedures for handling Appeals of physical health Adverse Benefit Determinations and shall assist Members in following Department's procedures.

4.1.3. Contractor shall give Members assistance in completing forms and other procedural steps in the Grievance and Appeals process, including, but not limited to, providing interpreter services and toll-free numbers with a Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability.

4.1.4. In compliance with 42 CFR 438.414 and 42 CFR 43810(g)(2)(xi), Contractor shall inform Network Providers and subcontractors, at the time they enter into a contract, about the following:

4.1.4.1. The Member's right to file an Appeal or Grievance, including:

4.1.4.1.1. The requirements and timeframes for filing.

4.1.4.1.2. The availability of assistance with filing.

4.1.4.1.3. The toll-free number to file orally.

4.1.4.1.4. The Member's right to a State Fair Hearing, how Members obtain a hearing, and the representation rules at a hearing.

4.1.4.1.5. The Member's right to request a continuation of benefits during an Appeal or State Fair Hearing filing.

4.1.4.2. Any rights the Provider has, with the written consent of the Member, to submit a Grievance, Appeal or otherwise challenge the failure of Contractor to cover a service.

4.1.4.3. Any timeliness considerations in filing a Grievance, filing for an Appeal, filing for a State Fair Hearing, or seeking a continuation of benefits.

4.1.5. With the written consent of the Member, Contractor shall allow a Provider or an authorized representative to request an appeal, file a grievance, or request a State fair hearing on behalf of a Member. When Member is used throughout this Section, it includes providers and authorized representatives consistent with this paragraph, with the exception that Providers cannot request continuation of benefits.

4.2. Quality of Care Grievances

4.2.1. Contractor shall establish and maintain a Quality of Care Grievance (QOCG) process through which individuals may express dissatisfaction about any matter related to this Contract other than an Adverse Benefit Determination. Expressions of dissatisfaction may include, but are not limited to:

4.2.1.1. Concern about having been misdiagnosed.

4.2.1.2. Concern about not receiving appropriate treatment.

4.2.1.3. Concern about receiving, or not receiving, care that adversely impacts or has the potential to adversely impact their health.

4.2.1.4. Concern about receiving covered services for which the quality provided by the health plan or provider does not meet professionally recognized standards of health care, including health care services not provided to the Member, or services provided in inappropriate settings.

4.2.2. Contractor shall take action to investigate all QOCGs for their Members, regardless of whether the QOCG is regarding a Network Provider or non-Network Provider.

4.2.3. Contractor shall have a QOCG process to document and respond to all QOCGs.

4.2.4. Contractor shall ensure that information about the QOCG process, including how to file a QOCG, is available to all Members and is provided to all Network Providers and subcontractors.

4.2.5. Contractor shall allow individuals to file a QOCG either verbally or in writing and shall acknowledge receiving the QOCG, per 42 CFR 438.402 and 42 CFR 438.406.

4.2.5.1. Contractor shall provide an individual with written notice of QOCG receipt within two business days.

4.2.6. Contractor shall not discourage the filing of QOCGs.

4.2.7. Contractor shall send preliminary information on QOCGs to Department using a reporting template or process established by Department.

4.2.7.1. DELIVERABLE: QOCG Reporting

4.2.7.2. DUE: Within two Business Days of receipt of the QOCG or issue identification by Contractor

4.2.8. When a QOCG is identified, Contractor shall conduct a formal inquiry, analyze, track, trend, and resolve QOCGs by doing the following, at a minimum:

4.2.8.1. Investigate the potential QOCG to determine whether the quality of care and services met professionally recognized standards of care.

4.2.8.2. Follow-up with the Member to determine if the Member's immediate health care needs are being met.

4.2.8.3. Refer QOCGs to Contractor's peer review committee when this venue is available and appropriate. Contractor shall manage peer review deliberations and results as set forth in Sections 12-36.5-104 and 12-36.5- 104.4, C.R.S. When a QOCG has been referred to peer review, Contractor shall inform the reporting individual of this in writing, including the provisions of Sections 12-36.5-104 and 12-36.5-104.4, C.R.S., which will limit disclosure of the results.

4.2.8.4. Refer or report the QOCG to the appropriate regulatory agency and Child or Adult Protective Services for further research, review, or action, when appropriate.

4.2.8.5. Notify the appropriate regulatory or licensing board or agency when the affiliation of a Network Provider is suspended or terminated due to a QOCG.

4.2.8.5.1. Contractor shall confer with Department if they are unsure of who the appropriate entities are that they must notify.

4.2.8.6. Make a recommendation to Department for how to resolve a QOCG regarding a non-Network Provider.

4.2.8.7. Ensure that Contractor decision-makers on QOCGs are not involved in prior levels of review or are subordinate to any Contractor staff who participated in a prior level of review, per 42 CFR 438.406.

4.2.8.8. Resolve QOCGs and provide verbal and written notice to the Member of the resolution within 90 calendar days of when the Member files the QOCG, per 42 CFR 438.408.

4.2.8.9. Extend the review timeline for 14 calendar days if a reporting individual requests an extension or if the delay is in the Member's best interest, per 42 CFR 438.408.

4.2.8.9.1. Contractor shall provide notification to Department that a QOCG review timeline is being extended at least two business days in advance of the first day of the extension.

4.2.8.9.2. Contractor shall provide documentation that demonstrates the need for an extension, if requested to by Department.

4.2.8.10. Inform the reporting individual of an extension to the review of their QOCG, if applicable, per 42 CFR 438.408.

4.2.8.10.1. Make reasonable efforts to give the reporting individual verbal notice of the delay, per 42 CFR 438.408.

4.2.8.10.2. Provide the reporting individual with written notice of the delay, within two business days, including the reason to extend the review timeframe and the Member's right to file a Grievance if they disagree with the decision to allow an extension to the resolution timeframe, per 42 CFR 438.408.

4.2.8.11. If a reporting individual is dissatisfied with the resolution of the QOCG, the reporting individual may bring the unresolved QOCG to Department for review and decision making. Department's decision on a QOCG is final.

4.2.8.12. Contractor shall document each QOCG in a summary to be sent to Department. This summary shall include, at a minimum:

4.2.8.12.1. Contact information for the reporting individual.

4.2.8.12.2. A description of the QOCG, including issues, dates, facility, provider, and involved parties, as applicable.

4.2.8.12.3. Steps taken by Contractor during the QOCG investigation and resolution process, including the name of the representative who documented and resolved the grievance.

4.2.8.12.4. Whether there was evidence to support or prove the truth of the QOCG.

4.2.8.12.5. Corrective action(s) implemented and their effectiveness.

4.2.8.12.6. Risk level of care, using a scale identified by Department.

4.2.8.12.7. Evidence of the QOCG resolution.

4.2.8.12.8. Any referral made by Contractor to peer review, a regulatory agency or a licensing board or agency. Contractor shall manage peer review information as set forth in Sections 12-36.5-104 and 12-36.5- 104.4, C.R.S.

4.2.8.12.9. Any notification made by Contractor to a regulatory or licensing agency or board.

4.2.8.12.10. Any outcome of the review, as determined by Contractor.

4.2.8.12.11. Contractor shall deliver QOCG summary to Department for review and approval in format agreed upon by Contractor and Department.

4.2.8.12.11.1. DELIVERABLE: QOCG Summary

4.2.8.12.11.2. DUE: Within 90 calendar days of Contractor receipt or knowledge of the QOCG, or within one Business Day of the end of an extension period.

4.2.9. Contractor shall document any QOCG submitted by a Network Provider to Contractor, and the solutions Contractor has offered to the Network Provider. Department may

review any of the documented solutions upon request. If Department determines the solution to be insufficient or otherwise unacceptable, it may direct Contractor to find a different solution or to follow a specific course of action.

4.2.10. If Department is contacted by a Member, a Member's family Member or caregiver, advocates, the Ombudsman for Medicaid Managed Care, or other individuals/entities with a QOCG regarding concerns about the care or lack of care a Member is receiving, Contractor shall keep Department informed about progress on resolving concerns in real time and shall advise Department of final resolution.

4.2.11. For QOCGs involving Network Providers, Contractor may have the QOCG reviewed by its professional review committee, as set forth in Sections 12-36.5-104 and 12-36.5-104.4, C.R.S.

4.2.11.1. Contractor shall follow state reporting and confidentiality requirements, per 12-36.5-104 and 12-36.5-104.4, C.R.S.

4.2.11.2. Contractor shall inform Department if it refers the matter to a peer review process.

4.2.12. Department may share information about QOCG investigations with Contractor.

4.2.12.1. Following receipt of QOCG information from Department, Contractor and Department shall collaborate on Department guidance for actions towards impacted Provider(s) regarding payments and restrictions on serving Members.

4.3. Notice of Adverse Benefit Determination

4.3.1. When a Contractor makes an adverse benefit determination as described in 42 C.F.R. § 438.400, Contractor shall send to the Member a notice of adverse benefit determination that meets the following requirements:

4.3.1.1. Is in writing.

4.3.1.2. Complies with the Member correspondence requirements of Colorado Revised Statute § 25.5-4-212(3):

4.3.1.2.1. Is written using person-first, plain language.

4.3.1.2.2. Is written in a format that includes the date of the correspondence and a Member greeting.

4.3.1.2.3. Is consistent, using the same terms throughout to the extent practicable including commonly used program names.

4.3.1.2.4. Is accurately translated into the second most commonly spoken language in the state if a Member indicates that this is the Member's written language of preference or as required by law.

4.3.1.2.5. Includes a statement translated into the top fifteen languages most commonly spoken by individuals in Colorado with limited English proficiency informing an applicant or Member how to seek further assistance in understanding the content of the correspondence.

4.3.1.2.6. Clearly conveys the purpose of the Member correspondence, the action or actions being taken by Department or its designated entity, if any, and the

specific action or actions that the Member must or may take in response to the correspondence.

4.3.1.2.7. Includes a specific description of any necessary information or documents requested from the applicant or Member.

4.3.1.2.8. Includes contact information for Member questions.

4.3.1.2.9. Includes a specific and plain language explanation of the basis for the denial, reduction, suspension, or termination of the benefit if applicable.

4.3.1.3. Complies with the language and format requirements of 42 C.F.R. § 43810, including but not limited to:

4.3.1.3.1. Is available in the state-established prevalent non-English languages in its region.

4.3.1.3.2. Is available in alternative formats for persons with special needs.

4.3.1.3.3. Is in an easily understood language and format.

4.3.1.3.4. Includes taglines in the prevalent non-English languages in the State, explaining the availability of written translations or oral interpretation to understand the information provided, and information on how to request auxiliary aids and services.

4.3.1.4. Explains the adverse benefit determination Contractor or its subcontractor has taken or intends to take.

4.3.1.5. Explains the reasons for the adverse benefit determination.

4.3.1.6. Identifies alternate services and/or level of care that are recommended instead of the requested service when the original request is denied for lack of medical necessity.

4.3.1.7. Provides information about the Member's right to file an Appeal, or the Provider's right to file an Appeal when the Provider is acting on behalf of the Member as the Member's designated representative.

4.3.1.8. Explains the Member's right to request a State Fair Hearing.

4.3.1.9. Describes how a Member can Appeal.

4.3.1.10. Gives the circumstances under which expedited resolution of an Appeal is available and how to request it.

4.3.1.11. Explains the Member's right to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued.

4.3.1.12. Explains the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's adverse benefit determination.

4.3.1.13. Explains how each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services.

4.3.2. Contractor shall ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

4.3.3. Contractor shall give notice according to the following schedule:

4.3.3.1. At least ten days before the date of action, if the adverse benefit determination is a termination, suspension or reduction of previously authorized Medicaid-covered services.

4.3.3.2. As least five days prior to the date of adverse benefit determination if Contractor has verified information indicating probable beneficiary fraud.

4.3.3.3. By the date of adverse benefit determination when any of the following occur:

4.3.3.3.1. The Member has died.

4.3.3.3.2. The Member submits a signed written statement requesting service termination.

4.3.3.3.3. The Member submits a signed written statement including information that requires termination or reduction and indicates that the Member understands that service termination or reduction will occur.

4.3.3.3.4. The Member has been admitted to an institution in which the Member is ineligible for Medicaid services.

4.3.3.3.5. The Member's address is determined unknown based on returned mail with no forwarding address.

4.3.3.3.6. The Member is accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.

4.3.3.3.7. A change in the level of medical care is prescribed by the Member's physician.

4.3.3.3.8. The notice involves an adverse determination with regard to preadmission screening requirements.

4.3.3.3.9. The transfer or discharge from a facility will occur in an expedited fashion.

4.3.3.4. On the date of adverse benefit determination when the adverse benefit determination is a denial of payment.

4.3.3.5. As expeditiously as the Member's health condition requires, but no longer than ten calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

4.3.3.5.1. Contractor may extend the ten calendar day service authorization notice timeframe of up to 14 additional days if the Member or the Provider requests extension; or if Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

4.3.3.5.2. If Contractor extends the ten-day service authorization notice timeframe, it must give the Member written notice of the reason for the extension and

inform the Member of the right to file a Grievance if he/she disagrees with the decision.

4.3.3.5.3. If Contractor extends the ten-day service authorization notice timeframe, it must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

4.3.3.6. On the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.

4.3.3.7. For cases in which a Provider, or Contractor, determine that following the standard authorization timeframe could seriously jeopardize the Member's life or health or his/her ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than 72 hours after receipt of the request for service.

4.3.3.7.1. Contractor may extend the 72-hour expedited service authorization decision time period by up to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

4.3.4. Contractor shall notify the requesting Provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

4.4. Handling Appeals for the Capitated Behavioral Health Benefit

4.4.1. Contractor shall handle Appeals of adverse benefit determination for the Capitated Behavioral Health Benefit, in compliance with 42 C.F.R. § 438.400.

4.4.2. Contractor shall acknowledge receipt of each Appeal, in accordance with 42 C.F.R. § 438.406(b)(1).

4.4.3. Contractor shall ensure that decision makers on Appeals were not involved in previous levels of review or decision-making nor a subordinate of any such individual.

4.4.4. The decision maker shall be a health care professional with clinical expertise in treating the Member's condition or disease if any of the following apply:

4.4.4.1. The Member is appealing a denial that is based on lack of Medical Necessity.

4.4.4.2. The grievance or appeal involves clinical issues.

4.4.5. Contractor shall allow Members, and Providers acting on behalf of a Member and with the Member's written consent, to file Appeals:

4.4.5.1. Within 60 calendar days from the date of Contractor's notice of adverse benefit determination.

4.4.6. Contractor shall ensure that oral inquiries seeking to Appeal an adverse benefit determination are treated as Appeals.

4.4.7. If the Member, or Provider acting on behalf of the Member, orally requests an expedited Appeal, Contractor shall not require a written, signed Appeal following the oral request.

4.4.8. Contractor shall provide a reasonable opportunity for the Member to present evidence and allegations of fact or law, in person as well as in writing.

4.4.9. If the Member requests an expedited Appeal resolution, Contractor shall inform the Member of the limited time available to present evidence and allegations of fact or law.

4.4.10. Contractor shall give the Member and the Member's representative an opportunity, sufficiently in advance before and during the Appeals process, to examine the Member's case file, including medical records and any other documents and records free of charge and sufficiently in advance of the resolution timeframe.

4.4.11. Contractor shall consider the Member, the Member's representative, or the legal representative of a deceased Member's estate as parties to an Appeal.

4.4.12. Contractor shall take no punitive action against a provider who either requests an expedited resolution or supports a Member's Appeal, in accordance with 42 C.F.R. § 438.4ten.

4.4.13. Contractor shall have only one level of Appeal for enrollees as required by 42 C.F.R. § 438.402(b).

4.4.14. Continuation of Benefits and Services During an Appeal

4.4.14.1. Contractor shall continue the Member's benefits while a Capitated Behavioral Health Benefit Appeal is in the process if all of the following are met:

4.4.14.1.1. The Member files the request for an appeal within 60 calendar days from the date of Contractor's notice of adverse benefit determination in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii).

4.4.14.1.2. A request for a continuation of benefits is filed on or before the later of:

4.4.14.1.2.1. ten days after Contractor mailed the notice of adverse benefit determination.

4.4.14.1.2.2. The intended effective date of Contractor's proposed adverse benefit determination.

4.4.14.1.3. The Appeal involves the termination, suspension or reduction of a previously authorized course of treatment.

4.4.14.1.4. The services were ordered by an authorized Provider.

4.4.14.1.5. The authorization period has not expired.

4.4.14.2. If Contractor continues or reinstates the Member's benefits while the Appeal is pending, the benefits shall be continued until one of the following occurs:

4.4.14.2.1. The Member withdraws the Appeal or request for a State Fair Hearing.

4.4.14.2.2. The Member does not request a State Fair Hearing with continuation of benefits within ten days after the date Contractor mails an adverse Appeal decision.

4.4.14.2.3. A State Fair Hearing decision adverse to the Member is made.

4.4.14.2.4. The service authorization expires, or the authorization limits are met.

4.4.14.3. Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date of reversal if the services were not furnished while the Appeal was pending, and if Contractor or State Fair Hearing Officer reverses a decision to deny, limit, or delay services.

4.4.14.4. Contractor shall pay for disputed services received by the Member while the Appeal was pending, unless state policy and regulations provide for the state to cover the cost of such services, when Contractor or State Fair Hearing Officer reverses a decision to deny authorization of the services.

4.4.15. Resolution and Notification of Appeals

4.4.15.1. Contractor shall resolve each Appeal and provide notice as expeditiously as the Member's health condition requires and no later than the date the extension expires, and not to exceed the following:

4.4.15.1.1. For standard resolution of an Appeal and notice to the affected parties, ten working days from the day the MCO or PIHP receives the Appeal.

4.4.15.2. Contractor may extend the timeframe for processing an Appeal by up to 14 calendar days if the Member requests; or Contractor shows (to the satisfaction of Department, upon its request) that there is a need for additional information and that the delay is in the Member's best interest.

4.4.15.2.1. Contractor shall provide the Member with written notice within two calendar days after the extension of the reason for any extension to the timeframe for processing an Appeal that is not requested by the Member. Contractor shall establish and maintain an expedited review process for Appeals when Contractor determines from a request from the Member or when the Network Provider indicates, in making the request on the Member's behalf or supporting the Member's request, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

4.4.15.2.2. If Contractor denies a request for expedited resolution of an Appeal, Contractor shall transfer the Appeal to the standard timeframe for Appeal resolution and give the Member prompt oral notice of the denial and a written notice within two calendar days after receiving the request for expedited resolution.

4.4.15.2.3. Contractor shall resolve each expedited Appeal and provide notice as expeditiously as the Member's health condition requires, within state-established timeframes not to exceed 72 hours after Contractor receives the expedited Appeal request.

4.4.15.2.4. Contractor may extend the timeframe for processing an expedited Appeal by up to 14 calendar days if the Member requests the extension; or Contractor

shows that there is need for additional information and that the delay is in the Member's best interest.

4.4.15.2.5. Contractor shall provide the Member with written notice within two calendar days and make a reasonable effort to give the Member prompt oral notice of the reason for any extension to the timeframe for processing an expedited Appeal that is not requested by the Member and inform the Member of the right to file a grievance if he or she disagrees with that decision.

4.4.15.2.6. Contractor shall provide written notice, and make reasonable efforts to provide oral notice, of the resolution of an expedited Appeal.

4.4.15.3. Contractor shall provide written notice of the disposition of the Appeals process, which shall include the results and data of the Appeal resolution.

4.4.15.4. For Appeal decisions not wholly in the Member's favor, Contractor shall include the following:

4.4.15.4.1. The Member's right to request a State Fair Hearing.

4.4.15.4.2. How the Member can request a State Fair Hearing.

4.4.15.4.3. The Member's right to continue to receive benefits pending a hearing.

4.4.16. State Fair Hearing

4.4.16.1. Contractor shall allow a Member to request a State Fair Hearing after the Member received notice that Contractor has upheld the adverse benefit determination.

4.4.16.1.1. The Member has 120 calendar days from the date of Contractor's adverse resolution notice to request a State Fair Hearing.

4.4.16.2. If Contractor does not adhere to the notice and timing requirements regarding a Member's Appeal, the Member is deemed to have exhausted the Appeal process and may request a State Fair Hearing.

4.4.16.3. Contractor shall be a party to the State Fair Hearing as well as the Member and his or her representative or the representative of a deceased Member's estate.

4.4.16.4. The state's standard timeframe for reaching its decision on a State Fair Hearing request is within 90 days after the date the Member filed the Appeal with Contractor, excluding the days the Member took to subsequently file for a State Fair Hearing.

4.4.16.5. Contractor shall participate in all State Fair Hearings regarding Appeals and other matters arising under this contract.

4.4.17. Expedited State Fair Hearing

4.4.17.1. When the Appeal is heard first through Contractor's Appeal process, Department's Office of Appeals shall issue a final agency decision for an expedited State Fair Hearing decision as expeditiously as the Member's health condition requires, but no later than 72 hours from Department's receipt of a hearing request for a denial of service that:

4.4.17.1.1. Meets the criteria for an expedited Appeal process but was not resolved with Contractor's expedited Appeal timeframes, or

4.4.17.1.2. Was resolved wholly or partially adversely to the Member using Contractor's expedited Appeal timeframes.

4.5. Ombudsman for Medicaid Managed Care

4.5.1. Contractor shall utilize and refer Members to the Ombudsman for Medicaid Managed Care to assist, at a minimum, with the following:

4.5.1.1. Problem-solving.

4.5.1.2. Grievance resolution.

4.5.1.3. In-plan and State Fair Hearing Appeals.

4.5.1.4. Referrals to Community resources, as appropriate.

4.5.1.5. Contractor shall share PHI, with the exception of psychotherapy notes and substance use disorder-related information, with the Ombudsman upon the Ombudsman's request, without requiring a signed release of information or other permission from the Member, unless Contractor has previously obtained written and explicit instructions from the Member not to share information with the Ombudsman.

4.5.1.6. Contractor shall create a policy outlining these requirements that can be easily distributed to Network Providers, subcontractors, advocates, families, and Members.

4.6. Adverse Benefit Determination Reporting

4.6.1. Contractor shall submit an Adverse Benefit Determination Appeals Report to Department or its contractor in a format and cadence determined by Department.

4.6.1.1. DELIVERABLE: Adverse Benefit Determination Appeals Report

4.6.1.2. DUE: 45 days after the end of the reporting quarter.

5. NETWORK DEVELOPMENT AND ACCESS STANDARDS

5.1. Establishing a Network

5.1.1. Contractor shall create, administer, and maintain a network of PCMPs and a network of behavioral health providers, building on the current network of Medicaid Providers, to serve the needs of its Members.

5.1.2. Contractor shall maintain a service delivery system that includes mechanisms for ensuring access to high-quality general and specialized care from a comprehensive and integrated provider network.

5.1.3. Contractor shall ensure that its contracted networks are capable of serving all Members, including contracting with Providers with specialized training and expertise across all ages, levels of ability, gender identities, languages, and cultural identities. Contractor's networks may include, but is not limited to, the following list of safety net providers:

5.1.3.1. Public and Private providers, including independent practitioners.

5.1.3.2. Federally Qualified Health Centers (FQHC).

5.1.3.3. Rural Health Clinics (RHC).

5.1.3.4. Comprehensive Community Behavioral Health Safety Net Provider (CCBHP).

5.1.3.5. Essential Behavioral Health Safety Net Provider (EBHSNP).

5.1.3.6. Substance Use Disorder Providers at each level defined by the American Society of Addiction Medicine (ASAM).

5.1.3.7. High Intensity Outpatient (HIOP) Providers.

5.1.3.8. School Based Health Centers (SBHC).

5.1.3.9. Indian Health Care Providers.

5.1.3.10. Essential Community Providers (ECP).

5.1.3.11. Providers capable of billing both Medicare and Medicaid.

5.1.4. Contractor shall take the following into consideration, as required by 42 C.F.R. § 438.206, when establishing and maintaining its networks:

5.1.4.1. The anticipated number of Members.

5.1.4.2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented relative to culture, language, and accessibility.

5.1.4.3. The numbers and types (in terms of training, experience and specialization) of providers required to furnish the covered services.

5.1.4.4. The numbers of participating providers who are accepting new Members.

5.1.4.5. The number of participating providers who offer after hour services.

5.1.4.6. The geographic location of providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, Members access to transportation and whether the location provides physical access and accessible equipment for Medicaid Members with disabilities.

5.1.5. Contractor shall develop and implement a strategy to recruit and retain qualified, diverse and culturally responsive Providers, including but not limited to, Providers who represent racial and ethnic communities, the diversity of gender and sexual identities, the deaf and hard of hearing community, the disability community, and other culturally diverse communities who may be served.

5.1.5.1. Contractor may use mechanisms such as telehealth to address geographic barriers to accessing clinical providers from diverse backgrounds.

5.1.6. Contractor shall document and post on its public website policies and procedures for the selection and retention of Providers.

5.1.6.1. Contractor shall ensure that its provider selection policies and procedures, consistent with 42 C.F.R. § 438.12, do not discriminate against particular providers

that serve high-risk populations or specialize in conditions that require costly treatment.

5.1.6.2. Contractor shall not discriminate against providers acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification.

5.1.6.3. Contractor shall comply with any additional provider selection requirements established by Department.

5.1.6.3.1. Contractor may deny Provider selection based on their own credentialing policies and procedures, so long as they are compliant with requirements established by Department, at any point during the contracting and credentialing process.

5.1.6.4. If Contractor declines to include individual or groups of Providers in its provider network, Contractor shall give the affected Providers written notice of the reason for its decision in accordance with 42 C.F.R. § 438.12.

5.1.6.5. Contractor shall complete the contracting processes or deny network admission within 90 days for at least 90% of all Provider applications. The 90 days begins upon the submission of a Provider's written request to contract with Contractor.

5.1.6.5.1. The contracting measurement period ends on the actual date of a signed and fully executed contract or when Contractor sends a formal document denying the provider admission into Contractor's network. The practice of contract backdating does not constitute compliance to this process for the purpose of reporting or meeting the measurement period standards.

5.1.6.5.1.1. The measurement period shall be tolled in the event Contractor and the Provider are in active contract negotiations, and Contractor has sent written notice to the Provider that the Provider's application has been approved.

5.1.6.5.2. Contractor shall deny the application from the contracting process if a Provider's application is not complete within 80 days. Contractor shall notify the Provider if the application is not complete prior to denial of the application.

5.1.6.5.3. Contractor shall respond to all Provider inquiries related to their contracting within two business days.

5.1.6.5.4. Contractor shall submit monthly data on provider contracting timeliness and responsiveness to providers using Department defined format.

5.1.6.5.4.1. DELIVERABLE: Contracting and Provider Responsiveness Report

5.1.6.5.4.2. DUE: Monthly

5.1.6.6. Contractor shall enter into Single Case Agreements with willing Providers of behavioral health services enrolled in Colorado Medicaid when Contractor cannot provide a covered service through its contracted Provider network within the timeliness standards of this contract and a Member needs access to a medically necessary, covered service.

5.1.6.6.1. Contractor shall consider any behavioral health Provider enrolled in Colorado Medicaid for a Single Case Agreement.

5.1.6.6.2. Contractor may refuse to offer Single Case Agreements based on factors of Provider rate and quality concerns.

5.1.6.6.3. Beginning January 1, 2024, Contractor shall ensure that the Single Case Agreement process is executed within 14 calendar days of at least 80% of all Provider or Member requests, and 30 calendar days of at least 90% of all Provider or Member requests. The 14 days begins upon the submission of the Member's or Provider's written request for a Single Case Agreement with an identified, Medicaid-enrolled Provider.

5.1.6.6.3.1. Beginning July 1, 2024, Contractor shall ensure that the Single Case Agreement process is executed within 14 calendar days of at least 90% of all Provider or Member requests. The 14 days begins upon the submission of the Provider's or Member's written request for a Single Case Agreement with an identified, Medicaid-enrolled Provider.

5.1.6.6.4. Contractor shall not require Providers that enter into Single Case Agreements to serve additional Members.

5.1.6.6.5. Contractor shall offer both in- and out-of-network Providers assistance in navigating its Single Case Agreement Process.

5.1.6.6.6. Contractor shall ensure all care coordination staff and staff who provide Member and Provider support are trained in the Single Case Agreement Process.

5.1.6.7. Contractor shall ensure that all Providers are enrolled in Health First Colorado and are eligible for participation in the Medicaid program, consistent with Provider disclosure, screening, and enrollment requirements, in accordance with 42 CFR 455.10-106 and 42 CFR 455.400-470.

5.1.7. Contractor shall document decisions on the admission or rejection of Providers in accordance with Contractor's publicly posted policies and procedures and provide documented decisions to Department upon request.

5.1.7.1. Contractor shall ensure that its network includes Providers who meet The Americans with Disabilities Act of 1990 (ADA) access standards and communication standards, or Contractor shall offer alternative locations that meet these standards.

5.1.8. Contractor shall ensure that its networks provide Contractor's Members with a reasonable choice of Providers.

5.1.9. Contractor shall allow each Member to choose a PCMP and behavioral health professional to the extent possible and appropriate.

5.1.10. Contractor shall continually work to expand and enhance the Medicaid networks, including activities such as recruiting new Providers and encouraging Network Providers to expand their capacity to serve more Members.

5.1.11. Contractor shall have policies and procedures describing the mechanisms used to ensure Provider compliance with the terms of this Contract.

5.1.12. Contractor shall document its relationship with and requirements for each PCMP and behavioral health provider in Contractor's network in a written contract.

5.1.13. Contractor shall offer contracts to all willing and qualified FQHCs, CCBHPs, BHPs, RHCs, and Indian Health Care Providers located in the Contract Region.

5.1.14. Contractor may not employ or contract with Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

5.1.15. To the extent Contractor has a Provider Network, Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian enrollee to a Network Provider in accordance with 42 C.F.R. § 438.14(b)(6).

5.2. PCMP Network

5.2.1. Contractor shall only enter into written contracts with primary care providers that meet the following criteria to qualify as a PCMP:

5.2.1.1. Enrolled as a Colorado Medicaid provider.

5.2.1.2. Licensed and able to practice in the State of Colorado.

5.2.1.3. Practitioner holds an MD, DO, or NP provider license.

5.2.1.4. Practitioner is licensed as one of the following specialties: pediatrics, internal medicine, family medicine, obstetrics and gynecology, or geriatrics.

5.2.1.4.1. Comprehensive community behavioral health safety net Providers and HIV/infectious disease practitioners may qualify as PCMPs with Contractor's approval if all other PCMP criteria are met.

5.2.1.5. The practice, agency, or individual provider, as applicable, renders services utilizing one of the following Medicaid Provider types:

5.2.1.5.1. Physician (Code 05).

5.2.1.5.2. Osteopath (Code 26).

5.2.1.5.3. Federally Qualified Health Center (Code 32).

5.2.1.5.4. Rural Health Clinic (Code 45).

5.2.1.5.5. School Health Clinic (Code 51).

5.2.1.5.6. Family/Pediatric Nurse Practitioner (Code 41).

5.2.1.5.7. Clinic-Practitioner Group (Code 16).

5.2.1.5.8. Non-physician Practitioner Group (Code 25).

5.2.1.6. Provides Care Coordination.

5.2.1.7. Provides 24/7 phone coverage with access to a clinician that can triage the Member's health need.

5.2.1.8. Has adopted and regularly uses universal screening tools including behavioral health screenings, uniform protocols, and guidelines/decision trees/algorithms to support Members in accessing necessary treatments.

5.2.1.9. Tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information.

5.2.1.10. Has weekly availability of appointments on a weekend and/or on a weekday outside of typical workday hours (Monday–Friday, 7:30 a.m.–5:30 p.m.) or school hours for School Health Clinics.

5.2.1.11. Uses available data (e.g., Department claims data, clinical information) to identify special patient populations who may require extra services and support for health or social reasons. The practice must also have procedures to proactively address the identified health needs.

5.2.1.12. Collaborates with Member, family, or caregiver to develop an individual care plan for Members with complex needs.

5.2.1.13. Uses an electronic health record or is working with Contractor to share data with Department.

5.2.2. Contractor may enter into a written agreement with a primary care Provider to fulfill some of the specific criteria listed above on behalf of a Provider, such as Contractor provides 24/7 phone coverage for a practice or provides Care Coordination for a practice. Contractor shall partner with these PCMPs to identify practice goals and support the PCMPs in working toward achieving these goals.

5.2.3. Contractor shall contract with all willing and qualified primary care practice sites located within Contractor's region that meet the criteria for being a PCMP.

5.2.3.1. Contractor shall consider each Practice Site within a health organization, group, or system as a separate PCMP Practice Site for the purposes of the Contactor's PCMP network.

5.2.4. To ensure PCMPs are affiliated with the RAE in interChange, Contractor shall submit, in a manner and format approved by Department, information relating to all newly contracted PCMPs. PCMP information shall include, at a minimum, the following:

5.2.4.1. Provider Type.

5.2.4.2. Provider Location ID.

5.2.4.3. NPI.

5.2.4.4. Tax ID/EIN.

5.2.4.5. Practice Legal Name.

5.2.4.6. Practice DBA (if applicable).

5.2.4.7. Address.

5.2.4.8. City.

5.2.4.9. Zip Code.

5.2.4.10. Email Contact.

5.2.4.11. Phone Number.

5.2.4.12. FQHC/RHC/CMHC Designation.

5.2.4.13. Specialty Designation (i.e. women only).

5.2.4.14. Enrollment Limit.

5.2.5. Contractor shall submit information for all Network Providers within contracted PCMP Practice Sites in a time, manner, and frequency determined by Department. The information shall include, but may not be limited to, the following:

5.2.5.1. Provider name.

5.2.5.2. Provider ID.

5.2.5.3. Address.

5.2.5.4. City.

5.2.5.5. State.

5.2.5.6. Zip code.

5.2.5.7. Telephone number.

5.2.5.8. Provider type.

5.2.5.9. Provider's spoken languages.

5.2.5.10. Accessibility information.

5.2.5.11. Gender restriction information.

5.2.5.12. Age limit information.

5.2.5.13. Panel status (open/closed).

5.2.6. Contractor shall not restrict the Member's free choice of family planning services and supplies providers.

5.2.7. If a female Member's designated primary care physician is not a women's health specialist, Contractor shall provide the Member with direct access to a women's health specialty within the Provider Network for covered routine and preventative women's health care services.

5.3. Behavioral Health Provider Network

5.3.1. Contractor shall establish and maintain a statewide network of behavioral health providers that spans inpatient, outpatient, laboratory, and all other covered mental health and substance use disorder services.

5.3.2. Contractor shall only enter into written contracts with behavioral health providers that are enrolled as Colorado Medicaid providers.

5.3.2.1. When developed by Department and the Behavioral Health Administration, Contractor shall use the Universal Contracting provisions as established in CRS 25.5-5-402 on a timeline agreed upon by Contractor and Department. Per CRS

25.5-5-402 inclusion of the Universal Contracting provisions does not preclude Contractor from incorporating other terms to drive value and accountability.

5.3.2.2. Contractor will collaborate with Department and the Behavioral Health Administration on the implementation of the Universal Contracting provisions and ongoing process improvement activities to ensure the Universal Contracting provisions are achieving the intended goals and objectives.

5.3.3. Contractor shall establish and manage an adequate network of High Intensity Outpatient (HIOP) service providers to ensure Members have access to services that can stabilize and support them in the community.

5.3.3.1. PERFORMANCE MEASURE: The performance metric shall be a demonstrated increase in a full array of HIOP providers over a baseline established within the first six months of the contract effective date.

5.3.4. Contractor shall review residential and inpatient SUD provider policies and procedures to ensure that they address the provision of onsite access and/or the facilitation of off-site access to medication assisted treatment.

5.3.5. Contractor shall not enroll IHS/Tribal 638 providers in its Specialty Behavioral Health Provider Network. Contractor's Network Providers shall serve tribal Members who seek Covered Services, as defined in Section 9.4 and Exhibit I. When Medicaid services are sought from IHS/Tribal 638 providers, those providers shall bill Department's fiscal agent.

5.3.6. Behavioral Health Provider Credentialing and Re-credentialing

5.3.6.1. Contractor shall ensure that all Behavioral Health Network Providers are credentialed and re-credentialed by Department-authorized credentialing entity.

5.3.6.1.1. Contractor shall have processes to collect the necessary credentialing information from Department-authorized credentialing entity in order to efficiently enter into and update Behavioral Health Network Provider contracts.

5.3.6.1.2. Contractor may not require any additional documentation from Providers for the purposes of credentialing and recredentialing.

5.3.6.2. Contractor shall not conduct its own credentialing or recredentialing processes.

5.3.6.3. Contractor shall not make requests to Providers for any documentation that matches documentation requested and verified as part of the credentialing and/or recredentialing process.

5.3.6.4. Contractor shall make contracting decisions with credentialed Providers based upon the adequacy of their Provider network and payment negotiations.

5.3.6.4.1. Contractor may choose to terminate a Provider from their network based upon quality or performance issues, or for cause.

5.3.6.5. Contractor shall ensure that the re-credentialing status has been updated for all individual behavioral health practitioners at least every three years.

5.3.6.6. Contractor shall ensure that all laboratory-testing sites providing services under the Contract have either a Clinical Laboratory Improvement Amendments (CLIA)

Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

5.4. Access to Care Standards

5.4.1. Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care to, to include, at minimum all of the following:

5.4.1.1. Serve all primary care and care coordination needs.

5.4.1.2. Serve all behavioral health needs.

5.4.1.3. Allow for adequate Member freedom of choice among Providers.

5.4.2. Contractor shall provide the same standard of care to all Members, regardless of eligibility category.

5.4.3. Contractor shall ensure the Provider network is sufficient to support minimum hours of Provider operation to include service coverage from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday.

5.4.4. Contractor's network shall provide for extended hours, outside the hours from 8:00 a.m. to 5:00 p.m., on evenings and weekends and alternatives for emergency room visits for after-hours urgent care.

5.4.4.1. Contractor shall ensure that evening and weekend support services for Members and families shall include access to clinical staff, not just an answering service or referral service staff.

5.4.5. Contractor shall implement a network management process and maintain an up-to-date database or directory of contracted Providers approved to deliver services. Contractor shall ensure that the directory is updated at least monthly and made available to Department.

5.4.6. Contractor shall ensure that its network provides for 24-hour availability of information, referral and treatment of emergency medical conditions in compliance with 42 C.F.R. § 438.3(q)(1).

5.4.7. Contractor shall ensure that its PCMP network complies with the time and distance standards in the following table:

Provider Type	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Dist	Time	Dist	Time	Dist	Time	Dist	Time	Dist
Acute Inpatient Hospital (Emergency services available 24/7)	20	10	45	30	80	60	75	60	10	10
Primary Care - Adult	20	10	15	10	30	20	40	30	70	60
Primary Care - Pediatric	20	10	15	10	30	20	40	30	70	60
Outpatient Clinical Behavioral Health	20	10	15	10	30	20	40	30	70	60

(Licensed, accredited, or certified professionals) - Adult										
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals) - Pediatric	20	10	15	10	30	20	40	30	70	60
General Pediatric Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	10	10
General Adult Psychiatrists and other Psychiatric Prescribers	20	10	45	30	60	45	75	60	10	10
SUD Treatment Practitioner - Adult	20	10	15	10	30	20	40	30	70	60
SUD Treatment Practitioner - Pediatric	20	10	15	10	30	20	40	30	70	60

5.4.8. Contractor shall ensure that its PCMP contractor network has a sufficient number of Network Providers per Provider Type listed in Table A so that each Member has their choice of at least two practitioners of the same Provider Type within the maximum time or the maximum distance for their county classification. For Rural and Frontier areas, Department may adjust this requirement based on the number and location of available Providers.

5.4.8.1. In the event that there are less than two practitioners that meet the Provider Type standards within the defined area for a specific Member, then Contractor shall not be bound by the requirements of the prior paragraph for that Member.

5.4.8.1.1. PERFORMANCE STANDARD: At least 90% of Members have choice of at least two Network Providers per Provider Type listed in Table A within the maximum time or the maximum distance for their county classification. 95% have at least one Network Providers per Provider Type listed in Table A within the maximum time or the maximum distance for their county.

5.4.8.2. Contractor shall use GeoAccess or a comparable service to measure the distance between the Members and the Network Providers in Contractor's Region.

5.4.8.3. For purposes of Network Adequacy reporting, Contractor shall not include Network Providers that have not provided care to Medicaid Members, measured by not submitting any Medicaid claims, within the previous 18 months.

5.4.8.4. Contractor shall maintain sufficient Indian or Tribal Providers in the PCMP Network to ensure timely access to services available under the Contract for Indian or Tribal Members who are eligible to receive services from such Providers, in accordance with the American Recovery and Reinvestment Act of 2009.

5.4.8.4.1. Indian or Tribal Members eligible to receive services from an Indian or Tribal Provider in the PCMP Network are permitted to choose that Indian or Tribal Provider as their PCMP, as long as that provider has the capacity to provide services.

5.4.8.4.2. Indian or Tribal Members eligible to receive services from an Indian or Tribal Provider in the PCMP Network are permitted to choose that Indian or Tribal Provider as their PCMP, as long as that provider has the capacity to provide services.

5.4.9. Contractor may use Department's template to request an exception from the maximum time and distance standards when a service area has an insufficient number of providers/facilities to meet the standard network adequacy criteria.

5.4.9.1. Department's approval of an exception on this basis does not relieve Contractor from demonstrating access to the specific service provided by the provider/facility type that is insufficient in the service area.

5.4.9.1.1. DELIVERABLE: Service Area Exception

5.4.9.1.2. DUE: Upon identification of insufficient providers/facilities in a service area to meet time and distance requirements

5.4.10. Contractor shall ensure its Provider Network is sufficient so that services are provided to Members on a timely basis, as follows:

5.4.10.1. Urgent Care – within 24 hours after the initial identification of need.

5.4.10.2. Outpatient Follow-up Appointments – within seven days after discharge from a hospitalization.

5.4.10.3. Non-urgent, Symptomatic Care Visit – within seven days after the request.

5.4.10.4. Well Care Visit – within one month after the request, unless an appointment is required sooner to ensure the provision of screenings in accordance with Department's accepted Bright Futures schedule.

5.4.10.5. The following additional timeliness standards apply only to the Capitated Behavioral Health Benefit:

5.4.10.5.1. Emergency Behavioral Health Care – by phone within 15 minutes after the initial contact, including TTY accessibility; in person within one hour of contact in Urban and suburban areas, in person within two hours after contact in Rural and Frontier areas.

5.4.10.5.2. Medication Assisted Treatment – initiation of treatment within 72 hours after a Member's request.

5.4.10.5.3. Non-urgent, Symptomatic Behavioral Health Services – within seven days after a Member's request.

5.4.10.5.3.1. Contractor shall not consider administrative intake appointments or group intake processes as a treatment appointment for non-urgent, symptomatic care.

5.4.10.6. Contractor shall meet updated timeliness standards that align with BHA network adequacy and access to care methodologies. This will likely include the updated service categories outlined in C.R.S. 27-50-300 or specific requirements for safety net services or providers.

5.4.10.7. Contractor shall not place Members on waiting lists unless a Member consents.

5.4.10.8. In collaboration with Department and other Managed Care Entities, Contractor shall develop and implement a statewide process for monitoring network compliance with the timeliness standards contained in this Work. This process will be designed in accordance with any available federal guidance.

5.4.10.8.1. PERFORMANCE STANDARD: Contractor shall collaborate with Department to set a target precent for compliance with timeliness standards detailed above.

5.4.11. Contractor shall take actions necessary to ensure that all primary care, Care Coordination, and behavioral health services covered under this Contract are provided to Members with reasonable promptness, including but not limited to the following:

5.4.11.1. Utilization of out-of-network Providers.

5.4.11.2. Using financial incentives to induce network or out-of-network Providers to accept Members.

5.4.12. Contractor shall establish policies and procedures with other RAEs to ensure continuity of care for all Members transitioning into or out of Contractor's enrollment, guaranteeing that a Member's services are not disrupted or delayed.

5.4.13. Contractor shall have a system in place for monitoring patient load in their Provider network and recruit Providers as necessary to assure adequate access to all covered services.

5.4.14. Contractor shall provide for a second opinion from a Network Provider or arrange for the Member to obtain a second opinion outside the network, at no cost to the Member.

5.4.15. Network Changes and Deficiencies

5.4.15.1. Contractor shall notify Department, in writing, of Contractor's knowledge of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network. The notice shall include:

5.4.15.1.1. Information describing how the change will affect service delivery, including total number of Members impacted.

5.4.15.1.2. Availability of covered services.

5.4.15.1.3. A plan to minimize disruption to the Members' care and service delivery.

5.4.15.1.4. A plan to correct any network deficiency, including measurable steps.

5.4.15.1.5. Strategy to provide status updates to Department.

5.4.15.1.5.1. DELIVERABLE: Network Changes and Deficiencies Notice

5.4.15.1.5.2. DUE: Within five days after Contractor's knowledge of the change or deficiency.

5.5. Network Adequacy Plan and Reports

5.5.1. Contractor shall create a Network Adequacy Plan as part of the Annual Network Management Strategic Plan that contains, at a minimum, the following information for both its PCMP and Behavioral Health Network:

5.5.1.1. How Contractor will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the Contract for all Members, including those with limited English proficiency and Members with physical or mental disabilities.

5.5.1.2. How Contractor will ensure that Network Providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

5.5.1.3. Number of Network Providers by provider type and areas of expertise particularly:

5.5.1.3.1. Adult primary care providers.

5.5.1.3.2. Pediatric primary care providers.

5.5.1.3.3. Adult mental health providers.

5.5.1.3.4. Pediatric mental health providers.

5.5.1.3.5. Substance use disorder providers.

5.5.1.3.6. Psychiatrists.

5.5.1.3.7. Child psychiatrists.

5.5.1.3.8. Psychiatric prescribers.

5.5.1.3.9. Family planning providers.

5.5.1.4. Number of Network Providers accepting new Medicaid Members by provider type.

5.5.1.5. Geographic location of providers in relationship to where Medicaid Members live.

5.5.1.6. Cultural and language expertise of providers.

5.5.1.7. Number of providers offering after-hours and weekend appointment availability to Medicaid Members.

5.5.1.8. Standards that will be used to determine the appropriate case load for providers and how this will be continually monitored and reported to Department to ensure standards are being met and maintained across Contractor's provider network.

5.5.1.9. Case load for behavioral health providers.

5.5.1.10. Number of behavioral health providers in the network that are able to accept mental health certifications and how this will be continually monitored to ensure enough providers are available to meet the needs in the region.

5.5.1.11. A description of how Contractor's network of providers and other Community resources meet the needs of the Member population in Contractor's Region, specifically including a description of how Members in special populations are able to access care.

5.5.2. Contractor shall create a Network Adequacy Report to Department on a quarterly basis. The Network Adequacy Report shall contain, at a minimum, the following information:

5.5.2.1. Number and percent of PCMPs accepting new Medicaid Members.

5.5.2.2. Number and percent of behavioral health providers accepting new Medicaid Members.

5.5.2.3. Number and percent of PCMPs offering after-hours appointment availability to Medicaid Members.

5.5.2.4. Number and percent of behavioral health providers offering after-hours appointments.

5.5.2.5. Performance meeting timeliness standards.

5.5.2.6. Number of behavioral health provider single-case agreements used.

5.5.2.7. New providers contracted during the quarter.

5.5.2.8. Providers that left Contractor's network during the quarter.

5.5.2.9. Additional information, as requested by Department.

5.5.2.10. Providers that have not had an encounter or claim within the previous 18 months and actions Contractor has taken to outreach these providers.

5.5.3. Contractor shall submit the Network Adequacy Report to Department.

5.5.3.1. DELIVERABLE: Network Adequacy Report

5.5.3.2. DUE: Quarterly, on the last Business Day of July, October, January, and April.

5.5.4. Network Roster

5.5.4.1. Contractor shall submit to Department a service provider roster file in a format determined by Department.

5.5.4.1.1. DELIVERABLE: Monthly Provider Roster

5.5.4.1.2. DUE Monthly, on the 15th of the month following the end of the previous months reporting period.

6. HEALTH NEIGHBORHOODS

6.1. Contractor shall promote Members' physical, behavioral and social well-being by creating a Health Neighborhood(s) consisting of a diverse network of health care providers and community organizations providing services to residents within Contractor's geographic region.

6.1.1. Contractor shall identify the natural and local communities that exist within Contractor's region and develop and implement unique Health Neighborhood strategies to coordinate and serve those local communities.

6.1.2. Contractor's efforts shall include increasing Member access to timely and appropriate Medicaid services, state benefits, and community-based resources that can positively impact the conditions in which Members live.

6.2. Health Neighborhood(s)

6.2.1. Contractor shall validate the value that all Medicaid providers offer to improve Member health and functioning. The successful engagement and utilization of the full range of Health Neighborhood providers, including specialty care, LTSS providers, hospitals, pharmacists, dental, non-emergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers, are critical to helping Members improve their health and life outcomes. In addition, the effective leveraging of the Health Neighborhood is a critical tool for controlling costs and wisely utilizing state resources.

6.2.2. Contractor shall establish and enhance relationships among its Network Providers and the Health Neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts.

6.2.2.1. Contractor shall use the Population Management Framework and Contractor's Population Management Strategic Plan to inform Contractor's efforts to manage and coordinate care among diverse networks of health providers and supportive organizations.

6.2.2.2. As Members living within Contractor's geographic region may be attributed to another RAE, Contractor shall collaborate with other RAEs to assist them in leveraging Contractor's Health Neighborhood to address Members' social and other health needs.

6.2.2.3. Contractor shall collaborate with other RAEs to leverage their Health Neighborhoods to help serve any of Contractor's enrolled Members who reside within the geographic region of another RAE.

6.2.2.4. Contractor shall collaborate with Local Public Health Agencies, Regional Health Alliances, hospitals, and other organizations in the region that have conducted community health needs assessments to focus Contractor's efforts and support the work of these other organizations to fill gaps in care in the region.

6.2.3. Contractor shall work to increase the number of specialists in the region who are enrolled as Medicaid Providers and who are accepting Medicaid Members.

6.2.4. Contractor shall design and implement strategies to engage specialty care providers that are critical to achieving Department's cost and quality goals for the ACC, value-based payment models, and facility cost and quality indicator program. Strategies shall include, but are not limited to:

6.2.4.1. Regularly scheduled outreach to specialty care providers about the Contractor and how the specialty care provider can contact the Contractor for assistance arranging supportive and wraparound services for Members.

6.2.4.2. Wraparound support services for Members to support Members' engagement in specialty care and reduce administrative burden for specialty care providers. This

may include services such as arranging NEMT, helping coordinate non-medical supports addressing health-related social needs impacting the Members condition, and ensuring the PCMP has shared appropriate clinical information and clinical questions.

6.2.4.3. Leveraging opportunities to share clinical and non-clinical data to facilitate a specialty care provider's effective and efficient treatment of the Member.

6.2.4.4. Establishing contracted relationships with targeted specialty care providers that include financial reimbursement for ongoing work or for the specialty care provider's partnership in achieving incentive-based outcomes, such as Key Performance Indicators or Shared Savings goals.

6.2.5. Contractor shall submit a Specialty Care Annual Report describing Contractor's plan to engage specialty care providers in the ACC for the upcoming 12 months and a report on the outcomes of Contractor's activities during the previous 12 months.

6.2.5.1. DELIVERABLE: Specialty Care Provider Engagement Strategy

6.2.5.2. DUE: Annually, by December 31

6.2.6. Contractor shall identify barriers to Provider participation in the Health Neighborhood, such as ineffective referral processes, high rates of Member no-shows, and ineffective communication. Contractor shall design and implement approaches to address these barriers to enable providers to appropriately care for more Medicaid Members.

6.2.6.1. Contractor shall implement programs to address the identified barriers to Provider participation in the Health Neighborhood and to support the efficient use of specialty care resources. The programs shall include, at minimum, all of the following:

6.2.6.1.1. Sharing of claims data as appropriate.

6.2.6.1.2. Providing Care Coordination, especially coordinating transportation and following up with Members that miss specialty care appointments.

6.2.6.1.3. Establishing financial relationships or other agreements with certain specialists to increase access for Medicaid Members.

6.2.6.1.4. Providing support in implementing and utilizing telehealth solutions.

6.2.7. Contractor shall establish and improve referral processes to increase Member access to appropriate care in the Health Neighborhood and reduce unnecessary utilization of limited specialty care resources.

6.2.7.1. Contractor shall promote the use of Department-adopted electronic consultation platform, through which specialists consult with PCMPs via a telecommunication platform.

6.2.7.1.1. Contractor shall educate Health Neighborhood Providers regarding the utilization of electronic consultation as a method to mitigate incomplete work-ups, reduce inappropriate or unnecessary specialty care visits, and improve timeliness of communication.

6.2.7.2. Contractor shall partner with Department on facility cost and quality indicator activities, which will offer Members and providers information about the quality of care and patient experience at hospitals and other health care facilities so that they can make the most informed decision about where to access their care.

6.2.7.2.1. Contractor shall actively endorse and direct referrals toward the highest-performing facilities as determined by Department's indicators.

6.2.7.2.2. Contractor shall collaborate with Department to develop best practices that support consistent and comprehensive PCMP adoption of available tools and cost and quality information to encourage PCMP referrals to higher preforming facilities and providers in a way that improves health equity, closes disparities, and improves affordability.

6.2.8. Contractor shall promote the Colorado Crisis Services among Providers and Members to ensure Members receive timely access to behavioral health interventions during a crisis.

6.2.8.1. Contractor shall establish arrangements with the Behavioral Health Service Organizations (BHASOs) and the Colorado Crisis Services vendors for the coordination of follow-up care for Medicaid Members.

6.2.9. Contractor shall acknowledge that hospitals are an essential part of the health care delivery system and Health Neighborhood and shall collaborate with hospitals to improve care transitions, implement person-centered planning at hospital discharge, and address complex Member needs, including needs of Members with behavioral health and intellectual and developmental disabilities.

6.2.10. Contractor shall utilize and disseminate to appropriate Network Providers admit/discharge/transfer (ADT) data to track emergency room utilization and improve the quality of care transitions into and out of hospitals. Contractor shall coordinate with hospitals directly or use a Health Information Exchange to access hospital ADT data.

6.2.11. Contractor shall collaborate with hospitals that are implementing the Hospital Transformation Program that connects hospitals to the Health Neighborhood and aligns hospital incentives with the goals of the ACC.

6.2.11.1. Contractor shall support hospitals in achieving their chosen projects, interventions, and performance goals for the Hospital Transformation Program.

6.2.12. Contractor shall work with LTSS providers, Case Management Agencies, No Wrong Door Entities, Area Agencies on Aging, and Aging and Disability Resources for Colorado to develop holistic approaches to assisting LTSS Members achieve health and wellness goals.

6.2.13. Contractor shall facilitate health data sharing among providers in the Health Neighborhood.

6.2.14. Contractor shall establish relationships and communication channels with the entities administering Department’s Non-Emergency Medical Transportation benefit to ensure Members are able to attend their medical appointments on time. Contractor shall designate a single point of contact to lead Contractor’s coordination of and collaboration with Non-Emergency Medical Transportation. Contractor shall share

feedback with Department on transportation challenges they face for their Members and other transportation issues of which they become aware.

6.2.15. Given the importance of oral health to Members' health and life outcomes, Contractor shall establish relationships and communication channels with Department's Dental Benefit managed care vendor to promote Member utilization of the dental benefits.

6.2.16. Contractor shall collaborate with local public health agencies to:

6.2.16.1. Design opportunities for integration of local public health activities into the ACC.

6.2.16.2. Identify any specific target activities that encourage the prioritization and adoption of initiatives that improve state performance on Medicaid CMS CORE Measures and meet the health needs of Members in the region, such as enrollment, health promotion, population health initiatives, and dissemination of public health information.

6.2.16.3. Explore appropriate funding approaches to support collaborative activities.

6.2.17. Contractor shall participate in and align its activities with advisory groups, existing programs, and statewide initiatives designed to strengthen the health care system, to include, at minimum, all of the following:

6.2.17.1. Behavioral Health Service Organizations (BHASOs), funded by the Behavioral Health Administration to provide behavioral health services to vulnerable populations.

6.2.17.2. Colorado Crisis System, Colorado's statewide resource for mental health, substance use, or emotional crisis help, information and referrals.

6.2.17.2.1. Contractor may, upon direction from Department, be required to contribute administrative funding from the Capitated Payment to the Crisis Line component of the Colorado Crisis System. Any payment from Contractor shall be agreed upon during the rate-setting process at the beginning of each performance year by July 31. Contractor may count these costs toward medical spend as activities that improve health care quality in their annual MLR calculations.

6.2.17.3. Department's formal process for Proposed Benefit Coverage Policies, which establishes the amount, scope, and duration of fee-for-service benefits, ensures that covered services are evidence-based and guided by best practices, and develops collaborative working relationships with stakeholders.

6.2.17.3.1. Contractor shall recruit providers and stakeholders, provide input on policies, understand changes to coverage, and educate providers.

6.2.17.4. Maternity Advisory Committee (MAC), a Department committee that reviews program data, provides input on Member quality and experience metrics, and gives recommendations to help improve Member experiences and maternity outcomes.

6.2.17.5. Pharmacy and Therapeutics Committee and Drug Utilization Review Board, which is Department's process to establish prior authorization criteria for drugs, prescribing guidelines, and the Preferred Drug List for Fee-for-Service.

6.2.17.6. Utilization Management (UM) Vendor, which manages Member programs and services such the Nurse Advice Line and the Client Overutilization Program (COUP).

6.2.17.6.1. Contractor shall establish a point of contact to communicate directly with the UM vendor.

6.2.17.6.2. Contractor shall work with the UM vendor to receive daily Nurse Advice Line data in order to identify and outreach Members likely to benefit from Care Coordination.

6.2.17.6.3. Contractor shall promote the Nurse Advice Line to Members and Providers as a resource for after-hours care and guidance.

6.2.17.6.4. Contractor shall work with the UM vendor regarding Members identified for Department's COUP program as described in Section 12.

6.3. Health-Related Social Needs (HRSN) and Health and Social Equity

6.3.1. Contractor shall demonstrate an understanding of the health disparities and inequities in their region and develop plans with Providers, Members and Community Stakeholders to optimize the physical and behavioral health of its Members.

6.3.2. Recognizing that the conditions in which Members live also impact their health and well-being, Contractor shall establish relationships and collaborate with community organizations that provide resources such as food, housing, energy assistance, childcare, education, social supports, and job training in the region.

6.3.3. Contractor shall know, understand, and implement initiatives to support local communities to optimize Member health and well-being, particularly for those Members with complex needs that receive services from a variety of agencies.

6.3.3.1. Contractor shall collaborate with school districts and schools to coordinate care and develop programs to optimize the growth and well-being of Medicaid children and youth.

6.3.4. Contractor shall support Members and Providers with accessing any centralized regional resource directory available listing all community resources available to Members.

6.3.4.1. Contractor shall not duplicate community efforts to create a directory. Instead, Contractor shall integrate, leverage, and participate in any existing state or regional efforts to build a regional resource directory, in particular the SHIE.

6.3.5. Contractor shall identify and promote Member referrals to and engagement with evidence-based and promising initiatives operating in the region that address the social determinants of health.

6.3.6. Contractor shall work with Community organizations to remove roadblocks to Member access to programs and initiatives, particularly evidence-based/promising practice programs in the region.

6.3.7. Contractor shall engage with hospitals, local public health agencies and Regional Health Alliances regarding existing community health needs and assessments to

develop, implement and align collaborative strategies to reduce health inequities and disparities in the community.

6.3.7.1. Contractor shall share information with community organizations in the region to support the identification of community social service gaps and needs and the implementation of strategies to address those gaps and needs, with a focus on Department identified priority areas and CMS Core Measure performance.

6.3.8. Contractor shall work in partnership with Department, other state agencies, and regional and local efforts in order to expand the community resources available to Members.

6.3.9. Health Equity

6.3.9.1. Contractor shall address health equity in Contractor's region and decrease health disparities for Members from underserved and marginalized communities that include, but are not limited to, racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency, and rural populations.

6.3.9.2. Contractor shall design and implement strategies to help achieve the goals of Department's Health Equity Plan while addressing the unique and local community disparities identified by Contractor and Health Neighborhood partners.

6.3.9.2.1. Contractor's activities shall include, but are not limited to, programs aimed at reducing disparities for vaccination rates, maternity and perinatal health, behavioral health, chronic care management and prevention.

6.3.9.3. Contractor shall enhance culturally responsive best practices among staff and Network Providers to improve health equity. Cultural responsiveness requires valuing diversity, seeking to further cultural knowledge, and working toward the creation of community spaces and workspaces where diversity is valued

6.3.9.4. Contractor shall document and submit a Health Equity Plan to identify and address specific and targeted health disparities that impact Members within Contractor's region. The plan shall include an inventory of current and future efforts around health equity to reduce disparity rates and improve health outcomes among Colorado's historically underserved and marginalized communities.

6.3.9.5. Contractor's Health Equity Plan shall align with the CMS Framework for Health Equity Priorities including, but not limited to:

6.3.9.5.1. Priority 1: Expand the Collection, Reporting, and Analysis of Standardizing Data

6.3.9.5.2. Priority 2: Assess Causes of Disparities within Programs, and Address Inequities in Policies and Operations to Close Gaps

6.3.9.5.3. Priority 3: Build Capacity of Contractor Workforce to Reduce Health and Health Care Disparities

6.3.9.5.4. Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

6.3.9.5.5. Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

6.3.9.5.5.1. DELIVERABLE: Health Equity Plan

6.3.9.5.5.2. DUE: December 31, 2025

6.3.9.6. Contractor shall modify the Health Equity Plan as directed by Department to account for any changes in the work, in Department's processes and procedures, in Contractor's processes and procedures, or to address any health equity related deficiencies determined by Department.

6.3.9.6.1. Contractor shall submit a Health Equity Report annually to highlight successes, challenges, opportunities, and changes to the Health Equity Plan.

6.3.9.6.1.1. DELIVERABLE: Health Equity Report

6.3.9.6.1.2. DUE: Annually, by December 31

6.3.10. Targeted Health-Related Social Needs

6.3.10.1. Food insecurity

6.3.10.1.1. Contractor shall work with Department to identify and implement strategic initiatives and best practices consistently across RAEs and Medicaid to improve food security and the related health of Medicaid Members.

6.3.10.1.2. Contractor shall establish a referral network of community organizations to improve Member access to available food resources in the Members' communities.

6.3.10.1.3. Contractor shall participate in and align its activities with advisory groups, existing programs, and statewide initiatives to leverage resources and break down barriers to food access.

6.3.10.1.4. Contractor shall provide training on nutrition assistance programs for staff during onboarding. This partnership can be conducted in partnership with a food advocacy organization in the state.

6.3.10.1.5. Contractor shall establish formal partnerships with community organizations to support individual's enrollment in SNAP and WIC.

6.3.10.1.5.1. Contractor shall make referrals to their region's state contracted SNAP outreach and application organization or a subrecipient of these organizations to increase Member enrollment in SNAP.

6.3.10.1.5.2. Contractor shall document and report the number of referrals made to SNAP outreach and application organizations in the Health Neighborhood Report.

6.3.10.1.6. Contractor shall train Network Providers on the referral process for WIC, including the requirement that Members submit biometric information as part of the application.

6.3.10.1.6.1. Contractor shall collaborate with WIC enrollment agencies and Network Providers to develop streamlined processes for the sharing of Member biometric data to reduce barriers to Member enrollment in WIC.

6.3.10.2. Housing insecurity

6.3.10.2.1. Services for the Homeless

6.3.10.2.1.1. Contractor shall identify Members who are actively homeless, at-risk of homelessness or have a history of homelessness using, at a minimum, Department-provided data, data from the Continuums of Care (CoCs), and data on housing needs from social need screenings.

6.3.10.2.1.2. Contractor shall provide care to Members who are homeless or at risk of homelessness by conducting outreach to Members with a history of homelessness and establishing partnerships with community-based organizations to connect such Members to housing services.

6.3.10.2.1.2.1. Contractor shall establish relationships with regional CoC partners and report on those partnerships in the Health Neighborhood Report.

6.3.10.2.1.2.2. Contractor shall establish partnerships with and collaborate with community organizations and other on-the-ground agencies to reach Members and support outreach efforts.

6.3.10.2.1.3. Contractor shall partner with local housing organizations, including but not limited to organizations who are part of the Coordinated Entry System, to provide the following types of assistance for Members who are homeless or at risk of homelessness:

6.3.10.2.1.3.1. Identifying housing options for Members at risk of experiencing homelessness, such as emergency shelter and temporary or bridge housing.

6.3.10.2.1.3.2. Assisting Members in filing applications for housing and gathering necessary documentation.

6.3.10.2.1.3.3. Coordinating the provision of supportive housing.

6.3.10.2.1.3.4. Coordinating housing-related services.

6.3.10.2.1.4. Contractor shall be a Member of the regional CoC's and participate in stakeholder meetings and case conferencing meetings, as necessary.

6.3.10.2.1.5. Contractor shall conduct quarterly assessments and provide documentation of housing status and homelessness for all Members.

6.3.10.2.2. Permanent Supportive Housing (PSH)

6.3.10.2.2.1. Contractor shall build and maintain a network of PSH providers in the region.

6.3.10.2.2.1.1. Contractor shall support the enrollment of PSH providers as Colorado Medicaid providers through contracting and network development efforts.

6.3.10.2.2.2. Contractor shall ensure the seamless meaningful connection of Members who are qualified for and enrolled in PSH with clinical services, especially during the period a Member is waiting to move into a permanent housing arrangement.

6.3.10.2.2.2.1. Contractor shall ensure care coordination services for Members qualified for PSH are documented and reported to Department in the Health Neighborhood Report or through another mechanism determined by Department.

6.3.10.2.2.2.1.1. Contractor shall report number of Members who qualified but are not yet enrolled in PSH, who received Care Coordination services from Contractor.

6.3.10.2.2.2.1.2. Contractor shall report on number of Members enrolled in PSH who received Care Coordination services from Contractor.

6.3.10.2.2.3. Contractor shall coordinate with PSH case managers to ensure referrals occur when needed, specifically to physical and behavioral health services.

6.4. Health Neighborhood Report

6.4.1. Contractor shall submit a report, twice per Contract year, to Department describing Contractor's activities to collaborate with and build the Health Neighborhood to support Members' health care and social needs, in addition to articulating plans for the Health Neighborhood in the Annual Network Management Strategic Plan.

6.4.2. Contractor shall submit the Health Neighborhood Report to Department in a format agreed upon by Department and Contractor.

6.4.2.1. DELIVERABLE: Health Neighborhood Report

6.4.2.2. DUE: Every six months, by August 15 and February 14

7. CARE COORDINATION AND POPULATION MANAGEMENT

7.1. Overview and Guiding Principles

7.1.1. Contractor shall ensure whole person Care Coordination and Case Management (referred to collectively as Care Coordination) is available to and provided for their enrolled Members using funds from both the Administrative Per-Member Per-Month payment and the monthly Capitated Payment for behavioral health services

7.1.1.1. Contractor shall use a health promotion/population management approach that aligns with Department's health care priorities, including those for value-based payments, to inform, assess, track and manage the health needs and outcomes of all its Members.

7.1.1.2. Contractor shall implement population management and Care Coordination activities that improve Member health, prevent disease progression, reduce unnecessary and/or avoidable utilization and costs, improve coordination of care across Medicaid programs, contain costs, facilitate effective care transitions, support individuals with complex needs, and improve the experience of care.

7.1.1.3. Contractor shall adopt population management and Care Coordination strategies that incorporate a detailed understanding of the distribution of health conditions, health related behaviors, recovery supports, and social determinants of health such as income, culture, race, age, family status, housing status, and education level.

7.1.1.4. Contractor shall possess capabilities to leverage and build upon Department's data systems and to perform analytics of both Contractor's and Department's data to successfully implement an information-based approach to delivering and coordinating care and services across the continuum.

7.1.1.5. Contractor shall have a comprehensive approach to population management that uses data to stratify the population and offers a range of interventions to support Members, with a particular focus on Members with chronic conditions, co-occurring conditions, and complex health and health-related social needs.

7.1.1.6. Contractor shall educate Network Providers on tools provided by Contractor, Department, and the State of Colorado that support provider implementation of best practices for population management and Care Coordination.

7.2. Population Management

7.2.1. Contractor shall design and implement population management activities in alignment with Department's health care priorities, including those for value-based payments.

7.2.1.1. Contractor shall implement and evaluate evidence-based and proven programs designed to improve the health and health-related social needs of Department identified populations and prevent disease progression of Department targeted health conditions.

7.2.1.2. Contractor shall collaborate with Department to implement a risk stratification methodology that captures the physical, behavioral, oral, and health-related social needs of Members.

7.2.1.3. Contractor shall place a particular focus on Department specified populations and health conditions, as well as Members identified for the Complex Health Management Tier, as described in Section 7.3, by Department and Contractor for outreach and interventions, including care coordination.

7.2.1.3.1. Contractor shall leverage data and resources to risk stratify beyond the Complex Health Management Tier population to effectively meet the unique needs of their assigned Members more broadly.

7.2.1.4. Contractor's population management activities shall include, but not be limited to, the following:

7.2.1.4.1. Member engagement and outreach.

7.2.1.4.2. Wellness promotion.

7.2.1.4.3. Supports to meet Members' health-related social needs, including coordinating with and supporting community-based organizations.

7.2.1.4.4. Strategies to reduce health disparities among enrolled Members.

7.2.1.4.5. Care Coordination for Members utilizing Medicaid services.

7.2.1.4.6. Support for PCMPs/Network Providers in providing each Member with a focal point of care and the appropriate level of care coordination.

7.2.1.4.7. Support for Network Providers participating in value-based payment to assist them in achieving quality targets and earning shared savings.

7.2.2. Contractor shall provide practice support to Network Providers and Health Neighborhood providers to support them with implementing Contractor's population management activities.

7.2.3. Contractor shall implement incentive arrangements and financial structures that reward Network Providers and Health Neighborhood providers for delivering increased value and improved outcomes in alignment with Contractor's population management activities.

7.2.4. Contractor shall describe its proposed population management activities in a Population Management Strategic Plan in a format determined by Department.

7.2.4.1. Contractor's Population Management Strategic Plan shall include a description of how Contractor will monitor the implementation of the Plan and evaluate the results of Contractor's population management activities, including milestones and targeted outcomes.

7.2.4.2. Contractor shall engage Members and Network Providers in the development and revising of the Population Management Strategic Plan and shall share the final, Department approved plan, with Network Providers and assist them in implementing the Population Management Strategic Plan.

7.2.5. Contractor shall submit the Population Management Strategic Plan to Department for review and integrate feedback as appropriate. Contractor shall only implement Department approved plan.

7.2.5.1. DELIVERABLE: Population Management Strategic Plan

7.2.5.2. DUE: Annually, July 1

7.3. Care Coordination Program Requirements

7.3.1. Contractor shall implement a comprehensive Care Coordination Program that addresses the full range of Members' physical health, behavioral health, oral health, and health-related social needs in a person- and family-centered, trauma-informed, and culturally responsive manner that supports the following Department objectives for Care Coordination:

7.3.1.1. Is available to Members in alignment with Contractor's Population Management Strategic Plan and Department's Care Coordination Model.

7.3.1.2. Is provided at the point of care/practice whenever possible, as well as between the practice and other Health Neighborhood providers and Community-Based Organizations (CBOs).

7.3.1.3. Utilizes a full suite of staff Members to address Member needs, including but not limited to Registered Nurses, Social Workers, Community Health Workers, Navigators, and Clinical Leads.

7.3.1.4. Effectively leverages existing resources within Contractor's region, including, but not limited to, Network Providers, Local Public Health Agencies, Community Health Workers, and Community-based Organizations.

7.3.1.5. Follows Department guidelines for stratification of the Member population to enable standardized performance monitoring of the ACC across the RAE Contractors.

7.3.1.6. Focuses on prevention, particularly Department-identified priorities and performance metrics, and improving Member health outcomes whenever possible, and at a minimum supports the maintenance of Member health and well-being.

7.3.1.7. Identifies Members at the acute care level and Members at risk of adverse health outcomes due to disease progression and/or health-related social needs and employs interventions to reduce the exacerbation of conditions.

7.3.1.8. Follows evidence based best practices whenever possible to improve the chances of Members achieving their health goals.

7.3.1.9. Reduces Member confusion and prevents duplication of efforts by collaborating with other entities, such as Case Management Agencies (CMAs), Dual Special Needs Plans (D-SNPs), Behavioral Health Administrative Service Organizations (BHASOs) and others.

7.3.1.10. Maximizes identification of and utilization of a dedicated Lead Care Coordinator to reduce duplication and organize multiagency Care Coordination activities to promote a holistic approach to a Member's care.

7.3.2. Contractor shall ensure that Care Coordination meets the following minimum requirements:

7.3.2.1. A three-tiered approach targeting Prevention, Condition Management, and Complex Health Management for Members

7.3.2.2. Protects Member privacy.

7.3.2.3. Is voluntary and consented to by the Member and/or their caregiver.

7.3.2.4. Strives to creatively engage Members in care by leveraging available community supports, including CBOs.

7.3.2.5. Provides interventions that meet the needs of the Member in a person/family centered manner.

7.3.2.6. Is trauma-informed.

7.3.2.7. Is culturally responsive.

7.3.2.8. Is accessible to Members through their preferred method: mobile, in-home, in the community, telephonic, and online as appropriate for their needs.

7.3.2.9. Connects Members to the resources required to carry out needed care and improves the closure of referral loops.

7.3.2.10. Bridges all delivery systems and state agencies involved in the Member's care.

7.3.2.11. Supports timely and consistent communication between the care coordinators, the providers delivering services to Members, the Member, and their care team.

7.3.2.12. Reduces duplication and promotes continuity of care by collaborating with the Member and the Member's care team to identify a lead care coordinator for Members receiving Care Coordination from multiple systems.

7.3.2.13. Addresses potential gaps in meeting the Member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs to achieve optimal health, wellness or end-of-life outcomes, according to Member preferences.

7.3.2.14. Is documented, for both medical and non-medical activities.

7.3.3. Contractor shall implement a Care Coordination Program that includes at minimum, but is not limited to the following activities:

7.3.3.1. General outreach and health promotion for all assigned Members.

7.3.3.2. Efforts to screen Members for both short and long-term health needs, including physical, behavioral, oral health, and health related social needs.

7.3.3.3. Targeted outreach to Members to promote adherence with evidence-based preventive care (e.g. well visit, immunizations, screenings, chronic condition routine monitoring).

7.3.3.4. Proactive outreach to Members with diagnosed conditions to promote adherence to a PCMP's Treatment Plan and evidence-based practices to improve outcomes and prevent exacerbation of diagnosed condition.

7.3.3.5. Coordination of Transitions of Care from clinical settings in accordance with NCQA standards and Section 7.7.

7.3.3.6. Medication reconciliation for Members in the Complex Health Management Tier and other Members as determined appropriate by Contractor or Network Providers.

7.3.3.7. Assurance of effective collaboration of multi-provider care teams, and as appropriate, multi-agency care teams, for Members in the complex health management tier and other Members as determined appropriate by Contractor or Network Providers.

7.3.3.7.1. Contractor or its designee for a specific Member shall, at a minimum, participate in multi-provider or multi-agency care teams.

7.3.3.7.2. Contractor or its designee shall take responsibility for convening and facilitating multi-provider or multi-agency care teams when no other provider or agency is identified as the primary care coordinator for a Member and when determined necessary by Contractor, its subcontractors or delegates, Network Providers, or a partner agency such as a county.

7.3.3.8. Mutually agreed upon partnership agreements to facilitate effective collaboration of Members that are jointly managed by Contractor and another agency.

7.3.3.9. Coordination of services to address Health-Related Social Needs, including but not limited to housing, food, and transportation, and follow-up to close referral loops.

7.3.3.10. Utilization of Department S-HIE and related systems to improve coordination of services, particularly community-based services addressing health-related social needs.

7.3.3.11. Strengthen and support the network of Community-Based Organizations to better meet needs of Members.

7.3.3.12. Connect Members with appropriate entities responsible for Member enrollment in other State benefits, such as SNAP and WIC, and assist Members with filling out applications

7.3.4. Contractor shall implement a Care Coordination Program utilizing tiers that identify the following populations and health objectives as further documented in Exhibit I Care Coordination Tiers.

7.3.4.1. Preventive health promotion: For Members who have minor or no existing health concerns, Contractor shall oversee the implementation of proactive and responsive Care Coordination interventions that assist Members in accessing evidence-based preventive care services as well as addressing health-related social needs. This shall include, but is not limited to:

7.3.4.1.1. Outreach, education, and access to Members in need of immunizations and leverage data to focus these efforts on priority populations and reducing health disparities.

7.3.4.1.2. Adults and children without oral health screenings.

7.3.4.1.3. Adult Members in need of adult preventative screening.

7.3.4.1.4. Children without well child visits.

7.3.4.2. Condition management: For Members with a diagnosed chronic condition, Contractor shall oversee the implementation, coordination, and utilization of evidence-based and proven programs designed to improve the health of Department identified populations and prevent disease progression of department identified health conditions. This shall include, but is not limited to, the following Members:

7.3.4.2.1. Adults and children with the following conditions:

7.3.4.2.1.1. Diabetes.

7.3.4.2.1.2. Asthma.

7.3.4.2.1.3. Pregnancy (peri-natal and 12 months post-natal).

7.3.4.2.1.4. Depression.

7.3.4.2.1.5. Anxiety.

7.3.4.2.1.6. SUD.

7.3.4.2.1.7. Serious Mental Illness

7.3.4.2.2. Adults with Department-identified conditions

7.3.4.2.3. Children with the following conditions:

7.3.4.2.3.1. Serious emotional disturbance

7.3.4.2.3.2. Independent Assessment indicating moderate needs.

7.3.4.2.3.3. Obesity.

7.3.4.2.3.4. Pervasive Developmental Disorder.

7.3.4.3. Complex health management: For Members with multiple conditions, complex needs and/or conditions that are not well managed, Contractor shall oversee the implementation, coordination, and utilization of longitudinal evidence-based and proven programs that involve multi-disciplinary care approaches to maintain or improve Member health. This shall include, but is not limited to, the following Members:

7.3.4.3.1. Adults and children who meet the following criteria:

7.3.4.3.1.1. Two or more physical and/or behavioral health conditions

7.3.4.3.1.2. Multisystem involvement, including but not limited to the following:

7.3.4.3.1.2.1. Child welfare.

7.3.4.3.1.2.2. HCBS.

7.3.4.3.1.2.3. Disability services.

7.3.4.3.1.2.4. Aging/adult services.

7.3.4.3.1.2.5. Criminal/juvenile justice.

7.3.4.3.1.2.6. Emergency/disaster relief services.

7.3.4.3.1.2.7. Refugee services.

7.3.4.3.1.2.8. Domestic violence and victim services.

7.3.4.3.1.3. Members who have been denied Private Duty Nursing (PDN) services

7.3.4.3.1.4. Utilization within a six-month timeframe that includes any of the following:

7.3.4.3.1.4.1. Two or more hospital readmissions.

7.3.4.3.1.4.2. 30 or more inpatient days.

7.3.4.3.1.4.3. Three or more ED visits.

7.3.4.3.1.4.4. Three or more mobile crisis contacts.

7.3.4.3.1.4.5. Adults who meet the following criteria:

7.3.4.3.1.4.6. Identified for COUP.

7.3.4.3.1.4.7. Escalated to Complex Solutions Meetings.

7.3.4.3.1.4.8. Deemed incompetent to proceed in previous year.

7.3.4.3.1.4.9. Children who meet the following criteria:

7.3.4.3.1.4.9.1. Independent Assessment indicating high needs.

7.3.4.3.1.4.9.2. Escalated to Creative Solutions Meetings.

7.3.4.3.1.4.9.3. Foster care and foster care emancipation.

7.3.4.3.1.4.9.4. At risk for out-of-home placement.

7.3.5. Contractor shall implement a tiered approach to Care Coordination based on Department's Member stratification model as described in Exhibit I. The Member stratification model takes into consideration the differences between children and adults and the conditions that would benefit from Care Coordination interventions

7.3.5.1. Contactor may incorporate their own unique Member stratification requirements within the guidelines established by Department to achieve Contractor's specific goals based on their analysis of their Members.

7.3.5.2. Contractor shall provide guidance to care coordinators in the use of clinical judgement to stratify Members who do not meet the minimum Department requirements by tier but who would benefit from care coordination interventions based on assessment and Member preferences.

7.3.5.3. Contractor shall ensure that the minimum specific Care Coordination activities are made available to Members based on their stratification within a tier as demonstrated in Exhibit I, Care Coordination Tiers.

7.3.5.3.1. Contractor's prevention tier shall offer, at a minimum, the following Care Coordination activities:

7.3.5.3.1.1. Brief needs screening and referrals, which may be pulled from PEAK and/or S-HIE.

7.3.5.3.1.2. Short-term monitoring/support.

7.3.5.3.1.3. Prevention outreach and education regarding evidence-based Medicaid services that include, but are not limited to, the following:

7.3.5.3.1.3.1. Adult Preventative Screenings.

7.3.5.3.1.3.2. Well child visits.

7.3.5.3.1.3.3. Child immunizations.

7.3.5.3.1.3.4. Oral health screening.

7.3.5.3.2. Contractor's condition management tier shall offer, at a minimum, the following Care Coordination activities:

7.3.5.3.2.1. Comprehensive needs assessment utilizing one of Department recommended assessments.

7.3.5.3.2.2. Condition-based care plan, established by the Member's provider or overseen by the RAE

7.3.5.3.2.3. Regular meetings with the Member at an appropriate frequency to meet the Members goals.

7.3.5.3.2.4. Condition management programming including, but not limited to, Maternity, Diabetes, Hypertension, Asthma, Chronic Obstructive Pulmonary Disease (COPD), pediatric wellness and overall health promotion programs which include tobacco cessation and behavioral health screenings and follow up care.

7.3.5.3.3. Contractor shall utilize existing condition management programs offered by Contractor or delivered through Contractor's Network Providers to manage and support Members with specific health conditions.

7.3.5.3.4. Contractor shall, at a minimum, develop programs to manage and support Members with specific health conditions identified by Department for which Contractor's Network Providers do not have existing programs.

7.3.5.3.5. Contractor shall submit a Condition Management Report in a format agreed upon by Department and Contractor. The report shall include information about Contractor's strategy and progress on programs to address Members with specific health conditions as identified by Department and Contractor, including details about programs specific to meeting the needs of children and youth.

7.3.5.3.5.1. DELIVERABLE: Condition Management Report

7.3.5.3.5.2. DUE: Every six months, by December 15 and June 15

7.3.5.3.6. Contractor's complex health management tier shall offer, at a minimum, the following Care Coordination activities:

7.3.5.3.6.1. Comprehensive needs assessment utilizing one of Department recommended assessments.

7.3.5.3.6.2. Comprehensive care plan. Contractor shall ensure Care Coordination is documented in the form of a care plan for Members who require more intense or extended assistance. Contractor shall ensure comprehensive care plans are regularly and sufficiently monitored and include the following:

7.3.5.3.6.2.1. An identified lead care coordinator, responsible for primary Member contact and assuring continuity of care and avoidance of duplication.

7.3.5.3.6.2.2. SMART goals developed in collaboration with the Member.

7.3.5.3.6.2.3. Be Member and/or caregiver driven.

7.3.5.3.6.3. Minimum monthly coordination with Member and treatment team.

7.3.5.3.6.4. Participation in Intensive Care Coordination/ High-Fidelity Wraparound for children and youth who qualify for those services.

7.3.5.3.6.5. Long-term monitoring and support.

7.3.5.3.6.6. Oversight, monitoring, and coordination of services with other agencies as appropriate.

7.3.5.3.7. PERFORMANCE STANDARD: 50% of Members who are stratified into the complex health management tier have at minimum a Comprehensive Care Plan. This Performance Standard will evolve following the first year of the Contract.

7.3.5.3.8. PERFORMANCE STANDARD: 50% of Members who are stratified into the complex health management tier engage with a care coordinator or the treatment team at least one time a month. This Performance Standard will evolve following the first year of the Contract.

7.3.5.4. Contractor shall submit a Care Coordination Report to Department in a format agreed to by Department and Contractor. The report shall include Care Coordination activities for Members in the complex health management tier performed by Contractor, Network Providers and Partners, and Subcontractors.

7.3.5.4.1. DELIVERABLE: Care Coordination and Complex Health Management Report

7.3.5.4.2. DUE: Every six months, by August 15th and February 14th

7.4. Care Coordination Delegation

7.4.1. Contractor may Subcontract or delegate Care Coordination accountability but shall be responsible for ensuring any subcontracted or delegated entity meets Contract Performance Standards and Reporting Requirements.

7.4.1.1. Contractor shall be responsible for monitoring delegated Care Coordination entities to ensure compliance with contracted requirements and performance standards.

7.4.1.2. Contractor shall provide any Care Coordination activities not offered by the delegated Care Coordination entity.

7.4.1.3. Contractor shall consider delegating to or subcontracting with Comprehensive Safety Net Providers to meet the Care Coordination requirements for Members with complex behavioral health needs.

7.4.2. Contractor shall create and submit a data feed or report in accordance with Department guidance that shall provide a comprehensive list of individual entities/organizations and/or Network Providers who are responsible for any forms of Care Coordination for Contractor's Members.

7.4.2.1. Contractor's data feed or report will define for each individual entity/organization and Network Provider the relationship between Contractor and the entity/organization and Network Provider regarding Care Coordination, including whether Contractor is primarily responsible for Care Coordination or whether Contractor has delegated or subcontracted Care Coordination accountability to the entity/organization or Network Provider.

7.4.2.1.1. DELIVERABLE: Care Coordination Roles Data feed or Report

7.4.2.1.2. DUE: Quarterly

7.5. Care Coordination Policy Guide for Children & Adults

7.5.1. Contractor shall document and implement a comprehensive Care Coordination Policy Guide for Children and Adults describing how Contractor will administer a Care Coordination Program in its region in accordance with the Work.

7.5.2. Contractor's Care Coordination Policy Guide for Children and Adults shall include, at a minimum, the following information:

7.5.2.1. Strategy for coordinating care for children across the continuum of health acuity

7.5.2.2. Strategy for coordinating care for adults across the continuum of health acuity

7.5.2.3. Strategy for how Contractor will ensure Care Coordination incorporates Member preferences and involves Members and their caregivers in determining Care Coordination activities

7.5.2.4. Descriptions of the specific interventions that Contractor will employ, the identified populations of focus, the criteria for deploying the interventions, and how Contractor will measure the effectiveness in alignment with Department guidelines.

7.5.2.4.1. Specific strategies for collaborating with systems and programs to support shared Members in Contractor's region and statewide as necessary, that includes but is not limited to those identified in Section 7.6.

7.5.2.4.2. Specific strategies for coordinating care for identified populations of focus, including but not limited to the following:

7.5.2.4.2.1. Pregnant Members (peri-natal and 12 months post-natal).

7.5.2.4.2.2. Indigenous Members/Tribes.

7.5.2.4.2.3. Youth transitioning into the adult healthcare system.

7.5.2.4.2.4. Members with serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), and co-occurring disorders.

7.5.2.4.2.5. Members with intellectual/developmental disabilities.

7.5.2.4.2.6. Members with co-morbid SMI and intellectual and development disabilities (IDD).

7.5.2.4.2.7. Aging/older adult Members.

7.5.2.4.2.8. Members who have been denied private duty nursing, as identified by Department.

7.5.2.4.2.9. Members identified for the COUP program.

7.5.2.4.2.10. Members deemed incompetent to proceed.

7.5.2.4.2.11. Members experiencing homelessness and/or participating in permanent supportive housing.

7.5.2.4.2.12. Members identified by Department as the "At-Risk Focus Population" who require intervention to prevent institutionalization.

7.5.2.4.3. Specific strategies for coordinating clinical transitions of care, that includes but is not limited to the clinical programs described in Section 7.7

7.5.2.4.4. Strategies for addressing Members' health-related social needs that includes but is not limited to housing, food security, and transportation.

7.5.2.4.5. Strategy for leveraging and supporting Network Providers in offering various levels of care coordination at the point of care and how Contractor will manage/oversee these activities to identify when additional resources or supports may be necessary for Members and to meet Department goals and objectives.

7.5.2.4.6. Strategy for formally delegating or subcontracting care coordination responsibilities to Network Providers, community organizations, and other entities, including requirements for data sharing, programs, and reporting.

7.5.2.4.7. Strategy for how Contractor will oversee, monitor and manage any delegated or subcontracted care coordination responsibilities to ensure Members are getting culturally responsive, appropriate support and services.

7.5.2.5. Contractor's Care Coordination Policy Guide for Children and Adults shall be made available to Members and Network Providers upon request.

7.5.2.6. Contractor shall submit the Care Coordination Policy Guide for Children and Adults to Department for approval prior to the Operational Start Date.

7.5.2.6.1. DELIVERABLE: Care Coordination Policy Guide for Children and Adults

7.5.2.6.2. DUE: 30 days prior to the Operational Start Date

7.5.2.7. Contractor shall update the Care Coordination Policy Guide for Children and Adults upon direction from Department to address identified challenges with Contractor's provision of appropriate Care Coordination.

7.5.2.8. Contractor shall collaborate with Department, Members, Network Providers, Contractor's Program Improvement Advisory Committee, and other relevant parties in creating and updating the Care Coordination Policy Guide for Children and Adults.

7.5.2.9. Contractor shall submit to Department sections of the Care Coordination Policy Guide for Children and Adults that have been revised by Contractor for approval within 30 days of the policy change.

7.5.2.9.1. DELIVERABLE: Revised Sections of the Care Coordination Policy Guide for Children and Adults

7.5.2.9.2. DUE: Within 30 days of policy change

7.6. System and program collaboration for shared Members

7.6.1. Contractor shall establish policies and procedures to facilitate effective collaboration, communication, and coordination with systems and programs serving shared Members and document them in the Care Coordination Policy Guide for Children and Adults. Systems and programs serving shared Members shall include but not be limited to the following:

7.6.1.1. Community-based organizations (CBOs).

7.6.1.2. CMAs.

7.6.1.3. D-SNPs.

7.6.1.4. BHASOs.

7.6.1.5. ICC/High Fidelity WRAP, as defined in Section ten.

7.6.1.6. Child welfare.

7.6.1.7. Criminal/juvenile justice.

7.6.2. Contractor shall establish a Business Associate Agreement (BAA), Memorandum of Understanding (MOU), or Subcontracting relationship with each entity listed in Section 7.6.1 to establish at minimum, all of the following:

7.6.2.1. A brief definition/overview of the collaborative work responsibilities.

7.6.2.2. Guiding principles and commitments to the partnerships.

7.6.2.3. Standards, processes, and workflows for cross-agency communication and coordination in various areas, including but not limited to regular meetings, training, Member outreach, case consultations, and transitions of care, as appropriate.

7.6.2.4. Roles and responsibilities, including which program will take on the role as lead care coordinator.

7.6.2.5. Bi-directional communication and data sharing.

7.6.2.6. A process for handling Members in complex or creative solutions as described in Section 7.7.

7.6.2.7. Data exchange and analysis protocols.

7.6.2.8. A process for escalating concerns when necessary.

7.6.3. Contractor shall meet the following minimum requirements for each individual system/program described in this section.

7.6.4. Community Based Organizations (CBOs)

7.6.4.1. Contractor shall strengthen and support a network of local CBOs in order to identify and engage with Members who are unreachable through conventional methods (e.g., phone, text, mail) and/or Members who underutilize preventive care, case management and condition support programs to improve quality outcomes and affordability.

7.6.4.2. Contractor shall identify appropriate CBOs in Contractor's region that may include, but are not limited to food banks, shelters, agencies supporting marginalized Members (covered immigrants, refugees, Indigenous Members/Tribes, homeless, etc.), community centers, etc.

7.6.4.3. Contractor shall prioritize CBOs that employ community health workers who are registered through CPDHE but are ineligible for Medicaid reimbursement.

7.6.4.4. Contractor may provide financial support to CBOs through their Administrative PMPM or project-based funding, to support CBOs in conducting outreach, health promotion, and care coordination for Contractor's Members.

7.6.4.5. Contractor may offer CBOs access to Contractor's care coordination platform, as deemed appropriate, and develop a data sharing plan with the CBO to ensure Contractor is able to report on required Care Coordination metrics, including meaningful engagement in Care Coordination.

7.6.4.6. Contractor may co-locate their own care coordinators or train existing CBO staff to conduct Care Coordination activities with support and guidance from Department,

especially for Members who face health inequities and those Members identified in the condition management and complex health management care coordination tiers.

7.6.4.7. Contractor shall leverage existing environmental scans, Department's and Contractor's health equity plan, and the Colorado Department of Public Health and Environment (CDPHE) to determine which locations and populations to focus on within their region.

7.6.5. Case Management Agencies (CMAs)

7.6.5.1. Contractor shall establish and maintain strong and ongoing relationships with all CMAs serving shared waiver Members as demonstrated by implementing all the following best practices:

7.6.5.1.1. Establishing a dedicated email address and phone line for CMAs in the region to submit information, questions, share updates, etc.

7.6.5.1.2. Responding to CMAs in a timely manner, no longer than two Business Days, to ensure Members needs are addressed.

7.6.5.2. Contractor shall ensure the following activities are completed by Care Coordinators working with CMAs on a routine basis:

7.6.5.2.1. Communicating the date, time, location and agenda for RAE-led meetings, forums and training and working collaboratively with the CMA liaison for any co-led RAE/CMA meetings.

7.6.5.2.2. Attending, documenting, and identifying follow-up tasks resulting from meetings, forums, and training.

7.6.5.2.3. Following-through on RAE tasks.

7.6.5.2.4. Proactively reaching out to CMAs regarding Members in the complex health management care coordination tier.

7.6.5.3. Contractor shall set regularly occurring meetings with its CMA Partners that include but are not limited to:

7.6.5.3.1. Weekly check-ins or huddles.

7.6.5.3.2. Monthly strategy meetings to discuss projects, activities and policy concerns or changes.

7.6.5.3.3. Caseload reviews to discuss all Members, including opportunities to engage Members in the appropriate RAE programs.

7.6.5.3.4. Local complex solutions/creative solutions.

7.6.5.3.5. Data sharing and analysis.

7.6.5.3.6. RAE-led cross agency forum for CMAs in their region

7.6.5.4. Contractor shall work with its CMA Partners to establish and document standard workflow for key activities, including, but not limited to:

7.6.5.4.1. Member outreach.

7.6.5.4.2. Referring cases to the RAE.

7.6.5.4.3. Transitions of care.

7.6.5.4.4. Escalating cases.

7.6.5.4.5. Preparing for and facilitating local or state-level Creative Solutions/Complex Solutions meetings.

7.6.5.4.6. Data sharing processes.

7.6.5.5. Contractor shall work with Department and its Partner CMAs to execute a data sharing agreement and identify key data elements to be shared, timing and transmission requirements.

7.6.5.5.1. Contractor shall utilize Department's Care and Case Management tool utilized by the CMAs to monitor Member activities to the extent possible.

7.6.5.6. Contractor shall engage its partner CMAs in a process to identify and evaluate existing electronic systems and workspaces that could be jointly used to improve communication and sharing of information.

7.6.5.6.1. Contractor shall adopt the use of the shared system(s) and processes that would work for each unique agency partnership.

7.6.5.7. Contractor shall have documented processes for performance improvement regarding Contractor's collaboration with CMAs to monitor and implement necessary improvements.

7.6.5.8. Contractor shall participate in Department led activities to improve oversight and monitoring. These may include at minimum, all of the following:

7.6.5.8.1. Utilizing data to evaluate performance.

7.6.5.8.2. Creating and participating in cross-functional group meetings to review data and deliverables.

7.6.5.8.3. Modifying surveys and tools to capture HCBS population specific information and data.

7.6.5.8.4. Engaging in remedies to improve performance including but not limited to providing mentorship, technical assistance, education, training, and/or other resources and supports.

7.6.5.9. For purposes of training new staff and ensuring consistent understanding across agencies, Contractor shall work with Department and its CMA partners to identify, create, participate in and administer training necessary to provide seamless care coordination to shared Members. Training topics may include, at minimum, all of the following:

7.6.5.9.1. Medicaid benefits and programs.

7.6.5.9.2. ACC overview and Managed Care Entity roles and responsibilities.

7.6.5.9.3. Applicable core competencies and skills such as motivational interviewing, transition planning, case presentations, cultural competency, and other relevant skills.

7.6.5.9.4. Managed Care Entity and CMA Workflows.

7.6.5.9.5. Data collection and analysis.

7.6.5.10. Contractor shall work with Department and its CMA Partners to explore new and innovative ways to improve the Member and caregiver experience.

7.6.6. Dual Special Needs Plans (D-SNPs)

7.6.6.1. Contractor shall partner with Department and D-SNPs to evolve the effective management and coordination of care for dually-enrolled Medicare and Medicaid Members over the course of the contract.

7.6.6.2. Contractor shall execute a Business Associate Agreement or Memorandum of Understanding (MOU) with each D-SNP in their region regarding the coordination of care for their mutually covered Members.

7.6.6.2.1. Contractor may pursue establishing a sub-contracted relationship with a D-SNP and value-based payment arrangement to ensure Members receive the most effective and comprehensive care.

7.6.6.3. As the D-SNP is the primary payer of most of a Member's care and often leading the care coordination for a Member, Contractor shall actively collaborate with the D-SNP to complement and support the D-SNPs Care Coordination activities, particularly as they relate to Medicaid services not covered by the D-SNP.

7.6.6.4. Contractor shall participate in D-SNP led care team meetings for Members, contributing to the development and implementation of care coordination.

7.6.6.5. Contractor shall provide mutually agreed upon Care Coordination activities and report on the outcomes to the D-SNP.

7.6.6.6. Contractor shall identify D-SNP enrolled Members on the Admission, Discharge, and Transfer (ADT) feeds and have processes to identify and coordinate appropriate care coordination services to optimize a Member's outcomes and reduce duplication of efforts.

7.6.6.7. Contractor shall conduct a comprehensive analysis of the benefit structure between D-SNP plans and the Medicaid benefits to ensure a thorough comprehension and application in coordinating Medicaid services for Members.

7.6.6.8. Contractor shall educate providers that serve both Medicaid and Medicare about the more robust Medicaid benefit structure, aiming to improve provider utilization of available benefits and patient outcomes.

7.6.6.9. Contractor shall ensure it has Care Coordination staff with Medicare and D-SNP expertise to ensure the overall effectiveness of Contractor's Care Coordination program.

7.6.6.10. Contractor shall establish a standard process of communication, including dedicated email and phone channels for care coordination activities with the D-SNP care coordinators, aiming to improve collaboration and care outcomes.

7.6.6.11. Contractor shall conduct monthly meetings with D-SNPs to review Members that are stratified in the Complex Health Management Care Coordination tier, aiming to improve care coordination outcomes for these Members.

7.6.6.12. Contractor shall track and ensure care coordination engagement rates and appropriate types of Care Coordination are being provided to the D-SNP Members. Contractor shall utilize the data collected to improve care outcomes and care coordination efforts.

7.6.6.13. Contractor shall establish a robust system to receive and manage Skilled Nursing Facility (SNF) and inpatient admission information provided by the D-SNP within two calendar days.

7.6.6.13.1. Contractor shall continuously monitor this system to ensure that timely and appropriate responses to these admissions are made, including, at minimum, necessary Care Coordination activities that contribute to the successful inpatient outcomes.

7.6.7. Behavioral Health Administrative Service Organizations (BHASOs)

7.6.7.1. Contractor shall develop a workflow with the BHASO in their region in order to notify one another when a Member is actively engaged in care coordination and will be transitioning from one entity to the other because of a change in Medicaid enrollment status.

7.6.7.1.1. Contractor shall make every effort to ensure Members returning to the RAE from a BHASO are re-assigned to the same Medicaid care coordinator, as appropriate.

7.6.7.2. For former BHASO Members newly receiving Medicaid, Contractor shall facilitate a smooth transition by ensuring an assigned care coordinator conducts the following activities:

7.6.7.2.1. Offers continued care coordination at the same level as provided under the BHASO.

7.6.7.2.2. Collects documentation that will aid in supporting the Member's care coordination goals, including but not limited to assessments, care plans, and/or crisis plans, as available.

7.6.7.3. If a Member is being disenrolled from Medicaid and has continued behavioral health needs, Contractor shall ensure the care coordinator conducts the following activities:

7.6.7.3.1. Connects the Member to the appropriate BHASO and follows up to ensure contact has been made.

7.6.7.3.2. Provides the BHASO care coordinator with documentation that will support the Member's continued care coordination needs are met, including but not limited to assessments, care plans, and/or crisis plans.

7.6.8. Foster Care

7.6.8.1. Contractor shall develop a workflow with each county child welfare office in Contractor's region that shall include, at minimum, all of the following:

7.6.8.1.1. Timely identification of children newly located in out-of-home placement.

7.6.8.1.2. Communicating with caseworker(s).

7.6.8.1.3. Obtaining a copy of the child's service plan (crisis plan if applicable).

7.6.8.1.4. Communication around status changes.

7.6.8.1.5. Scheduling team meetings.

7.6.8.2. Contractor shall address the complex health risks for children and youth in foster care by ensuring the following activities are completed:

7.6.8.2.1. Monitoring and coordinating a child or youth's utilization of consistent, preventative care in medical, behavioral, vision, and dental health.

7.6.8.2.2. Psychoeducation on the importance of taking medications prescribed in accordance with provider guidance

7.6.8.2.3. Psychoeducation on attending all scheduled appointments:

7.6.8.2.4. Promoting a child's safety, health, education, and emotional well-being

7.6.8.2.5. Participating in all scheduled team meetings.

7.6.8.3. Contractor shall collaborate with the county child welfare caseworker to identify which Members require meetings of the Member's care team to maintain and improve the Member's health and well-being.

7.6.8.3.1. Contractor shall negotiate with the county child welfare caseworker to determine who is responsible for arranging meetings of a Member's care team.

7.6.8.3.2. When determined appropriate, Contractor shall arrange and facilitate regular meetings of the Member's care team which may include but is not limited to the following representatives:

7.6.8.3.2.1. Caseworkers.

7.6.8.3.2.2. Foster parents.

7.6.8.3.2.3. Biological family.

7.6.8.3.2.4. PCMP.

7.6.8.3.2.5. Behavioral health administrator.

7.6.8.3.2.6. Juvenile justice coordinator.

7.6.8.3.2.7. School officials.

7.6.8.3.3. Contractor shall ensure that each area of a Member's service/care plan has been assigned to an appropriate individual of the Member's care team.

7.6.8.3.4. Contractor shall offer High-Fidelity Wraparound and Intensive Care Coordination to children and youth Members in out-of-home placement as appropriate and determined necessary.

7.6.9. Emancipated Foster Care

7.6.9.1. Contractor shall support youth who are transitioning out of foster care by completing, at minimum, all of the following activities:

7.6.9.1.1. Assess the young person's transition readiness to inform what tier of care coordination is most appropriate.

7.6.9.1.2. Provide education to young people preparing to emancipate, including:

7.6.9.1.2.1. How to locate providers and schedule appointments.

7.6.9.1.2.2. How to obtain transportation.

7.6.9.1.2.3. The importance of continuing with prescribed medications.

7.6.9.1.2.4. The importance of preventative care.

7.6.9.1.3. Support the young person's engagement with existing programs serving youth transitioning out of foster care, including the John H. Chafee Foster Care Program for Successful Transition to Adulthood.

7.6.9.2. Contractor shall implement evidence-based and promising practices to support the transition of emancipated foster care youth, which may include but are not limited to:

7.6.9.2.1. Transition to Independence Process (TIP) evidence-based model.

7.6.9.2.2. Got Transition.

7.6.10. Criminal/Juvenile Justice

7.6.10.1. Contractor shall participate in special workgroups created by Department or other state agencies to improve services and coordination of activities for populations involved in carceral settings.

7.6.10.2. Contractor shall partner with Department and the Colorado Department of Corrections (CDOC), Office of Juvenile Justice and Delinquency Programs (OJJDP), and jails in their defined service region to identify and provide services to Medicaid-eligible individuals being released from carceral settings to enable them to transition successfully to the community. Services shall include, but are not limited to:

7.6.10.2.1. Activities prior to an individual's release in accordance with any federally approved waiver agreement, including but not limited to an assessment to identify needs the Member will have upon release.

7.6.10.2.2. Care transition support, which may include but is not limited to supporting continued access to all medications prescribed to the Member during and/or prior to incarceration, including but not limited to MAT.

7.6.10.2.3. Care coordination.

7.6.10.2.4. Contractor shall receive and process a list from the CDOC containing information about incarcerated individuals who have recently been released or will be released in the near future.

7.6.10.2.5. Contractor shall process the lists to identify individuals who are assigned to Contractor or will be released to Contractor's region and are likely to be assigned to Contractor.

7.6.10.2.6. Contractor shall provide timely outreach and transitional support to individuals assigned to or who are likely to be assigned to Contractor to support their successful transition to the community.

7.6.10.2.7. Contractor shall coordinate transitional support between CDOC, OJJDP, jails, and other RAEs for individuals who were likely to but ultimately were not assigned to Contractor.

7.6.10.2.8. Contractor shall connect Members deemed incompetent to proceed with appropriate restoration services whether or not the services are covered by Medicaid, in coordination with the Office of Civil and Forensic Mental Health.

7.7. Transitions of Care (TOC)

7.7.1. Contractor shall develop and implement a Transitions of Care (TOC) Program that incorporates an evidence-based model consisting of a multi-disciplinary team as part of its Care Coordination model.

7.7.2. Contractor shall ensure that Care Coordination is offered to Members who are transitioning from one level of care to another, including but not limited to transitions from hospitals and mental health residential services, EDs, and mobile crisis to prevent unnecessary ED visits, rehospitalization, other adverse health outcomes, and/or utilization of the wrong level of care warranted for the Member's needs.

7.7.3. Contractor shall conclude the provision of transitional care only when Members have been successfully connected to needed services and supports for a minimum of three months.

7.7.4. Contractor shall develop policies and procedures for Department's review, as part of the Care Coordination Policy Guide for Children and Adults, which describe how TOC between settings shall be effectively managed.

7.7.4.1. Contractor shall collaboratively establish policies and procedures for conducting TOC services that meet the unique needs and requirements of individual settings and systems and avoids duplication of services. These policies and procedures shall include, but are not limited to, the following information:

7.7.4.1.1. How to communicate with staff at the specific setting/system.

7.7.4.1.2. How to identify Members who qualify for transitional care supports.

7.7.4.1.3. How to provide Care Coordination services while the Member is in the specific system/setting.

7.7.4.1.4. How to participate in the creation and implementation of the discharge or transition plan from the setting/system.

7.7.4.1.5. How to address Member concerns when they arise.

7.7.4.1.6. How to ensure adequate and appropriately trained clinical staff are involved as warranted by the Member's needs or at the request of Department.

7.7.4.2. Contractor shall document standards to exhaust all efforts to support discharge planning and to identify placement options before escalating to Creative/Complex Solutions as described in Section 7.7.12.

7.7.5. Contractor shall ensure Care Coordinators are trained on the TOC policies and procedures and that Care Coordinators are following the TOC policies and procedures.

7.7.6. Contractor shall ensure Care Coordinators performing TOC activities have the appropriate level of knowledge of the assigned system/setting to serve that population and solve Care Coordination problems for that population, including knowledge regarding out-of-state medical care as described in ten CCR 2505-108.013, and out-of-state Non-Emergent Medical Transport (NEMT) as described in 10 CCR 2505-10 8.014.7.

7.7.6.1. Contractor shall ensure Care Coordination staff have knowledge of Department's fee for service physical health benefits including, but not limited to, Department's policies and associated rules for out-of-state care, (NEMT), and in-home benefits such as private duty nursing, long-term home health, and personal care.

7.7.6.2. Upon request of Department Clinical Leadership, Contractor shall make available adequate and appropriately trained clinical staff (e.g. nurses or physicians) with experience in addressing a Member's needs.

7.7.7. Contractor shall ensure an easy-to-follow process is in place to conduct TOC activities on behalf of delegated providers at no cost to the provider if the provider is unable or unwilling to meet these guidelines.

7.7.8. Inpatient Hospital Review Program and Hospital/Residential TOC

7.7.8.1. Contractor shall collaborate with Department as requested on all components of TOC as it applies to hospitals, including future iterations, of Department's Inpatient Hospital Review Program (IHRP).

7.7.8.2. Contractor shall collaborate directly with hospitals to ensure the seamless transition of patients from the hospital setting to a lower level of care.

7.7.8.2.1. Contractor's collaborative efforts may include, at minimum, but are not limited to, all of the following:

7.7.8.2.1.1. Assisting with discharge medications.

7.7.8.2.1.2. Post-discharge appointments.

7.7.8.2.1.3. Establishing care provided in the home.

7.7.8.2.1.4. Admissions to long-term care, group home or residential services, or skilled care facilities (skilled nursing or hospital back-up care).

7.7.8.2.1.5. Restarting or setting up access to HCBS/waiver services.

7.7.8.2.1.6. Recuperative care or community resources for Members experiencing homelessness.

7.7.8.2.1.7. Other efforts as identified by Department.

7.7.8.3. Contractor shall establish mechanisms to prioritize Members who have a high-risk or complex medical conditions, are at risk for readmissions, or have barriers to discharge.

7.7.8.4. Contractor shall, at a minimum, ensure all of the following:

7.7.8.4.1. Establish partnerships and communication plans with all hospitals that serve its attributed Members.

7.7.8.4.2. Receive and incorporate IHRP data into its care coordination processes and procedures.

7.7.8.4.3. Document a process for handling discharges from out-of-state hospitals.

7.7.8.4.4. Develop Transitions of Care Reporting to be done in the normal cycle of reporting as determined by Department.

7.7.8.5. Contractor shall accept and review ADT data from all Colorado Health Information Exchange (HIE) platforms at least every business day to identify Members who have been hospitalized in a physical or behavioral health care setting or who are utilizing mental health residential services to prioritize TOC.

7.7.8.6. Contractor shall accept and process IHRP data daily, either from Department or Department's third-party vendor implementing the IHRP to prioritize TOC interventions.

7.7.8.7. For Members who are not already receiving care coordination, Contractor shall assign a lead care coordinator to conduct at minimum, all of the following activities:

7.7.8.7.1. Make introductions to the Member and/or their caregivers and inform them of the nature of transitional care coordination as described in this section.

7.7.8.7.2. Assess the Member for ongoing care coordination needs in the condition management or complex health management tiers.

7.7.8.8. Contractor shall ensure the Member's designated lead care coordinator shall conduct at minimum, all of the following activities:

7.7.8.8.1. Begin collaborating with the hospital/residential point of contact and the Member and/or their caregivers as soon as possible to prepare for successful discharge. Care coordination should not duplicate the efforts of the hospital/residential point of contact/discharge planner but should concentrate on implementing and monitoring the plan for the Member once discharged from the hospital.

7.7.8.8.2. Notify the Member's care team of their admission.

7.7.8.8.3. Within 48 business hours following discharge:

7.7.8.8.3.1. Make contact with the Member and/or their caregiver to:

7.7.8.8.3.1.1. Ensure a follow up appointment with a licensed health care provider has been scheduled following discharge within 30 days for physical health and seven days for behavioral health.

7.7.8.8.3.1.2. Support the Member with scheduling a follow up appointment with a licensed health care provider if no appointment exists.

7.7.8.8.3.1.3. Ensure the Member has the support and resources to attend their follow up appointment, including but not limited to transportation.

7.7.8.8.3.1.4. Conduct medication reconciliation.

7.7.8.8.3.1.5. Obtain a copy of the Member's discharge plan, and in the case of a behavioral health discharge, a copy of their crisis plan.

7.7.8.8.3.1.6. Notify the Member's care team of their discharge.

7.7.8.8.3.1.7. Contact the Member following discharge at least once a month, for at least three months, to ensure continuity of care has occurred and the Member's needs are met.

7.7.8.8.4. Contractor shall review TOC completion rates during quarterly leadership meetings with Department.

7.7.8.8.4.1. PERFORMANCE STANDARD: 30-day follow-up for physical health inpatient stay. Target is achieving the national average over the term of the Contract.

7.7.8.8.4.2. PERFORMANCE STANDARD: 7-day follow-up for behavioral health inpatient discharge. Target is achieving the national average over the term of the Contract.

7.7.8.8.5. Contractor shall submit IHRP Reports to Department monthly using a Department template.

7.7.8.8.5.1. DELIVERABLE: IHRP Report

7.7.8.8.5.2. DUE DATE: Monthly

7.7.9. Emergency Department TOC

7.7.9.1. Contractor shall review ADT data from all Colorado Health Information Exchange platforms at least every business day and have processes to identify Members who are overutilizing the ED and to identify Members who meet criteria for or who are at risk of meeting criteria for the complex health management tier as a result of ED visits.

7.7.9.2. Contractor shall assign a lead Care Coordinator to these Members to complete, at minimum, all of the following activities:

7.7.9.2.1. Use creative engagement efforts to outreach the Member, including leveraging ED staff, Network Providers, and/or the CBO Network.

7.7.9.2.2. Offer Care Coordination for Members who meet the Complex Health Management Tier criteria based on ED visits or assess for Care Coordination needs (for Members with rising risk).

7.7.9.2.3. Use strategies to determine the cause of the Member's repeated ED visits and offer education and other appropriate interventions to reduce inappropriate ED usage.

7.7.10. Mental Health Hospitals and Institutions for Mental Disease (IMDs) TOC

7.7.10.1. Contractor shall maintain policies, procedures, and strategies for helping to transition Members from Colorado Mental Health Hospitals and IMDs to safe and alternative environments.

7.7.10.2. Contractor shall participate in discussions and Care Coordination with the Colorado Mental Health Hospitals and IMDs, and Contractor shall have plans in place to provide medically necessary covered services once the Member has been discharged.

7.7.10.3. Contractor shall work with appropriate treatment providers in their region in order to transition children from Colorado Mental Health Hospitals and IMDs to safe and alternative step-down environments (e.g., home, residential, etc.). Contractors shall meet with appropriate treatment providers to develop and maintain protocols and procedures for how these transitions will take place in order to ensure continuity of care and continuation of services.

7.7.10.4. Contractor shall assign a liaison to serve as a regular point of contact with the Colorado Mental Health Hospital staff for Members who will return to or enter Contractor's geographic service area. Contractor's liaison, or their designee, shall engage in, at minimum, all of the following activities:

7.7.10.4.1. Monthly treatment planning meetings, when requested by Department or Colorado Mental Health Hospital.

7.7.10.4.2. Discharge planning meetings.

7.7.10.4.3. Face-to-face planning with Member.

7.7.10.4.4. Prompt in-person, email, telephone, and fax communication with treatment Providers sufficient to arrange a successful discharge from the Colorado Mental Health Hospital.

7.7.10.5. Contractor shall ensure the assigned Lead Care Coordinator for Members treated at a Colorado Mental Health Hospital or IMD supports successful Member discharge by arranging and coordinating medically necessary on-going treatment and health related social needs, including but not limited to the following activities:

7.7.10.5.1. Follow all inpatient transitions of care requirements, including assurance of a follow up appointment with a licensed behavioral health provider within seven days.

7.7.10.5.2. Assist and collaborate with the applicable contracted provider to expedite discharge and engagement in ongoing Covered Services, which may include the Member's participation in Supportive Housing Services.

7.7.10.6. Contractor shall work with Department, BHA, and other relevant state agencies to review cases of Members that have been indicated as posing difficulties for returning back to the community. Contractor shall identify barriers to discharge and develop an appropriate transition plan back to the community.

7.7.10.7. Contractor who was responsible for that Member upon admission to the Colorado Mental Health Hospital shall remain Contractor until the Member is reassigned by Department to a new Regional Accountable Entity.

7.7.11. Crisis System Transitions

7.7.11.1. Contractor shall coordinate care with the Colorado Crisis System to ensure timely follow-up outreach and treatment for enrolled Members who have accessed crisis services.

7.7.11.2. Contractor shall execute an MOU/BAA with the Mobile Crisis Provider(s) in their region that allows for Contractor to be swiftly notified when a Member has made a crisis contact.

7.7.11.3. Contractor shall ensure the crisis follow-up plan developed by Mobile Crisis is noted in the care coordination platform.

7.7.11.4. Contractor shall ensure that Members are offered follow up care coordination within one business day after a crisis contract.

7.7.11.5. Contractor shall track mobile crisis contacts and escalate Members to the Complex Health Management Tier when more than three crisis contacts have been made in a six-month timeframe.

7.7.11.5.1. Contractor shall ensure that Members who have been escalated to Complex Health Management Tier, as described in Exhibit I, Care Coordination Tiers for multiple crisis contacts shall have a crisis plan included in the care coordination platform, which may be pulled from another provider to avoid duplication.

7.7.12. Creative Solutions/Complex Solutions Expectations

7.7.12.1. Contractor shall lead and facilitate Complex Services Solutions meetings for adults and Creative Solutions meetings for children that include the Member's care team and Department staff in order to identify solutions for Members experiencing significant barriers to care, including but not limited to difficult placements.

7.7.12.2. Contractor shall use templates provided by Department to refer, track, and monitor Members involved in Creative/Complex Solutions, including, at minimum, all of the following information:

7.7.12.2.1. Demonstrate preventative efforts and attempts to identify Member solutions prior to referring to Creative/Complex Solutions.

7.7.12.2.2. Develop a plan to bridge support for Members between discharge from higher levels of care and waitlists for step-down services.

7.7.12.2.2.1. When solutions are unsuccessful, summarize the reasons and any missed opportunities and/or future plans to prevent similar outcomes.

7.7.12.3. Contractor shall report Creative/Complex solutions data on a template provided by Department for submission to Governor's Office.

7.7.12.3.1. DELIVERABLE: Creative/Complex Solutions Report

7.7.12.3.2. DUE: As determined by Department

7.8. Data, systems, & performance

7.8.1. Contractor shall ensure that Care Coordination tools, processes, and methods are available to and used by Network Providers.

7.8.2. Contractor shall ensure that clinical and claims data feeds, including but not limited to ADT data received from a Colorado health information exchange, monthly claims data, CMA case manager data feeds, the Inpatient Hospital Review Program data feed, and the Nurse Advice Line Data feed are actively used in providing care coordination for Members.

7.8.3. Contractor shall receive, process, and analyze clinical, claims, and other available data from the State and Contractor and shall work collaboratively with Department to stratify Contractor's population into the Care Coordination tiers, as well as identify trends and potentially avoidable costs.

7.8.4. Contractor shall facilitate data sharing across all treating providers, subcontractors, and delegated entities, and ensure the completion of necessary consents and releases of information.

7.8.5. Performance Metrics & Data Reporting and Performance Metrics

7.8.5.1. Contractor shall collect data on Member engagement in Care Coordination which shall be defined as bi-directional communication where the Member response is more than the Member opting out of Care Coordination.

7.8.5.1.1. Communication can occur in-person or through telecommunication including phone, text, video, or Member portal.

7.8.5.2. Contractor shall develop and maintain mechanisms to collect the Care Coordination engagement information from Subcontractors, delegated Care Coordination entities, and Network Providers in a manner that is the least burdensome for Network Providers.

7.8.5.2.1. Contractor shall be responsible for cleaning and collating the data for submission to Department.

7.8.5.3. Contractor shall submit Care Coordination engagement data to Department in a standardized format determined by Department.

7.8.5.4. Contractor shall submit, at a minimum, the following Care Coordination engagement data:

7.8.5.4.1. Member identifier for individuals who actively participated in a Care Coordination intervention during the previous month

7.8.5.4.2. Entity who provided the Care Coordination intervention

7.8.5.4.3. Date of Care Coordination intervention

7.8.5.4.4. Member identifier for individuals who opted out of Care Coordination.

7.8.5.4.4.1. DELIVERABLE: Care Coordination Engagement Data

7.8.5.4.4.2. DUE: Quarterly, October 15, January 15, April 15, July 15

7.9. Care Coordination Outcome Metrics

7.9.1. Contractor's Care Coordination program shall be evaluated based on Contractor's performance on the following metrics:

7.9.1.1. Care coordination engagement rate: The percent of Members in the Contractor's Complex Health Management tier who engaged in a Care Coordination activity each month during the previous quarter.

7.9.1.1.1. PERFORMANCE STANDARD: At a minimum, XX% of Members in the Complex Health Management tier engaged in a Care Coordination activity during the previous quarter. The Performance Standard will be evaluated and adjusted annually in negotiations between Contractor and Department.

7.9.1.2. Hospital All-cause Readmission rate based on NCQA methodology

7.9.1.2.1. PERFORMANCE STANDARD**:** Contractor shall maintain a Hospital All-cause Readmission rate below a threshold of XX% for Members in the Complex Health Management and Condition Management tiers during the previous quarter. The Performance Standard will be evaluated and adjusted annually in negotiations between Contractor and Department.

7.9.1.3. Transitions of care from hospitals based on NCQA methodology

7.9.1.3.1. PERFORMANCE STANDARD**:** Contractor shall achieve a Transitions of Care performance rate at a minimum rate of XX% for Members in the Complex Health Management and Condition Management tiers during the previous quarter. The Performance Standard will be evaluated and adjusted annually in negotiations between Contractor and Department.

7.9.1.4. Ambulatory Care: Emergency Department (ED) Visits based on NCQA methodology

7.9.1.4.1. PERFORMANCE STANDARD**:** Contractor shall maintain an ED Visit performance rate below the threshold of XX% for Members in the Complex Health Management and Condition Management tiers during the previous quarter. The Performance Standard will be evaluated and adjusted annually in negotiations between Contractor and Department.

7.9.1.5. Contractor may be eligible to receive additional funding based on achieving targeted performance goals for one or multiple Care Coordination outcome metrics.

8. PROVIDER SUPPORT PRACTICE TRANSFORMATION

8.1. Overview and Guiding Principles for Provider support and practice transformation

8.1.1. Contractor shall serve as a central point of contact for Network Providers regarding Medicaid services and programs, Department Value Based Payment strategies and programs, regional resources, clinical tools, integrated care, and general administrative information.

8.1.2. Contractor shall serve as a vital support to the success and sustainability of primary care and the continuum of behavioral health throughout their region by providing data, actionable analytics, education, and wraparound services and supports to make it easier for Network Providers to deliver care to Members and by reducing administrative burdens and barriers where possible.

8.1.2.1. Taking into consideration alignment with other RAEs and HCPF efforts, Contractor shall identify and work to reduce administrative burdens and barriers for Network Providers where possible and engage Department as necessary around statewide issues and challenges Network Providers face across the RAE regions.

8.1.3. Contractor shall use Contractor's Population Health Management Strategy defined in Section 7 to guide Contractor's Practice Support activities for Network Providers.

8.1.4. Contractor shall offer Network Providers the following types of support, described in further detail in the rest of this section: general information and administrative support, provider training, data systems and technology support, practice transformation, and financial support.

8.1.5. Contractor shall offer and provide Practice Support to Network Providers regarding operations and activities that include, but are not limited to:

8.1.5.1. Continuous quality improvement coaching and education on the delivery of evidence-based medicine.

8.1.5.2. Coordinating and integrating primary care and behavioral health services.

8.1.5.3. Enhancing the delivery of team-based care by leveraging all staff to provide services within their full scope of practice and by incorporating community health workers, which may include patient navigators, peers, promotors, and other lay health workers, in accordance with the implementation of C.R.S. 25.5-5-334.

8.1.5.4. Adopting best practices in primary care delivery in accordance with the Colorado Division of Insurance's (CDOI) Aligned Core Competencies for Primary Care alternative payment models.

8.1.5.5. Adopting best practices in the delivery of behavioral health care in accordance with standards established by the BHA.

8.1.5.6. Advancing business practices and clinical workflow by adopting and using health technologies, including health technologies offered by Department including:

8.1.5.6.1. eConsult.

8.1.5.6.2. Prescriber tool.

8.1.5.6.3. Social Health Information Exchange (SHIE), as it evolves in partnership between the Office of eHealth Innovation and Department.

8.1.5.7. Participating in Department Value-Based Payment models.

8.1.5.8. Activities designed to improve Member health and experience of care.

8.1.6. Contractor shall submit an annual Provider support and practice transformation report that includes, at a minimum all of the following information:

8.1.6.1. The types of information and administrative support, provider trainings, and data and technology support Contractor shall offer and make available to Network Providers.

8.1.6.2. The practice support and practice transformation activities Contractor shall implement to support successful provider participation in Department efforts to

integrate behavioral and physical health care delivery, to incorporate community health workers into the Medicaid delivery system, to implement Value-Based Payment models and to achieve Department quality and cost savings metrics.

8.1.6.3. The practice transformation strategies Contractor will offer to help practices progress along CDOI's defined aligned core competencies for primary care alternative payment models as well as strategies to help practices engage with Contractor's efforts to implement their Population Management Strategy.

8.1.6.4. How the Contractor is supporting Network Providers and the region with improving coordination throughout the Health Neighborhood and reducing costs. Details could include practice support, utilization of Department dashboards and data, performance data, and more.

8.1.6.5. Descriptions of Contractor's work, including successes and lessons learned, during the previous year.

8.1.6.6. Savings and engagement performance by each PCMP, for each delegated obligation or program

8.1.6.7. Comparison between Contractors engagement and savings versus Delegated PCMP engagement and savings.

8.1.6.8. Reporting of barriers and burdens Network Providers face, the strategies Contractor pursued to help ease identified barriers and burdens, and identification of issues that may require Department and or State intervention.

8.1.6.9. Contractor shall submit the Annual Provider support and practice transformation Strategic Plan to Department.

8.1.6.9.1. DELIVERABLE: Annual Provider support and practice transformation Report

8.1.6.9.2. DUE: Annually, by August 1

8.2. Provider Communication

8.2.1. Contractor shall ensure that Contractor's Provider communications adhere to Colorado Medicaid's brand standards.

8.2.2. Contractor shall maintain consistent communication, both proactive and responsive, with Network Providers and other partners, and promote communication among Network Providers.

8.2.3. Contractor shall maintain, staff, and publish the number for a toll-free telephone line that Providers may call regarding general information, administrative support, and complaints.

8.2.3.1. During Business Hours, Contractor shall ensure that no more than 5% of calls are abandoned in any consecutive 30-day period. A call shall be considered abandoned if the caller hangs up after that caller has waited in the call queue for 180 seconds or longer.

8.2.3.2. Contractor shall ensure that the average length of time callers wait in the call queue before the call is answered is two minutes or less during each calendar month.

8.2.3.3. Contractor shall have no more than five calls during each business week that have a maximum delay of ten minutes or longer, and no calls shall have a maximum delay over 20 minutes.

8.2.3.4. Contractor shall respond to all Provider inquiries within two Business Days.

8.2.3.5. Contractor shall submit monthly response time data from its Provider telephone line in the Call Line Statistics Report.

8.2.4. Contractor shall collaborate with Department to respond to, and address complaints submitted to Department through the Managed Care Provider Complaint Form or other mechanism.

8.2.4.1. Contractor shall outreach Providers who have submitted a complaint to Department within two Business Days of Department informing Contractor.

8.2.4.1.1. PERFORMANCE STANDARD: 90% of Providers who expressed a complaint to Department shall be outreached within two Business Days of Department informing Contractor of the complaint. 100% of Providers who expressed a complaint to Department shall be outreached within five Business Days of Department informing Contractor of the complaint.

8.2.5. Contractor shall establish a process for responding to and resolving barriers and problems reported by Network Providers related to Contractor's payment and benefits systems.

8.2.6. Contractor shall expeditiously resolve Provider Complaints.

8.2.6.1. For Provider issues that cannot be resolved within one week, Contractor shall document a process for how they are working to resolve the issue and provide a weekly update to Department, either in writing or during a regularly scheduled meeting.

8.2.6.1.1. PERFORMANCE STANDARD: 90% of Provider complaints submitted to Department or Contractor shall be resolved by Contractor, as determined by Department, within 20 Business Days of receipt.

8.2.6.2. Contractor shall collaborate with Department on how to best communicate with and work with Providers who regularly submit multiple complaints and communications, including determining when it may be appropriate to establish signed communications plans with a Provider establishing clear processes and expectations regarding communications.

8.2.7. Contractor shall assist any Program provider who contacts Contractor, including providers not in Contractor's region who need assistance determining which Members are attributed to their practice.

8.2.7.1. Department will provide data to Contractor on all Members for this purpose.

8.2.8. Contractor shall use a variety of communication methods, including at minimum, email lists, newsletters and other methods, to communicate with Providers and Subcontractors and inform them of relevant Medicaid information and changes to any of Contractor's or Department's policies and programs.

8.2.9. Contractor shall have a defined process to monitor the effectiveness of communication with Network Providers and Subcontractors, and to address communication deficiencies or crisis situations, including how Contractor shall increase staff, contact hours or other steps Contractor shall take if existing communication methods for Providers are insufficient.

8.3. General Information and Administrative Support

8.3.1. Contractor shall ensure informational support for Network Providers, while being mindful of not duplicating existing materials.

8.3.2. Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for all of the following topics:

8.3.2.1. General information about Medicaid, the ACC, and Contractor's role and purpose.

8.3.2.2. Department's process for handling appeals of physical health adverse benefit determinations and Contractor's process for handling appeals of behavioral health adverse benefit determinations.

8.3.2.3. Available Member resources, including the Member provider directory.

8.3.2.4. Clinical resources, such as screening tools, clinical guidelines, practice improvement activities, templates, trainings and any other resources Contractor has compiled.

8.3.2.5. Community-based resources and inventories for health-related social needs, such as childcare, food assistance, services supporting elders, housing assistance, utility assistance and other non-medical supports.

8.3.2.6. Department's Value-Based Payment strategy and models available to Network Providers.

8.3.3. Contractor shall distribute information and provide technical assistance to complement Department's efforts to help Network Providers understand the following Colorado Medicaid program information:

8.3.3.1. Medicaid eligibility

8.3.3.2. Medicaid covered benefits

8.3.3.3. State Plan services

8.3.3.4. EPSDT

8.3.3.5. HCBS waiver services

8.3.3.6. Capitated Behavioral Health Benefit

8.3.3.7. Claims and billing procedures

8.3.3.8. Prescriber tool opioid risk mitigation module and affordability module

8.3.3.9. Out-of-state medical care as described in 10 CCR 2505-10 8.013.

8.3.3.10. Out-of-state NEMT as described in 10 CCR 2505-10 8.014.7.

8.3.4. Contractor shall inform Network Providers of key Department contractors, their roles and responsibilities, including:

8.3.4.1. Colorado Medicaid's fiscal agent

8.3.4.2. Electronic Data Warehouse (EDW).

8.3.4.3. Enrollment broker.

8.3.4.4. Pharmacy Benefit Management System.

8.3.4.5. Provider Performance and Quality Measurement (PPQM).

8.3.4.6. Utilization Management.

8.3.4.7. Oral Health contractor.

8.3.4.8. Non-Emergent Medical Transportation administrators.

8.3.4.9. Case Management Agencies.

8.3.4.10. Nurse Advice Line.

8.3.4.11. Crisis Services System.

8.3.5. Contractor shall act as a liaison between Department and its other contractors, partners and providers.

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

8.3.7. Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:

8.3.7.1. Medicaid provider enrollment.

8.3.7.2. Member eligibility and coverage policies.

8.3.7.3. Service authorization and referral.

8.3.7.4. Member and PCMP assignment and attribution.

8.3.7.5. PCMP designation.

8.3.7.6. Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.

8.3.7.7. Prescriber tool opioid risk mitigation module and affordability module.

8.3.7.8. eConsult tool and benefit.

8.3.8. Contractor shall use, and recommend to Network Providers, medical management, clinical and operational tools to ensure optimal health outcomes and to control costs for Members. The suite of tools and resources should offer a continuum of support for Network Providers and the broader Health Neighborhood.

8.4. Provider Training

8.4.1. Contractor shall, at a minimum, develop trainings and host forums for ongoing training regarding the Program and the services Contractor offers.

8.4.2. Contractor shall promote participation of Network Providers in state, local, and Contractor specific training programs.

8.4.2.1. Contractor shall promote the BHA's learning management system for all Providers delivering services under the capitated behavioral health benefit.

8.4.3. Contractor shall ensure that trainings and updates on the following topics are made available to Contractor's Network Providers every six months:

8.4.3.1. Colorado Medicaid eligibility and application processes.

8.4.3.2. Medicaid benefits.

8.4.3.3. Access to Care standards.

8.4.3.4. EPSDT.

8.4.3.5. Contractor's Population Management Strategic Plan, including care coordination model

8.4.3.6. American Society of Addiction Medicine (ASAM) criteria.

8.4.3.7. Use and proper submission of BHA supported data collection and other tools, including the most current BHA data collection products that track SUD, crisis and mental health encounter data; the referrals and bed tracking tool; and the Central Registry Medication Assisted Treatment tool.

8.4.3.8. Cultural competency.

8.4.3.9. Equity, Diversity, Inclusion and Accessibility.

8.4.3.10. Member rights, Grievances, and Appeals.

8.4.3.11. Quality improvement initiatives, including those to address population health.

8.4.3.12. Principles of recovery and psychiatric rehabilitation.

8.4.3.13. Trauma-informed care.

8.4.3.14. Education on Department Value-Based Payment methodologies, at minimum, specifically during the time leading up to and during Contractor and Network Provider's contract execution and regular amendment process, including:

8.4.3.14.1. How to participate.

8.4.3.14.2. Best practices for success.

8.4.3.14.3. Measure selection and equity, quality and affordability measure achievement.

8.4.3.14.4. Chronic condition improvement strategies.

8.4.3.14.5. Strategies to ensure financial sustainability, including considerations for prospective payments, PMPMs, budgeting for Shared Savings and other non-traditional revenue streams.

8.4.3.14.6. Opportunities for Network Providers to take advantage of no-cost offerings from Contractor that could increase the likelihood of improved cost and quality metric performance that includes but is not limited to programmatic and

administrative supports, tools, recurring actionable analytics reports or data feeds.

8.4.3.15. Non-emergency medical transportation.

8.4.3.16. Other trainings identified in consultation with Department.

8.4.4. Contractor shall ensure that trainings on the topics listed above are made available for Network Providers at least every six months.

8.4.5. Contractor shall maintain a record of training activities it offers and submit to Department upon request.

8.5. Data Systems and Technology Support

8.5.1. Contractor shall have expertise to support providers in implementing and utilizing health information technology (Health IT) systems and data. Contractor shall keep up to date with changes in Health IT in order to best support providers.

8.5.2. Contractor shall educate and inform Network Providers about the data reports and systems available to the providers and the practical uses of the available reports.

8.5.3. Contractor shall make available technical assistance and training for Network Providers on how to use the following state-supported HIT systems in complement to existing Department efforts:

8.5.3.1. Contractor's Care Coordination Tool.

8.5.3.2. The EDW and PPQM Systems.

8.5.3.3. Colorado interChange (MMIS).

8.5.3.4. Behavioral Health Administration's data collection products that track SUD, crisis, and mental health encounter data.

8.5.3.5. PEAK website and PEAKHealth mobile app.

8.5.3.6. Regional health information exchange.

8.5.3.7. Electronic consultation and referral tools.

8.5.3.8. Prescriber tool.

8.5.3.9. Social Health Information Exchange.

8.5.3.10. Behavioral Health Administration's referral and bed tracking tool and Medication Assisted Treatment Central Registry.

8.5.3.11. Provider Portal.

8.5.3.12. Department provided Value-Based Payment related portal and dashboards.

8.5.4. Contractor shall participate in and encourage Network Provider participation in learning collaboratives or other regional or statewide meetings on state and Department efforts to advance HIT systems and data aggregators in Colorado.

8.5.4.1. Contractor shall identify opportunities to complement and support state and Department hosted meetings and facilitate gatherings in Contractor's region upon Department's request and as Contractor deems appropriate.

8.5.5. Contractor shall offer the following supports to Network Providers on managing and utilizing data:

8.5.5.1. Provide practice-level data/reports and/or assist Network Providers in utilizing Department provided data and reports.

8.5.5.2. Train practices on how to utilize data to:

8.5.5.2.1. Succeed in Department administered Value-Based Payment models.

8.5.5.2.2. Improve care for Complex Members.

8.5.5.2.3. Improve Transitions of Care.

8.5.5.2.4. Improve care for Members with Department identified health conditions.

8.5.5.2.5. Implement wellness and prevention strategies.

8.5.5.2.6. Reduce inappropriate and inefficient care.

8.5.5.2.7. Understand how their practice is performing on Key Performance Indicators and other health outcome measures.

8.5.5.2.8. Identify Members who require additional services.

8.5.5.3. Contractor shall possess the expertise and establish the infrastructure to support outbound raw claims data extracts to the Network Providers, both behavioral health claims from Contractor's internal system and physical health claims data from Department.

8.5.5.3.1. Contractor shall establish a process for PCMPs to request raw claims data extracts from Contractor.

8.5.6. State Supported HIT Systems

8.5.6.1. Contractor shall provide technical and other support to Network Providers to increase the adoption and utilization rates of all state-supported HIT systems.

8.5.6.2. Contractor shall keep track of which Network Providers do not have specific tool functionality for state-supported HIT systems within their EHRs and periodically share this list with Department.

8.5.6.3. eConsult

8.5.6.3.1. Contractor shall encourage PCMPs to adopt and utilize Department's eConsult platform, or other Department approved platforms, to expand the accessibility of specialist care to Members and enhance the PCMPs' capacity to provide comprehensive care to Members.

8.5.6.3.2. Contractor shall provide targeted outreach and workflow support to PCMPs who care for Members with limited access to transportation and/or who live in rural and frontier areas to increase adoption of eConsult and to try and provide as much care as possible through the PCMP, reducing the need for Members to travel for services that can be coordinated and managed effectively by the PCMP.

8.5.6.3.3. Contractor shall promote eConsult tools to specialty care providers in Contractor's region to increase their participation in eConsults and to improve specialty care providers workflows, experience of care, and Member no-show rates.

8.5.6.3.4. Contractor shall coordinate with Department and its eConsult vendor on eConsult, sharing lessons learned and reporting challenges faced by Network Providers and Health Neighborhood providers in the adoption and utilization of eConsult.

8.5.6.4. Social Health Information Exchange (SHIE)

8.5.6.4.1. Contractor shall disseminate information and provide technical assistance to Network Providers and the Health Neighborhood about the SHIE and promote the adoption of the SHIE and associated interoperable technologies for referring Members to health improvement programs and community resources for health-related social needs.

8.5.6.4.2. Contractor shall support Network Providers with incorporating utilization of the SHIE within practice workflows.

8.5.6.4.3. Contractor shall establish processes with Network Providers regarding when and how Contractor can assist, follow-up, and/or wraparound additional services for Members referred for programs through the SHIE.

8.5.6.5. Regional Health Information Exchange

8.5.6.5.1. Contractor shall facilitate clinical information sharing by supporting Network Providers in connecting EHRs with the regional HIEs for exchanging clinical alerts, clinical quality measures data, and HCPF specific reporting requirements.

8.5.6.5.1.1. Contractor shall promote the use of Office of the National Coordinator for Health Information Technology (ONC) Interoperability Standards for PCMP EHR systems, to improve data exchange. These standards are at https://www.healthit.gov/policy-researchers-implementers/interoperability.

8.5.6.5.1.2. Contractor shall assist Network Providers in accessing all available resources, such as the Clinical Health Information Technical Advisor (CHITA) support, to increase transfer of clinical documents (CCDs) to support accurate reporting of CMS Core Measures.

8.5.6.5.1.3. Contractor shall identify and address gaps in information sharing or data quality among Network Providers, Contractor and Department.

8.6. Practice Transformation

8.6.1. Contractor shall offer practice transformation support to Network Providers interested in improving performance and participating in Value-Based Payment models.

8.6.2. Contractor shall make available to Network Providers individualized practice coaching on topics that include, but are not limited to, the following:

8.6.2.1. Team-based care and leveraging all staff to provide services within their full scope of practice.

8.6.2.2. Improving business practices and workflow.

8.6.2.3. Continuous quality improvement coaching and education on the delivery of evidence-based medicine.

8.6.2.4. Financial planning for quality-based payments and non-traditional payment arrangements, such as prospective payments.

8.6.2.5. Coordinating and integrating primary care and behavioral health services.

8.6.2.6. Incorporating lay health workers, such as promotors, peers, community health workers, and patient navigators in accordance with the implementation of C.R.S. 25.5-5-334.

8.6.2.7. Addressing Members' health related social needs.

8.6.2.8. Implementing health programming to advance Contractor's Population Management Strategic Plan.

8.6.2.9. Activities designed to improve Member health and experience of care.

8.6.3. Contractor shall partner with any interested Network Provider to identify the existing strengths of the Network Provider and to design and implement practice transformation strategies that build on these strengths and support the Network Provider in achieving its individualized practice goals.

8.6.4. Contractor shall collaborate with Department and stakeholders around the design and implementation of a PCMP Assessment Tool that inventories, evaluates and captures information about a PCMP's unique competencies within CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models.

8.6.4.1. Contractor shall assess Contractor's PCMPs at least one time annually using Department-approved standardized PCMP Assessment Tool. Contractor shall partner with Department and PCMPs to continually improve the PCMP Assessment Tool and reduce the administrative burden on PCMPs.

8.6.4.2. Contractor shall collaborate with Department on developing a reporting template that communicates the continuum of competencies for Contractor's network of PCMPs and how the network of PCMPs is advancing their competencies over time.

8.6.4.3. PERFORMANCE STANDARD: Contractor shall show the PCMP Network's year-over-year progression along CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models based on results of the PCMP Assessment Tool.

8.6.5. Contractor shall offer expertise and resources necessary for practice transformation ranging from assistance with efficiency and performance enhancements to comprehensive practice redesign.

8.6.6. Contractor shall support Network Providers in increasing efficiencies and cost management at both the practice and the health system level by coaching providers to reduce the utilization or delivery of low-value services and supporting the identification and analysis of service overutilization.

8.6.7. Contractor shall partner with interested Network Providers to establish and document feasible, measurable transformation goals that best fit a practice's overall operational strategy. Based on the practice's goals, Contractor shall develop a practice transformation plan to:

8.6.7.1. Connect Network Providers to practice transformation resources that are readily available in the region.

8.6.7.2. Educate Network Providers about the methods, principles, best practices, and benefits of practice transformation.

8.6.7.3. Provide technical assistance, tools and resources as appropriate.

8.6.7.4. Measure the Network Provider's progress against the identified transformation goals.

8.6.8. Contractor shall use existing practice transformation and support organizations in the region and the state and coordinate with existing efforts, when appropriate, to reduce duplication of efforts and overburdening practices.

8.6.9. Contractor's practice transformation activities that should be available ongoing to any interested Network Provider shall include, but not be limited to:

8.6.9.1. Sharing RAE-developed chronic condition and health improvement programs.

8.6.9.2. Helping Network Providers understand their performance against their peers so that gaps can be addressed, and best practices can be shared to improve the performance of other Network Providers.

8.6.9.3. Sharing actionable data with Network Providers to improve their ability to prioritize Care Coordination and Member engagement.

8.6.9.4. Working with Network Providers to meet regional access, quality (CMS Core Measures), and other outcome and equity goals, including Department's health equity plan goals.

8.6.9.5. Helping Network Providers identify and address affordability opportunities or gaps.

8.6.9.6. Support practices with evaluating and improving business processes to enhance financial sustainability.

8.6.9.7. Working with Network Providers to understand gaps in Medicaid access, such as specialty care and intensive outpatient services, so Contractor and Department can work to address such gaps in each region.

8.6.9.8. Establishing processes for improved coordination with and referrals to specialty care providers.

8.6.9.9. Working with Network Providers to develop Care Coordination and chronic condition self-management support services, placing an emphasis on managing chronic diseases such as diabetes and hypertension, and reducing unnecessary emergency department (ED) use and total cost of care.

8.6.9.10. Assisting Network Providers on integrating new tools and best practices into their workflows, such as utilizing eConsults, the Prescriber Tool OpiSafe and

Affordability RTBI modules, SHIE, emerging cost and quality indicators, and other innovations that evolve through Phase III of the ACC.

8.6.9.11. Offering learning opportunities so practices can effectively utilize community health workers, integrated behavioral health providers, and other health care providers in a comprehensive, team-based manner.

8.6.9.12. Building established networks of community-based organizations and other local and regional services to make available to Network Providers and Members.

8.6.9.13. Helping Network Providers utilize and leverage state investments in rural health, such as Department's implementation of Senate Bills 22-200 and 23-298.

8.6.10. Value-Based Payment Practice Support Activities

8.6.10.1. Contractor shall provide practice support that enables Network Providers to adopt and be successful in Value-Based Payment models through improving quality of care and health outcomes and transitioning their financial model.

8.6.10.2. Contractor shall support Network Providers participation in Department's and Contractor's Value-Based Payment models for both behavioral health and primary care.

8.6.10.3. Contractor shall support the success and sustainability of Network Providers in transitioning away from historical fee-for-service models in accordance with Department's Value-Based Payment strategy and any Department rules and regulations.

8.6.10.3.1. Contractor shall serve as an essential resource to help Network Providers maximize payment by improving their performance on health outcome metrics.

8.6.10.3.2. Contractor shall support Network Providers to ensure they understand how their payments can vary based on performance on health outcome goals, and then provide practice transformation activities to enable the interested Network Providers to achieve the performance goals.

8.6.10.3.3. Contractor's ability to earn performance payments and shared savings are dependent upon Contractor's successful support of Network Providers in achieving Value-Based Payment goals and metrics.

8.6.10.4. Contractor's value-based practice support activities shall include, but not be limited to:

8.6.10.4.1. Educating Network Providers about all Value-Based Payments available to the provider.

8.6.10.4.2. Support selecting measures as needed considering the Network Provider's patient panel and community resources, Network Provider areas of strength, and other value-based programs in which the Network Provider is participating.

8.6.10.4.3. Support achieving CMS core metric performance at Department designated benchmarks.

8.6.10.4.4. Clinical Quality Education and Chronic Condition Improvement Strategies

8.6.10.4.5. Workflow evaluation and enhancements

8.6.10.4.6. Guidance and assistance in receiving and utilizing data shared from Department and the RAE

8.6.10.4.7. Data Analytics and provider-level reporting, including training on how to read and process the data and make practice-level changes.

8.6.10.4.8. Clinical and process strategies to successfully reach quality targets and earn Value Based Payments.

8.6.10.4.9. Individualized support on strategies to ensure financial sustainability, including:

8.6.10.4.9.1. Explanations of and considerations for practice transition to prospective payments, quality-based payments, PMPMs, Shared Savings, and other non-traditional revenue streams.

8.6.10.4.9.2. Budgeting and accounting considerations for payment transition

8.6.10.4.9.3. Bookkeeping and financial records support, including best practices for reconciliation of prospective payments to utilization.

8.6.10.4.10. Tools and processes to ensure equitable access to Members

8.6.10.4.11. Assistance coordinating Member care

8.6.10.5. Contractor shall participate in Value-Based Payment initiatives, meetings, trainings and strategic planning lead by Department, Behavioral Health Administration, and Department of Insurance.

8.6.10.6. Contractor shall designate staff and communication methods, such as a dedicated phone line and email address, for the exclusive purpose of providing support to PCMPs and responding to PCMP questions regarding Department's primary care Value-Based Payment models.

8.6.10.7. Contractor shall designate staff and communication methods, such as a dedicated phone line and email address, for the exclusive purpose of providing support to Comprehensive Community Behavioral Health Safety Net Providers and Essential Behavioral Health Safety Net Providers and responding to questions regarding Contractor's and Department's Value-Based Payment models for behavioral health.

8.6.10.8. Contractor shall serve as an essential resource to help PCMPs understand their Department generated payment rates in Department's Value-Based Payment programs.

8.6.10.8.1. Contractor shall be the primary point of contact for PCMPs to explain the rates and their calculation methodology. Contractor shall serve as the primary point of questions and for questions which Contractor cannot answer Contractor shall refer those questions to Department for further clarification.

8.6.10.9. Based on the needs of the region and the existing practice transformation resources available, Contractor shall offer trainings, learning collaboratives, and/or other resources to support practices in participating in Department's Value-Based Payment models.

8.6.10.9.1. Contractor shall leverage Department tools and resources for trainings to reduce provider confusion and ensure consistency around the models.

8.6.10.10. Contractor shall design and implement a documented annual strategy to maximize the Contractor's and Network Providers' attainment of shared savings within the region.

8.6.10.10.1. Contractor shall submit their documented annual strategy to Department for review and approval.

8.6.10.10.1.1. DELIVERABLE: RAE Annual Shared Savings Strategy

8.6.10.10.1.2. DUE: Annually, by June 1.

8.6.10.10.2. Following the initial year of the Work, the Contractor shall submit a report to Department describing the Contractor's efforts to maximize shared savings within the region, the results of those activities, lessons learned, and how the Contractor may modify its shared savings strategy.

8.6.10.10.2.1. DELIVERABLE: RAE Annual Shared Savings Strategy Report

8.6.10.10.2.2. DUE: Annually, by February 1.

8.7. Financial Support/Value-Based Payments

8.7.1. Contractor shall promote the reduction in administrative burden on Network Providers by aligning Contractor's practice support and Value-Based Payment initiatives to national and state Value-Based Payment models, including, but not limited to:

8.7.1.1. Department's Primary Care Alternative Payment Models.

8.7.1.2. Colorado Department of Insurance's (CDOI's) Primary Care Alternative Payment rules and regulations.

8.7.1.3. Colorado's implementation of the Center for Medicare & Medicaid Services (CMMI's) Making Care Primary model.

8.7.1.4. Behavioral Health Value-Based Payment models.

8.7.2. Contractor shall design and implement behavioral health Value-Based Payment arrangements and practice support activities in accordance with Department-approved models and the Behavioral Health Administration's rules and regulations.

8.7.3. PCMP Payment Program

8.7.3.1. Contractor shall design and implement a PCMP Payment Program for PCMP Network Providers to complement Department's Primary Care Alternative Payment Models and to improve PCMPs' ability to deliver high-quality health outcomes for Members and maximize payment.

8.7.3.1.1. Contractor's PCMP Payment Program shall include strategies for distributing the following types of payments:

8.7.3.1.1.1. Prospective payments varied by Member acuity.

8.7.3.1.1.2. Pay for performance payments.

8.7.3.1.1.3. Shared Savings generated by PCMPs in their region in Department administered value-based payment programs.

8.7.3.1.2. Contractor's PCMP Payment Program shall be designed to achieve the following goals and objectives:

8.7.3.1.2.1. Invest in primary care.

8.7.3.1.2.2. Increase Member access to care.

8.7.3.1.2.3. Improve the quality of care by supporting PCMP adoption of and ongoing implementation of advanced primary care components in alignment with CDOI's Aligned Core Competencies for Primary Care Alternative Payment Models.

8.7.3.1.2.4. Support the effective and appropriate delivery of Care Coordination Program activities in alignment with Section 7, Care Coordination and Population Management.

8.7.3.1.2.5. Reduce health disparities in Contractor's region.

8.7.3.1.2.6. Enable PCMPs to care for Members with higher acuity.

8.7.3.1.2.7. Reward PCMPs for achieving Department established population health goals.

8.7.3.1.2.8. Incentivize PCMP adoption of Department and state supported health technologies, such as the Prescriber Tool and eConsult.

8.7.3.1.2.9. Improve the affordability of the Medicaid program thereby enabling the protection of Member benefits, program access, and provider reimbursements.

8.7.3.1.3. Similar to the CDOI Primary Care Alternative Payment Model and CMMI's Making Care Primary program, Contractor shall design and implement a three-tier payment framework that can flexibly respond to the unique capacities, population, and goals of PCMPs. Contractor's payment framework should take into consideration the results of the PCMP Assessment Tool.

8.7.3.1.3.1. Contractor's three tier payment framework shall reflect the following:

8.7.3.1.3.1.1. Level 1 PCMPs will be focused on foundational, excellent primary care, including good communication, access to care, prevention, screenings, and referrals. These PCMP practices may receive less financial support but more services and supports from Contractor such as care coordination and health improvement program access.

8.7.3.1.3.1.2. Level 2 PCMPs will be focused on implementing population management tools, evaluating continuity of care, and developing care coordination, services. The RAEs will provide more practice support, such as data analysis and dashboards to identify Members in need, access to health improvement programs, and help incorporating new innovations (tools) and processes into their workflows.

8.7.3.1.3.1.3. Level 3 PCMPs will be operating advanced primary care models. The RAEs will focus on payment models that can support the sustainability of advanced models of care delivery, such as integrated behavioral health care, while helping to incorporate Colorado Medicaid innovations, such as cost and quality indicators, eConsults, and health-related social needs supports.

8.7.3.1.4. Contractor shall design the PCMP Payment Program in such a way as to support and incentivize PCMPs to progress along the continuum of advanced primary care in alignment with Colorado Department of Insurance's Aligned Core Competencies for Primary Care Alternative Payment Models.

8.7.3.1.5. Contactor's PCMP Payment Program shall directly support PCMP participation in Department's Value-Based Payments, particularly PCMP transition to partial and full prospective payment for physical health services.

8.7.3.2. Contractor shall make payments directly to PCMP Network Providers from Contractor's administrative Per-Member Per-Month Payment in accordance with Contractor's PCMP Payment Program.

8.7.3.2.1. Contractor shall distribute, in aggregate, at least 33% of Contractor's administrative PMPM payments received from Department to their PCMP Network Providers.

8.7.3.2.2. Contractor shall distribute PMPM payments to their Network Providers in a manner that varies based on Member acuity to provide greater resources for Members with higher needs.

8.7.3.3. Contractor shall collaborate with Department to determine how Pay for Performance and Shared Savings payments will be distributed to participating Network Providers. Department may calculate and direct how certain payments will be awarded and distributed to participating Network Providers. Contractors may be eligible to retain a percentage of shared savings generated as an incentive to support PCMP success in their region.

8.7.3.4. Contractor shall detail individual PCMP payment arrangements in their written contract with the Network Provider.

8.7.3.5. Contractor shall provide Stakeholders with opportunities to participate in and provide input toward the development of Contractor's PCMP Payment Program.

8.7.3.5.1.1. Contractor shall have final decision-making authority in creating the strategy while ensuring a collaborative and transparent process. Contractor shall give Stakeholders advance notice of all forums and shall give them an opportunity to participate in and provide input toward the development of the PCMP Payment Program.

8.7.4. Financial Support for Rural Providers

8.7.4.1. Contractor shall design and implement funding strategies to enhance financial support of Network Providers and other Medicaid providers in rural communities to complement Department's implementation of Senate Bill 22-200 and Senate Bill

23-298 and other work to support the sustainability of rural health services and to better manage care for Members living in rural areas.

8.7.4.2. Contractor shall consider opportunities to fund investments in needed and shared infrastructure and services across rural hospitals and rural clinics that may include care coordination models, software, technology upgrades, and assistance connecting to, maintaining, and utilizing state HIT systems, particularly the state Health Information Exchanges.

8.7.5. Pay for Performance

8.7.5.1. Contractor shall share incentive payments earned for performance with PCMP Network Providers and other Health Neighborhood participants in a manner that is aligned with meeting the objectives of the ACC and Contractor's Population Health Management Strategy. Contractor has the flexibility to design innovative approaches to distribute funds in a way that maximizes performance at the Provider/Health Neighborhood level and that addresses cost trend and clinical quality outcome metrics.

8.7.5.1.1. Contractor in its discretion shall negotiate payment arrangements and amounts with its Network Providers, Health Neighborhood participants and community-based organizations.

8.8. Reporting Requirements

8.8.1. RAE Administrative Payment Report

8.8.1.1. Contractor shall submit to Department for review and approval a detailed reporting of the PCMP Payment Program and payment strategy to be established with Health Neighborhood providers. This information shall be reported as administrative payments made in the Quarterly Financial Report.

8.8.1.2. The RAE Administrative Payment Report shall be designed to complement the Annual Provider support and practice transformation Strategic Plan.

8.8.1.2.1. DELIVERABLE: RAE Administrative Payment Report

8.8.1.2.2. DUE: Annually, by August 1.

8.8.1.3. Contractor shall submit a RAE Administrative Payment Report to Department any time Contractor makes changes to its payment arrangements with Network Providers and Health Neighborhood providers.

8.8.1.3.1. DELIVERABLE: Updated RAE Administrative Payment Report

8.8.1.3.2. DUE: Within 30 days prior to the new changes to payment arrangements.

8.8.2. Provider Performance Statements

8.8.2.1. Contractor shall create and send to Network Providers quarterly Provider Performance Statements that offer detailed information about practice-level performance and Contractor's and Department's payments distributed to the Network Provider during the past quarter.

8.8.2.2. Contractor's Provider Performance Statements shall combine Department-generated information as well as Contractor's information.

8.8.2.3. Contractor's Provider Performance Statements shall include, but is not limited to, the following information:

8.8.2.3.1. Quality metric performance results calculated by Department or its designated vendor.

8.8.2.3.2. Quality metric performance results calculated by Contractor.

8.8.2.3.3. Description of whether Provider's performance met criteria for payment for each specific quality metric.

8.8.2.3.4. Clear identification of payments distributed for specific metric performance.

8.8.2.3.5. Recommended action(s) the Network Provider could take to meet the target performance goal and earn pay for performance payments.

8.8.2.3.6. Recommendations of how Contractor can support the Network Providers to improve performance in the future.

8.8.2.4. Contractor shall educate Network Providers on how to read the Provider Performance Statement, how to track and reconcile payments, understand the financial implications, and develop a plan for improvement.

8.8.3. Value-Based Payment Scorecards

8.8.3.1. Contractor shall collaborate with Department and its Value-Based Payment vendor to make available to participating Network Providers practice level scorecards documenting individual practice performance and relevant actionable data to support Network Providers in achieving the performance metrics associated with the Value-Based Payment model in which they are participating.

8.8.3.2. Contractor shall support Network Providers by utilizing the Value-Based Payment scorecards to communicate information that includes, but is not limited to:

8.8.3.2.1. Performance results reported by Department or its designated vendor providing data analytics regarding Value-Based Payment models.

8.8.3.2.2. Member level data identifying how the Network Provider could intervene to achieve a specific performance metric.

8.8.3.3. Contractor shall support the dissemination of the scorecard as timely as possible to enable Network Providers to take action before the performance period ends.

8.8.3.4. Contractor shall implement innovative strategies to address any data lags that impact metric calculations.

8.8.3.5. Contractor shall educate Network Providers on how to read the scorecard, understand the financial implications, and develop a plan for improvement.

8.8.4. Provider Satisfaction Survey

8.8.4.1. Contractor shall implement a Provider Satisfaction Survey to assess the effectiveness and usefulness of Contractor's provider support, practice transformation, and provider relations.

8.8.4.2. Contractor shall develop a Provider Satisfaction Survey Plan.

8.8.4.2.1. Contractor's Provider Satisfaction Survey Plan will include the process by which Contractor shall administer the Provider Satisfaction Survey to Providers, including how it will make it available to Providers, how it will receive completed surveys, how it will choose which Providers are included in the survey, and how it will maximize the response rate.

8.8.4.2.2. Contractor shall deliver the Provider Satisfaction Survey Plan to Department for review and approval prior to implementation.

8.8.4.2.2.1. DELIVERABLE: Provider Satisfaction Survey Plan

8.8.4.2.2.2. DUE: 30 days prior to the Operational Start Date

8.8.4.2.3. Contractor shall review its Provider Satisfaction Survey Plan annually with Department to determine if there any modifications are necessary and that the Provider Satisfaction Survey is accurately measuring the Provider's experience and the responses received are timely, in sufficient numbers, and applicable. Contractor shall make all required edits to the Provider Satisfaction Survey Plan based on this review or as directed by Department.

8.8.4.2.3.1. DELIVERABLE: Updated Provider Satisfaction Survey Plan

8.8.4.2.3.2. DUE: Annually, by July 1

8.8.4.2.4. Contractor shall administer all Provider Satisfaction Surveys in accordance with the most recently approved Provider Satisfaction Survey Plan and using the most recently approved version of the Provider Satisfaction Survey. Contractor shall not administer any version of the Provider Satisfaction Survey prior to Department's approval.

8.8.4.3. Contractor's Provider Satisfaction Survey shall measure Provider satisfaction with Contractor's Work in categories that include, but are not limited to, the following:

8.8.4.3.1. Customer service, including responsiveness, promptness, and ease to reach a satisfactory resolution for both digital and telephonic interactions with customer service representatives.

8.8.4.3.2. Effectiveness, accuracy and applicability of Provider education training and materials.

8.8.4.3.3. Effectiveness and applicability of practice transformation efforts.

8.8.4.3.4. Effectiveness and usability of Contractor provided tools, data, and analytics.

8.8.4.3.5. PAR processing and determinations.

8.8.4.3.6. Claims processing.

8.8.4.4. Contractor shall administer a Provider Satisfaction Survey at least biannually.

8.8.4.5. Contractor shall submit its Provider Satisfaction Survey data to Department upon request for Department evaluation of results.

8.8.4.6. Contractor shall submit its evaluation of Provider Satisfaction Survey data and results to Department identifying areas of need and make recommendations

addressing provider needs through training, system updates, automation, etc. that result in better Member outcomes.

8.8.4.6.1. DELIVERABLE: Provider Satisfaction Survey Evaluation

8.8.4.6.2. DUE: Annually

9. CAPITATED BEHAVIORAL HEALTH BENEFIT

9.1. Overview/Guiding Principles

9.2. These principles will be applied to this portion of the Work:

9.3. Contractor shall administer and deliver the Capitated Behavioral Health Benefit.

9.3.1. As the Administrator of the Capitated Behavioral Health Benefit, Contractor shall, at minimum, ensure delivery of all of the following:

9.3.1.1. Receive a Capitated Payment for each Member and ensure the Capitated Payments support Members achieving behavioral health and wellbeing and are not diverted for meeting Contractor's physical health responsibilities.

9.3.2. Employ strategic health care management practices described throughout the Contract in administering the benefit, create financial incentives to drive quality care and have strong Member experience protections.

9.3.3. Administer the Capitated Behavioral Health Benefit in a manner that ensures, at minimum all of the following:

9.3.3.1. Fully integrated with the entirety of the Work outlined in the Contract thereby creating a seamless experience for Members and Providers.

9.3.3.2. Remain in compliance with Department's and the BHA's rules and regulations governing the provision of behavioral health services in the State.

9.3.3.3. Remain in compliance with Department's and the BHA's rules and regulations governing the provision of behavioral health services in the State.

9.3.4. Contractor shall increase access to behavioral health services for all Medicaid Members, by ensuring at minimum, all of the following:

9.3.4.1. Assume comprehensive risk for all covered inpatient and outpatient behavioral health services.

9.3.4.2. Take full responsibility for providing, arranging for or otherwise taking responsibility for the provision of all Medically Necessary covered behavioral health services.

9.3.5. Contractor shall commit to administering the Capitated Behavioral Health Benefit in line with the following principles:

9.3.5.1. Recovery and Resilience: Treatment that supports Members in making positive changes in their behaviors so they can improve their health and life outcomes. Positive changes are achieved by sharing information, building skills, and empowering Members to make changes by leveraging individual strengths and

protective factors. The benefits of recovery and resilience principles extend across ages and settings and can be particularly helpful for low-income children.

9.3.5.2. Trauma-informed: Treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences on Members' health.

9.3.5.3. Least Restrictive Environment: The provision of community-based supports and services that enable individuals with serious mental illness and other disabilities to live in the community to the greatest extent possible and as appropriate.

9.3.5.4. Culturally Responsive: Providers and provider staff deliver effective, understandable, and respectful care in a manner compatible with Members' cultural health beliefs, practices and preferred language.

9.3.5.5. Prevention and Early Intervention: Broad community-wide efforts to reduce the impact of mental health and substance use disorders on individuals and communities that include, but are not limited to, the following:

9.3.5.5.1. Improving the public's understanding of mental health and substance use disorders.

9.3.5.5.2. Normalizing mental health and substance use disorders as legitimate and treatable health issues.

9.3.5.5.3. Normalizing primary care as an ideal setting for treating appropriate mental health and substance use disorders.

9.3.5.5.4. Promoting education and public awareness of mental health and substance use disorder symptoms.

9.3.5.5.5. Increasing access to effective treatment and supporting individual recovery.

9.3.5.6. Integrated Care: Commitment to implementing integrated care approaches in line with Department initiatives.

9.3.5.7. Evidence-based: Treatment is provided in accordance with the best available research and clinical expertise.

9.3.5.8. Member and Family Centered Care: Services and supports are provided in the best interest of the individual to ensure that the needs of the individual and family are being addressed. Systems, services, and supports are based, when appropriate, on the strengths and needs of the entire family or community.

9.3.5.9. Health Equity and Inclusion: Contractor shall consider factors related to health equity and inclusion to ensure Members have access to culturally appropriate, disability competent care, and meaningful care. Contractor shall ensure Members have access to culturally appropriate, disability competent, and meaningful care by considering factors related to health equity and inclusion.

9.3.5.9.1. Contractor shall develop policies and procedures on how Contractor shall respond to requests from Network Providers for interpreter services.

9.3.6. Contractor is not required to reimburse for, or provide coverage for, a counseling or referral service that it would otherwise be required to provide, if Contractor objects to the service on moral or religious grounds.

9.3.6.1. Contractor shall furnish information about the services that Contractor does not cover because of moral or religious objections to Department whenever it adopts such a policy during the term of the contract.

9.3.6.2. If Contractor does not cover counseling or referral services because of moral or religious objections and chooses not to convey information on how and where to obtain such services, Department shall provide that information to Members.

9.3.7. Contractor shall track Network Providers who do not offer Covered Services because the provider objects to the service on moral or religious grounds in order for the Contractor to ensure Members understand their ability to access alternative services and can make their own fully informed choices.

9.3.8. Contractor shall work with Department and Network Providers on the implementation of ASAM, 4th Edition.

9.4. Covered Services

9.4.1. Contractor shall provide or arrange for the provision of all medically necessary Covered Services as detailed in this section, represented by procedures listed in the State Behavioral Health Services Billing Manual posted on Department's website for all Primary and Principal Diagnosis indicated in Exhibit K, Capitated Behavioral Health Benefit Covered Services and Diagnoses.

9.4.2. Contractor shall ensure access to care for all Members in need of Medically Necessary covered mental health and substance use disorder services in accordance with 10 CCR 2505- 10 8.076.1.8. The Capitated Behavioral Health Benefit does not include behavioral services covered in 1915(c) waivers for individuals with intellectual and developmental disabilities.

9.4.3. Contractor shall provide Covered Services in multiple community-based venues to increase accessibility and improve outcomes. Treatment sites may include but are not limited to schools, PCMP Practice Sites, homeless shelters, skilled nursing and assisted living residences, and Members' homes.

9.4.4. Contractor shall manage the delivery of the following State Plan Services for Members:

9.4.4.1. Hospital Services

9.4.4.1.1. Inpatient Psychiatric Hospital Services.

9.4.4.1.1.1. Contractor's responsibility for all inpatient hospital services is based on the Principal Diagnosis that requires inpatient level of care.

9.4.4.1.1.2. Acute Care/General Hospital Services

9.4.4.1.1.2.1. Contractor shall not be financially responsible for inpatient hospital services when the Member's Principal Diagnosis is physical in nature, regardless of if the physical health hospitalization includes some covered psychiatric conditions or procedures to treat a secondary covered psychiatric diagnosis.

9.4.4.1.1.2.2. Contractor shall be financially responsible for the hospital stay when the Member's Principal Diagnosis is a covered psychiatric or SUD

diagnosis, even when the diagnosis includes some physical health procedures (including labs and ancillary services).

9.4.4.1.1.2.2.1. Inpatient SUD services include ASAM 3.7 or 3.7WM levels of care that provide a planned and structured regimen of 24-hour medically managed/monitored evaluation, observation, addiction treatment in an inpatient setting.

9.4.4.1.1.2.2.2. Contractor shall not be financially responsible for ASAM level 4 services.

9.4.4.1.1.3. Free-Standing Psychiatric Hospital

9.4.4.1.1.3.1. Short-term stays in an IMD associated with a psychiatric Principal Diagnosis must be for lengths of stay of no more than 15 days during the period of the Monthly Capitation Payment.

9.4.4.1.1.3.1.1. This length of stay limit only applies to Members aged 21-64.

9.4.4.1.1.3.1.2. This length of stay limit does not apply to inpatient stays associated with SUD diagnoses.

9.4.4.1.1.3.2. Contractor shall receive a monthly Capitation Payment for retroactively enrolled Members who received IMD services up to 90 days prior to their eligibility determination.

9.4.4.1.1.4. State Hospitals

9.4.4.1.1.4.1. Treatment services provided in a State Hospital for Members under 21 and over 65 years old.

9.4.4.1.2. Outpatient Hospital Services: Outpatient hospital services are defined as a program of care in which the Member receives services in a health care facility but does not remain in the facility 24 hours a day.

9.4.4.1.2.1. Contractor shall be financially responsible for all Medicaid services associated with a Member's outpatient hospital treatment, including all psychiatric and associated medical and facility services, labs, x-rays, supplies, and other ancillary services, when the procedure(s) are billed on a UB-04 and ANSI 837-I X12 claim form, and the Principal Diagnosis is a covered behavioral health diagnosis.

9.4.4.1.2.2. Contractor shall be financially responsible for Intensive Outpatient Program (IOP) services performed in outpatient hospital setting, when the procedure is billed on a UB-04 and ANSI 837-I X12 claim form, and the Principal Diagnosis is a covered behavioral health diagnosis.

9.4.4.2. Emergency Services and Post-Stabilization Care Services:

9.4.4.2.1. Contractor shall cover and pay for Emergency Services and Post-stabilization Care Services as specified in 42 C.F.R. § 438.114(b) and 42 C.F.R. § 422.113(c).

9.4.4.2.2. Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor.

9.4.4.2.3. Contractor shall cover and pay non-contracted providers for Emergency Services no more than the amount that would have been paid if the service had been provided by a Network Provider.

9.4.4.2.4. Contractor shall not be responsible for outpatient emergency room services billed on a UB-04 for the treatment of a primary substance use disorder.

9.4.4.2.5. Contractor shall be responsible for practitioner emergency room claims billed on a CMS-1500, when the procedure(s) is listed in the State Behavioral Health Services Billing Manual, and the Primary Diagnosis is a covered behavioral health diagnosis when a diagnosis is required.

9.4.4.2.6. Contractor shall not refuse to cover treatment obtained under either of the following circumstances:

9.4.4.2.6.1. A Member had an Emergency Medical Condition in which the absence of immediate medical attention would not necessarily have had the outcomes specified in the definition of Emergency Medical Condition.

9.4.4.2.6.2. A representative of Contractor instructs the Member to seek Emergency Services.

9.4.4.2.7. Contractor shall allow Members to obtain Emergency Services outside the primary care case management system regardless of whether the Case Manager referred the Member to the Network Provider that provided the services.

9.4.4.2.8. Contractor shall not refuse to cover Emergency Services based on the Emergency Room Provider, hospital, or Fiscal Agent not notifying Contractor of the Member's screening and treatment within ten calendar days of presentation for Emergency Services.

9.4.4.2.9. Contractor shall not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

9.4.4.2.10. Contractor shall acknowledge and commit to demonstrating that the attending Emergency Physician, or the provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge; that determination is binding on Contractor for coverage and payment.

9.4.4.2.11. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's provider network that are pre-approved by Contractor.

9.4.4.2.12. Contractor shall be financially responsible for Post-Stabilization Care Services, as defined in Section 9.4.4.2.14, obtained within or outside Contractor's network that are not pre-approved by Contractor, but administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

9.4.4.2.12.1. Contractor does not respond to a request for pre-approval within one hour.

9.4.4.2.12.2. Contractor cannot be contacted.

9.4.4.2.12.3. Contractor and the treating provider cannot reach an agreement concerning the Member's care and a plan provider is not available for consultation. In this situation, Contractor shall give the treating provider the opportunity to consult with a plan Provider and the treating provider may continue with care of the Member until a plan provider is reached or one of the criteria in 42 C.F.R. § 422.113(c)(3) is met.

9.4.4.2.13. Contractor shall limit charges to Members for Post-Stabilization Care Services to an amount no greater than what Contractor would charge the Member if he or she had obtained the services through Contractor.

9.4.4.2.14. Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved shall end when, at minimum, the following:

9.4.4.2.14.1. A plan provider with privileges at the treating hospital assumes responsibility for the Member's care.

9.4.4.2.14.2. A plan provider assumes responsibility for the Member's care through transfer.

9.4.4.2.14.3. Contractor and the treating provider reach an agreement concerning the Member's care.

9.4.4.2.14.4. The Member is discharged.

9.4.4.2.15. Nothing in Section 9.4 shall preclude Contractor from conducting a retrospective review consistent with these rules regarding Emergency and Post-Stabilization Care Services.

9.4.4.2.16. Contractor shall be financially responsible for Emergency Services when the Member's Primary or Principal Diagnosis is a covered psychiatric diagnosis, even when some physical health conditions are present, or a medical procedure is provided.

9.4.4.2.17. Contractor shall not be financially responsible for Emergency Services when the Primary or Principal Diagnosis is physical in nature regardless of whether procedures are provided to treat a secondary behavioral health diagnosis.

9.4.4.2.18. *Professional Hospital Services:* Contractor shall be financially responsible for all professional services provided in a hospital, when the procedure(s) is listed in the State Behavioral Health Services Billing Manual and is billed on a CMS-1500 and ANSI 837-P X12 claim form, and the Primary Diagnosis is a covered behavioral health diagnosis when a diagnosis is required.

9.4.4.3. Substance Use Disorder Residential Services

9.4.4.3.1. Contractor shall cover Residential SUD services which are defined as follows:

9.4.4.3.1.1. Residential SUD services: SUD services in accordance with ASAM 3 levels of care that provide 24-hour medically monitored or clinically managed structure, support and clinical interventions for patients who require time and structure to practice and integrate their recovery and coping skills. Residential level of care treatment provides safe, stable living environments for patients who need them to establish or maintain their recovery.

9.4.4.3.2. Contractor shall be responsible for all residential SUD services based on the presence of a Principal or Primary SUD Diagnosis and demonstration of medical necessity based on the ASAM Criteria for the level of care provided.

9.4.4.3.3. Contractor shall cooperate with federal evaluators and make any data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation.

9.4.4.3.4. High Intensity Outpatient Services

9.4.4.3.4.1. Intensive Outpatient Program: Services provided in an outpatient setting and are focused on maintaining and improving functional abilities for a Member through a comprehensive and coordinated individualized and recovery-oriented treatment/service plan, utilizing multiple concurrent services and treatment modalities rendered by a multidisciplinary treatment team lasting a minimum of 3 hours per day.

9.4.4.3.4.2. Partial Hospitalization/Outpatient Day Treatment: A treatment alternative to a higher level of care (residential and inpatient hospitalization) as a step toward community reintegration. Treatment is comprehensive in a structured, non- residential program of therapeutic activities lasting more than 4 hours but less than 24 hours per day, including associated laboratory services as indicated.

9.4.4.3.5. Outpatient Services

9.4.4.3.5.1. Crisis Services are provided during a behavioral health emergency, which can involve unscheduled, immediate, or special interventions in response to a crisis with a Member.

9.4.4.3.5.1.1. Behavioral Health Secure Transport: Urgent transportation for Members who are experiencing a behavioral health crisis and require transportation for behavioral health stabilization and treatment, including transportation to providers and between provider facilities.

9.4.4.3.5.1.2. Mobile Crisis Response: The community-based brief intervention, stabilization, and de-escalation of a Member experiencing a behavioral health crisis, including necessary follow-up care.

9.4.4.3.5.2. Screening and Assessment: Screening is provided to address the needs of those seeking behavioral health treatment services in a timely manner. This involves an initial appraisal of an individual's need for services. Assessment Services are the process, both initial and ongoing, of collecting and evaluating information about a Member for developing a profile on which to base treatment/service planning and referral (2 CCR 502-1, 190.1). An assessment may also use a diagnostic tool to gather the information necessary, including services related to Diagnosis, Psychological Testing/Neuropsychological Testing, or Treatment/Service Planning.

9.4.4.3.5.3. Treatment Services: Treatment services utilize a variety of methods to treat mental, behavioral, and substance use disorders. The goal is to alleviate emotional disturbances and reverse or change maladaptive patterns of

behavior in order to encourage a Member's personal growth and development. Treatment can include individual, group, and family psychotherapy, and targeted case management.

9.4.4.3.5.4. Physician Services: Evaluation and Management (E/M) Services cover a broad range of services for Members in both inpatient and outpatient settings. They are generic in the sense that they are intended to be used by all physicians, nurse-practitioners, and physician assistants and to be used in primary and specialty care alike. These services include medication management: monitoring of medications prescribed, and consultation provided to Members by a physician or other medical practitioner authorized to prescribe medications as defined by state law, including associated laboratory services as indicated.

9.4.4.3.5.5. Medication-assisted treatment: Administration of Methadone or another approved controlled substance to an opiate dependent Member for the purpose of decreasing or eliminating dependence on opiate substances.

9.4.4.4. Special Coverage for Members Under 21

9.4.4.4.1. Contractor shall provide or arrange for the provision of the following Covered Services for Members under the age of 21, including unique services available only to children and traditional services that have specific requirements for the treatment of Members under the age of 21:

9.4.4.4.1.1. Inpatient Psychiatric Treatment: A program of care for Members aged 20 and under in which the Member remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the state. Members who are inpatient on their 21st birthday are entitled to receive inpatient benefits until discharged from the facility or until their 22nd birthday, whichever is earlier, as outlined in 42 C.F.R. § 441.151.

9.4.4.4.1.2. Psychiatric Residential Treatment Facility (PRTF): Inpatient psychiatric services for individuals under age 21 provided in a facility that is not a hospital and provides services under the direction of a physician, licensed pursuant to part 1 of article 36 of title 12, C.R.S.

9.4.4.4.1.3. Qualified Residential Treatment Programs (QRTP): Residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

9.4.4.4.1.4. Residential Substance Use Disorder Treatment: Contractor shall be responsible for residential substance use disorder treatment services delivered for all youth under the age of 21, including those in the custody of the Colorado Department of Human Services (CDHS). Residential SUD services are provided in substance use disorder facilities licensed by the Behavioral Health Administration.

9.4.4.4.1.5. Psychotherapy Services: Autism Spectrum Disorder (ASD) shall be a covered diagnosis for Members under 21 years of age in addition to all other

Primary and Principal diagnoses listed in Exhibit K, Capitated Behavioral Health Benefit Covered Services or Diagnoses.

9.4.4.4.1.6. Outpatient Services: Contractor shall cover a select set of outpatient services for Members under 21 without a covered diagnosis as listed in the State Behavioral Health Services Billing Manual.

9.4.4.4.2. Contractor shall be responsible for services provided to justice-involved youth in compliance with the State's 1115 Waiver.

9.4.4.4.3. Contractor shall provide or arrange for the provision of all Medically Necessary behavioral health services for Primary and Principal diagnoses listed in Exhibit K, Capitated Behavioral Health Benefit Covered Services or Diagnoses for children under the age of 21, in accordance with Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280, and all applicable case law and sub-regulatory guidance.

9.4.4.4.4. If a requested EPSDT service is not covered under the capitation, Contractor shall arrange for appropriate services regardless of diagnosis or the Medicaid party responsible for reimbursing the services.

9.4.5. Non-State Plan 1915(b)(3) Waiver Services

9.4.5.1. Contractor shall provide or arrange for the following 1915(b)(3) Waiver services to Members in at least the scope, amount and duration proposed in the State Behavioral Health Services Billing Manual. All 1915(b)(3) services provided to children/youth from age 0 to 21, except for respite and vocational rehabilitation, are included in the State Plan as EPSDT services.

9.4.5.2. Mental Health Residential Services – Any type of 24-hour psychiatric care, excluding room and board, provided in a non-hospital, non-nursing home setting. Residential services are appropriate for children, youth, adults and older adults who need 24 hour supervised care in a therapeutic environment. This includes Crisis Stabilization Units (CSU), Acute Treatment Units (ATU), and Adult Mental Health Transitional Living Homes.

9.4.5.3. Outpatient Services

9.4.5.3.1. Recovery Services – Recovery-oriented services promote self-management of psychiatric symptoms, relapse prevention, treatment choices, mutual support, enrichment, social supports, and rights protection. Services may be provided at schools, churches, or other community locations. Services to include, at minimum, all of the following:

9.4.5.3.1.1. Peer counseling and support services.

9.4.5.3.1.2. Peer-run employment services.

9.4.5.3.1.3. Peer mentoring for children and adolescents.

9.4.5.3.1.4. Recovery groups.

9.4.5.3.1.5. Warm lines.

9.4.5.3.1.6. Psychosocial rehabilitation

9.4.5.3.1.7. Advocacy services. This can also include Clubhouse and Drop-in Centers – In clubhouses, Members utilize their skills for clerical work, data input, meal preparation, providing resource information or reaching out to fellow Members. Staff and Members work side-by-side, in a unique partnership. In drop-in centers, Members plan and conduct programs and activities in a club-like setting.

9.4.5.3.1.7.1. Contractor may consider utilizing the competency-based guidelines or training peer support specialists and recovery coaches.

9.4.5.3.2. Vocational Services – Services designed to assist adult and adolescent Members who are ineligible for state vocational rehabilitation services and require long-term services and supports in developing skills consistent with employment and/or in obtaining employment.

9.4.5.3.3. Assertive Community Treatment (ACT): A service delivery model providing comprehensive, individualized, locally-based treatment to adult Members with serious behavioral health disorders. ACT services are provided by a multidisciplinary treatment team and are available 24 hours a day, 7 days a week, 365 days a year.

9.4.5.3.4. Respite Services: Temporary or short-term care of a child, adolescent or adult provided by adults other than the birth parents, foster parents, adoptive parents, family or caregivers with whom the Member normally resides, that is designed to give the usual caregivers some time away from the Member to allow them to emotionally recharge and become better prepared to handle the normal day-to-day challenges.

9.4.5.4. Prevention/Early Intervention Activities: Screening and outreach to identify at-risk populations, proactive efforts to educate and empower Members to choose and maintain healthy life behaviors and lifestyles that promote positive behavioral health. Services can be population-based, including proven media, written, peer advocate, and group interventions, and are not restricted to face-to-face interventions.

9.4.6. Contractor shall regularly evaluate the effectiveness of the 1915(b)(3) Waiver services over the term of this Contract.

9.4.6.1. Contractor shall propose any changes to the 1915(b)(3) Waiver services to Department and Department shall approve any changes prior to implementation of the changes.

9.5. Utilization Management

9.5.1. Contractor shall facilitate seamless access to and actively manage the utilization of covered behavioral health services.

9.5.2. Contractor shall provide Covered Services, described in Section 9.4 in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under Fee-for-Service Medicaid.

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

9.5.4. Contractor may place appropriate limits on a service as follows:

9.5.4.1. On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity.

9.5.4.1.1. Contractor shall determine Medical Necessity under EPSDT based on an individualized clinical review of a Member's medical status and in consideration that the requested treatment can correct or ameliorate a diagnosed health condition.

9.5.5. For Utilization Management (UM), provided the services furnished can reasonably be expected to achieve their purpose.

9.5.5.1. Contractor shall not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members, whether or not the benefits are furnished by the same Contractor.

9.5.5.2. For Members also enrolled in a physical health MCO, Contractor may only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or SUD benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQLT in the same benefit classification of the Members medical/surgical benefits.

9.5.5.3. Contractor's Utilization Management program ensures that provided family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning to be used.

9.5.6. Contractor shall develop and maintain a documented Utilization Management Program and Procedures, in compliance with 42 CFR 438.905 and 438.910, that includes, at a minimum, all of the following:

9.5.6.1. Utilization Management Program guidelines that consider the needs of Members.

9.5.6.2. Utilization Management Program and procedures designed and implemented in accordance with standards adopted by national accreditation organizations.

9.5.6.3. Periodic review and updates to utilization management guidelines as appropriate.

9.5.6.4. Evidence of a behavioral health practitioner's involvement in program development and implementation.

9.5.6.5. Description of the Utilization Management Program structure and assignment of responsibility for utilization management activities to appropriate individuals.

9.5.6.6. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

9.5.6.7. Identification of the type of personnel responsible for each level of Utilization Management decision-making.

9.5.6.8. Development and implementation of standards for the individual denying a service authorization request or authorizing a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease or that the individual has documented a consultation with a health care professional with clinical expertise in treating the Member's condition or disease.

9.5.6.9. Contractor shall not provide incentives, through conditional or contingent payments or by any other means, for those making the determination to deny, limit, or discontinue Medically Necessary services.

9.5.6.10. Development and implementation of standards for Utilization Management personnel to consult with the ordering Provider prior to denial or limitation of requested/provided services.

9.5.6.11. Development and implementation of standards to ensure that services supporting beneficiaries with ongoing or chronic health conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

9.5.6.12. Clear and specific criteria for discharging Members from treatment.

9.5.6.12.1. Contractor shall include criteria in Member materials and information.

9.5.6.12.2. Contractor shall note individualized criteria for discharge agreed upon by Member and Provider in the Member's health care record and modified, by agreement, as necessary.

9.5.6.13. Policies and procedures for the use and periodic review of written clinical decision-making criteria based on clinical evidence.

9.5.6.14. Contractor shall deliver a draft Utilization Management Program and Procedures

9.5.6.14.1. DELIVERABLE: Utilization Management Program and Procedures

9.5.6.14.2. DUE: As requested by Department

9.5.7. Contractor shall implement Contractor's approved Utilization Management Program and Procedures.

9.5.8. Contractor's Utilization Management process shall in no way impede timely access to services.

9.5.9. Contractor shall establish clear procedures for providers and Members to easily access the utilization management decision-making criteria upon request.

9.5.10. Contractor shall disseminate practice guidelines to Members and potential Members upon request.

9.5.11. Contractor shall provide education and ongoing guidance to Members and providers about its Utilization Management Program and protocols.

9.5.12. Contractor shall submit written documentation to Department of any proposed significant changes to Contractor's Utilization Management Program and Procedures at least 30 days in advance of the proposed change going into effect.

9.5.12.1. DELIVERABLE: Utilization Management Program and Procedures

9.5.12.2. DUE: 30 days in advance of the effective date

9.5.13. Contractor shall communicate any changes to clinical review criteria and Contractor's Utilization Management Program and procedures to Network Providers at least 30 calendar days in advance of the effective date of the changes.

9.6. Prior Authorization Request (PAR) Requirements

9.6.1. Contractor shall make determinations regarding prior authorization requests as expeditiously as possible to ensure compliance with the following standards as well as the Notice of Adverse Benefit Determination requirements described in Section 4.3. These requirements include the following:

9.6.1.1. Standard Authorization: As expeditiously as the Member's health condition requires, but no longer than seven calendar days following receipt of the request for service.

9.6.1.1.1. Contractor may extend the seven calendar day service authorization notice timeframe of up to 14 additional days if the Member or the Provider requests extension; or if Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

9.6.1.1.1.1. If Contractor extends the seven day service authorization notice timeframe, it must issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

9.6.1.2. Authorization for Residential Service Requiring IA: As expeditiously as the Member's health condition requires, but no longer than 14 calendar days following the receipt of the request for an IA.

9.6.1.3. Expedited Authorization: For cases in which a Provider, or Contractor, determine that following the standard authorization timeframe could seriously jeopardize the Member's life or health or his/her ability to attain, maintain, or regain maximum function, Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than 72 hours after receipt of the request for service.

9.6.1.3.1. Contractor may extend the 72 hours expedited service authorization decision time period by up to 14 calendar days if the Member requests an extension, or if Contractor justifies a need for additional information and how the extension is in the Member's interest.

9.6.1.4. Authorization of Inpatient and Residential Services, not including Special Connections: As expeditiously as the Member's health condition requires, but no longer than 72 hours following the initial request.

9.6.1.4.1. PERFORMANCE STANDARD: 95% of authorizations requests for inpatient and residential SUD services not associated with the Special Connections program determined within 72 hours following the initial request, and 100% of authorizations requests determined within 96 hours following the initial request.

9.6.1.5. Authorization for Special Connections Program: As expeditiously as the Member's health condition requires, but no longer than 24 hours following the initial request.

9.6.1.5.1. PERFORMANCE STANDARD: 95% of authorizations requests for the Special Connections program determined within 24 hours following the initial request, and 100% of authorization requests determined within 48 hours following the initial request.

9.6.2. Contractor shall make all reasonable efforts to collect all missing, inadequate or incomplete information of PAR Requests in order to make determinations within the established timeframes.

9.6.2.1. Contractor shall keep administrative denials of PAR Requests for missing, inadequate, or incomplete information to a minimum.

9.6.2.1.1. PERFORMANCE STANDARD: Administrative denials shall not be more than XX% of all PAR Reviews conducted in a month.

9.6.2.2. Contractor shall appropriately classify prior authorization requests and make determinations within the contracted timeframes in accordance with the following Performance Standard:

9.6.2.2.1. PERFORMANCE STANDARD: 90% of standard prior authorization requests will be determined within ten calendar days following receipt of the request for service. 100% of standard prior authorization requests will be determined within 24 calendar days following receipt of the request for service.

9.6.3. SUD Utilization Management Requirements

9.6.3.1. Contractor shall prior authorize residential and inpatient SUD services except as stated herein.

9.6.3.1.1. Contractor shall utilize ASAM criteria only to determine medical necessity for residential and inpatient substance use disorder treatment services.

9.6.3.1.2. Contractor shall not require prior authorization for admission to a 3.2WM or 3.7WM service. Medical necessity is required, and Contractor may review the case at any time to determine if medical necessity is met, but a Member may not be denied admission because authorization is being reviewed. If it is determined that WM was not medically necessary at the time of admission, Contractor may deny payment back to the date of admission.

9.6.3.1.3. Contractor shall perform a continued stay authorization review for all stays longer than five days for a 3.2WM and longer than four days for 3.7WM.

9.6.3.2. Contractor shall authorize the initial minimum number days of care specified for each of the following SUD service:

9.6.3.2.1.1.1. Special Connections Program: 30 days of care

9.6.3.2.1.1.2. ASAM Level 3.1, 3.3, and 3.5: 14 days of care

9.6.3.2.1.1.3. ASAM Level 3.7: Seven days of care

9.6.3.2.1.1.4. ASAM Level 3.2WM: Five days of care before concurrent authorization

9.6.3.2.1.1.5. ASAM Level 3.7WM: Four days of care before concurrent authorization

9.6.3.2.1.2. Contractor shall not require prior authorization for the non-pharmaceutical components of MAT.

9.6.4. Utilization Management for Members with Co-occurring Disabilities

9.6.4.1.1. Contractor shall ensure that Members who have co-occurring disabilities have access to necessary behavioral health services that are clinically and culturally appropriate. Co-occurring disabilities include, at minimum, all of the following:

9.6.4.1.1.1. Intellectual or developmental disabilities (I/DD).

9.6.4.1.1.2. Autism Spectrum Disorder.

9.6.4.1.1.3. Cognitive impairments.

9.6.4.1.1.4. Fetal Alcohol Syndrome Disorder.

9.6.4.1.1.5. Organic brain syndrome

9.6.4.1.1.6. Brain injury.

9.6.4.1.1.7. Physical disabilities.

9.6.4.1.1.8. People who are deaf, blind, deaf/blind, hard of hearing, and/or other disabilities.

9.6.4.1.2. Contractor shall ensure that practitioners use current best practices when assessing for, screening for, and/or diagnosing behavioral health conditions in Members who have co-occurring disabilities.

9.6.4.1.3. Contractor may defer its final authorization decision until sufficient information is received to confirm a diagnosis for Members with co-occurring disabilities. Such a decision to pend or delay authorization does not itself infer a delay in the initiation of treatment. Treatment may be initiated as part of an extended evaluation process, but this does not presume a covered diagnosis or continued service authorization beyond this evaluation period.

9.6.4.1.4. Contractor shall not deny services for a covered diagnosis on the basis that the covered diagnosis is not primary, and regardless of etiology.

9.6.4.1.4.1. Contractor shall make medical necessity determinations based on the presence of a covered diagnosis and Contractor's determination that the issues requiring treatment are related to that covered diagnosis.

9.6.4.1.4.2. Other diagnoses, including a co-occurring disability, must be present to explain variances from DSM-5 criteria.

9.6.4.1.4.3. Any decision to deny services or authorize a service in an amount, duration, or scope that is less than requested to a Member with an

intellectual/developmental disability must be reviewed by an individual competent in the use of the DM-ID-2 as an adaptive diagnostic tool that satisfies DSM-5 criteria.

9.6.4.1.5. Contractor shall ensure Medicaid Members with a co-occurring disability have access to the full spectrum of appeal rights for adverse benefit determinations rendered with regard to clinical services for the treatment of covered behavioral health diagnoses.

9.6.4.2. Utilization Management for Members Under 21

9.6.4.2.1. Contractor shall ensure that all services including those provided under EPSDT are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

9.6.4.2.1.1. Contractor shall not deny or reduce the amount, duration, and scope of services provided under EPSDT as long as the service is supporting a Member to maintain stability or level of functioning or making treatment progress.

9.6.4.2.2. Contractor shall use the most current edition of the Statewide Standardized Utilization Management (SSUM) Guidelines or other decision support tool authorized by Department in conjunction with National Standard Guidelines when making medical necessity determinations for Members under the age of 21.

9.6.4.2.3. Contractor shall utilize processes beyond the standards adopted by national accreditation organizations for determining Medical Necessity for children under 21 years of age in order to comply with EPSDT requirements.

9.6.4.2.4. Contractor shall approve or deny all requests for QRTP services according to the requirements in this section of the Contract, EPSDT, and all applicable federal and state guidelines.

9.6.4.2.5. Contractor shall use an Independent Assessment (IA) to inform their Medical Necessity Determination according to 10 CCR 2505-10 8.765.14.A.2 when Contractor is not able to approve Qualified Residential Treatment Program (QRTP) services with available clinical information for youth seeking this level of care.

9.6.4.2.5.1. Contractor shall only use an IA for initial authorization purposes. Contractor shall not use an IA for continuing authorizations.

9.6.4.2.5.2. Contractor shall accept for consideration an IA completed at the request of another payer dated within 30 days of a request made to Contractor.

9.6.4.2.5.3. Contractor may wait for the IA to be completed before placing a youth in a QRTP, and then respond to the IA findings.

9.6.4.2.5.4. Contractor may place a youth in a QRTP while the IA is being completed.

9.6.4.2.5.4.1. Contractor shall authorize QRTP placement for up to 14 days if Contractor chooses to place a youth in a QRTP, prior to receiving the results of the IA.

9.6.4.2.5.4.2. If the IA finding does not recommend QRTP services, Contractor shall authorize up to 30 additional days at the QRTP in order to transition the youth out of the QRTP.

9.6.4.2.5.5. If Contractor denies a request for QRTP services due to non-covered diagnosis, Contractor shall refer the youth for an IA and pay for the assessment which is required for QRTP services to be covered via Fee-For-Service.

9.6.4.2.5.5.1. Contractor shall refer the youth for an IA within 24 hours of the denial due to non-covered diagnosis.

9.6.4.2.6. Contractor shall work with QRTP staff to begin discharge planning at admission so there is a discharge plan in place when the Member no longer meets Medical Necessity criteria for continuing authorizations.

9.6.4.2.7. Contractor shall coordinate the most effective and appropriate Level of Care for the youth in the least restrictive environment.

9.6.5. Peer to Peer Consultation

9.6.5.1. Contractor shall provide Peer-to-Peer consultations that are defined as a process for the Member's ordering or rendering provider to discuss a denial determination of an authorization with Contractor's physician. This review may also include the submission of additional clinical information for review.

9.6.5.2. Contractor shall conduct a Peer-to-Peer consultation for any Network Provider who is dissatisfied with Contractor's decision on any type of review and who has requested the Peer to Peer consultation after a denial or partial denial decision.

9.6.5.3. Contractor shall offer a Peer to Peer consultation to any Provider regardless of the PAR timeline.

9.6.5.4. Contractor shall review any additional clinical information during the Peer to Peer consultation, if submitted within the first five days following a denial decision

9.6.6. Notification of Denied Services and Alternative Services

9.6.6.1. Contractor shall inform Members, or their families/designated representative, by email, phone, or mail of the approved timeframe for select authorized services, such as residential treatment and inpatient hospitalizations, so that Members, or their representatives, are aware of how long the services have been authorized for and therefore may request a continuation of and/or additional services if needed. Contractor shall record and document its notification of Members and families.

9.6.6.2. If Contractor determines that the Member does not meet standards of Medical Necessity for behavioral health services, Contractor shall inform the Member about alternative services and/or level of care that are recommended instead of the requested services and how other appropriate services may be obtained, pursuant to federal Medicaid managed care rules. Contractor shall coordinate within their system and the Health Neighborhood to refer the Member to the appropriate providers, such as CMAs.

9.6.6.3. Contractor shall not be liable for any Covered Services provided prior to the date a Member is enrolled under this Contract or after the date of disenrollment.

9.6.6.4. Contractor shall not hold a Member liable for Covered Services:

9.6.6.4.1. Provided to the Member, for which Department does not pay Contractor.

9.6.6.4.2. Provided to the Member, for which Department or Contractor does not pay the provider that furnishes the service under a contract, referral, or other arrangement.

9.6.6.4.3. Furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor provided the services directly.

9.6.6.5. Contractor shall program and design a UM tracking system to meet data submission guidelines established by Department.

9.6.6.5.1. Contractor shall submit Utilization Management Data to Department or its contractor in a format determined by Department.

9.6.6.5.1.1. DELIVERABLE: Utilization Management Data

9.6.6.5.1.2. DUE: Monthly, no later than 15 calendar days following the month for which the data covers

9.7. Parity Compliance

9.7.1. Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

9.7.1.1. To meet the requirements of 42 CFR 440.395, Contractor shall cover, in addition to services covered under the state plan, any behavioral health services necessary for compliance with the requirements for Parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K. Identification of services will be contingent upon work done by parity contractor's analysis.

9.7.2. Contractor may not impose Non-Quantitative Treatment Limits (NQTLs) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

9.7.2.1. Contractor's pre-authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits as described in 42 CFR 440.395(b)(4).

9.7.2.2. Contractor shall provide to Department all necessary documentation to show that behavioral health services provided through the MCE delivery system and/or through an external entity are compliant with the Federal parity requirements under 42 CFR 438, subpart K:

9.7.2.3. Contractor shall provide all documentation necessary for determination of Contractor's compliance with Federal parity requirements. Contractor shall provide this documentation upon request for Department's annual report as required by C.R.S. 25.5-5-421.

9.7.2.3.1. DELIVERABLE: Parity Report Documentation

9.7.2.3.2. DUE: Within 21 calendar days of Department documentation request.

9.8. Providers

9.8.1. Contractor shall incorporate into Network Provider contracts requirements for compliance with BHA statute and regulations regarding data collection policies and procedures, including the following:

9.8.1.1. The use of BHA technology related to inpatient behavioral health bed availability and placement.

9.8.1.2. Changes to and compliance with the BHA data collection products that track SUD, crisis and mental health encounter data.

9.8.1.3. Changes to and compliance with the Medication Assisted Treatment Central Registry for individuals receiving Medication Assisted Treatment.

9.8.2. Contractor shall not prohibit or restrict a provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding:

9.8.2.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

9.8.2.2. Any information the Member needs to decide among all relevant treatment options.

9.8.2.3. The risks, benefits, and consequences of treatment or non-treatment. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

9.8.3. Contractor shall use the most current version of the Combined RAE Behavioral Health Outpatient Audit Tool when completing chart reviews/quality audits of outpatient behavioral health providers.

9.8.4. Out of Network Providers

9.8.4.1. If Contractor is unable to provide covered behavioral health services to a particular Member within its network, Contractor shall provide the Covered Services out-of-network at no cost to the Member in accordance with the access to care standards described in Section 5.4.

9.8.4.1.1. Contractor shall coordinate payment with out-of-network providers and ensure the cost to the Member is no greater than it would be if the services were furnished within its network.

9.8.4.2. Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to Out-Of-Network Providers for mental health or SUD benefits that are comparable to, and applied no more stringently than, the processes,

strategies, evidentiary standards, or other factors in determining access to Out- Of-Network Providers for medical/surgical benefits in the same classification.

9.8.4.2.1. Transitions of Care: Contractor shall provide continuity of care for Members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems.

9.8.4.2.2. Continued Services to Members: Contractor shall comply with the state's transition of care policy to ensure the continued access to services during a transition from one RAE to another RAE as required in 42 C.F.R. § 438.62.

9.8.5. Free-Standing Psychiatric Hospitals

9.8.5.1. Contractor shall maintain a written collaborative agreement with Colorado Mental Health Hospitals and other IMDs for mental illness. The collaborative agreement shall include, but is not limited to, the following:

9.8.5.1.1. The ADA requirement that Members be served in the most integrated setting appropriate to their needs, include the responsibilities of the Members providers, as applicable, to ensure a seamless transition of care upon admission and discharge to the community.

9.8.5.1.2. Agreements regarding information sharing and collaboration between Contractor and Colorado Mental Health Hospitals and other IMDs for mental illness.

9.8.5.1.3. Mutually developed admission and utilization review criteria bases for determining the appropriateness of admissions to or continued stays.

9.8.5.2. To provide the full continuum of Medically Necessary Services covered under the Capitated Behavioral Health Benefit, Contractor shall establish agreements with a statewide network of Colorado State Hospitals and Free-Standing Psychiatric Hospitals.

9.8.5.2.1. Contractor shall offer Value-Based Payment agreements with a statewide network of Private IMDs and negotiate in good faith.

9.8.5.3. Contractor's Value-Based Payment agreement with an individual Private IMD shall:

9.8.5.3.1. Incentivize quality care and outcomes that may include follow-up after discharge, average length of stay, readmission rates, and stabilization of symptoms.

9.8.5.3.2. Adhere to the principle of serving Members in the least restrictive environment.

9.8.5.3.3. Require proactive, collaborative management of Members.

9.8.5.3.4. Support the timely transition of Members to outpatient, community-based care.

9.8.5.3.5. Be a signed contract or legal agreement.

9.8.5.4. Contractor shall submit confirmation of an executed Value-Based Payment agreement with an individual Private IMD and the payment details and associated metrics to Department.

9.8.5.5. Transitioning Members from Colorado Mental Health Hospitals

9.8.5.5.1. Contractor shall maintain policies, procedures, and strategies for helping to transition Members from Colorado Mental Health Hospitals to safe and alternative environments. Contractor shall participate in discussions and care coordination with the Colorado Mental Health Hospitals, and Contractor shall have plans in place to provide medically necessary Covered Services once the Member has been discharged from the Colorado Mental Health Hospitals.

9.8.5.5.2. Contractor shall work with appropriate treatment providers in their region in order to transition children from hospitals to safe and alternative step-down environments, such as home and residential. Contractors shall meet with appropriate treatment providers to develop and maintain protocols and procedures for how these transitions will take place in order to ensure continuity of care and continuation of services.

9.8.5.5.3. Contractor shall work with the Colorado Mental Health Hospitals to execute communication and transition plans for Members.

9.8.5.5.4. Once Contractor's Members are discharged from a Colorado Mental Health Hospital, Contractor shall be responsible for arranging and coordinating medically necessary on-going treatment.

9.8.5.5.5. Contractor who was responsible for that Member upon admission to the Colorado Mental Health Hospital shall remain Contractor until the Member is reassigned by Department to a new Regional Accountable Entity.

9.8.6. Discharge Planning and Follow-up

9.8.6.1. Contractor shall designate a liaison to assist in facilitating a coordinated discharge planning process for Members admitted to Colorado Mental Health Hospitals or other IMDs for mental illness.

9.8.6.1.1. Contractor's liaison shall assist and collaborate with the applicable contracted provider to expedite discharge and engagement in ongoing Covered Services.

9.8.6.2. Contractor shall actively participate in Colorado Mental Health Hospital and IMDs for mental illness treatment team meetings and discharge planning meetings to ensure that Members receive treatment in the least restrictive environment complying with the ADA and other applicable State and federal regulations.

9.8.6.3. Contractor shall actively assist the Colorado Mental Health Hospitals and other IMDs for mental illness in the development of a written discharge plan within 24 hours of admission.

9.8.6.4. Contractor shall ensure an appointment with an appropriate mental health clinician is scheduled and that transportation has been arranged for the appointment prior to discharging a Member. Such appointment shall occur within seven calendar days after discharge.

9.8.6.4.1. Contractor shall ensure that Members receiving ACT team services shall be seen within 24 hours of discharge by the applicable Provider.

9.8.6.5. Contractor shall ensure that the discharge progress note shall be provided to the aftercare Provider prior to a Member discharge.

9.8.6.5.1. For ACT team service recipients, Contractor shall ensure that the discharge progress note is provided to the ACT provider, within 24 hours of Member discharge.

9.8.6.6. Contractor shall ensure providers contact Members within 72 hours of discharge from Colorado Mental Health Hospitals, free-standing Psychiatric Hospitals, or other facility identified as an Institute of Mental Disease (IMD) for mental disease in order to review the discharge plan, support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

9.8.6.6.1. PERFORMANCE STANDARD**:** The performance metric shall be that 100% of Members discharged shall have been attempted to be contacted within 72 hours.

9.8.6.7. Contractor shall ensure mobile crisis response providers contact Members within five calendar days of onset of a crisis episode in order to support the Member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and answer any questions the Member may have.

9.8.6.7.1. PERFORMANCE STANDARD**:** The performance metric shall be that 100% of Members who have had contact with mobile crisis response have had follow-up contact within five days.

9.8.6.8. Contractor shall ensure sufficient providers in their network to serve Members who are justice-involved. This includes contracting with Department of Corrections and Department of Youth Services Approved Treatment Providers (ATP).

9.8.6.8.1. PERFORMANCE STANDARD**:** The performance metric shall be a continuity of care measure connected to the percentage of Members who were served during the 90 days pre-release and continue to engage in services during the 90 days post-release.

9.8.6.9. Contractor shall actively work with ED, residential, and inpatient facilities to ensure Members are discharged in a timely manner. For Members who remain in a facility after they are determined ready to discharge, Contractor shall meet Department-established benchmarks for transitioning a Member based on setting.

9.8.6.9.1. PERFORMANCE STANDARD: The performance metric shall be compliance with Department-established benchmark.

9.8.6.10. Contractor shall work with Department, BHA, and other relevant state agencies to review cases of Members that have been indicated as posing difficulties for returning back to the community. Contractor shall identify barriers to discharge and develop an appropriate transition plan back to the community.

9.9. Reduction in Behavioral Health Readmissions and Emergency Department (ED) Utilization

9.9.1.1. Contractor shall have a documented plan to reduce readmissions and emergency department utilization attributed to a Member's behavioral health. The plan shall include but is not limited to:

9.9.1.1.1. Measurable strategies to reduce 30-day, 90-day, and 180-day readmission rates in residential and inpatient treatment settings for mental illness and SUD.

9.9.1.1.2. Strategy for monitoring the thirty 30-day, 90-day, and 180-day readmission rates to:

9.9.1.1.3. Colorado's Mental Health Hospitals, Free-standing Psychiatric Hospitals, PRTFs, QRTPs, and other State-determined IMDs for mental illness

9.9.1.1.4. Residential and inpatient treatment providers of SUD.

9.9.1.1.5. Repeated ED utilization rates attributed to mental illness and SUD.

9.9.1.1.6. Contractor's approach to ensuring Members experiencing readmissions or repeated ED utilization have access to a full array of Medically Necessary outpatient medication and Covered Services after discharge from residential, inpatient or ED care due to a Behavioral Health reason, with sufficient frequency and amounts, to support the Member's progress on achieving their Behavioral Health goals.

9.9.1.1.7. Policies for reviewing Member specific data with the Member's providers, which may include the Member's PCMP and other Mental Health or Substance Use Disorder Treatment Programs, as applicable.

9.9.1.1.7.1. PERFORMANCE STANDARD: The performance measure shall be a reduction in repeat ED visits, ED visits post discharge from residential or inpatient treatment, and readmissions to residential and inpatient treatment within 30 days per Department-established benchmarks.

9.10. Measurement Based Care

9.10.1. Contractor shall have staff with expertise in the use of Measurement Based Care for Behavioral Health. Measurement Based Care "involves the systematic administration of symptom rating scales and use of the results to drive clinical decision making at the level of the individual patient. Aggregated symptom rating scale data can be used for professional development at the provider level and for quality improvement at the clinic level and to inform payers about the value of mental health services delivered at the health care system level." (Fortney et. al. 2017).

9.10.2. Contractor shall support Safety Net Providers in adopting Measurement Based Care as part of their clinical practice. Support may include financial assistance, sharing of technology and data solutions, and practice transformation activities.

9.10.3. Contractor shall support Safety Net Providers in building a measurement-based care program aligned with best practice and key principles of Measurement Based Care that shall include at minimum, all of the following:

9.10.3.1. Selection of validated brief symptom rating tools that are validated for frequent measurement and are appropriate for specific populations served.

9.10.3.2. Clinical training and staff readiness.

9.10.3.3. Workflow and operational considerations, including identified frequency of measurement (recommend twice per month and no less than one time per month) aligned with best practice.

9.10.3.4. Development of a registry or use of a technology solution to track measurements and clinical progress and support clinician and organizational review of patient and aggregate data:

9.10.3.4.1. Monitor that technology solutions are easy for Members and clinicians to use.

9.10.3.4.2. Monitor that treatment adaptation occurs in response to clinical data.

9.10.3.4.3. Collaborative, data-driven reevaluation of the treatment plan and level of care planning.

9.10.4. Contractor shall partner with Safety Net Providers implementing Measurement Based Care to gather and analyze data and reports to increase treatment efficacy and efficiency. Contractor shall identify:

9.10.4.1. Members experiencing treatment deterioration.

9.10.4.2. Members who are not progressing as expected within their treatment plan.

9.10.4.3. Providers or programs that need quality improvement and plans for improvement.

9.10.4.4. Populations or system-level challenges where the safety net network is demonstrating minimal improvement and where innovation or Contractor engagement may be needed to develop an alternative.

9.10.5. Contractor shall submit a Measurement Based Care Report to Department that describes, at a minimum, the following information:

9.10.5.1. Number and names of practices utilizing Measurement Based Care.

9.10.5.2. Number and names of practices Contractor is working with to adopt Measurement Based Care, including projected timeline for implementation.

9.10.5.3. Performance of specific Measurement Based Care metrics.

9.10.5.4. Description of how Contractor is using Measurement Based Care Outcomes to improve the management of the covered behavioral health services and increasing access to appropriate care for Members.

9.10.5.4.1. DELIVERABLE: Measurement Based Care Report

9.10.5.4.2. DUE: Annually, on February 1

9.11. Payments

9.11.1. Contractor shall reimburse practitioners for the provision of Covered Services within Contractor's established Utilization Management policies and agreed upon payment arrangements.

9.11.2. Unless otherwise stated in the Work, Contractor shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

9.11.3. Required Reimbursement Strategies

9.11.3.1. Comprehensive Safety Net Provider Reimbursement

9.11.3.2. Contractor shall reimburse Comprehensive Safety Net Providers as licensed by the BHA Department established encounter rate for services identified for allowable costs. Department reserves the right to change the minimum requirement payment to Comprehensive Safety Net Providers to align with behavioral health safety net reforms in the future.

9.11.3.3. Contractor shall reimburse each Comprehensive Safety Net Provider the encounter rate calculated in accordance with Department documented procedures.

9.11.3.4. Contractor shall update the Comprehensive Safety Net encounter rates upon Department notification on a quarterly basis.

9.11.3.5. Contractor shall participate in quarterly accuracy audits with Comprehensive Safety Net Providers. Should Department recognize any discrepancy in Comprehensive Safety Net Provider payments (less than the full encounter rate), Contractor is responsible for reimbursing the Comprehensive Safety Net Provider the difference of the encounter payment and the initial reimbursement amount. Comprehensive Safety Net Provider visits are defined in Exhibit XX.

9.11.3.6. Contractor shall submit the Encounter Data for Comprehensive Safety Net Provider visits to Department per the specifications provided in Section 11.

9.11.3.7. Contractor shall negotiate with Comprehensive Safety Net Providers on reimbursement policy for services not included in the encounter rate, such as services not required of Comprehensive Safety Net Providers.

9.11.3.7.1. In addition to an encounter rate, Contractor shall implement a complementary value-based purchasing arrangement with Comprehensive Safety Net Providers to create incentives and financing to support improved quality and to assist in mitigating perverse financial incentives.

9.11.3.7.2. Contractor shall design the value-based purchasing arrangements with Comprehensive Safety Net Providers in accordance with Department's standardized framework.

9.11.3.7.3. Contractor shall design their own unique risk parameters within Department's standardized framework, including the amount of incentives.

9.11.3.7.4. Contractor may implement penalties for not meeting established quality performance metrics.

9.11.3.8. Contractor shall design the value-based purchasing arrangement utilizing Department identified, statewide quality metrics, Exhibit XX. The initial set of quality measures shall include the following:

9.11.3.8.1. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (CCBHC measure)

9.11.3.8.2. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (CCBHC measure)

9.11.3.8.3. Depression Remission at twelve Months (CCBHC measure)

9.11.3.8.4. Time to Services (I-SERV; CCBHC measure)

9.11.3.8.5. Follow-Up After Hospitalization for Mental illness: Ages 6+ (NQF 0576)

9.11.3.8.6. Follow-Up After Emergency Department Visit for Mental illness: Ages 6+ (NQF 3489)

9.11.3.9. Contractor shall participate in Department's accuracy audits process for Comprehensive Safety Net Providers and is required to complete any necessary documentation upon Department's request.

9.11.3.10. Contractor shall participate in Department's accuracy audits process for Comprehensive Safety Net Providers and is required to complete any necessary documentation upon Department's request.

9.11.4. FQHC and RHC Encounter Reimbursement

9.11.4.1. Contractor shall reimburse the FQHC or RHC by at least the encounter rate in accordance with 10 CCR 2505-10 § 8.700.6 and the Medicaid state plan for each FQHC or RHC visit, for services identified in 10 CCR 2505-10 § 8.700.3 for allowable costs identified in 10 CCR 2505-10 § 8.700.5. Department reserves the right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

9.11.4.2. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505- 10 § 8.700.6c.

9.11.4.2.1. Department notifies Contractor of the FQHC and RHC rates on a quarterly basis.

9.11.4.2.1.1. Department conducts quarterly accuracy audits with FQHCs and RHCs. Should Department recognize any discrepancy in FQHC or RHC payments (less than the full encounter rate), Contractor is responsible for reimbursing the FQHC or RHC the difference of the encounter payment and the initial reimbursement amount. FQHC and RHC visits are defined in 10 CCR 2505-10 § 8.700.1.

9.11.4.3. If multiple behavioral health services are provided by an FQHC or RHC within one visit, Contractor shall require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. Contractor shall pay the FQHC or RHC at minimum the encounter rate.

9.11.4.4. Contractor shall submit the Encounter Data for FQHC and RHC visits to Department per the specifications provided in Section 11.

9.11.4.5. Contractor shall participate in Department's accuracy audits process for FQHCs and RHCs and is required to complete the documentation located at https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms upon Department's request.

9.11.4.6. Contractor shall ensure the utilization and paid amounts for FQHC encounters in flat files matches those sent to Department for the Managed Care Accuracy Audit Review (MCAAR).

9.11.5. Essential Safety Net Provider Reimbursement

9.11.5.1. Contractor shall reimburse Essential Safety Net Providers in accordance with Department guidance for identified services to promote access to the essential services provided and support quality care.

9.11.5.1.1. Department reserves the right to change the minimum requirement payment to Essential Safety Net Providers to align with behavioral health safety net reforms in the future.

9.11.5.2. Contractor shall provide an enhanced payment for identified essential services in accordance with the minimum add-on payments established by Department in the Directed Payment Fee Schedule in the State Behavioral Health Services Billing Manual. Department will notify Contractor of the minimum Essential Safety Net Provider add-on payments on a frequency established by Department.

9.11.5.3. Contractor shall submit the Encounter Data for Essential Safety Net Provider visits to Department per the specifications provided in Section 11.

9.11.5.4. Contractor shall participate in Department's accuracy audits process for Essential Safety Net Providers and is required to complete any necessary documentation upon Department's request.

9.11.6. Directed Payment Fee Schedule

9.11.6.1. Contractor shall collaborate with Department and the BHA to identify services that are critical and often challenging to offer to Members as few providers will accept Contractor's established rate for the service.

9.11.6.2. Contractor shall reimburse Network Providers, at a minimum, the rates reflected on the Directed Payment Fee Schedule in the State Behavioral Health Services Billing Manual.

9.11.6.3. Contractor shall collaborate with Department to develop appropriate processes that enable Department to monitor the reasonableness of Contractor's reimbursement rates for Network Providers.

9.12. Physician Incentive Plans

9.12.1. Contractor shall disclose to Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

9.12.1.1. Physician Incentive Plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any Member.

9.12.2. Contractor shall only operate physician incentive plans if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

9.12.2.1. If Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, Contractor shall ensure that the physician or physician group has adequate stop-loss protection.

9.12.2.1.1. DELIVERABLE: Physician Incentive Plan

9.12.2.1.2. DUE: On the Effective Date or upon implementation of a Physician Incentive Plan

9.13. Integrated Care

9.13.1. Contractor shall reimburse identified integrated care practices in accordance with Department-established payment strategies that include coverage of select integrated care codes and Value-Based Payment approaches to support the increase and sustainability of integrated care sites.

9.14. Third Party Payer Liability

9.14.1. Contractor shall develop and implement systems and procedures to identify potential third parties that may be liable for payment of all or part of the costs for providing Covered Services under this Contract. All Members are required to assign their rights to any benefits to Department and agree to cooperate with Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

9.14.1.1. Potential liable Third Parties shall include any of the sources identified in 42 C.F.R. §433.138 relating to identifying liable third parties. Contractor shall coordinate with Department to provide information to Department regarding commercial third-party resources.

9.14.1.2. In the case of commercial health coverage, Contractor shall notify Department's Fiscal Agent, by telephone or electronically via the provider portal of any Third-Party Payers, excluding Medicare, identified by Contractor. If the Third-Party Payer is Medicare, Contractor shall notify Department and provide the Member's name and Medicaid identification along with the Medicare identification number electronically via the Fiscal Agent's provider portal. If the Member has health insurance coverage other than Medicare.

9.14.1.2.1. Contractor shall submit to Department's Fiscal Agent the following information:

9.14.1.2.1.1. Member's Medicaid identification number

9.14.1.2.1.2. Member's full name.

9.14.1.2.1.3. Identification of the health carrier or health plan

9.14.1.2.1.4. Member's health plan identification and group numbers

9.14.1.2.1.5. Policy holder's full name

9.14.1.2.1.5.1. DELIVERABLE: Third-Party Resource Identification

9.14.1.2.1.5.2. DUE: Within five Business Days electronically to the Fiscal Agent's provider portal from the time when the third-party resource is identified by Contractor.

9.14.1.3. Contractor shall inform Members, in its written communications and publications, that when a third party is primarily liable for the payment of the costs of a Member's medical benefits, the Member shall comply with the protocols of the Third Party, including using Providers within the Third Party's network, prior to receiving non-emergency medical care.

9.14.1.4. Contractor shall also inform its Members that failure to follow Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that Contractor would have been liable to pay. If Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to Contractor or the Network Provider for payment or cost of the care or services.

9.14.1.5. Contractor shall not restrict access to Covered Services due to the existence of possible or actual third-party liability.

9.14.1.6. Contractor shall also identify and pursue third-party payers in the case of an accident or incident where coverage should be paid by accident or casualty coverage. Managed care entities are afforded the right to seek Medicaid's lien pursuant to 25.5-4-301(12), C.R.S.

9.14.1.6.1. In the case of accident or casualty coverage, Contractor shall actively pursue and collect from third-party resources that have been identified except when it is reasonably anticipated by Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by Contractor.

9.14.1.7. In addition to compensation paid to Contractor under the terms of this Contract, Contractor may retain as income all amounts recovered from third-party resources, up to Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

9.14.1.8. With the exception of Section 9.12. and except as otherwise specified in contracts between Contractor and Network Providers, Contractor shall pay all applicable co-payments, coinsurance and deductibles for approved Covered Services for the Member from the third-party resource using Medicaid lower-of pricing methodology except that, in any event, the payments shall be limited to the amount that Medicaid would have paid under Medicaid Fee- for-Service:

9.14.1.8.1. The sum of reported third party coinsurance and/or deductible or

9.14.1.8.2. Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

9.14.1.9. Contractor shall pay, except as otherwise specified in contracts between Contractor and Network Providers, all applicable copayment, coinsurance and deductibles for approved Medicare Part B Services processed by Medicare Part A. These services include therapies and other ancillary services provided in a skilled nursing facility, outpatient dialysis center, independent rehabilitation facility or rural health clinic. In any event, payments shall be limited to the amount that Medicaid would have paid under Medicaid Fee-for-Service.

9.14.1.10. Contractor shall enter into a Coordination of Benefits Agreement with Medicare and participate in the automated claims crossover process in order to serve dually eligible Members.

9.15. Medical Loss Ratio (MLR)

9.15.1. Contractor shall calculate and report the MLR according to the instructions provided on the MLR template and the guidance provided in 42 C.F.R. § 438.8(a).

9.15.2. The first annual measurement period will begin upon the start of the Operational Period of the Contract and end on June 30, 2026.

9.15.3. Subsequent annual measurement periods will align with the state fiscal year, beginning on July 1 and ending on June 30 of the subsequent calendar year.

9.15.4. Contractor shall submit an MLR report to Department, for each MLR reporting year, that includes:

9.15.4.1. Total incurred claims.

9.15.4.2. Expenditures on quality improvement activities.

9.15.4.3. Expenditures related to activities compliant with program integrity requirements.

9.15.4.4. Non-claims costs.

9.15.4.5. Premium revenue.

9.15.4.6. Taxes.

9.15.4.7. Licensing fees

9.15.4.8. Regulatory fees.

9.15.4.9. Methodology(ies) for allocation of expenditures.

9.15.4.10. Any credibility adjustment applied.

9.15.4.11. The calculated MLR.

9.15.4.12. Any remittance owed to the state, if applicable.

9.15.4.13. A comparison of the information reported with the audited financial report.

9.15.4.14. A description of the aggregation method used to calculate total incurred claims.

9.15.4.15. The number of Member months.

9.15.4.16. All data provided by Contractor for the purpose of MLR calculation shall use actual costs.

9.15.5. Contractor shall allow for three months claims runout before calculating the MLR. Department will validate the MLR in accordance with federal guidance.

9.15.5.1. Contractor shall submit the completed MLR calculation on Department approved template and provide supporting data and documentation per 42 CFR 438.8(k), including, but not limited to, all encounters, certified financial statements and reporting, and flat files, in compliance with Department guidelines, for the

measurement period by January 15. Contractor shall submit Encounter claims in compliance with requirements in Section 11.

9.15.5.1.1. DELIVERABLE: MLR calculation template and supporting data and documentation

9.15.5.1.2. DUE: Annually, by January 15th of each year.

9.15.6. Contractor's Medical Spend will be calculated using audited supplemental data provided in Contractor's annual financial reporting and verified using Encounter Data submitted through flat file submission on a secure server, until such time that Department deems it appropriate for such Encounter Data submissions to be sent through the State's Colorado interchange.

9.15.6.1. MLR Target: Contractor shall have an MLR of at least 85%. Contractor shall calculate a cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by Department.

9.15.6.2. The MLR calculation is the ratio of the numerator (as defined in accordance with 42 CFR 438.8(e)) to the denominator (as defined in accordance with 42 CFR 438.8(f)).

9.15.7. Contractor shall include each expense under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

9.15.7.1. Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

9.15.7.2. Contractor shall ensure that shared expenses, including expenses under the terms of a management contract, are apportioned pro rata to the contract incurring the expense.

9.15.7.3. Contractor shall ensure that expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, are borne solely by the reporting entity and are not apportioned to the other entities.

9.15.7.4. The numerator is the sum of Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's fraud reduction activities.

9.15.7.5. Contractor shall round the MLR to three decimal places. For example, if the MLR is 0.8255 or 82.55%, it shall be rounded to 0.826 or 82.6%.

9.15.7.6. Contractor shall aggregate data for all Medicaid eligibility groups covered under this Contract.

9.15.7.7. If Contractor's MLR does not meet or exceed the MLR Target, then Contractor shall reimburse Department the difference using the following formula:

9.15.7.8. Reimbursement amount shall equal difference between the adjusted earned revenue and the net qualified medical expenses divided by the MLR Target as specified in federal regulations 42 CFR 438.8(f)(2)(vi).

9.15.7.9. Contractor shall reimburse Department within 30 days of Department finalizing the MLR validation. Department shall designate the MLR rebate and initiate the recovery of funds process by providing notice to Contractor of the amount due, pursuant to 10 CCR 2505-10 § 8.050.3 A-C Provider Appeals, as well as § 8.050.6 Informal Reconsiderations in Appeals of Overpayments Resulting from Review or Audit Findings.

9.15.7.9.1. Department will validate the MLR after any annual adjustments are made. Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

9.15.8. Subcontracted Claims Adjudication Activities

9.15.8.1. Contractor shall require any subcontractors providing claim adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

9.15.8.1.1. In any instance where Department makes a retroactive change to the capitation payments for an MLR reporting year where the MLR report has already been submitted to Department, Contractor shall:

9.15.8.1.1.1. Re-calculate the MLR for all MLR reporting years affected by the change;

9.15.8.1.1.2. Submit a new MLR report meeting the applicable requirements.

9.15.8.1.1.2.1. DELIVERABLE: MLR Calculation Template

9.15.8.1.1.2.2. DUE: Annually, on January 15

9.15.9. Medicaid Reporting Template

9.15.9.1. Contractor shall submit an Annual Certified Rate Setting Financial Template that provides a summary of Contractor's financial data for the rate setting cycle, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. Department will provide the template and an Information Request List (IRL) to Contractor no less than 60 days in advance of the due date.

9.15.9.1.1. Contractor shall not modify the Annual Certified Rate Setting Financial Template, unless written approval is provided by Department, and shall submit supporting data and documentation as outlined in the IRL to provide clarity and detail. Department may modify the template and will notify Contractor within five business days of the modification.

9.15.9.1.2. Contractor shall submit any requested supporting data and documentation to Department and the designated outside vendor within seven business days of Department's request.

9.15.9.1.2.1. DELIVERABLE: Annual Certified Rate Setting Financial Template with supporting data and documentation listed in the IRL

9.15.9.1.2.2. DUE: Annually, by November 15th of each year

9.15.10. Medicaid Payment in Full

9.15.10.1. Except as allowed in the Contract, Contractor shall not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf, for Covered Services provided pursuant to this Contract.

9.15.10.2. Except as allowed in the Contract, Contractor shall ensure that all of its Subcontractors and Network Providers do not, for any reason, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member, or any persons acting on a Member's behalf other than Contractor, for Covered Services provided pursuant to this Contract.

9.15.10.3. This section shall not be construed to limit the ability of any of Contractor's Subcontractors or Network Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against Contractor for any service provided pursuant to this Contract or any other agreement entered into between that Subcontractor or Network Provider and Contractor.

9.15.10.4. This provision shall survive the termination of this Contract, for authorized services rendered prior to the termination of this Contract, regardless of the reason for the termination. This provision shall be construed to be for the benefit of Contractor's Members.

9.15.10.5. For fees or premiums charged by Contractor to Members, Contractor may be liable for penalties of up to $25,000.00 or double the amount of the charges, whichever is greater. Department will deduct from the penalty the amount of overcharge and return it to the affected Members.

9.15.10.6. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 C.F.R. §§ 95.1 and 95.7, Department must file all claims for reimbursement of payments to Contractor with CMS within two years after the calendar quarter in which Department made the expenditure. Contractor and Department shall work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If Department is unable to file Contractor's claims or capitation payments within two years after the calendar quarter in which Department made the expenditure due to inadequate or inaccurate Contractor records, and Department does not meet any of the exceptions listed at 45 C.F.R. § 95.19, no claims or capitations will be paid to Contractor for any period of time disallowed by CMS. Furthermore, Department shall recover from Contractor all claims and capitations paid to Contractor for any period of time disallowed by CMS.

9.15.10.6.1. PERFORMANCE STANDARD: Contractor shall meet the requirements of FFS timely payment, per 42 CFR 447.46, including the paying of 90% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt; and

paying 99% of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.

9.15.10.7. A clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in Department's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

9.15.10.8. Contractor shall ensure that the date of receipt is the date that Contractor receives the claim, as indicated by its date stamp on the claim; and that the date of payment is the date of the check or other form of payment.

9.15.10.8.1. DELIVERABLE: Timely Clean Claims Payment Report

9.15.10.8.2. DUE: Quarterly, within 45 days following the end of the quarter for which the report covers

10. STANDARDIZED CHILD AND YOUTH BENEFIT

10.1. Overview and Guiding Principles

10.1.1. Contractor shall implement Department's Standardized Child and Youth Benefit in accordance with this section and the complete policies and procedures as described in Department's detailed policy document to be developed in collaboration with community stakeholders including Contractor and other Managed Care Entities.

10.1.2. Contractor shall collaborate with Department, stakeholders, and other relevant parties to refine the design and operational implementation of the Standardized Child and Youth Benefit to improve the delivery of the full continuum of behavioral health services for children and youth ages 0-20, and for some Foster Care Youth ages 21-26.

10.1.3. Contractor shall partner with Department and other state partners to implement the 2024 Child and Youth Behavioral Health Statewide Implementation Plan.

10.1.4. Contractor shall collaborate with the Behavioral Health Administration (BHA) and (Behavioral Health Administrative Service Organizations) BHASOs to improve service access, quality, care coordination, and monitoring and reporting of child and youth behavioral health data.

10.1.5. Contractor shall leverage health neighborhood and care coordination strategies to collaborate with other child and family serving systems–with particular emphasis on Child Welfare, criminal justice and school-based services.

10.1.6. Contractor shall be responsible for ensuring that all child and youth Medicaid Members with behavioral health needs in the state receive a standardized level of care that includes:

10.1.6.1. EPSDT Outreach.

10.1.6.2. Universal screening process.

10.1.6.3. Independent assessment for higher acuity children and youth who meet relevant criteria.

10.1.6.4. Level of care determinations based on results of the universal screenings or Independent Assessments that guarantee access to a set of Medicaid Covered Services.

10.1.6.5. Care coordination that corresponds to those service levels, including Intensive Treatment Planning (ITP) and High-Fidelity Wraparound (HFW) for children and youth who qualify.

10.1.6.6. Monitoring and quality assurance processes.

10.1.7. Contractor shall document and implement policies and procedures describing how Contractor shall comply with and work to meet the goals and objectives of the Standardized Child and Youth Benefit.

10.1.7.1. DELIVERABLE: Standardized Child and Youth Benefit Policies and Procedures

10.1.7.2. DUE DATE: 30 days prior to Operational Start Date

10.2. EPSDT Outreach

10.2.1. Contractor shall inform pregnant women and EPSDT eligible Members, or their families or caregivers, about the EPSDT program, in accordance with requirements specified in 42 CFR § 441.56 and the State Medicaid Manual Chapter V, Section 5121.

10.2.2. Contractor shall inform Members about the EPSDT program generally within 60 days of the Member's initial Medicaid eligibility determination or after a Member regains eligibility following a greater than 12-month period of ineligibility.

10.2.3. Contractor shall inform Members about the EPSDT program generally within 60 days of identification of the Member being pregnant.

10.2.4. At least one time annually, Contractor shall outreach Members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care".

10.2.5. Contractor shall provide EPSDT-eligible Members, including children involved with Child Welfare, with the following minimum information:

10.2.5.1. The benefits of preventive health care, including the American Association of Pediatrics' "Bright Futures Guidelines."

10.2.5.2. The services available to Members under the EPSDT program.

10.2.5.3. Where EPSDT services are available.

10.2.5.4. How to obtain EPSDT services.

10.2.5.5. That EPSDT services are available without cost to the Member.

10.2.5.6. How to request necessary transportation, reimbursement for mileage, and transportation scheduling assistance.

10.2.6. Contractor shall be accountable for providing information on EPSDT at least once to households with multiple EPSDT-Eligible Members residing in the household. Contractor shall not be held accountable for providing EPSDT information to each individual EPSDT-Eligible Member residing in the household.

10.2.7. Contractor does not need to inform households more than once in a twelve-month period when Members lose and regain Medicaid eligibility during that twelve-month period.

10.2.8. Contractor's communications about EPSDT shall be delivered using easy-to-understand, non-technical language.

10.2.9. Contractor shall use a combination of oral and written materials to outreach EPSDT-eligible Members, including but not limited to:

10.2.9.1. Mailed letters, brochures, or pamphlets.

10.2.9.2. Face-to-face interactions.

10.2.9.3. Telephone calls.

10.2.9.4. Video-conferencing.

10.2.9.5. Automated calls.

10.2.9.6. Email messages.

10.2.9.7. Text/SMS messaging.

10.2.10. Contractor shall conduct outreach activities to EPSDT-eligible Members to ensure that children receive regularly scheduled examinations of physical and mental health, growth, development, and nutritional status in accordance with the American Association of Pediatrics' "Bright Futures Guidelines."

10.2.11. Contractor shall monitor EPSDT-eligible Members' receipt of screenings and examinations in accordance with American Association of Pediatrics' "Bright Futures Guidelines."

10.2.12. Contractor shall employ proven best practices for outreach including:

10.2.12.1. Using multiple methods of communication.

10.2.12.2. Staggering message delivery to different days of the week or hours of the day.

10.2.12.3. Limit telephone (including automated) calls and text messages to between the hours of 8 a.m. and 9 p.m. Monday through Friday and 10 a.m. through 4 p.m. Saturday or Sunday.

10.2.12.4. Attempt to reach Members more than once through multiple methods.

10.2.12.5. Target outreach activities to particular "at risk" groups, to be defined by Contractor and with final approval by Department. For example, mothers with babies to be added to assistance units, families with infants, or adolescents, first time eligible, and those not using the program for over two years might benefit most from oral methods.

10.2.13. Contractor shall provide referrals to Title V and similar programs, when appropriate to the individual needs of the Member. Title V and similar programs include, but are not limited to:

10.2.13.1. Head Start.

10.2.13.2. Early Intervention under the Individuals with Disabilities Education Act (IDEA). the Special Supplemental Food Program for Women, Infants and Children (WIC). school health programs of state and local education agencies (including the Education for all Handicapped Children Act of l975).

10.2.13.3. Social services programs under Title XX.

10.2.14. Contractor shall develop and share best practices with Department for educating Members about EPSDT and for outreaching EPSDT-Eligible Members to improve adherence to the American Association of Pediatrics (AAP) "Bright Futures Guidelines".

10.2.15. Contractor shall actively participate with Department and other RAEs in creating a mutually-agreed upon document establishing evidence-based standards for communication and outreach related to EPSDT.

10.2.16. Contractor shall submit to Department an annual EPSDT Outreach Plan that describes processes utilized to effectively inform individuals as required, generally, within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

10.2.16.1. DELIVERABLE: EPSDT Outreach Plan

10.2.16.2. DUE: Annually, on July 31

10.2.17. Contractor shall submit a quarterly EPSDT Outreach Report to Department, in a format to be determined by Department. The Quarterly EPSDT Outreach Report shall include descriptions of Contractor's communication methods for outreach and individual Member reporting of completed outreach activities and attempted outreach activities.

10.2.17.1. DELIVERABLE: EPSDT Outreach Report

10.2.17.2. DUE: Quarterly, 45 days after the end of the reporting period

10.3. Universal Screenings

10.3.1. Contractor shall assist Department in ensuring EPSDT eligible populations receive regularly scheduled examinations and evaluations of their general physical and mental health, growth, development, and nutritional status, in accordance with 42 CFR Part 441 Subpart B.

10.3.2. In the support of this goal, Contractor shall:

10.3.2.1. Implement policies, training, and practice transformation activities for Network Providers that improve Colorado's compliance with Bright Futures American Association Pediatrics (AAP) recommendations for preventive pediatric healthcare, also known as the "periodicity schedule," in primary care settings.

10.3.2.2. Implement policies, training, and care integration strategies into diverse child and youth settings including, but not limited to schools, crisis settings, and other community-based organizations.

10.3.2.3. Ensure that developmental, social, behavioral, and mental health screeners are universally delivered to children and youth.

10.3.3. Contractor shall design, with input from Department and other Managed Care Entities, an EPSDT Uniform Accountability Strategy describing best practices for all Managed Care Entities to follow to ensure state compliance with EPSDT.

10.3.3.1. In developing an EPSDT Uniform Accountability Strategy, Contractor shall leverage Department provided resources that include, but are not limited to:

10.3.3.1.1. National experts.

10.3.3.1.2. National landscape and best practices.

10.3.3.1.3. Data and systems support to execute on plan.

10.3.3.2. Contractor shall participate in creating an EPSDT Uniform Accountability Strategy that shall include, but is not limited to:

10.3.3.2.1. Training and outreach plan on improving performance, including how Managed Care Entities will ensure providers are using the screening tools developed according to CRS 27-62-103, which required the state, in partnership with the community, to select developmentally appropriate and culturally competent statewide behavioral health standardized screening tools for primary care providers.

10.3.3.2.2. Plans for engaging providers and places of service across the community (e.g. schools, crisis providers) to ensure that early identification of child and youth conditions are captured where families are most often seeking services.

10.3.3.2.3. Recommendations for identifying positive screens and tracking referrals to Treatment; and

10.3.3.2.4. Contractor reporting and partnership commitment to improve EPSDT screening and referral to treatment compliance.

10.3.4. Contractor shall work in partnership with Department and other Managed Care Entities to complete the EPSDT Uniform Accountability Strategy within six months of Contract execution.

10.3.5. Contractor shall ensure additional screening tools are utilized that may be appropriate for children and youth with other systems involvement or comorbidities.

10.3.6. Contractor shall ensure that providers are deploying additional screening tools when they are clinically appropriate and evidence-based. Additional relevant screeners may include but are not limited to:

10.3.6.1. The Massachusetts Youth Screening Instrument - Second Version (MAYSI-2).

10.3.6.2. BHA Crisis Assessment Tool

10.3.6.3. Child and Adolescent Needs and Strengths (CANS) -Screen that may be developed for or adopted in Colorado.

10.3.6.4. Contractor shall support Network Providers using additional screeners for populations which may include, but are not limited to, children and youth who:

10.3.6.4.1. Are already in behavioral health treatment.

10.3.6.4.2. Have received Colorado Crisis Services.

10.3.6.4.3. Have hospital admission or emergency room visits.

10.3.6.4.4. Are receiving services from a school-based behavioral health professional.

10.3.6.4.5. Are engaged in Juvenile assessment centers.

10.3.7. Contractor shall ensure that its network includes providers who are certified on the use of the different approved screening tools to align with reliability and validity.

10.3.8. For every positive behavioral health screen under AAP Bright Futures, Contractor shall follow up with the Member and primary care provider to ensure an appropriate referral to a behavioral health provider has been made.

10.3.9. Contractor shall ensure children and youth with any screen that indicates the presence of a condition (i.e. a positive screen) see an appropriate specialist for follow up care within 30 days of identified need. This includes but is not limited to positive behavioral health, developmental and physical health screens, including, but not limited to:

10.3.9.1. Vision.

10.3.9.2. Dental.

10.3.9.3. Early intervention.

10.3.10. Contractor shall work with Department to ensure that state data systems are identifying children and youth with a screen that indicates the presence of a condition (i.e., a positive screen) and that Contractor is able to track them to appropriate specialty care.

10.3.10.1. PERFORMANCE STANDARD: Achieve the national average for 30 day follow up for positive screens by the fifth year of the contract.

10.4. Standardized Independent Assessment

10.4.1. Contractor shall utilize a Standardized Independent Assessment (IA) to gather a child or youth Member's psychosocial history and presenting concerns, and to determine diagnoses and baseline level of functioning, in accordance with requirements established by Department and Behavioral Health Administration.

10.4.2. Contractor shall utilize a process and tool approved by Department and Behavioral Health Administration that is designed specifically for identifying children and youth who meet criteria for an IA. Department approved pre-screening tool will be designed to identify children and youth at risk of out of home placement due to behavioral health conditions and/or multisystem involvement, including but not limited to children and youth requiring residential care.

10.4.3. Contractor shall ensure an IA is provided to children and youth who meet Department established criteria identified through the pre-screen.

10.4.4. If a parent or legal guardian requests an IA, Contractor shall complete a pre-screen to determine if an IA is needed for treatment planning and/or placement.

10.4.5. Contractor shall adhere to the standards and format for IAs as established by Department and the Behavioral Health Administration, including, but not limited to:

10.4.5.1. The Child and Adolescent Needs and Strengths (CANS) tool–a multi-purpose information integration tool developed for children's services to support decision-making, including on level of care and service planning, facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

10.4.6. Contractor shall partner with Department, Behavioral Health Administration, and Providers to establish timeliness requirements for the completion of an IA and the frequency of IA based on Member acuity.

10.4.7. Contractor shall utilize a CANS Decision Support Model designed for Colorado as part of the IA to assist in determining level of care and treatment planning for children and youth, as required by Department and Behavioral Health Administration.

10.4.8. Contractor shall use the CANS Decision Support Model to determine eligibility for Intensive Treatment Planning and High-Fidelity Wraparound interventions.

10.4.9. Contractor shall establish contracts with the BHASOs for the Standardized IA.

10.4.10. Contractor shall collaborate with BHASOs to ensure IA Providers are trained in managed care policy, utilization and resource management, and medical necessity by the RAEs and quality standards by the Behavioral Health Administration

10.4.11. The RAEs will provide training to the IA Providers in managed care policy, utilization and resource management.

10.4.12. Contractor shall include, at a minimum, the following requirements in its contracts with the BHASOs:

10.4.12.1. A process to report or provide the IA and/or the outcome of the IA to Department and Contractors.

10.4.12.2. IA must be completed within ten Business Days of the referral.

10.4.13. When the Independent Assessment determines a child's or youth's eligibility for High-Fidelity Wraparound (HFW) or Intensive Treatment Planning (ITP) services, Contractor shall facilitate a treatment team meeting within 14 calendar days of the notification of the completion of the IA. The treatment team meeting shall include:

10.4.13.1. Child/youth.

10.4.13.2. Family/Caregiver.

10.4.13.3. IA Provider.

10.4.13.4. Natural supports (friends, neighbors, interested stakeholders).

10.4.13.5. HFW facilitator or ITP Coordinator.

10.4.13.6. Treatment providers.

10.4.13.7. Any relevant social service or education entities.

10.4.14. Contractor shall have all necessary data sharing agreements in place to leverage the IA data to manage child and youth behavioral health in the standardized benefit.

10.4.15. Contractor shall collaborate with Department, the BHA and the IA providers to support the collection, reporting and leveraging of IA data, level of care determinations from the IA, and any other relevant data.

10.4.16. Contractor shall collaborate with providers and state entities to make sure the IA data is appropriately shared and organized.

10.5. Standardized Child and Youth Benefit Levels of Care

10.5.1. Contractor shall administer the Standardized Child and Youth Benefit in a manner that is responsive to the unique needs of children and youth utilizing standardized levels of care that are complete across the full continuum of care. These levels of care will include, at least:

10.5.1.1. Community Level of Care: Prevention and Early Intervention services that include in-home dyadic care (0.5).

10.5.1.2. Base Outpatient: Outpatient Services (1.0); Trauma-Designed Outpatient Services (1.3); Community Crisis Services (1.5).

10.5.1.3. Intensive Outpatient: Transition Services (2.0); Intensive Outpatient Services (2.1); Partial Hospitalization Services (2.5); Intensive Home-Based Services (2.7).

10.5.1.4. Residential: Clinically Managed Low-Intensity Residential Services (3.1); Clinically Managed Medium-Intensity Residential Services (3.5); Medically Managed High-Intensity Inpatient (3.7).

10.5.1.5. Inpatient: Medically Managed Intensive Inpatient Services (4.0).

10.5.1.6. Intensive Supports: Waiver Support Services that may cross the above categories (5.0).

10.5.2. Contractor shall coordinate the array of treatment services available through the levels of care which includes those services available through the Capitated Behavioral Health Benefit, Medicaid Fee for Service, EPSDT, and the HCBS Waivers. Services included in the above levels will be developed in further collaboration with community stakeholders.

10.5.2.1. Contractor shall provide or arrange for all medically necessary behavioral health services for children and youth under the age of 21 in accordance with the requirements in Section 9, Capitated Behavioral Health Benefit, particularly unique requirements for children and youth located at 9.4.4.4 and 9.6.4.2.

10.5.3. Contractor shall use screeners and IA to coordinate and authorize care along the standardized levels of care in accordance with criteria that will be developed in partnership with Department and stakeholders.

10.5.4. Contractor shall comply with Department established standardized eligibility criteria for determining a child or youth Member's level of care and service category.

10.5.5. If a Member is unable to access an identified service that it is Contractor's responsibility to cover due to provider capacity or regional limitations, Contractor shall

enter into single case agreements with existing Colorado Medicaid enrolled providers or recruit additional providers to ensure Member needs are met. In some cases, providers may be located out of state.

10.5.6. Home Visiting Programs

10.5.6.1. Contractor shall partner with established and evidence-based home visiting programs in the region to increase utilization of home visiting services, Medicaid reimbursement for home visiting services, and coordination between clinicians and home visiting providers.

10.5.6.1.1. Contractor shall contract with home visiting services in their region to pay for a menu of evidence-based home visiting services that have been approved by the Colorado Department of Early Childhood and in accordance with approved state and federal requirements.

10.5.6.1.2. Contractor shall document and submit to Department their plan to contract with the home visiting services that are most appropriate to serve the needs of Members in their region.

10.5.6.1.2.1. DELIVERABLE: Home Visiting Strategy

10.5.6.1.2.2. DUE: Annually, September 1

10.5.6.1.3. Contractor shall work with community partners, including but not limited to Providers, hospitals, counties, and family resource centers, to ensure appropriate referrals are made for families who can benefit from a home visiting model.

10.5.6.1.4. Contractor shall work with Department to find a mechanism to report on the utilization of home visiting programs by Members in the region.

10.6. High-Fidelity Wraparound (HFW) and Intensive Treatment Planning (ITP)

10.6.1. Contractor shall provide care coordination in accordance with the requirements in Section 11, particularly the criteria for identifying children and youth for care coordination tiers.

10.6.2. Contractor shall make ITP or HFW available for children and youth with more complex care coordination needs due to behavioral health conditions that put them at risk of out of home placement, as identified through the IA process.

10.6.3. Contractor shall collaborate with ITP or HFW providers who create Child and Family Centered Plans that determine the Treatment Plan for eligible children and youth.

10.6.4. Contractor shall authorize services from the Child and Family Centered Plan and participate in coordination of care for those services when the ITP/HFW Case Manager deems appropriate.

10.6.5. Contractor shall engage in regularly scheduled trainings with ITP/HFW providers to ensure that the documentation of medical necessity in the Child and Family Centered Plans meets NCQA requirements for managed care accreditation.

10.6.6. Contractor may ask for clarification or additional information from the ITP/HFW provider on the Family and Child Centered Plan.

10.6.6.1. Contractor's Requests for additional information cannot delay treatment for the child or youth greater than 48 hours and Contractor shall provide the Member care determined necessary by the ITP/HFW Provider in the interim during resolution.

10.6.7. Intensive Treatment Planning (ITP)

10.6.7.1. Contractor shall make available ITP for eligible children and youth who have complex behavioral health needs, as identified through the Standardized IA. The following populations shall be considered for ITP:

10.6.7.1.1. Children and youth receiving Out-of-State Residential Treatment.

10.6.7.1.2. Youth over age 21.

10.6.7.1.3. Children and youth with complex physical health needs with low/no behavioral health needs or chronic condition.

10.6.7.1.4. Children and youth in placements with difficulty engaging in HFW, and/or permanency is unknown.

10.6.7.2. For Children and Youth who meet criteria for ITP, Contractor shall contract with a state approved entity that can provide the ITP required for that Member.

10.6.7.3. ITP shall include, at a minimum, the following:

10.6.7.3.1. Provide structured treatment/service planning and care coordination using a Wraparound- informed model/principles for children/youth with behavioral health needs.

10.6.7.3.2. Utilize the Child and Adolescent Needs and Strengths tool to fidelity for ongoing treatment and services planning.

10.6.7.3.3. The RAE Tier 3 Care Coordinator role within ITP shall include: Coordinates the treatment services provided under the treatment plan, liaises between the providers, family and treatment team and the RAE UM, billing and provider relations teams, Engages with the treatment team/family as a participant of the treatment team, not as the facilitator or primary point of contact.

10.6.8. High-Fidelity Wraparound (HFW)

10.6.8.1. Contractor shall make available High-Fidelity Wraparound for eligible children and youth with severe or complex behavioral health needs, as identified through the IA.

10.6.8.2. For Children and Youth who meet criteria for HFW, Contractor shall contract with a BHA approved entity that can provide the HFW required for that Member. HFW will be provided in accordance with National Wraparound Initiative standards.

10.6.8.3. HFW shall, at a minimum:

10.6.8.3.1. Utilize the Child and Adolescent Needs and Strengths tool to fidelity for ongoing treatment and services planning as it aligns with HFW.

10.6.8.3.2. Create and regularly update an Individualized Treatment/Service Plan developed using the CANS.

10.6.8.3.3. Meet requirements for HFW as established by the National Wraparound Initiative for Members that have high behavioral health needs and/or multi-

system involvement; including Face-to-face contact and ongoing contact with the family, Member, and Members of the treatment team as it aligns with HFW.

10.6.8.4. The RAE Tier 3 Care Coordinator role within HFW shall include: Coordinates the treatment services provided under the treatment plan, liaises between the providers, family and treatment team and the RAE UM, billing and provider relations teams, Engages with the treatment team/family as a participant of the treatment team, not as the facilitator or primary point of contact.

10.7. Monitoring and Quality Assurance

10.7.1. Contractor shall facilitate data sharing across all treating providers and ensure the completion of necessary consents and releases of information. This includes with the Behavioral Health Administration and Department of Health Care Policy and Financing.

10.7.2. Contractor shall facilitate sharing of data that must include, but is not limited to:

10.7.2.1. Standardized Independent Assessments completed and outcomes.

10.7.2.2. The CANS tool from the IA, High-Fidelity Wraparound intervention, and Intensive Treatment Planning intervention

10.7.2.3. ITP/HFW eligibility determinations and care planning.

10.7.2.4. Level of Care determinations and changes in level of care determinations.

10.7.3. Contractor shall collaborate with Department and BHA to evolve the gathering and monitoring of relevant data to continually improve the state's ability to assess adherence to and support of a Child and Family-centered care planning process consistent with High Fidelity Wraparound practice and System of Care Principles. The organizations will develop processes and tools that will allow the measurement of performance outcomes that include, but are not limited to:

10.7.3.1. Providing a copy of the completed IA to the appropriate BHA staff for tracking and analysis of the overall program.

10.7.3.2. Monitoring the comprehensiveness of the child and family-centered plan needs and goals to ensure that all necessary ICC/HFW and other provider services and supports are incorporated into the child and family-centered plan of care.

10.7.3.3. Monitoring alignment between child and family-centered care plan needs and goals, and Standardize Child and Youth Benefit service authorizations.

10.7.3.4. Training needs for ICC/HFW staff involved with the UM process.

10.7.3.5. Training needs related to medical necessity, child and family-centered plans, and appropriate levels of services.

10.7.3.6. Reviewing the Standardized Child and Youth Benefit list of services that are subject to prior authorization to determine whether there is an ongoing need for prior authorization to ensure appropriate utilization of services.

10.7.3.7. Using provider advisory feedback to identify opportunities to standardize and streamline service authorization processes to reduce administrative burden for providers.

10.7.3.8. Monitoring for updates to ODM clinical coverage criteria, evidence-based nationally recognized medical necessity guidelines, and other professional literature to inform and update the Standardize Child and Youth Benefit's clinical coverage policies and criteria.

10.7.4. Contractor shall partner with Department to establish performance metrics for the Standardized Child and Youth Benefit that may include:

10.7.4.1. Number of children with and without well-child visits.

10.7.4.2. Number of screens completed in compliance with "Periodicity Schedule."

10.7.4.3. Successful/Not Successful referrals to treatment within 60 or 90-days.

10.7.4.4. Number of children with/without a behavioral health screen during well-child visit.

10.7.4.5. Data related to other screener tools/mechanisms [e.g. The Massachusetts Youth Screening Instrument - Second Version (MAYSI-2), Crisis Assessment Tool (CAT), or a CANS-Screen].

10.7.4.6. Data related to the Standardized Independent Assessment and the CANS tool.

10.7.4.7. Percent of providers by provider type meeting screening standards.

10.7.5. Contractor shall collaborate with Department to establish a public dashboard and/or other public reporting mechanism.

11. DATA ANALYTICS AND CLAIMS PROCESSING SYSTEMS

11.1. Overview and Guiding Principles

11.1.1. Contractor shall use data and analytics to successfully operate the ACC.

11.1.2. Contractor shall possess the resources and capabilities to leverage existing data systems and analytics tools or create new ones as necessary to perform the Work, conscious to avoid the creation of duplicative systems.

11.1.3. Contractor shall leverage Department provided tools and data in conjunction with Contractor's data analytic resources to distribute data to Network Providers and partners in the Health Neighborhood in a manner that makes it easy for Providers to implement interventions that can improve Member health and outcomes, as well as Network Provider performance.

11.1.4. Contractor shall take appropriate action, based on the results of its searches, queries and analyses, to improve performance, target efforts on areas of concern, and apply the information to make changes and improve the health of Contractor's Members.

11.2. Department Provided Tools and Resources

11.2.1. Contractor shall use tools provided by Department, including those currently in development, and other available resources to establish performance benchmarks, monitor provider performance across key cost and utilization metrics, and support Members in accessing needed care and supports. The existing tools provided by Department include, but are not limited to, the following:

11.2.1.1. Colorado interChange (MMIS)

11.2.1.1.1. Contractor shall maintain an interface that enables Contractor to use the Colorado interChange Provider Portal to retrieve eligibility, enrollment and attribution information for Members.

11.2.1.1.2. At a minimum, Contractor shall have the capabilities to utilize and process HIPAA standard transactions, such as, but not limited to, the 834 form.

11.2.1.2. Enterprise Data Warehouse (EDW)

11.2.1.2.1. Contractor shall use the EDW and MOVEit server to access Member claims, roster reports, and raw data, as well as a variety of custom reports to conduct population health management and support Member care coordination.

11.2.1.2.2. Contractor shall leverage custom data feeds including, but not limited to the following, in order to perform the Work:

11.2.1.2.2.1. Weekly vaccine record reports from the Colorado Immunization Information System.

11.2.1.2.2.2. Bimonthly judicial rosters of Members that have recently or will shortly exit the probation system.

11.2.1.2.2.3. Daily Colorado Department of Directions reports of incarcerated persons that may be released within the next 90 days and persons who were released within the past 30 days.

11.2.1.2.2.4. Daily DSNP (Dual Special Needs Plan) admission files from DSNP Hospitals and Skilled Nursing Facilities.

11.2.1.2.3. Contractor shall have the capacity to share data via MOVEit to the EDW in accordance with agreed upon file specifications and Department security standards. Such data may include Member-level Care Coordination information and utilization management performance,

11.2.1.3. Provider Performance and Quality Measures (PPQM)

11.2.1.3.1. Contractor shall use the PPQM tool to access Contractor's and Network Providers' performance on NCQA-certified HEDIS measures and CMS Core Measures derived from Medicaid claims data and other available sources.

11.2.1.3.2. Contractor shall access standard analytics and reports from the PPQM tool, including Member and attribution lists, trended Key Performance Indicator data, nationally recognized quality and utilization measures, and cost data.

11.2.1.3.3. Contractor may design queries and searches it requires within the PPQM tool to support Contractor's population health management strategy and interventions.

11.2.1.3.4. Contractor shall support and encourage Network Provider use of the provider-facing web portal that is part of the PPQM tool. The web portal will provide information on Member rosters, gaps in care reporting, cost data, and provider performance on NCQA-certified HEDIS measures and CMS Core Measures derived from Medicaid claims data and other available sources.

11.2.1.4. 42 C.F.R. Part 2 Data

11.2.1.4.1. Department will provide Contractor with Part 2 Data for Members enrolled with Contractor, subject to the limitations and requirements contained in this contract provision and 42 C.F.R. Part 2.

11.2.1.4.1.1. Contractor shall only use the Part 2 Data for three specific purposes:

11.2.1.4.1.1.1. To assess calculation and payment for performance measures.

11.2.1.4.1.1.2. To achieve the Potentially Avoidable Cost Key Performance Indicator targets.

11.2.1.4.1.1.3. To provide care coordination and/or case management services in support of payment or health care operations.

11.2.1.4.1.2. Contractor shall not use the Part 2 Data for any other purpose unless appropriate consent is obtained pursuant to 42 C.F.R. Part 2.

11.2.1.4.1.3. Contractor is fully bound by the provisions of 42 C.F.R. Part 2 upon receipt of the Part 2 Data:

11.2.1.4.1.3.1. Consistent with 42 CFR § 2.32(a)(1), this Part 2 Data will be disclosed to Contractor from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit Contractor from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

11.2.1.4.1.3.2. Contractor shall implement appropriate safeguards, including written policies and procedures, to prevent unauthorized uses and disclosures of 42 C.F.R. Part 2 data. These policies and procedures shall be documented and reported in Contractor's Data Governance Policy.

11.2.1.4.1.3.3. Contractor shall immediately report any unauthorized uses, disclosures, or breaches of Part 2 Data to Department.

11.2.1.4.1.3.4. Contractor may only redisclose Part 2 Data to a third party if the third party is a contract agent of Contractor, helping to perform its duties under the Contract, and the contract agent only discloses the information back to Contractor or to Department.

11.2.2. Contractor shall develop and implement processes to receive and process the following data feeds and to act on the information as expeditiously as possible to address Member needs and improve quality performance. Department Provided Data Feeds.

11.2.2.1. Contractor shall receive direct ADT data feeds from one of Colorado's regional health information exchanges.

11.2.2.2. Contractor shall receive and process the Nurse Advice Line data feed from the Nurse Advice Line contractor.

11.2.2.2.1. Contractor shall distribute information from the Nurse Advice Line to the appropriate Network Provider for follow-up by the Network Provider.

11.2.2.2.2. For Members who were referred to the ED by the Nurse Advice Line but who do not appear to have received follow up care, Contractor shall ensure that the Member's designated PCMP or Contractor outreaches the Member as timely as possible to assess whether the Member needs care or assistance accessing appropriate care.

11.2.2.3. Contractor shall receive the Inpatient Hospital Review Program data feed from Department.

11.2.2.4. Social Health Information Exchange (SHIE)

11.2.2.4.1. Contractor shall participate in and monitor activities for the state design and implementation of the SHIE, or Phase II of the Prescriber Tool, being developed in collaboration with the Office of eHealth Innovation.

11.2.2.4.2. Contractor shall adopt interoperable technologies as needed to effectively connect to the statewide SHIE for screening, referral, care coordination, and population health analytics.

11.2.2.4.3. As the SHIE tool is implemented and evolves, Contractor shall participate fully in SHIE through activities that may include:

11.2.2.4.3.1. Receiving referrals for care coordination and other services,

11.2.2.4.3.2. Sending referrals to community resources and other external partners,

11.2.2.4.3.3. Coordinating care within cross-organizational teams, and

11.2.2.4.3.4. Providing data and analytics to support regional population health analytics in collaboration with state agencies, local public health agencies, and other trusted partners.

11.2.2.5. As the following tools continue to be developed, Contractor may be required to receive and process data from the following:

11.2.2.5.1. AssureCare Care and Case Management Tool.

11.2.2.5.2. EConsult.

11.2.2.5.3. Prescriber Tool.

11.2.2.5.4. Cost and quality referral indicators.

11.3. RAE Maintained Systems

11.3.1. Contractor shall work with Department to ensure that the tools employed by Contractor to meet the obligations under this contract are sufficient, including receiving, reviewing and discussing the recommendations made by Department.

11.3.2. Contractor shall ensure that it meets all federal regulations regarding standards for privacy, security, electronic health care transaction and individually identifiable health information, the privacy regulations found at 42 C.F.R. Part 2, 45 C.F.R. § 160, 162 and 164, 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), and State of Colorado Cyber Security Policies. See Colorado Cyber Security Policies at http://oit.state.co.us/ois/policies.

11.3.3. Contractor shall control the use or disclosure of Protected Health Information (PHI) as required by the HIPAA Business Associate agreement or as required by law. No confidentiality requirements contained in this Contract shall negate or supersede the provisions of the HIPAA privacy requirements.

11.3.4. Contractor shall create a data governance policy that describes the circumstances when Contractor shall allow other entities, including providers and Community organizations, full access to Member level data, including how behavioral health data will be shared.

11.3.4.1. Contractor shall update the data governance policy annually and provide to Department upon request.

11.3.5. Care Coordination Tool

11.3.5.1. Contractor shall possess and maintain an electronic Care Coordination Tool to support communication and coordination among Members of the Provider Network and Health Neighborhood. Contractor shall make it available for use by providers and care coordinators not currently using another tool.

11.3.5.2. Contractor shall ensure that the Care Coordination Tool:

11.3.5.2.1. Works on mobile devices.

11.3.5.2.2. Supports HIPAA and 42 CFR Part 2 compliant data sharing.

11.3.5.2.3. Provides role-based access to providers and care coordinators.

11.3.5.3. Contractor shall ensure the Care Coordination Tool can collect and aggregate, at a minimum, the following information:

11.3.5.3.1. Name and Medicaid ID of Member for whom Care Coordination interventions were provided.

11.3.5.3.2. Age.

11.3.5.3.3. Gender identity.

11.3.5.3.4. Race/ethnicity.

11.3.5.3.5. Name of entity or entities providing Care Coordination, including the Member's choice of lead care coordinator if there are multiple coordinators.

11.3.5.3.6. Care Coordination notes, activities and Member needs.

11.3.5.3.7. Stratification level.

11.3.5.4. Contractor shall ensure that its Care Coordination Tool has the capacity to capture information that can aid in the creation and monitoring of a care plan for the

Member, such as clinical history, medications, social supports, Community resources, and Member goals.

11.3.5.5. Contractor shall collect and be able to report to Department the information from the Care Coordination Tool for its entire network. Although Network Providers and subcontracted Care Coordinators may use their own data collection tools, Contractor shall require them to collect and report on the same data.

11.3.5.6. Contractor shall work with Department to plan for how the Care Coordination Tool can exchange data with other Department tools such as the EDW and the LTSS Case Management system.

11.3.6. Claims Processing System for Capitated Behavioral Health Benefit

11.3.6.1. Contractor shall maintain a claims processing system to reimburse providers for Covered Services under the Capitated Behavioral Health Benefit and produce encounter claims.

11.3.6.2. Contractor shall ensure that its claims processing has the capability to process claims using the billing procedure codes specified in the State Behavioral Health Services Billing Manual. The State Behavioral Health Services Billing Manual can be found on Department's website.

11.3.6.3. Behavioral Health Encounter Data Reporting through the MMIS

11.3.6.3.1. Contractor shall submit all Encounter Data on all State Plan and 1915(b)(3) Waiver services included within the Capitated Behavioral Health Benefit electronically, following the Colorado Medical Assistance Program policy rules found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). Contractor shall ensure that the quality and timeliness of its Encounter Data meets the state's standards.

11.3.6.3.2. Contractor shall submit Encounter Data in the ANSI ASC X12N 837 format directly to Department's Fiscal Agent using Department's data transfer protocol. Contractor shall submit any 837 format encounter claims, reflecting paid, adjusted or denied by Contractor, via a regular monthly batch process. Contractor shall submit all encounter claims in accordance with the following:

11.3.6.3.2.1. Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

11.3.6.3.2.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

11.3.6.3.2.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

11.3.6.3.3. Contractor shall submit 95% of all Encounter Data within 30 days, and 100% within 120 days after the end of the month in which the claim was adjudicated. Contractor shall submit Encounter Data into the MMIS each month.

11.3.6.3.4. Contractor shall make an adjustment to encounter claims when Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed except as noted otherwise. If Department discovers errors or a conflict with a previously adjudicated encounter claim, Contractor shall adjust or void the encounter claim within 14 calendar days of notification by Department.

11.3.6.3.5. Contractor shall submit 95% of accurate Encounter Data no later than30 days, and 100% no later than 120 days following the month in which Contractor adjudicated a provider claim.

11.3.6.3.5.1. PERFORMANCE STANDARD: 95% of accurate Encounter Data no later than 30 days, and 100% no later than 120 days following the month in which Contractor adjudicated a provider claim.

11.3.6.3.6. Contractor shall submit all necessary Encounter Data, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR 438.242.

11.3.6.3.6.1. Contractor shall submit monthly data certifications for all Encounter Data used for rate setting, in compliance with 42 C.F.R. § 438.604 and 438.606. Contractor shall ensure that the data certification includes certification that data submitted is accurate, complete and truthful, and that all paid encounters are for Covered Services provided to or for enrolled Members.

11.3.6.3.6.1.1. DELIVERABLE: Certified Encounter Data submission

11.3.6.3.6.1.2. DUE: Monthly, on the last Business Day of the month

11.3.6.3.7. Contractor shall submit its raw Encounter Data, excluding data protected by 42 C.F.R. Part 2, to the Colorado All-Payer Claims Database (APCD) in accordance with the guidelines found in the most current version of the Center for Improving Value in Health Care: Colorado All-Payer Claims Database Data Submission Guide found at http://www.colorado.gov/hcpf.

11.3.6.3.8. Contractor shall comply with changes in Department data format requirements as necessary. Department reserves the right to change format requirements following consultation with Contractor, and retains the right to make the final decision regarding format submission requirements.

11.3.6.3.9. Contractor shall use enrollment reports to identify and confirm Membership and provide a definitive basis for payment adjustment and reconciliation. Contractor shall ensure that the data transmissions and enrollment reports shall include:

11.3.6.3.9.1. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction.

11.3.6.3.9.2. HIPAA X12N 834 Health Care Enrollment and Maintenance standard transaction.

11.3.6.3.9.3. HIPAA X12N 834 Daily Roster.

11.3.6.3.9.4. HIPAA X12N 834 Monthly Roster: Generated on the first Business Day of the month.

11.3.6.3.9.5. Colorado interChange Encounter Reconciliation Report.

11.3.7. Flat File Submission

11.3.7.1. Quarterly, Contractor shall electronically submit a flat file table that contains all encounters for that State Fiscal Year, with one record per encounter, which Contractor shall certify as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

11.3.7.1.1. Department shall provide Contractor with the specifications for the flat file submission.

11.3.7.1.2. Department shall conduct a quality review of the submission to determine if flat file meets the required specifications.

11.3.7.1.2.1. DELIVERABLE: Certified Quarterly Flat File

11.3.7.1.2.2. DUE: Quarterly, on the 21st day of the month following the close of a State Fiscal Quarter.

11.3.7.2. Contractor shall submit a flat file that contains 95% of paid claim lines within 30 days of the claim paid quarter.

11.3.7.3. Contractor shall submit a flat file that contains 100% of paid claim lines within 60 days of the claim paid quarter.

11.3.7.4. Contractor shall be responsible for the accuracy of flat file submissions.

11.3.7.5. Flat file accuracy is determined quarterly for completeness of data fields, and annually for completeness of inclusion of all claims.

11.3.8. Annual Submission

11.3.8.1. Contractor shall on an annual basis electronically submit a flat file and data certification certifying the flat file is as accurate, complete, and truthful based on Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer or Chief Financial Officer or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

11.3.8.1.1. Department will provide Contractor with the specifications for the annual flat file submission.

11.3.8.1.2. Department will conduct a quality review of the annual submission to determine if the flat file meets the required specifications.

11.3.8.1.2.1. DELIVERABLE: Certified Annual Flat File

11.3.8.1.2.2. DUE: Annually, by October 31

11.4. Interoperability Rule

11.4.1. Contractor shall implement and maintain a secure, standards-based application program interface (API) aligning with Department's implementation timeline. The API shall:

11.4.1.1. Be available through a public-facing digital endpoint on Contractor's website.

11.4.1.2. Include complete and accurate provider directory information.

11.4.1.2.1. The provider directory must meet the same technical standards as the patient access API, excluding the security protocols related to user authentication and authorization.

11.4.1.2.2. The provider directory information shall be updated no later than 30 calendar days after Department or Contractor receives the provider directory information or updates to provider directory information.

11.4.1.3. Comply with the requirements of 42 CFR § 438.242, 45 CFR § 170.215, as well as the provider directory information specified in § 438.10.

11.4.1.4. Provide current Members, or their personal representatives, with access to claims and Encounter Data within one Business Day of receipt, including:

11.4.1.4.1. Adjudicated claims, including data for payment decisions that may be appealed, were appealed, or in the process of appeal.

11.4.1.4.2. Provider remittances and beneficiary cost-sharing pertaining to adjudicated claims.

11.4.1.4.3. Services and Items Provided in Treatment

11.4.1.5. Clinical information within one Business Day of receipt, if collected and maintained by Contractor, including:

11.4.1.5.1. Diagnoses and Related Codes.

11.4.1.5.2. Medical Records and Reports.

11.4.1.5.3. Statements of Medical Necessity.

11.4.1.5.4. Laboratory Test Results.

11.4.1.6. Information about covered outpatient drugs within one Business Day after the effective date of any update, including:

11.4.1.6.1. Formulary of prescription drugs and costs to the Member.

11.4.1.6.2. Preferred drug list information.

11.4.2. Contractor shall comply with the requirements of 42 CFR § 438.62 by developing and maintaining a process for the electronic exchange of, at a minimum, the data classes and elements included in the United States Core Data for Interoperability (USCDI) content standard adopted at 45 CFR § 170.213.

11.4.3. Contractor shall incorporate the United States Core Data for Interoperability (USCDI) standards for data classes and elements received from other plans about the Member.

11.4.4. Contractor shall, upon request by a Member:

11.4.4.1. Incorporate into its records Member data with a date of service on or after January 1, 2016, from any other payer that has provided coverage to the Member within the preceding five years.

11.4.4.2. Send all such data to any other payer that currently covers the Member, or a payer that the Member specifically requests to receive the data classes and elements included in the USCDI content standards, any time during a Member's enrollment with Contractor and up to five years after disenrollment.

12. OUTCOMES, QUALITY ASSESSMENT, AND PERFORMANCE IMPROVEMENT PROGRAM

12.1. Overview and Guiding Principles

12.1.1. Contractor shall use data and analytics as part of its continuous quality improvement strategy for the full range of management, coordination and care activities, including, but not limited to, process improvement, population health management, federal compliance with federal regulations, claims processing, outcomes tracking and cost control.

12.1.1.1. Contractor shall analyze the key cost drivers within Contractor's region and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

12.1.1.2. Contractor shall report Contractor's findings to Department in a timely manner, this may be using an appropriate existing Deliverable, such as the Annual Provider support and practice transformation Strategic Plan; through an appropriate meeting with Department, such as the Quarterly Leadership Meeting; or through an ad hoc communication vehicle.

12.1.1.3. Contractor shall be responsible for monitoring utilization of low value services and analyzing cost categories that are growing faster than would normally be expected.

12.1.2. Contractor shall implement and maintain an ongoing comprehensive quality assessment and performance improvement program (Quality Improvement Program) that complies with 42 C.F.R. § 438.310-370.

12.1.3. Contractor shall take into consideration the federal definition of quality when designing its program. The Centers for Medicare and Medicaid Services (CMS) defines quality as the degree to which Contractor increases the likelihood of desired outcomes of its Members through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge and interventions for performance improvement.

12.1.4. Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for both the PCCM Entity and PIHP.

12.2. Quality Improvement Program

12.2.1. Contractor's Quality Improvement Program shall align with Department's Quality Strategy and include population health objectives as well as clinical measures of quality

care. Quality Improvement Program activities shall, at a minimum, consist of all of the following:

12.2.1.1. Performance improvement projects.

12.2.1.2. Collection and submission of performance measurement data, including Member experience of care.

12.2.1.3. Mechanisms to detect both underutilization and overutilization of services.

12.2.1.4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs as defined by Department.

12.2.1.5. Quality of care concerns.

12.2.1.6. External Quality Review.

12.2.1.7. Advisory committees and learning collaboratives.

12.2.2. Contractor shall develop and submit a Quality Improvement Plan to Department and/or its designee outlining how Contractor plans to implement its Quality Improvement Program. Contractor shall make reasonable changes to the Quality Improvement Plan at Department's direction.

12.2.2.1. DELIVERABLE: Quality Improvement Plan

12.2.2.2. DUE: July 1

12.2.3. Upon Department approval, Contractor shall implement the Quality Improvement Plan.

12.2.4. Contractor shall review and update the Quality Improvement Plan at least one time annually.

12.2.4.1. DELIVERABLE: Quality Improvement Plan Update

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

12.2.5. Contractor shall submit an Annual Quality Report to Department and/or designee, detailing the progress and effectiveness of each component of its Quality Improvement Program. Contractor shall include at minimum, all of the following in the report:

12.2.5.1. A description of the techniques Contractor used to improve its performance.

12.2.5.2. A description of the qualitative and quantitative impact the techniques had on quality.

12.2.5.3. The status and results of each Performance Improvement Project conducted during the year.

12.2.5.4. Lessons learned.

12.2.5.5. Opportunities for improvement.

12.2.5.6. Contractor shall submit the Annual Quality Report to Department.

12.2.5.6.1. DELIVERABLE: Annual Quality Report

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

12.2.5.7. Contractor shall publicly post its Annual Quality Report.

12.3. Performance Improvement Projects

12.3.1. Contractor shall conduct Performance Improvement Projects designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

12.3.2. Contractor shall complete Performance Improvement Projects on a multiyear cycle, including annual reporting, to facilitate the integration of project findings and information into the overall quality assessment and improvement program, and to produce new information on quality of care each year.

12.3.3. Contractor shall have a minimum of two Behavioral Health Performance Improvement Projects chosen in collaboration with Department that include at minimum, all of the following: one clinical project that may include physical health integration into behavioral health and one non-clinical project.

12.3.3.1. Contractor shall conduct Performance Improvement Projects on topics selected by Department or by CMS when Department is directed by CMS to focus on a particular topic.

12.3.4. Contractor shall have the capacity to conduct up to two additional Performance Improvement Projects upon request from CMS after year one of this Contract.

12.3.5. Contractor shall ensure that Performance Improvement Projects include the following:

12.3.5.1. Measurement of performance using objective quality indicators.

12.3.5.2. Implementation of system interventions to achieve improvement in quality.

12.3.5.3. Evaluation of the effectiveness of the interventions.

12.3.5.4. Planning and initiation of activities for increasing or sustaining improvement.

12.3.6. Contractor shall participate in a Performance Improvement Project learning collaborative at the end of each Performance Improvement Project cycle hosted by Department that includes sharing of data, outcomes, and interventions.

12.3.7. Contractor shall submit Performance Improvement Projects for validation by Department's External Quality Review Organization (EQRO) to determine compliance with requirements set forth in 42 C.F.R. § 438.350, and as outlined in External Quality Review Organization Protocol for Validating Performance Improvement Projects document. These requirements include:

12.3.7.1. Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction.

12.3.7.2. Mechanisms to detect both under-utilization and over-utilization of services.

12.3.7.3. Mechanisms designed to assess the quality and appropriateness of care furnished to Members with special health care needs.

12.3.7.4. Measurement of performance using objective valid and reliable quality indicators.

12.3.7.5. Implementation of system interventions to achieve improvement in quality.

12.3.7.6. Empirical evaluation of the effectiveness of the interventions.

12.3.8. Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report described in Section 12.2.5.

12.4. Performance Measurement

12.4.1. Contractor shall participate in the measurement and reporting of performance measures required by Department, with the expectation that this information will be placed in the public domain.

12.4.2. Contractor shall consult with Department to develop measurement criteria, reporting frequency and other performance measurement components. Department will determine the final measurement and pay for performance criteria.

12.4.3. Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

12.4.4. Contractor shall provide data, as requested, to enable Department or its designee to calculate the performance measures, unless the data is already in Department's possession.

12.4.5. Contractor shall support Network Providers and care coordinators to collect and report information required to calculate the performance measures.

12.4.6. Contractor shall track their performance on identified measures monthly through the PPQM and other data resources as appropriate.

12.4.7. Contractor shall have the opportunity to provide comments regarding any and all of Department's documented calculation methodologies for pay for performance measures three months prior to the start of the performance period.

12.4.8. Contractor shall track and report on additional performance measures when they are developed and required by CMS, the State or Department.

12.4.9. Contractor shall collect at the request of Department information from Network Providers necessary to supplement the calculation of CMS Adult and Child Core Measure sets.

12.4.10. Contractor shall have a strategy for supporting Network Providers in achieving the national average performance on the CMS Adult and Child Core Measure sets.

12.4.11. ACC Pay for Performance

12.4.11.1. Contractor shall participate in at minimum of three components of pay for performance.

12.4.11.1.1. Key Performance Indicators

12.4.11.1.1.1. Contractor shall be capable of working to improve performance for up to nine Key Performance Indicators (KPIs) in order to earn performance payments. KPIs will be established at Department's discretion to align with new statewide initiatives and through consultation with Department, RAEs, and stakeholders. KPIs may include:

12.4.11.1.1.1.1. Child and Adolescent Well-care Visits.

12.4.11.1.1.1.2. Childhood Immunization Status.

12.4.11.1.1.1.3. Screening for Depression and Follow-up.

12.4.11.1.1.1.4. Comprehensive Diabetes Care: HbA1c Poor Control.

12.4.11.1.1.1.5. Controlling High Blood Pressure.

12.4.11.1.1.1.6. Emergency Department Visits.

12.4.11.1.1.1.7. Timeliness of Prenatal Care.

12.4.11.1.1.1.8. Postpartum Care.

12.4.11.1.1.2. Detailed KPI specifications can be found in the data specifications document developed and maintained by Department. This specifications document may be updated at any time by Department in collaboration with Contractor.

12.4.11.1.2. Flexible Funding Pool

12.4.11.1.2.1. Contractor may be eligible to earn additional payments from the Flexible Funding Pool that will be created from any monies not distributed to the RAEs for KPI performance. The flexible funding pool may be used to reinforce and align evolving program goals and to focus Contractor attention on priority program outcomes.

12.4.11.1.2.2. Contractor may be eligible to receive payments from the flexible funding pool to:

12.4.11.1.2.2.1. Incentivize provider participation in new state or federal initiatives that align with the ACC and other initiatives to be determined by Department.

12.4.11.1.2.3. Department will design and update the flexible funding pool strategy, payment methodology, and distribution plan in consultation with the RAEs.

12.4.11.1.3. Behavioral Health Incentive Program

12.4.11.1.3.1. Subject to available funding, Contractor may be eligible to participate in a Behavioral Health Incentive Program.

12.4.11.1.3.2. The metrics for the Behavioral Health Incentive Program may include:

12.4.11.1.3.2.1. Follow-Up After Emergency Department Visit for SUD (7 days)

12.4.11.1.3.2.2. Follow-Up After Hospitalization for Mental Illness (7 days)

12.4.11.1.3.2.3. Initiation and Engagement of Substance Use Disorder Treatment

12.4.11.1.3.3. Detailed Behavioral Health Incentive Program measure specifications can be found in the data specifications document developed and maintained by Department. This specifications document may be updated at any time by Department in collaboration with Contractor.

12.4.12. Additional Performance Measurement

12.4.12.1. Commitment to Quality Program

12.4.12.1.1. Contractor shall strive to achieve all the Performance Standards agreed to in the Work. Contractor shall commit to excellence in achieving these Performance Standards by contributing funding to a holding account in the amounts detailed in this section when Contractor does not achieve an established Performance Standard.

12.4.12.1.1.1. Contractor and Department will agree on how the funding that is contributed to the holding account shall be distributed no later than six months following Department's acceptance of Contractor's state fiscal year quarter four Quarterly Financial Report. Contractor shall not distribute these funds to either Contractor, entities with ownership interest in Contractor, or Department. Funds shall only be used for intents enumerated in this Work, such as but not limited to, supporting the health neighborhood(s), improving Member health, improving access to care, or efforts to achieve KPI or Shared Savings goals. Funds shall not be used to enhance provider reimbursement beyond 100% of their contractual terms for timely payment.

12.4.12.1.1.2. Contractor financial contributions made for missing Performance Standard shall be made from Contractor's profit margin, as defined by the difference between total revenue earned through this Work and total expense for annual performance periods as reported through the quarterly financial review process and in alignment with Contractors annual financial forecasted expense allocations.

12.4.12.1.1.3. Contractor shall bear the responsibility of proving that reimbursements are deducted from Contractor's profit margin during the quarterly financial review meetings with Department.

12.4.12.1.1.4. Contractor shall not pass on the cost of these contributions to the Commitment to Quality Program to Network Providers or Subcontractors that support the Work. Contractor shall not absorb the cost of this reimbursement by reducing staff or resources dedicated to the Work.

12.4.12.1.2. Funding the Commitment to Quality Program

12.4.12.1.2.1. Contractor shall contribute the following amount of funding to the Commitment to Quality Program holding account following a determination by Department of the number and percent of the Performance Standards Contractor achieved during the previous state fiscal year:

12.4.12.1.2.1.1. 0% of Contractor's profit margin if they meet 90% or more of the Performance Standards.

12.4.12.1.2.1.2. 5% of Contractor's profit margin if they meet 85-89% of the Performance Standards.

12.4.12.1.2.1.3. 15% of Contractor's profit margin if they meet 80-84% of the Performance Standards.

12.4.12.1.2.1.4. 25% of Contractor's profit margin if they meet less than 80% of the Performance Standards.

12.4.12.2. Public Reporting

12.4.12.2.1. Contractor shall improve network performance on core performance measures that will be reported publicly at least one time annually. The Public Reporting measures will be divided in the following way:

12.4.12.2.1.1. Key Performance Indicators

12.4.12.2.1.2. Retired KPIs

12.4.12.2.1.3. Behavioral Health Incentive Program measures

12.4.12.2.1.4. CMS Adult and Child Core Measure sets

12.4.12.2.1.5. Clinical and Utilization Measures as relevant, including HEDIS measures that align with other state and federal initiatives.

12.4.12.2.1.6. BHA established performance metrics

12.4.12.2.1.7. Member experience of care as described in Section 12.5.

12.4.12.2.1.8. Utilization management and operational information, including authorizations and denials of services.

12.4.12.2.1.9. Contractor shall not be eligible to earn payments for performance on the Public Reporting measures unless, Department, at its discretion, allows Contractor to earn performance payments on one or more of the Public Reporting measures.

12.4.12.2.1.10. Contractor may, at its discretion, use any of the Public Reporting measures to establish a pay for performance program for Network Providers.

12.4.12.3. Health Equity and Performance Improvement

12.4.12.3.1. Contractor shall disaggregate their performance and utilization data at least by race and ethnicity, language, and disability status in strategic priority areas and make this information available to Department and stakeholders upon request.

12.4.12.3.2. Contractor shall collaborate with Department and stakeholders in the development of health equity measures, which may require the addition of new measures or the adjustment of existing measures.

12.4.12.3.3. Over the performance period for any or all performance measures, Contractor shall collaborate with Department to understand performance results, collect high quality data for measurement, and develop and implement interventions to improve performance results to the benefit of Members and providers.

12.5. Member Experience of Care

12.5.1. Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by Contractor and Network Providers.

12.5.2. Contractor shall use tools to measure Member perception and those tools shall include, at a minimum, the use of Member surveys, anecdotal information, call center data, and Grievance and Appeals data.

12.5.3. Contractor shall assist Department or contractor with the annual administration of the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) and any subsequent survey tool required by CMS for both adults and children.

12.5.3.1. Contractor shall work with Department to customize the CAHPS survey and to develop a sampling methodology.

12.5.3.2. Contractor shall develop strategies with Department to increase Member participation in the health plan CAHPS survey.

12.5.4. Contractor shall support the BHA in administering any surveys among Members accessing behavioral health services at Safety Net Providers and other contracted Behavioral Health Providers.

12.5.5. Contractor shall use the results and data from CAHPS, surveys for Behavioral Health, and all other surveys conducted by Contractor to inform Contractor's Quality Improvement Plan.

12.5.6. Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

12.5.6.1. Contractor shall monitor interventions and report on them at least one time annually in the Member Experience of Care Strategy and Report.

12.5.6.2. Contractor shall develop a corrective action plan for a Network Provider when a pattern of complaint is detected, when trends in decreasing Member satisfaction are detected, or when a serious complaint is reported.

12.5.7. Contractor shall design and document a Member Experience of Care Strategy and Report that shall include, but is not limited to, the following information:

12.5.7.1. Strategy to survey Members at least once per quarter for all Members who accessed services during a recent period of time as defined by Contractor.

12.5.7.2. Strategy to survey Members at least two times per year for all Members who gained Medicaid eligibility during the previous 12 months.

12.5.7.3. Process to analyze Contractor's call center information and Grievances and Appeals data to better understand Members' experience.

12.5.7.4. Process to assist Department and BHA with survey implementation.

12.5.7.5. Analysis of findings regarding Member experience from the previous year and modifications Contractor has made to its operations in response to these findings.

12.5.7.6. Contractor's interventions and any corrective action plans with specific network providers based on Member experience findings.

12.5.7.7. Lessons learned from Contractor's activities to collect information about Member experience.

12.5.7.7.1. DELIVERABLE: Member Experience of Care Strategy and Report

12.5.7.7.2. DUE: Annually, by the last Business Day in August.

12.6. Mechanisms to Detect Overutilization and Underutilization of Services

12.6.1. Contractor shall implement and maintain mechanisms to detect overutilization and underutilization of services, and to assess the quality and appropriateness of care furnished to Members, including Members with special health care needs. Contractor may incorporate mechanisms developed for Contractor's Utilization Management program.

12.6.2. Client Over-Utilization Program (COUP)

12.6.2.1. Contractor shall partner with Department in administering the COUP for Members who meet the criteria for inappropriate over-utilization of health care services.

12.6.2.2. Quarterly, Department will give Contractor a list of all the Members who have met Department's overutilization criteria and were notified in writing of their overutilization.

12.6.2.2.1. When appropriate, Contractor may identify other Members for inclusion in COUP.

12.6.2.3. Contractor shall outreach and intervene with Members identified as meeting overutilization criteria in accordance with the Care Coordination requirements in Section 7 in order to link the Members to appropriate and available services.

12.6.2.4. Contractor shall monitor Members' utilization of services and pharmaceuticals and coordinate ongoing care.

12.6.2.5. For Members who remain on the overutilization list after a period of intervention, Contractor shall perform a clinical review to determine the appropriateness of restricting the Member to either one medical provider and/or one pharmacy (lock in).

12.6.2.5.1. Contractor shall appear as an expert witness in a State Fair Hearing for a Member who has appealed lock-in status.

12.6.2.6. Contractor shall recruit providers to serve as lock-in providers.

12.6.2.6.1. Contractor shall educate providers on what it means to be a lock-in provider, as well as provide informational materials.

12.6.2.6.2. Contractor shall provide technical assistance to providers who will serve as primary lock-in providers.

12.6.2.6.3. Contractor shall submit a quarterly COUP referral list to Department for Members who are determined to be appropriate for lock-in.

12.6.2.6.4. DELIVERABLE: COUP Lock-in Referral Report.

12.6.2.6.5. DUE: On the tenth calendar day of the second month of each quarter.

12.7. External Quality Review

12.7.1. Annually, Contractor shall participate in an external independent Site Review and performance measure validation in order to review compliance with Department standards and Contract requirements. External quality review activities shall be conducted in accordance with federal regulations 42 C.F.R. § 438 and the CMS mandatory activity protocols.

12.7.2. Contractor shall participate in an external quality review that includes a review of the:

12.7.2.1. Contractor’s activities in its role as a PCCM Entity

12.7.2.2. Contractor's activities in its role as a PIHP for the Capitated Behavioral Health Benefit.

12.7.2.3. Contractor’s administration of the Contract as an integrated program.

12.7.3. Contractor shall participate in an annual external review that may include, but is not limited to, the following:

12.7.3.1. Medical Record review. For external review activities involving Medical Record abstraction, Contractor shall obtain copies of the Medical Records from the sites in which the services reflected in the encounter occurred at no cost to Department or its vendors.

12.7.3.2. Performance improvement projects and studies.

12.7.3.3. Surveys.

12.7.3.4. Network adequacy during the preceding 12 months.

12.7.3.5. Calculation and audit of quality and utilization indicators.

12.7.3.6. Administrative data analyses.

12.7.3.7. Review of individual cases.

12.7.3.8. Care Coordination record review.

12.7.3.9. Provider site visits.

12.7.3.10. Encounter Data validation.

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

12.8. Advisory Committees and Learning Collaboratives

12.8.1. To ensure the Program is effectively serving Members and providers, Contractor shall participate in multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the Program overall and guiding the improvement of program performance.

12.8.2. Statewide Program Improvement Advisory Committees (PIAC)

12.8.2.1. Contractor shall participate in a statewide PIAC to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Members and providers in the Program. For the statewide PIAC, Contractor shall:

12.8.2.1.1. Designate one of Contractor’s Key Personnel to attend monthly meetings.

12.8.2.1.2. Nominate one representative from one of Contractor’s regional PIACs or MACs to serve as a member of the statewide PIAC and ensure they consistently attend and participate in monthly meetings. The representative cannot be employed by Contractor.

12.8.3. Regional Program Improvement Advisory Committee (PIAC)

12.8.3.1. Contractor shall create at least two Regional PIACs within Contractor's region to engage stakeholders and solicit guidance regarding the different needs and characteristics of the areas served.

12.8.3.2. Contractor shall ensure that the PIACs include, at a minimum, all of the following stakeholder representatives:

12.8.3.2.1. Members.

12.8.3.2.2. Members' families and/or caregivers.

12.8.3.2.3. PCMPs.

12.8.3.2.4. Behavioral health providers.

12.8.3.2.5. Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

12.8.3.2.6. Other individuals who can represent advocacy and Community organizations, local public health, and child welfare interests.

12.8.3.3. Contractor's Regional PIAC shall have the following responsibilities:

12.8.3.3.1. Review Contractor's deliverables.

12.8.3.3.2. Discuss program policy changes and provide feedback.

12.8.3.3.3. Provide representatives for the statewide PIAC.

12.8.3.3.4. Review Contractor's and Program's performance data.

12.8.3.3.5. Review Member materials and provide feedback.

12.8.3.4. Contractor shall ensure that its Regional PIACs:

12.8.3.4.1. Be directed and chaired by one of Contractor's Key Personnel as approved by Department.

12.8.3.4.2. Have a formal, documented Membership and governance structure that is posted on Contractor's website for public viewing.

12.8.3.4.3. Have a formal budget for the operations of the Regional PIAC.

12.8.3.4.4. Conduct regular meetings, no less than quarterly, in a format that encourages the active participation of Members and their family or caregivers and best meets the needs of Contractor's region.

12.8.3.4.4.1. Contractor shall ensure these meetings create an environment in which Members and their family or caregivers feel safe providing feedback.

12.8.3.4.5. Open all scheduled meetings to the public.

12.8.3.4.6. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

12.8.3.4.7. Accommodate individuals with disabilities.

12.8.4. Member Advisory Committee (MAC)

12.8.4.1. Contractor shall create at least two regional Member Advisory Committees (MACs) within Contractor's region to engage stakeholders and solicit guidance regarding the different needs and characteristics of the areas served.

12.8.4.2. Contractor's MACs shall have the following responsibilities:

12.8.4.2.1. Discuss the Member experience of Contractor's activities and the delivery of Medicaid services within Contractor's region.

12.8.4.2.2. Discuss Contractor's and its Network Providers activities to advance culturally competent, accessible care within Contractor's region.

12.8.4.2.3. Discuss Contractor's policy changes and provide feedback.

12.8.4.2.4. Provide representatives for the statewide PIAC.

12.8.4.2.5. Review Contractor's and Program's performance data.

12.8.4.2.6. Review Member materials and provide feedback.

12.8.4.3. Contractor shall ensure that its Regional MACs:

12.8.4.3.1. Be directed and chaired by someone experienced in EDIA and Member engagement.

12.8.4.3.2. Have a formal budget for the operations of the Regional MAC.

12.8.4.3.3. Hold regular meetings, no less than quarterly, in a manner that supports the active participation of Members and their family or caregivers and best meets the needs of Contractor's region.

12.8.4.3.4. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

12.8.4.3.5. Accommodate individuals with disabilities.

12.8.5. Regional Health Equity Committee

12.8.5.1. Contractor shall establish a Regional Health Equity Committee that shall discuss issues of equity and health disparities within Contractor's region.

12.8.5.2. Contractor shall ensure that the Regional Health Equity Committee includes, at a minimum, the following stakeholder representatives:

12.8.5.2.1. Members, including Members with disabilities.

12.8.5.2.2. PCMPs.

12.8.5.2.3. Behavioral health providers.

12.8.5.2.4. Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

12.8.5.2.5. Advocacy organizations.

12.8.5.2.6. Community organizations, including local public health and child welfare agencies.

12.8.5.3. Contractor shall strive to ensure the Membership of the Regional Health Equity Committee appropriately represents the demographic breadth of the region, with a focus on recruiting BIPOC, disabled, and other focus populations identified in Contractor's Health Equity Plan.

12.8.5.4. Contractor's Regional Health Equity Committee shall have the following responsibilities:

12.8.5.4.1. Discuss EDIA challenges within Contractor's region and provide recommendations for addressing health disparities.

12.8.5.4.2. Inform the design of Contractor's Health Equity Plan and provide oversight of the plan's implementation.

12.8.5.4.3. Provide feedback on Contractor's and its Network Providers activities to advance EDIA within Contractor's region, particularly regarding Member engagement activities.

12.8.5.4.4. Review Contractor's and Program's EDIA performance data.

12.8.5.5. Contractor shall ensure that its Regional Health Equity Committee:

12.8.5.5.1. Be directed and chaired by Contractor's EDIA Officer.

12.8.5.5.2. Have a formal budget for the operations of the Regional Health Equity Committee.

12.8.5.5.3. Hold regular meetings, no less than two times annually, in a manner that supports the active participation of Members and individuals of different cultures, ethnicities, language preferences, and abilities.

12.8.5.5.4. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

12.8.5.5.5. Accommodate individuals who speak a primary language other than English.

12.8.5.5.6. Accommodate individuals with disabilities.

12.8.6. Quality Improvement Committee

12.8.6.1. Contractor shall have its Quality Improvement Director participate in Department's Quality Improvement Committee to provide input and feedback regarding quality improvement priorities, performance improvement topics, measurements and specifics of reporting formats and timeframes, and other collaborative projects.

12.8.7. ACC Operations Meeting

12.8.7.1. Contractor shall have its Regional Contract Manager and other relevant staff Members participate with Department staff and other Regional Accountable Entity staff in Department's ACC Operations meetings held at least one time per month. The Operations Meeting provides an opportunity for Contractor to learn about programs and policies impacting the ACC and Contractors, as well as to provide input and feedback regarding Department policies and the operations of the ACC.

12.8.8. Operational Learning Collaborative.

12.8.8.1. Contractor shall participate in Department Operational Learning Collaborative meetings to monitor and report on Contractor and ACC activities including, but not limited to, the following.

12.8.8.1.1. Wellness activities.

12.8.8.1.2. Provider payment models.

12.8.8.1.3. Health Promotion and Population Stratification and Management.

12.8.8.1.4. Member engagement.

12.8.8.1.5. EDIA activities.

12.8.8.1.6. Health Neighborhood and Community development.

12.8.8.1.7. Provider support and practice transformation.

12.8.8.1.8. Data analytics.

12.8.8.1.9. Care Coordination, including cross-agency, cross-system activities.

12.8.8.1.10. Health information initiatives and technologies.

12.8.8.1.11. Strategies used to address social determinants of health.

12.8.8.1.12. Transitions of Care, including hospital discharge and LTSS Members transitioning to the community.

12.8.8.2. Contractor shall share best practices and lessons learned with other Regional Accountable Entities while gaining insights from them to improve implementation of the ACC.

12.8.8.3. Contractor shall participate in annual and ad hoc learning collaboratives to monitor specific program activities and share lessons learned.

12.8.9. Cost Collaborative

12.8.9.1. Contractor shall actively participate in a Department-led Cost Collaborative to identify and control unnecessary and/or avoidable costs within the Medicaid Program. One critical objective of this collaborative is to align incentives and focus across the health continuum from value-based payment strategies to quality performance objectives and care coordination risk stratification hierarchy.

12.8.9.2. Contractor shall receive, process, and analyze Statewide data and shall work collaboratively with Department to identify trends and potentially avoidable costs.

12.8.9.3. Contractor shall work with Department to identify and review:

12.8.9.3.1. Cost outliers.

12.8.9.3.2. Programs not meeting engagement or savings targets.

12.8.9.3.3. System challenges impacting performance.

12.8.9.3.4. Gaps in data and information.

12.8.9.3.5. Standardized cost dashboards.

12.8.9.4. To support the Cost Collaborative, Contractor shall:

12.8.9.4.1. Assist in improving the flow of necessary data and information between Contractor, their Network Providers and Department.

12.8.9.4.2. Identify early areas of opportunity for cost management.

12.8.9.4.3. Share ideas regarding best and promising practices and the return on investment.

12.8.10. Behavioral Health Operations Meeting

12.8.10.1. Contractor shall host a quarterly meeting with representatives from Department to review Contractor's performance administering the Capitated Behavioral Health Benefit.

12.8.10.2. Contractor shall, at a minimum, review the following information:

12.8.10.2.1. Behavioral health network access.

12.8.10.2.2. Claims processing performance.

12.8.10.2.3. Utilization management performance.

12.8.10.2.4. Responsiveness to Provider complaints and Member Grievances.

12.8.10.2.5. Utilization trends.

12.8.10.2.6. Waitlists for any behavioral health services.

12.8.10.2.7. Hospital transition performance.

12.8.10.2.8. Performance managing children with high acuity needs.

12.8.10.2.9. Performance as it relates to any approved 1115 Demonstration waiver regarding behavioral health services.

12.8.10.2.10. Quality performance.

12.8.10.2.11. Activities to promote and support integrated behavioral health.

12.8.10.2.12. Other topics requested by Department.

12.8.10.3. Contractor shall produce and submit relevant data reports to Department two weeks prior to each quarterly meeting.

12.8.10.3.1. DELIVERABLE: Capitated Behavioral Health Benefit Report

12.8.10.3.2. DUE: No less than two weeks prior to each quarterly meeting the report covers

12.8.11. Program and Data (PAD) Meeting

12.8.11.1. Contractor shall actively participate in Department-led Program and Data Meetings to analyze Contractor's performance on quality metrics and other Department-identified priorities that may include outcomes of collaboration with CMAs and progress on outcome goals related to care coordination.

12.8.11.2. Contractor shall staff PAD meetings with data analytic and program staff educated in the topic being explored for each meeting, this could include care coordination staff, practice transformation coaches, and other experts employed by Contractor.

12.8.11.3. Contractor shall conduct analyses in advance of each meeting and share Contractor's findings which shall include, but not be limited to:

12.8.11.3.1. Performance trends.

12.8.11.3.2. Data gaps.

12.8.11.3.3. Promising practices and lessons learned.

12.8.11.3.4. Areas of opportunity.

12.8.11.3.5. Recommendations for how Department can better support Contractor around the specific topic.

12.8.11.4. Contractor shall provide input and feedback regarding quality improvement priorities and measurements.

12.8.12. RAE Quarterly Leadership Meeting

12.8.12.1. Contractor shall host a quarterly meeting with Department leadership (to include the Executive Director) to review the following:

12.8.12.1.1. Performance reports that summarize Contractor performance, including:

12.8.12.1.1.1. Care Coordination.

12.8.12.1.1.2. Administration of the Capitated Behavioral Health Benefit.

12.8.12.1.1.3. Population Health Management Report.

12.8.12.1.1.4. Network Adequacy Report.

12.8.12.1.1.5. Grievances and Appeals.

12.8.12.1.1.6. Member Engagement.

12.8.12.1.1.7. Administrative Payment Arrangements.

12.8.12.1.1.8. Client Over-Utilization Program.

12.8.12.1.2. Areas of opportunity and challenge to be addressed for Contractor to improve performance, including barriers to properly address those opportunities and challenges.

12.8.12.1.3. Provider areas of opportunity and where Department can be of assistance.

12.9. Ad Hoc Quality Reports

12.9.1. Contractor shall provide to Department or its agents any information or data relative to the Contract. In such instances, and at the direction of Department, Contractor shall fully cooperate with such requests and furnish all data or information in a timely manner, in the format in which it is requested.

12.9.1.1. Contractor shall have at least 30 calendar days, or a timeframe mutually agreed upon between Department and Contractor, to fulfill such requests.

12.9.1.2. Contractor shall certify that data and information it submits to Department is accurate.

13. COMPLIANCE AND PROGRAM INTEGRITY

13.1. Program Integrity Compliance Program Requirements

13.1.1. Contractor shall have a program in place for ensuring compliance with the ACC Program rules, Contract requirements, state and federal regulations and confidentiality regulations, and a program to detect Fraud, Waste and Program Abuse. Contractor shall ensure that all aspects of the system are focused on providing high-quality services that are of Medical Necessity in accordance with Contract requirements.

13.1.2. Contractor shall comply with all applicable CMS regulations in 42 C.F.R. § 438.

13.1.3. Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by Contractor for coverage of services and payment of claims, shall have a compliance program to implement and maintain arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Program Abuse.

13.1.4. The compliance program shall be approved by Contractor's Chief Program Officer and Compliance Officer.

13.1.5. Contractor shall ensure that the compliance program, at a minimum includes:

13.1.5.1. Written policies and procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements and standards and all applicable federal and state requirements.

13.1.5.2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

13.1.5.3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing Contractor's compliance program and its compliance with the requirements under the Contract.

13.1.5.4. A system for training and education for the Compliance Officer, Contractor's Key Personnel, and Contractor's employees for the federal and state standards and requirements under the Contract.

Contractor shall ensure that this training is conducted in a manner that allows Department to verify that the training has occurred.

13.1.5.5. Effective lines of communication between the Compliance Officer and Contractor's employees.

13.1.5.6. Enforcement of standards through well publicized disciplinary guidelines.

13.1.5.7. Establishment and implementation of procedures and a program integrity infrastructure that includes, at least:

13.1.5.7.1. Adequate systems and staff for routine internal monitoring and auditing of compliance risks.

13.1.5.7.2. Prompt response to compliance issues as they are raised.

13.1.5.7.3. Investigation of potential compliance problems as identified in the course of self-evaluation and audits.

13.1.5.7.4. Correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract. Contractor shall ensure that the system includes the following Processes:

13.1.5.7.4.1. Monitoring Members for improper prescriptions for controlled substances, inappropriate emergency care or card-sharing.

13.1.5.7.4.2. Screening all provider claims processed or paid by Contractor collectively and individually, for Suspected Fraud, Waste or Program Abuse.

13.1.5.7.4.3. Identifying Overpayments to providers, including but not limited to, instances of up-coding, unbundling of services, services that were billed for but never rendered, inflated bills for services and goods provided or any other improper payment.

13.1.5.7.4.4. Recovering Overpayments to providers.

13.1.5.7.4.5. Identifying and promptly report to Department instances of Suspected Fraud, Waste and Program Abuse.

13.1.5.7.4.6. Member verification of services. Specifically, to provide individual notices to all or a statistically significant sample of Members who received services to verify and report whether services billed by providers were actually received by Members.

13.1.5.8. Contractor shall have a process for Network Providers to report and return Overpayments to Contractor, including, at least:

13.1.5.8.1. Requirements for Network Providers to report to Contractor when they have received an Overpayment.

13.1.5.8.2. To return the Overpayment to Contractor.

13.1.5.8.3. To notify Contractor in writing of the reason for the Overpayment within 60 calendar days after the date on which the Overpayment was identified.

13.1.5.9. Contractor shall supply Department the information submitted by a Network Provider related to an identified Overpayment within 30 calendar days of receiving the same information.

13.1.5.10. Contractor, if it makes or receives annual payments under the Contract of at least $5,000,000.00, shall have written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

13.1.5.11. Contractor shall comply with Department policies related to recoveries of Overpayments.

13.1.5.11.1. Contractor shall not retroactively recover provider payments if:

13.1.5.11.1.1. A recipient was initially determined to be eligible for medical benefits pursuant to section 25.5-4-205 when the provider has an eligibility guarantee number for the recipient, or:

13.1.5.11.1.2. Contractor makes an error processing the claim, but the claim is otherwise accurately submitted by the provider.

13.1.5.11.2. Contractor shall not retroactively recover provider payments after 12 months from the date a claim was paid, except in the following instances:

13.1.5.11.2.1. Medicare, Commercial insurance, or third-party liability is the primary payer for a claim.

13.1.5.11.2.2. The claim is the subject of a state or federal audit, including audits contractually required by Department.

13.1.5.11.2.3. The claim is subject to a law enforcement investigation.

13.1.5.11.2.4. The claim submitted was a duplicate.

13.1.5.11.2.5. The claim is fraudulent.

13.1.5.11.2.6. The provider improperly billed the claim.

13.1.5.11.2.7. The claim was submitted with a billing code or diagnosis code that inaccurately or incorrectly resulted in reimbursement or bypassed prior authorization requirements.

13.1.5.11.3. If Contractor retroactively recovers a provider payment that is equal to $1000 or more, Contractor shall work with the provider to develop a payment plan if the provider requests a payment plan.

13.1.6. Contractor shall have a process for the prompt referral to Department and the State Medicaid Fraud Control Unit (MFCU) of all cases where the agency or entity has actual and reasonable cause to believe that there is Suspected Medicaid Fraud and Waste, Program Abuse and Patient Abuse, neglect, and exploitation, and false representation. The process shall be aligned with applicable requirements set forth in Statement of Work.

13.1.6.1. Neglect is the willful failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness, including any neglect that constitutes a criminal violation under state law.

13.1.6.2. Exploitation includes any wrongful taking or use of funds or property of a patient residing in a health care facility or board and care facility that constitutes a criminal violation under state law.

13.1.6.3. False representation is any inaccurate statement that is relevant to a claim for reimbursement and is made by a provider or Member who has actual knowledge of the truth or false nature of the statement, or by a provider or Member who has actual knowledge of the truth or false nature of the statement, or by a provider or Member acting in deliberate ignorance of or with reckless disregard for the truth of the statement.

13.1.6.3.1. DELIVERABLE: Compliance Program documents and information

13.1.6.3.2. DUE: Annually, by July 31

13.1.6.3.3. Contractor shall modify the Compliance Program as requested by Department within ten Business Days following the receipt of Department's requested changes.

13.1.6.3.3.1. DELIVERABLE: Compliance Program revisions and changes

13.1.6.3.3.2. DUE: Within ten Business Days following Department's request

13.2. Compliance Plan Requirements

13.2.1. Contractor shall have a documented Compliance Plan that implements all elements of the Compliance Program.

13.2.2. Contractor shall ensure adequate and dedicated staffing and resources needed in order to successfully implement the Compliance Plan and routinely monitor providers and Members to detect and prevent aberrant billing practices, potential Fraud, Waste, and Program Abuse, and promptly address potential compliance issues and problems.

13.2.3. Contractor shall ensure the Compliance Plan, at minimum, includes:

13.2.3.1. A risk assessment of Contractor's various Fraud, Waste, and Program Abuse, and program integrity processes.

13.2.3.2. An outline of activities proposed for the next reporting year regarding, at least:

13.2.3.2.1. Compliance and audit activities, including, but not limited to:

13.2.3.2.1.1. Conducting prospective, concurrent, and/or post-payment reviews of claims, including, but not limited to:

13.2.3.2.1.1.1. Medical records reviews.

13.2.3.2.1.1.2. Data mining.

13.2.3.2.1.1.3. Desk audits.

13.2.3.2.1.2. Verifying provider adherence to professional licensing and certification requirements.

13.2.3.2.1.3. Verifying provider records and other documentation to ensure services billed by providers were actually rendered.

13.2.3.2.1.4. Reviewing goods provided and services rendered for Fraud, Waste and Program Abuse.

13.2.3.2.1.5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).

13.2.3.2.2. Contractor shall not include activities related to administrative billing issues, such as financial statement audits.

13.2.3.2.3. Education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud, Waste, and Program Abuse to ensure that all of its officers, directors, managers, and employees know and understand the provisions of Contractor's Compliance Program and Compliance Plan.

13.2.3.2.4. Provider education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud, Waste, and Program Abuse and on identifying and educating targeted providers with patterns of incorrect billing practices and/or Overpayments.

13.2.3.2.5. Cost avoidance measures taken to avoid improper payments from being made.

13.2.3.2.6. Descriptions of specific controls in place for prevention and detection of Overpayments and potential or Suspected Fraud, Waste, and Program Abuse, including but not limited to:

13.2.3.2.6.1. Automated pre-payment claims edits.

13.2.3.2.6.2. Automated post-payment claims edits.

13.2.3.2.6.3. Desk audits on post-payment review of claims.

13.2.3.3. Work plans for the next year regarding conducting both announced and unannounced site visits and field audits to providers defined as high-risk (e.g., providers with cycle/auto billing activities, providers offering DME, home health, mental health, and transportation services) to ensure services are rendered and billed correctly.

13.2.4. Contractor shall submit its Compliance Plan to Department for review and approval. Contractor shall only submit finalized Compliance Plans to Department for review and approval.

13.2.4.1. DELIVERABLE: Compliance Plan

13.2.4.2. DUE: July 31, 2025

13.2.5. Contractor shall review its Compliance Plan and make any necessary revisions for the following reporting year. Contractor shall submit revised Compliance Plans to Department for review and approval.

13.2.5.1. DELIVERABLE: Compliance Plan documents and information

13.2.5.2. DUE: Annually, by July 31, starting in the second Contract year

13.2.6. Contractor shall modify the Compliance Plan as requested by Department within ten Business Days following the receipt of Department's requested changes.

13.2.6.1. DELIVERABLE: Compliance Plan revisions and changes

13.2.6.2. DUE: Ten Business Days following Department's request

13.3. Reports and Disclosures

13.3.1. Contractor shall follow all requirements in this Statement of Work Section 13.3 to notify Department of all work, activities, and events occurring under the requirements of Statement of Work Section 13.1.

13.3.1.1. Reports Requiring Monthly Notification

13.3.1.1.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a one-month period.

13.3.1.1.2. Contractor shall report, at minimum:

13.3.1.1.2.1. All identified or recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including whether the Overpayment was related to an audit or Fraud case, and dates when overpayments were recovered or a self-disclosure.

13.3.1.1.2.2. All suspended claim reimbursements and payments to a provider, including information on whether the suspension is related to an audit or Fraud case, including the dates of when reimbursements and payments were suspended.

13.3.1.1.2.3. All provider circumstance changes where a provider is no longer in Contractor's network, but was not removed for cause, including providing information on why the provider was withdrawn.

13.3.1.1.2.4. Any provider terminations not based on quality or performance or for cause, including, but not limited to:

13.3.1.1.2.4.1. A change in ownership or control of a provider.

13.3.1.1.2.4.2. A provider voluntarily withdrawing from the MCE's network.

13.3.1.1.2.4.3. The death of a provider.

13.3.1.1.2.4.4. Contractor shall provide the following:

13.3.1.1.2.4.4.1. Date of removal.

13.3.1.1.2.4.4.2. Reason for the termination.

13.3.1.1.2.4.4.3. Numbers of Members served by the provider.

13.3.1.1.2.4.4.4. Plan to ensure that Members receive continuous services.

13.3.1.1.2.4.5. Any other information as specified by Department.

13.3.1.1.3. Contractor shall use the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

13.3.1.1.3.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report

13.3.1.1.3.2. DUE: Within ten Business Days after the end of each month

13.3.1.1.4. Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by Department within 10 Business Days following the receipt of Department's requested changes.

13.3.1.1.4.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

13.3.1.1.4.2. DUE: Within ten Business Days following Department's request

13.3.1.2. Reports Requiring Semi-Annual Notification

13.3.1.2.1. Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a six-month period.

13.3.1.2.2. The six-month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

13.3.1.2.3. Contractor shall use the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

13.3.1.2.4. Contractor shall report, at minimum:

13.3.1.2.4.1. A narrative outlining the compliance activities listed below and an explanation for any audits that were mentioned in the previous compliance plan that were not completed or any audits that were added after the compliance plan submission.

13.3.1.2.4.2. All audits or reviews which have been started, are on-going or completed as part of the Compliance Program and Compliance Plan, including, at least:

13.3.1.2.4.2.1. Issue(s) being reviewed or audited.

13.3.1.2.4.2.2. The status of the review or audit.

13.3.1.2.4.2.3. The start and end dates of services covered by the review or audit.

13.3.1.2.4.2.4. The start and end dates of the review or audit.

13.3.1.2.4.3. All instances of Suspected Fraud, Waste and Program Abuse, discovered and reported to Department and the MFCU, including:

13.3.1.2.4.3.1. The suspected issue.

13.3.1.2.4.3.2. The start and end dates of the services suspected to involve Fraud.

13.3.1.2.4.3.3. The approximate amount of the claims affected and the date of report to Department and the MFCU.

13.3.1.2.4.4. All verification conducted of Member services, including:

13.3.1.2.4.4.1. The number of notices sent to Members to verify and report whether services billed by providers were actually received by Members.

13.3.1.2.4.4.2. The number of responses received, number of responses warranting further action.

13.3.1.2.4.5. All identified or recovered Overpayments resulting from all work, activities, and events as part of the Compliance Program and Compliance Plan, including:

13.3.1.2.4.5.1. Whether the Overpayment was related to an audit or Fraud case.

13.3.1.2.4.5.2. Dates of when Overpayments were identified.

13.3.1.2.4.5.3. Dates when Overpayments were recovered.

13.3.1.2.4.5.4. Any other information as specified by Department.

13.3.1.2.5. Contractor shall not include activities related to administrative billing issues, such as reviews of financial statements or credit balances.

13.3.1.2.5.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Report

13.3.1.2.5.2. DUE: Within 45 days of the end of the six-month reporting period

13.3.1.2.6. Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by Department within 10 Business Days following the receipt of Department's requested changes.

13.3.1.2.6.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

13.3.1.2.6.2. DUE: Within ten Business Days following Department's request

13.3.1.3. Disclosures Requiring Prompt Notification

13.3.1.3.1. Provider Terminations

13.3.1.3.1.1. Contractor shall notify Department of the decision to terminate any existing Network Provider on the basis of quality or performance issues or for cause per 10 CCR 2505-10, Section 8.076.1.7.

13.3.1.3.1.2. Contractor shall provide the following:

13.3.1.3.1.2.1. Provider's name and identification number.

13.3.1.3.1.2.2. Date of removal.

13.3.1.3.1.2.3. Number of Members served by the provider.

13.3.1.3.1.2.4. Reason for the termination.

13.3.1.3.1.2.5. Narrative describing how Contractor intends to provide or services for affected Members after the termination.

13.3.1.3.1.2.6. Any additional information as required by Department.

13.3.1.3.1.2.6.1. DELIVERABLE: Notice of Network Provider Termination for Quality of Performance or For Cause

13.3.1.3.1.2.6.2. DUE: Within two Business Days of the decision to terminate for quality or performance issue terminations or terminations for cause

13.3.1.3.2. Changes in Member Circumstances Affecting Eligibility

13.3.1.3.2.1. In accordance with 42 C.F.R. 438.608 (a)(3), Contractor shall promptly notify Department when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including, but not limited to, all of the following:

13.3.1.3.2.1.1. Changes in the Member's residence.

13.3.1.3.2.1.2. The death of a Member.

13.3.1.3.2.2. Contractor shall use the Provider/Member Change in Circumstance Disclosure template.

13.3.1.3.2.3. Contractor shall provide, at least, the following:

13.3.1.3.2.3.1. The Member's name.

13.3.1.3.2.3.2. Medicaid ID number.

13.3.1.3.2.3.3. Date of change.

13.3.1.3.2.3.4. Description of the change.

13.3.1.3.2.3.5. Any additional information as required by Department.

13.3.1.3.2.3.5.1. DELIVERABLE: Monthly Member Change in Circumstance Disclosure Report

13.3.1.3.2.3.5.2. DUE: Within ten Business Days after the end of each month

13.3.1.3.3. Overpayments

13.3.1.3.3.1. Contractor, or any Subcontractor delegated responsibility by Contractor for coverage of services and payment of claims under this contract, shall implement and maintain arrangements or procedures for prompt reporting within ten business days of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to Department.

13.3.1.3.3.1.1. DELIVERABLE: Notice of Overpayments Identified or Recovered

13.3.1.3.3.1.2. DUE: Within ten Business Days of identification or recovery of an overpayment

13.3.1.4. Disclosures Requiring Notification within 30 Days

13.3.1.4.1. Provider Licensure and Professional Review Actions

13.3.1.4.1.1. Contractor shall report all adverse licensure and professional review actions it has taken against any provider, in accordance with 45 C.F.R. Subtitle A, Part 60, Subpart B, to the National Practitioner Data Bank and to the appropriate state regulatory board. Following is a list of reportable actions:

13.3.1.4.1.1.1. Malpractice payments.

13.3.1.4.1.1.2. Licensure and certification actions.

13.3.1.4.1.1.3. Negative actions or findings.

13.3.1.4.1.1.4. Adverse actions.

13.3.1.4.1.1.5. Health Care-related Criminal Convictions.

13.3.1.4.1.1.6. Health Care-related Civil Judgments.

13.3.1.4.1.1.7. Exclusions from Federal or state health care programs.

13.3.1.4.1.1.8. Other adjudicated actions of decisions.

13.3.1.4.1.1.8.1. DELIVERABLE: Notification of Adverse Licensure of Professional Review

13.3.1.4.1.1.8.2. DUE: Must be submitted to Department and National Practitioner Data Bank within 30 days following the action being reported.

13.3.1.5. Disclosures Requiring Notification within 60 days

13.3.1.5.1. Overpayments and Excess Capitation Payments

13.3.1.5.1.1. Within 60 calendar days of identifying any Overpayments, per 42 C.F.R 438.608(d)(2), and any excess capitation payments, Contractor shall report and return an Overpayment to Department.

13.3.1.5.1.2. Contractor shall provide the following:

13.3.1.5.1.2.1. Client information.

13.3.1.5.1.2.2. Claims information.

13.3.1.5.1.2.3. Encounter Data information.

13.3.1.5.1.2.4. Paid amounts.

13.3.1.5.1.2.5. Provider information.

13.3.1.5.1.2.6. Dates of when Overpayment was identified and recovered.

13.3.1.5.1.2.7. Recovery amounts.

13.3.1.5.1.2.8. Capitation information.

13.3.1.5.1.2.9. Any other information as required by Department.

13.3.1.5.1.3. Contractor shall use the Overpayment and Recovery Disclosure template.

13.3.1.5.1.3.1. DELIVERABLE: Overpayment and Recovery Notification Disclosure

13.3.1.5.1.3.2. DUE: Within 60 calendar days of identifying capitation or other payments

13.4. Fraud, Waste, and Program Abuse

13.4.1. Contractor shall participate in routine meetings, held by Department to discuss issues related to program integrity compliance activities and Fraud, Waste, and Program Abuse involving Medicaid funds and resources. The frequency of such meetings shall be at the sole discretion of Department.

13.4.2. Contractor shall temporarily suspend all review activities or actions related to any provider upon request of Department.

13.4.3. Contractor shall abandon a review and stop all work on the review when requested to do so by Department.

13.4.4. Contractor shall provide expert assistance to Department, its Recovery Audit Contractor, and the MFCU, as requested by Department, related to review of overpayments, abuse, suspension of payments, or termination of a Network Provider, or the investigation of Suspected Fraud by a Network Provider.

13.4.5. Contractor shall provide expert assistance that includes, but is not limited to, the following topics:

13.4.5.1. Any reports made pursuant to this section.

13.4.5.2. Any medical records review or Medical Necessity findings or determinations made pursuant to this Contract.

13.4.5.3. Provider treatment and business practices.

13.4.5.4. Provider billing practices and patterns.

13.4.6. Contractor shall meet with Department, its contractors or the MFCU to explain any reports or findings made pursuant to the section. It shall cooperate with and provide assistance, including testimony, with any review, recovery effort, informal reconsideration, Appeal or investigation conducted by the federal or state government, law enforcement, the Program Integrity Section, Department's contractors, federal or state auditors, or any other entity engaged in program integrity functions.

13.4.7. Contractor shall not take any kind of recovery action or initiate any kind of activity against a Network Provider when potential Fraud is suspected without the approval of Department.

13.4.8. Contractor shall not take any action that might interfere with an investigation of possible Fraud by Department, the MFCU, or any other law enforcement entity. Contractor shall assist Department, the MFCU or any other law enforcement entity as requested with any preliminary or full investigation.

13.4.9. Contractor shall temporarily suspend all review activities or actions related to any provider which Contractor suspects is involved in fraudulent activity. Contractor shall continue its investigation as requested by Department.

13.5. Provider Fraud

13.5.1. Contractor shall notify Department and the MFCU when it identifies or suspects possible provider Fraud as the result of any activities in its performance of the Contract, including any Utilization Management or review activities.

13.5.2. Upon identification or suspicion of suspected provider Fraud, Contractor shall use the MCO Suspected Fraud Written Notice template to notify Department and the MFCU in writing.

13.5.3. Contractor shall provide the following, at minimum:

13.5.3.1. Written documentation of the findings.

13.5.3.2. Information on any verbal or written reports.

13.5.3.3. Copies of any written reports.

13.5.3.4. All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, in a mutually agreed upon format.

13.5.3.5. Information on the identification of any affected claims that have been discovered.

13.5.3.6. Any claims data associated with its report (in a mutually agreed upon format, if possible).

13.5.3.7. Any information as required by Department.

13.5.3.7.1. DELIVERABLE: Managed Care Suspected Fraud Written Notice

13.5.3.7.2. DUE: Within three Business Days from the initial discovery to Department and the MCFU

13.5.4. Contractor shall provide any additional information which supplements or modifies the Managed Care Suspected Fraud Written Notice within three Business Days following the receipt of a request for the same by Department or MFCU.

13.5.4.1. DELIVERABLE: Managed Care Suspected Fraud Written Notice Revisions and Additional Information

13.5.4.2. DUE: Within three Business Days following Department's or the MFCU's request

13.6. Member Fraud

13.6.1. Contractor shall notify Department when it identifies or suspects possible Member Fraud as the result of any activities in its performance of the Contract, including any Utilization Management or review activities.

13.6.2. Upon identification or suspicion of suspected Member Fraud, Contractor shall use the Managed Care Suspected Member Fraud Written Notice template and send the complete form and accompanying documentation to Department at report.clientfraud@state.co.us.

13.6.3. Contractor shall provide the following, at minimum:

13.6.3.1. All verbal and written reports related to the Suspected Fraud.

13.6.3.2. All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, the Member's State ID number, and Member's date of birth if applicable.

13.6.3.3. Information regarding the identification of any affected claims that have been discovered.

13.6.3.4. Any claims data associated with its report (in a mutually agreed upon format, if possible).

13.6.3.5. Any information as required by Department.

13.6.3.5.1. DELIVERABLE: Managed Care Suspected Member Fraud Written Notice

13.6.3.5.2. DUE: Within three business days from the initial discovery to Department

13.7. Suspension of Payments Due to a Credible Allegation of Fraud

13.7.1. Contractor shall suspend payments due to a Credible Allegation of Fraud in full or in part only at the direction of Department, in accordance with 42 C.F.R. § 455.23.

13.7.2. Contractor shall release suspended payment amounts to the provider within one payment cycle when directed to do so by Department.

13.7.3. Contractor shall not suspend payment when law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

13.7.4. Department may suspend payments to Contractor if Contractor is under investigation for a Credible Allegation of Fraud.

13.7.5. When Contractor has suspended payments to a provider due to a Credible Allegation of Fraud, Contractor shall create and provide to Department a monthly report of payments which have been suspended.

13.7.5.1. DELIVERABLE: Suspended Payments Report

13.7.5.2. DUE: On the tenth Business Day of each month for the previous month where payments to a provider have been suspended due to a Credible Allegation of Fraud

13.8. Quality Improvement Inspection, Monitoring, and Site Reviews

13.8.1. Contractor shall enable and support Department or its designee to conduct site reviews of Contractor's, Subcontractors', or providers' locations on an annual basis or more frequently if Department determines more frequent reviews to be necessary in its sole discretion to determine compliance with applicable Department regulations and the requirements of this Contract.

13.8.2. Site Reviews may include, but are not limited to:

13.8.2.1. Determining compliance with:

13.8.2.1.1. State and federal requirements.

13.8.2.1.2. Contracts.

13.8.2.1.3. Provider agreements.

13.8.2.2. Medicaid service provision and billing procedures.

13.8.2.3. Medicaid Bulletins and Provider Manuals.

13.8.3. Contractor shall cooperate with Department site review activities to monitor Contractor performance.

13.8.4. Contractor shall allow Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

13.8.5. Contractor shall allow Department or its designee to conduct an emergency or unannounced review for instances including, but not limited to, Member safety, quality of care, and Suspected Fraud or financial viability. Department may determine when an emergency review is required in its sole discretion.

13.8.6. Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by Department.

13.8.7. For routine Site Reviews, Contractor shall participate in the preview of the monitoring instrument to be used as part of the assessment and shall be contacted by Department or its designee for mutually agreed upon dates for a site review.

13.8.7.1. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to Contractor at least three weeks prior to the visit.

13.8.7.1.1. Contractor shall submit copies of policies, procedures, manuals, handbooks, reports and other requested materials to facilitate Department and/or designee's desk audit prior to the Site Review.

13.8.7.2. Contractor has a minimum of 30 days to submit the required materials for non-emergency reviews.

13.8.8. Contractor shall make available all records and documents related to the execution of this Contract, either on a scheduled basis, or immediately on an emergency basis, to Department and its agents for Site Review.

13.8.8.1. Delays in the availability of such documents and records may subject Contractor to remedial actions. These records and documents shall be maintained according to statutory or general accounting principles and shall be easily separable from other Contractor records and documents.

13.8.9. Department will transmit a written report of the Site Review to Contractor within 45 days of the Site Review. Contractor is allowed 30 days to review the preliminary report and respond to the findings. The final report will indicate, at least, areas of strength, suggestions for improvement, and required actions. A copy of the Site Review report and Contractor response will be transmitted to the Colorado Department of Regulatory Agencies, Division of Insurance.

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

13.8.10.1. Department may extend the time frame for corrective action in its sole discretion. Department may also reduce the time frame for corrective action if delivery of Covered Services for Members is adversely affected or if the time reduction is in the best interests of Members, as determined by Department.

13.8.10.2. For corrective action plans affecting the provision of Covered Services to Members, Contractor shall ensure that Covered Services are provided to Members during all corrective action periods.

13.8.10.3. Department will not accept any data submitted by Contractor to Department or its agents after the last site visit day towards compliance with the visit in the written report. Department will only apply this data toward the corrective action plan.

13.8.11. Contractor shall understand that the Site Review may include reviews of a sample of Network Providers to ensure that Network Providers have been educated and monitored by Contractor about the requirements under this Contract.

13.8.12. If the Site Reviewers wish to inspect a Network Provider location, Contractor shall ensure that:

13.8.12.1. Network Providers make staff available to assist in the audit or inspection effort.

13.8.12.2. Network Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

13.9. Prohibitions

13.9.1. Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. Contractor shall not pay a Network Provider for provider-preventable conditions, as identified in the State Plan and 42 C.F.R. § 438(g). Contractor shall ensure that Network Providers identify provider- preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

13.9.1.1. Contractor shall create a Provider Preventable Conditions Report that includes all provider-preventable conditions. Contractor shall submit this report to Department on an annual basis.

13.9.1.1.1. DELIVERABLE: Provider Preventable Conditions Report

13.9.1.1.2. DUE: Annually, no later than July 31 of each year.

13.9.2. Contractor shall ensure all Network Providers are enrolled with Department as Medicaid Providers, consistent with provider disclosure, screening, and enrollment requirements, and no payment is made to a Network Provider pursuant to this Contract if a Network Provider is not enrolled with the state as Medicaid provider. This provision does not require the Network Provider to render services to Fee-for-Service beneficiaries.

13.9.3. Department will not make payment to Contractor, if Contractor is:

13.9.3.1. An entity that could be excluded from under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

13.9.3.2. An entity that has a contract for the administration, management or provision of medical services, the establishment of policies, or the provision of operation support, for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act or an individual described in in the section on prohibited affiliations or that has been excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.

13.9.3.3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:

13.9.3.3.1. Any individual or entity excluded from participation in federal health care programs.

13.9.3.3.2. Any individual or entity that would provide those services through an excluded individual or entity.

13.9.3.4. Contractor shall not pay a provider or Subcontractor, directly or indirectly, for the furnishing of any good or service if:

13.9.3.4.1. The provider or Subcontractor is excluded from participation in federal health care programs.

13.9.3.4.2. The provider of Subcontractor has a relationship described in the section on prohibited affiliations.

13.9.4. Prohibited Affiliations

13.9.4.1. Contractor is prohibited from having a relationship with an individual or entity that is excluded from participation in any federal health care program as described in Sections 1128 and 1128A of the Social Security Act.

13.9.4.2. Contractor shall not knowingly have a relationship with:

13.9.4.2.1. A director, officer, or partner who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.9.4.2.2. A Subcontractor which is, or is affiliated with, a person/entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.9.4.2.3. A person with ownership or more than 5% of Contractor's equity who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.9.4.2.4. An employment, consulting, or other arrangement with an individual or entity for the provision of the contracted items or services who is, or is affiliated with a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.9.4.2.5. A Provider which is, or is affiliated with, a person/entity that is, debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation at 48 C.F.R. § 2.101 or from participating in non-procurement activities under regulations issued under

Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 or excluded from participation in federal health care programs.

13.9.4.3. Contractor shall provide written disclosure to Department of any prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, as defined in 438.608(c)(1).

13.9.4.4. If Department learns that Contractor has a prohibited relationship with a person or entity who is debarred, suspended, or otherwise excluded from participation in any federal health care programs, Department:

13.9.4.4.1. Must notify the Secretary of Department of Health and Human Services Secretary of the noncompliance.

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

13.9.4.4.3. May not renew or extend the existing agreement with Contractor unless the Secretary provides to Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

13.9.5. Prohibited Payments

13.9.5.1. Contractor shall not make payments:

13.9.5.1.1. For an item or service, other than an emergency item or service, not including items or services furnished in an emergency room of a hospital, furnished:

13.9.5.1.1.1. Under the plan by an individual or entity during any time period when the individual or entity is excluded from participation under title V, XVII, or XX or under title XIX pursuant to § 1128, 1128A, 1156, or 1842(j)(2);

13.9.5.1.1.2. At the medical direction or on the prescription of a physician, during the period when the physician is excluded from participation under title V, XVIII, or XX or under title XIX pursuant to § 1128, 1128A, 1156, or 1842(j)(2), and when the person furnishing such item or service knew, or had reason to know, of the exclusion; or

13.9.5.1.1.3. By an individual or entity to whom Department has failed to suspend payments during any period when there is a pending investigation of a Credible Allegation of Fraud against the individual or entity, unless Department determines there is a good cause not to suspend such payments.

13.9.5.1.2. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

13.9.5.1.3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

13.9.5.1.4. For home health care services provided by an agency or organization, unless the agency provides Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

13.10. General Compliance and Program Integrity Requirements

13.10.1. Business Transaction Disclosures

13.10.1.1. Contractor shall submit, full and complete information about:

13.10.1.1.1. The ownership of any subcontractor with whom Contractor has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request; and

13.10.1.1.2. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of the request.

13.10.1.2. DELIVERABLE: Disclosure of Business Transactions

13.10.1.3. DUE: Within 35 calendar days following a request by Department or by the Secretary of Department of Health and Human Services.

13.10.2. Ownership or Control Disclosures

13.10.2.1. Contractor shall disclose to Department information regarding ownership or control interests in Contractor at the time of submitting a provider application, at the time of executing the Contract with the State, at Contract renewal or extension, and within 35 calendar days of either a change of ownership or a written request by Department.

13.10.2.2. Contractor shall include the following ownership and control disclosure information in a form to be provided by Department:

13.10.2.2.1. The name, title and address of any individual or entity with an ownership or control interest in Contractor. The address for a corporation shall include as applicable primary business address, every business location, and P.O. Box address.

13.10.2.2.2. Date of birth and Social Security Number of any individual with an ownership or control interest in Contractor.

13.10.2.2.3. Tax identification number of any corporation or partnership with an ownership or control interest in Contractor, or in any subcontractor in which Contractor has a 5% or more interest.

13.10.2.2.4. Whether an individual with an ownership or control interest in Contractor is related to another person with an ownership or control interest in Contractor as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which Contractor has a 5% or more interest is related to another person with ownership or control interest in Contractor as a spouse, parent, child, or sibling.

13.10.2.2.5. The name of any other Medicaid provider (other than an individual practitioner or Group of Practitioners), Fiscal Agent, or managed care entity in which an owner of Contractor has an ownership or control interest.

13.10.2.2.6. The name, title, address, date of birth, and Social Security Number of any Managing Employee of Contractor.

13.10.2.2.6.1. DELIVERABLE: Ownership or Control Disclosures

13.10.2.2.6.2. DUE: Annually on July 31, and within 35 calendar days of either a change of ownership or a written request by Department.

13.10.3. Conflict of Interest

13.10.3.1. Contractor shall comply with the conflict of interest safeguards described in 42 C.F.R. §438.58 and with the prohibitions described in Section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

13.10.3.2. The term "conflict of interest" means that:

13.10.3.2.1. Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

13.10.3.2.2. The relationship between the third party and Department is such that one party's interests could only be advanced at the expense of the other's interests.

13.10.3.2.3. A conflict of interest exists even if Contractor does not use information obtained from one party in its dealings with the other.

13.10.3.3. Contractor shall submit a full disclosure statement to Department, setting forth the details that create the appearance of a conflict of interest.

13.10.3.3.1. DELIVERABLE: Conflict of Interest Disclosure Statement

13.10.3.3.2. DUE: Within ten Business Days of learning of an existing appearance of a conflict of interest situation.

13.10.3.4. As required by CRS 25.5-5-402, Contractor may be required to submit quarterly data about rates paid to providers in their network. If required to do so, Contractor shall submit required rate information on a template provided by Department on the last day of each State fiscal quarter.

13.10.3.4.1. DELIVERABLE: Supplemental Conflict of Interest Data

13.10.3.4.2. DUE: Quarterly, on the last day of each State fiscal quarter

13.10.4. Subcontracts and Contracts

13.10.4.1. Contractor shall disclose to Department copies of any existing subcontracts and contracts with providers upon request.

13.10.4.2. Contractor shall ensure that no Member is billed by a Subcontractor or provider for any amount greater than would be owed if Contractor provided the services directly or in violation of 25.5-4-301(1)(a)(I), (II) and (II.5), C.R.S.

13.10.4.2.1. DELIVERABLE: Subcontracts and Provider Contracts

13.10.4.2.2. DUE: Within five Business Days of Department's Request.

13.10.5. Screening of Employees and Contractors

13.10.5.1. Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the HHS-OIG.

13.10.5.2. Contractor shall, prior to hire or contracting, and at least monthly thereafter, screen all of its employees and Subcontractors against the HHS-OIG's List of Excluded Individuals (LEIE) to determine whether they have been excluded from participation in Medicaid.

13.10.5.3. If Contractor determines that one of its employees or Subcontractors has been excluded, then Contractor shall take appropriate action in accordance with federal and state statutes and regulations and shall report the discovery to Department.

13.10.5.3.1. DELIVERABLE: Notification of Discovery of Excluded Employee or Subcontractor

13.10.5.3.2. DUE: Within five Business Days of discovery

13.10.6. Disclosure of Information on Persons Convicted of Crimes

13.10.6.1. Upon submitting a provider application, upon execution of the Contract, upon renewal or extension of the Contract, and within 35 calendar days of the date of a written request by Department, Contractor shall disclose the identity of any person who:

13.10.6.1.1. Has an ownership or control interest in Contractor, or who is a managing employee of Contractor; and

13.10.6.1.2. Has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX services program, or Title XXI of the Social Security Act.

13.10.6.1.2.1. DELIVERABLE: Disclosure of Information on Persons Convicted of Crimes

13.10.6.1.2.2. DUE: Within 35 calendar days of either a change of ownership or a written request by Department.

13.10.7. Security Breaches and HIPAA Violations

13.10.7.1. In the event of a breach of the security of sensitive data Contractor shall immediately notify Department and the Office of Information Technology (OIT) of all suspected loss or compromise of sensitive data within five Business Days of the suspected loss or compromise and shall work with Department regarding recovery and remediation.

13.10.7.2. Contractor shall comply with the requirements of C.R.S. § 6-1-716 and any other applicable state and federal laws and regulations.

13.10.7.3. Contractor shall report all HIPAA violations as described in the HIPAA Business Associates Addendum.

13.10.7.3.1. DELIVERABLE: Security and HIPAA Violation Breach Notification

13.10.7.3.2. DUE: Within five Business Days of becoming aware of the breach

13.10.8. Maintenance of Records

13.10.8.1. Contractor shall ensure that all Subcontractors and providers comply with all record maintenance requirements of the Contract.

13.10.8.2. Notwithstanding any other requirement of the Contract, Contractor shall retain and require Subcontractors to retain, as applicable, enrollee Grievance and Appeal records in accordance with 42 C.F.R. § 438.416, base data in accordance with 42 C.F.R. § 438.5(c), MLR reports in accordance with 42 C.F.R. § 438.8(k), and the data, information, and documentation specified is 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610 for a period of no less than 10 years.

13.10.9. Inspection and Audits

13.10.9.1. Contractor shall allow Department, CMS, HHS-OIG, the Comptroller General and their designees to inspect and audit any records or documents of Contractor or its Subcontractors and shall allow them to, at any time, inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted.

13.10.9.2. Notwithstanding any other provision in the Contract, Contractor shall allow Department, CMS, the HHS-OIG, the Comptroller General and their designees this authority for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

13.10.9.3. Contractor shall allow CMS or its agent or designated contractor and Department or its agent to conduct unannounced, on-site inspections for any reason.

13.10.9.4. In the event that right of access is requested, Contractor and/or its Subcontractors or providers shall:

13.10.9.4.1. Make staff available to assist in any audit or inspection under the Contract.

13.10.9.4.2. Provide adequate space on the premises to reasonably accommodate Department, state or federal or their designees' personnel conducting all audits, Site Reviews or inspections.

13.10.9.4.3. The Secretary of Health and Human services, Department of Health and Human Services, and Department have the right to audit and inspect any books or records of Contractor or its subcontractors pertaining to the ability of Contractor or its subcontractor's ability to bear the risk of financial losses.

13.10.9.4.4. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of Contractor's, Subcontractor's or providers' provision of care.

13.10.9.4.5. Contractor shall allow access to Contractor's claims system and claims data by Department staff for program integrity activities.

13.10.9.4.6. In consultation with Department, Contractor shall participate in compliance monitoring activities and respond to any Department or designee request for information related to compliance monitoring, including Encounter Data analysis and Encounter Data validation (the comparison of Encounter Data with Medical Records). Department may request other information or analyses needed for compliance monitoring.

13.10.9.5. Contractor shall submit to Department copies of any existing policies and procedures, upon request by Department, within five Business Days.

13.10.9.6. Must have staff available to assist in any audit or inspection under the Contract.

13.11. Financial Reporting

13.11.1. To achieve the ACC's objective of greater accountability and transparency, Contractor shall participate in a robust financial reporting program.

13.11.2. Contractor shall submit financial information to Department on both a quarterly and annual basis, and attend in-person quarterly meetings to review and discuss Contractor's financial information as follows:

13.11.2.1. Contractor shall quarterly compile financial information that shall include, but not be limited to, the following:

13.11.2.1.1. Quarterly internal financial statements, including balance sheet and income statement.

13.11.2.1.2. Quarterly trial balance listing all account numbers, descriptions and amounts.

13.11.2.1.3. Crosswalk and/or allocation schedule(s) to link the quarterly trial balance to the quarterly financial report.

13.11.2.1.4. Quarterly financial report using a template that has been mutually agreed upon by Contractor and Department. The report shall contain a detailed accounting of the total revenue received from Department during the quarter and how payments were spent, including but not limited to, the following information:

13.11.2.1.4.1. The amount and percentage of PMPM payments spent during the reporting period to support the following categories of work:

13.11.2.1.4.1.1. PCMP Network Provider support, with a break-down of administrative payments made to PCMPs based on the payment strategy used (PMPM or other payment arrangement.)

13.11.2.1.4.1.2. Care Coordination, with a break-down of dollars spent on contracted Care Coordination and that provided by Contractor.

13.11.2.1.4.1.3. Practice support to include specific information about the types of practices supported.

13.11.2.1.4.1.4. Administration.

13.11.2.1.4.1.5. Network development.

13.11.2.1.4.1.6. Community infrastructure and Health Neighborhood participants.

13.11.2.1.4.1.7. Systems support and capital infrastructure investments.

13.11.2.1.4.1.8. Subcontractors.

13.11.2.1.4.1.9. The categories listed above may be expanded as a result of the process of developing the reporting template.

13.11.2.1.4.2. A breakdown of how the PMPM payments were spent for each category of work.

13.11.2.2. Contractor shall submit the Quarterly Financial Information to Department.

13.11.2.2.1. DELIVERABLE: Quarterly Financial Information

13.11.2.2.2. DUE: No later than 45 days from the end of the state fiscal quarter.

13.11.3. Contractor shall compile an Audited Annual Financial Statement that includes, at a minimum, the following:

13.11.3.1. Annual internal financial statements, including balance sheet and income statement.

13.11.3.2. Audited annual financial statements prepared in accordance with Statutory Accounting Principles (SAP). The audited annual financial statements must be certified by an independent public accountant and Contractor's Chief Financial Officer or their designee.

13.11.4. Contractor shall submit the Audited Annual Financial Statement to Department in a template provided by Department and modified as needed. Department will provide 60 days advance notice to Contractor prior to requiring the use of a modified template.

13.11.4.1. DELIVERABLE: Audited Annual Financial Statement

13.11.4.2. DUE: No later than six months from the end of the fiscal year that the statement covers.

13.11.5. Contractor shall participate in quarterly meetings with Department to formally present and review the quarterly financial reports submitted to Department. These meetings will be held by Department not more than 30 days after the submission of the report. Contractor shall ensure that the Chief Program Officer and CFO are in attendance at these meetings.

13.11.6. Contractor shall submit other financial reports and information as requested by Department or its designee.

13.11.7. Contractor shall assist Department in verifying any reported information upon Department's request. Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:

13.11.7.1. Fact-checking.

13.11.7.2. Auditing reported data.

13.11.7.3. Performing site visits.

13.11.7.4. Requesting additional information.

13.11.8. If Department determines that there are errors or omissions in any reported information, Contractor shall produce an updated report that corrects all errors and includes all omitted data or information. Contractor shall submit the updated report to Department within ten days from Department's request for the updated report.

13.11.8.1. DELIVERABLE: Updated Financial Reports or Statements

13.11.8.2. DUE: Ten calendar days from Department's request for the updated report or statement.

13.12. Graduate Medical Education (GME) Hospital Report

13.12.1. Contractor shall submit data quarterly according to the specifications provided by Department. Contractor shall certify all data submitted is accurate, complete and

truthful based on Contractor's best knowledge, information and belief. Contractor shall ensure that this certification is signed by either the Chief Program Officer or the Chief Financial Officer (CFO) or an individual who has delegated authority to sign for, and who reports directly to, the Chief Program Officer or CFO.

13.12.1.1. DELIVERABLE: Graduate Medical Education Report

13.12.1.2. DUE: Quarterly on July 31, October 31, January 31, and April 30.

13.13. Solvency

13.13.1. Contractor shall notify Department, upon becoming aware of or having reason to believe that it does not, or may not, meet the solvency standards, established by the State for health maintenance organizations.

13.13.2. Contractor shall not hold liable any Member for Contractor's debts, in the event Contractor becomes insolvent.

13.13.3. Contractor shall not hold liable any Member for Covered Services provided to the Member, for which Department does not pay Contractor, or for which Department or Contractor does not pay the provider that furnished the service under a contractual, referral, or other arrangement.

13.13.4. Contractor shall not hold liable any Member for Covered Services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if Contractor covered the services directly.

13.13.5. Contractor shall provide assurances satisfactory to Department that its provision against the risk of insolvency is adequate to ensure that Members will not be liable for Contractor's debt, in the event Contractor becomes insolvent.

13.13.5.1. DELIVERABLE: Solvency Notification

13.13.5.2. DUE: Within two Business Days of becoming aware of a possible solvency issue.

13.14. Warranties and Certifications

13.14.1. Contractor shall disclose to Department if it is no longer able to provide the same warranties and certifications as required at the Effective Date of the Contract.

13.15. Actions Involving Licenses, Certifications, Approvals and Permits

13.15.1. Provider Insurance

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

13.15.1.1.1. Physicians participating in Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of $500,000.00 per incident and $1,500,000.00 in aggregate per year.

13.15.1.1.2. Facilities participating in Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of $500,000.00 per incident and $3,000,000.00 in aggregate per year.

13.15.1.1.3. Sections 13.15.1.1.1 and 13.15.1.1.2 shall not apply to Physicians and facilities in Contractor's network which meet any of the following requirements:

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

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

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

13.15.1.2. Contractor shall notify Department of:

13.15.1.2.1. Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of Section 10, 16, -401, et seq., C.R.S. as a Health Maintenance Organization.

13.15.1.2.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

13.15.1.2.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract.

13.15.1.2.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

13.15.1.2.3.2. DUE: Within two Business Days of Contractor's notification.

13.16. Federal Intermediate Sanctions

13.16.1. Department may implement any intermediate sanctions, as described in 42 CFR 438.702, if Contractor:

13.16.1.1. Fails substantially to provide medically necessary services that Contractor is required to provide, under law or under its Contract with Department, to a Member covered under the Contract.

13.16.1.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

13.16.1.3. Acts to discriminate among Members on the basis of their health status or need for health care services.

13.16.1.4. Misrepresents or falsifies information that it furnishes to CMS or to Department.

13.16.1.5. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider.

13.16.1.6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.

13.16.1.7. Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.

13.16.1.8. Has violated any of the other applicable requirements of sections 1903(m), 1932, or 1905(t) of the Act and any implementing regulations.

13.16.2. Notice of Sanction and Pre-Termination Hearing

13.16.2.1. Before imposing any of the intermediate sanctions specified in this section, the State must give the affected entity timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

13.16.2.2. Before terminating any contracts with Contractor, the State must provide Contractor a pre-termination hearing.

13.16.2.3. Prior to a pre-termination hearing, the State must provide Contractor with the following:

13.16.2.4. Written notice of its intent to terminate, the reason for termination, and the time and place of the hearing,

13.16.2.5. After the hearing, the State must provide Contractor written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination, and

13.16.2.6. For an affirming decision, give enrollees of Contractor notice of the termination and information on their options for receiving Medicaid services following the effective date of termination.

13.16.3. Payments provided for under the Contract –shall be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

13.17. Termination Under Federal Regulations

13.17.1. Department may terminate this Contract for cause and enroll any Member enrolled with Contractor in other Plan, or provide their Medicaid benefits through other options included in the State plan, if Department determines that Contractor has failed to:

13.17.1.1. Carry out the substantive terms of its contracts.

13.17.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

13.17.2. Before terminating Contractor's Contract as described in this section, Department shall:

13.17.2.1. Provide Contractor a cure notice that includes, at a minimum, all of the following:

13.17.2.1.1. Department's intent to terminate.

13.17.2.1.2. The reason for the termination.

13.17.2.1.3. The time and place for the pre-termination hearing.

13.17.2.2. Conduct a pre-termination hearing.

13.17.2.3. Give Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

13.17.2.4. If Department determines, after the hearing, to terminate the Contract for cause, then Department shall send a written termination notice to Contractor that contains the effective date of the termination.

13.17.2.4.1. Upon receipt of the termination notice, Contractor shall give Members enrolled with Contractor notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

13.17.3. Once Department has notified Contractor of its intent to terminate under this section, Department may give Members enrolled with Contractor written notice of Department's intent to terminate the Contract.

13.17.4. Department may choose to impose any of the following intermediate sanctions if Contractor violates any applicable requirements of sections 1903(m) or 1932 of the Social Security Act and its implementing regulations:

13.17.4.1. Allow Members enrolled with Contractor to Disenroll immediately, without cause.

13.17.4.2. Suspend all new enrollments to Contractor's managed care capitation initiative, after the date the Secretary or Department notifies Contractor of a determination of violation of any requirement under sections 1903(m) or 1932 of the Act.

13.17.4.3. Suspend payments for all new enrollments to Contractor's managed care capitation initiative until CMS or Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

13.17.5. Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor shall not be paid for that work. If the state paid Contractor in advance to work on a no-longer- authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

14. COMPENSATION AND INVOICING

14.1. Summary of Compensation to Contractor

14.1.1. Compensation to Contractor shall consist of the following:

14.1.1.1. An administrative per-Member per-month (PMPM) payment Exhibit XX, Payment, for each active Member assigned to Contractor on the first day of the month and for Members whose enrollment starts from the 2nd through the 17th of the month, excluding any Members enrolled in Contractor's MCO, if applicable.

14.1.1.2. An actuarially certified monthly Capitated Payment Exhibit XX, Payment, for each active Member assigned to Contractor on the first day of the month and for Members whose enrollment starts from the 2nd through the 17th of the month. Department will set the monthly Capitated Payment rate at the actuarially certified point estimate in accordance with 42 C.F.R. § 438.

14.1.2. Compensation to Contractor may also consist of the following:

14.1.2.1. Key Performance Indicator incentive payments or Performance Pool payments based on Contractor's performance.

14.1.2.2. An annual behavioral health incentive payment based on Contractor's performance on defined behavioral health metrics.

14.1.2.3. Shared savings payment based on Contractor's performance in supporting its network of PCMPs in achieving shared savings goals.

14.2. Process for Administrative Per-Member Per-Month Payment and Capitated Payment

14.2.1. Department will calculate the number of active Members enrolled in Contractor's plan based on the enrollment information in the Colorado interChange.

14.2.2. Department will remit all administrative PMPM payments and Capitated Payments through the Colorado interChange via electronic funds transfer to a bank account designated by Contractor. Department will provide Contractor with a monthly payment report through the Colorado interChange.

14.2.2.1. Contractor shall ensure the accuracy of direct deposit information provided to Department and update such information as needed.

14.2.3. Department will remit all PMPM payments and Capitated Payments to Contractor within the month for which the payment applies.

14.2.3.1. In the event that Contractor is not compensated for a Member in a month for which Contractor should have been compensated, Department will compensate Contractor for that Member retroactively.

14.3. Special Provisions for Monthly Capitated Payment

14.3.1. The monthly Capitated Payment shall be considered payment in full for all Covered Services set forth in Section 9.4.

14.3.2. In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Section 9.4 and any other provision of the Contract, Section 9.4 shall prevail over other provisions of this Contract.

14.3.3. Department will recoup partial capitation payments for short term stays in an IMD that exceed 15 days during the period of a monthly capitation payment.

14.3.4. Actions Impacting Existing Rates

14.3.4.1. Contractor shall inform Department prior to making changes to rate payment methodologies, provider recoupments, or other financial adjustments that may impact the underlying assumptions the rate is built on.

14.4. Pay for Performance

14.4.1. Key Performance Indicator (KPI) Incentive Program

14.4.1.1. Department will implement a KPI incentive program through which Contractor may earn payment for meeting established performance goals.

14.4.1.2. The KPI incentive payment will be set and paid as follows:

14.4.1.2.1. Department will determine the proportion of funds associated with the KPI Incentive Program that shall not exceed 25% of the total administrative PMPM allocated by Department to the Contractor.

14.4.1.2.2. Department will pay an incentive payment to Contractor for each individual KPI that Contractor meets or exceeds the established performance goal.

14.4.1.2.3. Department shall provide to Contractor documented calculation methodology for all measures prior to the first distribution of funds. Department shall release the calculation methodology as a draft and shall provide a comment period of no less than two weeks prior to releasing as final. Department will determine the final measurement and pay for performance criteria.

14.4.1.2.4. Department will remit all Payments on KPIs to Contractor within 180 days from the last day of the quarter in which the KPI incentive payments were earned. Department will calculate the KPI incentive payment as of the end of each quarter based off Contractor's performance.

14.4.1.2.4.1. Department may consult with the RAEs to modify the KPIs, KPI performance goals, and the individual KPI PMPM payment amounts, by amendment to the Contract or the specifications document.

14.4.1.2.5. Department will remit all incentive payments through the Colorado interChange.

14.4.2. Performance Pool

14.4.2.1. Department will distribute the monies in the performance pool to Contractor based on an annual strategy created in consultation with the RAEs.

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

14.4.2.3. Department will remit all incentive payments through the Colorado interChange.

14.4.3. Behavioral Health Incentive Program Payment

14.4.3.1. Department will implement a Behavioral Health Incentive Program enabling Contractor to receive incentive payments for the improvement of Behavioral Health Incentive Measures as described in Exhibit C, Rates.

14.4.3.2. The Behavioral Health Incentive Program will be implemented in accordance with 42 CFR 438.6(b)(2) ensuring that the arrangement with Contractor:

14.4.3.2.1. Does not provide for payment in excess of 105% of the approved capitation payments.

14.4.3.2.2. Is for a fixed period of time and incentive performance shall be measured during the rating period under the Contract in which the performance incentive program is applied.

14.4.3.2.3. Is not renewed automatically.

14.4.3.2.4. Is made available to both public and private contractors under the same terms of performance.

14.4.3.2.5. Is not conditioned on Contractor entering into or adhering to intergovernmental transfer agreements.

14.4.3.2.6. Is necessary to support program initiatives as specified in the state's quality strategy.

14.4.3.3. Department will calculate the Behavioral Health Incentive Program payment as described in Exhibit X, Payment.

14.4.3.4. Department will provide to Contractor documented calculation methodology for all measures prior to the first distribution of funds. Department will release the calculation methodology as a draft and will provide a comment period of no less than two weeks prior to releasing as final. Department will determine the final measurement and pay for performance criteria.

14.4.3.5. Department will distribute funding for achieving Behavioral Health Incentive Program performance annually by June 30 of every State Fiscal Year following the measurement period for the Behavioral Health Incentive Program.

14.5. Payment Calculation Disputes

14.5.1. In the event that Contractor believes that the calculation or determination of any payment is incorrect, Contractor shall notify Department of its dispute within 30 days following the receipt of the payment calculation or determination. Department will review calculation or determination and may make changes based on this review. The determination or calculation that results from Department’s review shall be final. No disputed payment shall be due until after Department has concluded its review.

14.6. Recoupments

14.6.1. Department shall recoup monthly administrative PMPM payment, and Capitated Payment amounts or pay for performance payments paid to Contractor in error. Error may be either human or machine error on the part of Department, Contractor, or otherwise. Error includes, but is not limited to, lack of eligibility, computer error,

change in RAE enrollment due to a Member choosing a new PCMP, or situations where the Member cannot use Contractor's facilities.

14.6.2. Contractor shall refund to Department any overpayments due Department within 30 days after discovering the overpayments or being notified by Department that overpayments are due. If Contractor fails to refund the overpayments within 30 days, Department shall deduct the overpayments from the next payment to Contractor.

14.6.3. Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, Contractor shall refund any overpayments due to Department, by check or warrant, with a letter explaining the nature of the payment, within 90 days of termination.

14.6.4. Payments made by Department to Contractor due to Contractor’s omission, fraud, and/or defalcation, as determined by Department, shall be deducted from subsequent payments.

14.6.5. Where Membership is disputed between two Contractors, Department shall be final arbitrator of Membership and shall recoup any monthly administrative PMPM payments and Capitated Payments.

14.7. Contractor’s obligation to refund all calculated rebates continues subsequent to the termination of the Contract.

14.8. Closeout Payments

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

14.9. Compensation

14.9.1. Contractor shall receive payment as specified in Exhibit C, Rates.

14.10. Detailed Invoicing and Payment Procedures

14.10.1. Contractor shall invoice Department on a monthly basis, by the 15th Business Day of the month following the month for which the invoice covers. Contractor shall not invoice Department for a month prior to the last day of that month.

14.10.2. The invoice shall contain all of the following for the month for which the invoice covers.

14.11. Closeout Payments

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