CONTRACT AMENDMENT #15

SIGNATURE AND COVER PAGE

State Agency Department of Health Care Policy and Financing	**Original Contract Number** 20-148621
Contractor Denver Health Medical Plan	**Amendment Contract Number** 20-148621A15
Current Contract Maximum Amount All State Fiscal Years Payments in this Contract shall be dependent upon and limited by the number of Members enrolled in the program.	**Contract Performance Beginning Date** January 1, 2020 **Current Contract Expiration Date** June 30, 2025

THE PARTIES HERETO HAVE EXECUTED THIS AMENDMENT

Each person signing this Amendment represents and warrants that he or she is duly authorized to execute this Amendment and to bind the Party authorizing his or her signature.

CONTRACTOR Denver Health Medical Plan	**STATE OF COLORADO** **Jared S. Polis, Governor** Department of Health Care Policy and Financing
By:_____ Date: _____	By:_____ Date: _____

In accordance with §24-30-202 C.R.S., this Amendment is not valid until signed and dated below by the State Controller or an authorized delegate.

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD

By:_____

Amendment Effective Date:_____

1. PARTIES

This Amendment (the "Amendment") to the Original Contract shown on the Signature and Cover Page for this Amendment (the "Contract") is entered into by and between Contractor and the State.

2. TERMINOLOGY

Except as specifically modified by this Amendment, all terms used in this Amendment that are defined in the Contract shall be construed and interpreted in accordance with the Contract.

3. AMENDMENT EFFECTIVE DATE AND TERM

A. Amendment Effective Date

This Amendment shall not be valid or enforceable until the Amendment Effective Date shown on the Signature and Cover Page for this Amendment. The State shall not be bound by any provision of this Amendment before that Amendment Effective Date, and shall have no obligation to pay Contractor for any Work performed or expense incurred under this Amendment either before or after of the Amendment term shown in **§3.B** of this Amendment.

B. Amendment Term

The Parties' respective performances under this Amendment and the changes to the Contract contained herein shall commence on the Amendment Effective Date shown on the Signature and Cover Page for this Amendment and shall terminate on the termination of the Contract.

4. PURPOSE

The purpose of this amendment is to update the Statement of Work and payments.

5. MODIFICATIONS

The Contract and all prior amendments thereto, if any, are modified as follows:

A. Exhibit B-13, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit B-14, Statement of Work, attached hereto and incorporated by reference into the Contract. All references to Exhibit B, B-1, B-2, B-3, B-4, B-5, B-6, B-7, B-8, B-9, B-10, B-11, B-12 and B-13 shall henceforth be a reference to Exhibit B-14.

B. Exhibit E-12, Payment, is hereby deleted in its entirety and replaced with Exhibit E-13, Payment, attached hereto and incorporated by reference into the Contract. All references to Exhibit E, E-1, E-2, E-3, E-4, E-5, E-6, E-7, E-8, E-9, E-10, E-11 and E-12 shall henceforth be a reference to Exhibit E-13.

C. Exhibit I-5, Capitated Behavioral Health Benefit Covered Services & Diagnoses, is hereby deleted in its entirety and replaced with Exhibit I-7, Capitated Behavioral Health Benefit Covered Services & Diagnoses, attached hereto and incorporated by reference into the Contract. All references to Exhibit I, I-1, I-2, I-3, I-4, I-5, and I-6 shall henceforth be a reference to Exhibit I-7.

D. Exhibit P, HB21-1289 Implementation, attached hereto, is hereby added to the contract.

6. LIMITS OF EFFECT AND ORDER OF PRECEDENCE

This Amendment is incorporated by reference into the Contract, and the Contract and all prior amendments or other modifications to the Contract, if any, remain in full force and effect except as specifically modified in this Amendment. Except for the Special Provisions contained in the Contract, in the event of any conflict, inconsistency, variance, or contradiction between the provisions of this Amendment and any of the provisions of the Contract or any prior modification

to the Contract, the provisions of this Amendment shall in all respects supersede, govern, and control. The provisions of this Amendment shall only supersede, govern, and control over the Special Provisions contained in the Contract to the extent that this Amendment specifically modifies those Special Provisions.

EXHIBIT A, HIPAA BUSINESS ASSOCIATES ADDENDUM

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

RECITALS

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

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

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

The parties agree as follows:

1. Definitions.

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

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

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

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

2. Obligations of Associate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Obligations of CE.

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

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

4. Termination.

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

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

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

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

c. Effect of Termination.

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

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

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

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

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

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

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

10. Amendment.

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

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

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

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

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

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

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ATTACHMENT A-1

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

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

"No Additional Permitted Uses" or type in additional permitted uses

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

"No additional permitted disclosures" or type any additional permitted disclosures.

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

"No subcontractors" or type the names of any subcontractors that will receive Protected Information.

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

Upon receipt of PHI from the Department.

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

"No additional restrictions on Use of Data" or type any additional restrictions.

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

7. This HIPAA Business Associate Addendum is related to data provided by the Department and used by the Contractor to perform the work in Sections 7.3.5, 11.3.10.4.1, and 12.8.8 of Exhibit B, Statement of Work.

EXHIBIT B-14, STATEMENT OF WORK

1. ACCOUNTABLE CARE COLLABORATIVE

1.1. The Department has created the Accountable Care Collaborative to improve client health and reduce costs in the Medicaid Program.

1.1.1. Contractor shall assist the Department in reducing avoidable and unnecessary costs within the Medicaid Program without negatively impacting access to high-value services or positive program outcomes.

1.1.2. Contractor shall actively participate in a Department-led Collaboration (the 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 alternative payment methodologies to quality performance objectives and care coordination risk stratification hierarchy. Ultimately, this coordination will result in improved savings, results and stakeholder performance.] Contractor shall:

1.1.2.1. Assist the multi-payor collaborative and the Department in the selection of ten to 15 specific and consistent quality metrics which physicians shall be evaluated on.

1.1.2.2. Identify gaps in the data and information needed to successfully engage in the cost containment work.

1.1.2.3. Assist in improving the flow of necessary data and information between Contractor, their Network Providers and the Department.

1.1.2.4. Identify and act on areas of opportunity to better manage trend, referral practices, improve quality, and identify high risk members by leveraging analytical tools, emerging industry best/promising practices, and innovations that support high quality, efficient care.

1.1.2.5. Share ideas regarding best and promising practices and the associated return on investment.

1.1.2.6. Assist in identifying strategies to create capacity for cost containment work, which could include narrowing or lessening the focus on certain Contractor responsibilities; and

1.1.2.7. Maximize its focus on cost-containment in appropriate balance with other key responsibilities, by identifying the top eight to ten critical elements for successful implementation of Phase II.

1.1.3. Contractor shall within the first 120 days of the Contract identify key performance metrics and targets in the following two areas:

1.1.3.1. Percent of Members receiving care coordination.

1.1.3.2. Access Standards.

1.1.4. Contractor shall manage the managed care capitation initiative for physical health, such that the capitation rates may be set at two percent or more below the fee-for-service equivalent. The savings target of two percent may be adjusted based on mutual agreement by the Department and Contractor upon completion of an actuarial and data review process. The actuarial and data review process shall be completed in advance of the annual rates setting process for rates effective on July 1, 2020, and every year thereafter. The Department and Contractor may agree to set an alternate target, as appropriate, to reflect policy objectives regarding the total cost of care and value-based payment, upon completion of the actuarial review process. In no case shall the target be set a level greater than 100% of the fee-for-

service equivalent, pursuant to budget neutrality requirements set forth in the Colorado statutes.

1.1.5. Contractor shall work with the Department to develop standardized cost dashboards.

1.1.6. The Department will support Contractor in its cost containment efforts by:

1.1.6.1. Providing and assisting with the exchange of needed data and information;

1.1.6.2. Creating a safe environment and a culture of collaboration for the sharing of ideas;

1.1.6.3. Empowering Contractor to manage conflict and to collaborate with the Department to make decisions related to this work; and

1.1.6.4. Supporting overall Contractor cost containment efforts by using available levers to require provider engagement and participation and to support Contractor in the resolution of conflict.

1.1.6.5. Collaborating with Contractor to ensure rate setting methodologies incentivize efficient care delivery and allow for adequate investment over time to maintain high levels of efficiency.

1.1.7. Contractor shall receive, process, and analyze Statewide data and work collaboratively with the Department to identify trends and potentially avoidable costs.

1.1.8. Contractor shall:

1.1.8.1. Complete connectivity to the Department's Utilization Management (UM) Vendor, eQHealth, and EMR connectivity to CORHIO.

1.1.8.2. Adopt the use of the Prescriber Tool upon release by the Department.

1.1.8.3. Develop and implement a Care Improvement Plan that will address the impactable population (the top five percent most expensive Members) to demonstrate an overall 1.5-2 to 1 ROI.

1.1.8.4. Complete a comprehensive overview and report on its perinatal/maternity program that includes the percent of pregnant Members using the maternity program and number of providers for each program.

1.1.8.5. Complete a comprehensive overview of programs addressing the top eight chronic conditions identified by the Department and listed below. The report shall, include the percent of Members participating and the number of providers for each of the following:

1.1.8.5.1. Complex Newborns.

1.1.8.5.2. Diabetes.

1.1.8.5.3. Hypertension.

1.1.8.5.4. Cardiovascular Disease.

1.1.8.5.5. COPD.

1.1.8.5.6. Anxiety/Depression.

1.1.8.5.7. Pain Management.

1.1.8.5.8. Substance Use Disorder (SUD).

1.1.8.6. Contractor may propose to report on programs for other chronic conditions prevalent among their enrolled members with Department approval.

1.1.9. Contractor shall implement the Department's Population Management Framework to improve member health, prevent disease progression, reduce unnecessary and/or avoidable utilization and costs, improve coordination of care across Medicaid programs, and contain costs. Contractor shall, at a minimum:

1.1.9.1. Focus outreach, programming, and care coordination on members utilizing Medicaid services.

1.1.9.2. Implement and evaluate evidence-based and proven programs designed to improve the health of Department targeted populations and prevent disease progression of Department targeted health conditions.

1.1.9.3. Effectively coordinate care for members identified by the Department as having complex health needs.

1.1.9.4. Redistribute administrative funding received by Contractor to ensure the appropriate level of financial resources are made available for coordinating care for members identified by the Department as having complex health needs.

1.1.9.5. Be accountable for achieving annually established cost trend and clinical quality outcome metrics.

2. TERMINOLOGY

2.1. In addition to the terms defined the base contract, acronyms and abbreviations are defined at their first occurrence in this Contract, Statement of Work. The following list of terms shall be construed and interpreted as follows:

2.1.1. 1915(b)(3) Services – Alternative, non-State Plan Services described in 42 C.F.R. § 440 and provided under the Departments 1915(b)(3) waiver such as: intensive case management, Assertive Community Treatment (ACT), respite care, vocational services, clubhouses and drop-in center services, recovery services, educational and skills training courses, prevention/early intervention and residential services.

2.1.2. Accountable Care Collaborative (ACC) – A program designed to affordably optimize Member health, functioning, and self-sufficiency. The primary goals of the Program are to improve Member health and life outcomes and to use state resources wisely. Regional Accountable Entities (RAEs) work in collaboration with Primary Care Medical Providers (PCMPs) that serve as medical homes, behavioral health providers, and other health providers and Members to optimize the delivery of outcomes-based, cost-effective health care services.

2.1.3. Adverse Benefit Determination – The denial or limited authorization of a requested service, including determinations based on the type or level or service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; reduction suspension, or termination of a previously authorized service; denial, in whole or in part, of payment for a service; failure to provide services in a timely manner; failure of Contractor to act with the timeframes provided in 42 CFR 438.408(b)(1) – (2) regarding the standard resolution of grievances and appeals; and the denial of an enrollee's request to dispute a financial liability.

2.1.4. ASAM - (American Society of Addiction Medicine) Professional medical society that defines treatment guidelines for addictive, substance-related and co-occurring conditions.

2.1.5. APM-see Primary Care Alternative Payment Model

2.1.6. Appeal – A review by a MCO, PHIP or PAHP, of an Adverse Benefit Determination.

2.1.7. Behavioral Health – Behavioral health refers to a level of psychological well-being, not just an absence of mental illness. When used in this Contract it is referring to both mental health and substance use.

2.1.8. Behavioral Health Entity - Defined in C.R.S. §27-50-101 as a facility or provider organization engaged in providing community-based health services, which may include services for a behavioral health disorder but does not include detention and commitment facilities operated by the Division of Youth Services within the Department of Human Services or services provided by a licensed or certified mental health care provider under the provider's individual professional practice act on the provider's own premises.

2.1.9. Business Hours – 8:00 a.m.–5 p.m. Mountain Time each Business Day.

2.1.10. Business Intelligence and Data Management System (BIDM System) – a data warehouse that collects, consolidates, and organizes data from multiple sources, and fully integrates Medicaid eligibility and claims data for reporting, analytics and decision support.

2.1.11. Business Interruption - Any event that disrupts Contractor's ability to complete the Work for a period of time, and may include, but is not limited to a Disaster, power outage, strike, loss of necessary personnel or computer virus.

2.1.12. CAHPS – the Consumer Assessment of Healthcare Providers and Systems Health Plan Surveys.

2.1.13. Capitated Behavioral Health Benefit – A statewide benefit that advances the emotional, behavioral, and social well-being of all Members. The benefit promotes psychological health, the ability to cope and adapt to adversity, and the realization of Members' abilities. The benefit provides comprehensive State Plan and non-State Plan mental health and substance use disorder services. The benefit operates under a monthly capitation.

2.1.14. Capitated Payments –Monthly payments the Department makes on behalf of each Member for the provision of non-fee-for-service physical and non-fee-for service behavioral health services.

2.1.15. Care Coordination – The deliberate organization of Client care activities between two or more participants (including the Client and/or family members/caregivers) to facilitate the appropriate delivery of physical health, behavioral health, functional Long Term Services and Supports (LTSS) supports, oral health, specialty care, and other services. Care Coordination may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a Member's health and social needs.

2.1.16. Centers for Medicare and Medicaid Services (CMS) – The United States federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program.

2.1.17. Child Health Plan Plus (CHP+) – CHP+ is Colorado's Children's Health Insurance Program (CHIP). A title XXI program, it is a low-cost health insurance program for uninsured Colorado children under age 19 and prenatal women whose families earn too much to qualify for Medicaid but cannot afford private insurance.

2.1.18. Client – An individual eligible for and enrolled in the Colorado Medicaid program.

2.1.19. Closeout Period - The period beginning on the earlier of 90 days prior to the end of the last Extension Term or notice by the Department of its decision to not exercise its option for an

Extension Term, and ending on the day that the Department has accepted the final deliverable for the Closeout Period, as determined in the Department-approved and updated Closeout Plan, and has determined that the closeout is complete.

2.1.20. Client Over-Utilization Program (COUP) – A program to assist Clients who are shown, through development and review of Client utilization pattern profiles, to have a history of unnecessary or inappropriate utilization of care services.

2.1.21. Code of Federal Regulations (CFR) – The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the Federal Government.

2.1.22. Cold-Call Marketing – any unsolicited personal contact by the MCO with a Potential Member for the purposes of marketing as defined at 42 CFR 438.104.

2.1.23. Colorado interChange - The Department's Medicaid Management Information System and supporting services, which includes: Fiscal Agent Operations Services, Provider Web Portal, online provider enrollment, claims processing and payment, Electronic Data Interchange (EDI), Electronic Document Management System (EDMS), provider call center, help desk, and general information technology functionality and business operations

2.1.24. Colorado Medicaid – A program authorized by the Colorado Medical Assistance Act (Section 25.5-4-104, et seq., C.R.S.) and Title XIX of the Social Security Act.

2.1.25. Colorado Mental Health Institute – State-run psychiatric hospitals located in Fort Logan and Pueblo.

2.1.26. Colorado Revised Statutes (C.R.S.) – The legal codes of Colorado; the codified general and permanent statutes of the Colorado General Assembly.

2.1.27. Colorado's 10 Winnable Battles – Public health and environmental priorities that have known, effective solutions focusing on healthier air, clean water, infectious disease prevention, injury prevention, mental health and substance use, obesity, oral health, safe food, tobacco and unintended pregnancy. The initiative is overseen by the Colorado Department of Public Health and Environment.

2.1.28. Community – For the Accountable Care Collaborative, Community is defined as the services and supports that impact Member well-being, including Health Neighborhood providers and organizations that address the spiritual, social, educational, recreational, and employment aspects of a Member's life.

2.1.29. Community Centered Boards (CCB) – A for-profit or nonprofit private corporation, which, when designated pursuant to 27-10.5-105, C.R.S., provides case management services to Clients with developmental disabilities. A CCB is authorized to determine eligibility of such Clients within a specified geographical area and serves as the single point of entry for Clients to receive services and supports under 27-10.5-101 et seq., C.R.S.

2.1.30. Community Mental Health Centers (CMHC) – An institution that provides mental health services required by §1916(c)(4) of the Public Health Service Act (US) and certified by the appropriate State authorities as meeting such requirements.

2.1.31. Complex Members – Department defined subset of adult and pediatric Members as stated in the Performance Pool data specification document. Contractor may develop a different definition of Complex Members subject to approval and periodic review by the Department.

2.1.32. Comprehensive Community Behavioral Health Provider (Comprehensive Provider) – a

licensed Behavioral Health entity or Behavioral Health Provider approved by the Behavioral Health Administration to provide Care Coordination and the Behavioral Health safety net services as defined in § 27-50-101(11), C.R.S., either directly or through formal agreements with Behavioral Health Providers in the community or region.

2.1.33. Comprehensive Risk Contract – A risk contract between the Department and an MCO that covers comprehensive services that includes inpatient hospital services and any of the following services, or any three or more of the following services: outpatient hospital services, rural health clinic services, Federally Qualified Health Center (FQHC) services, other laboratory and x-ray services, nursing facility service, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, family planning services, physician services, and home health services as defined in 42 C.F.R. § 438.2.

2.1.34. Contract Funds – The funds that have been appropriated, designated, encumbered, or otherwise made available for payment by the State under this Contract.

2.1.35. Contractor Pre-Existing Material – Material, code, methodology, concepts, process, systems, technique, trade or service marks, copyrights, or other intellectual property developed, licensed or otherwise acquired by Contractor prior to the Effective Date of this Contract and independent of any services rendered under any other contract with the State.

2.1.36. Covered Drugs – Drugs currently covered by the Medicaid program and includes those products that require prior authorization by the Colorado Medicaid program. Covered Drugs must be dispensed by a Network Provider except for Emergency Services and must be prescribed by Network Providers or requested by an authorized prescriber as a result of authorized Referral, Emergency Services, dental care, or obtained under the Medicaid Mental Health Capitation Program. Covered Drugs shall also mean drugs for which payments are made by Contractor as a result of Appeal and External Review Processes.

2.1.37. Credible Allegation of Fraud - May be an allegation which has been verified by the state, from any source, including but not limited to the following: Fraud hotline complaints, claims data mining, and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case- by-case basis as defined at 42 C.F.R. § 455.2.

2.1.38. Deliverable - Any tangible or intangible object produced by Contractor as a result of the work that is intended to be delivered to the Department, regardless of whether the object is specifically described or called out as a "Deliverable" or not.

2.1.39. Department – The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado.

2.1.40. Designated Client Representative – any person, including a treating health care professional, authorized in writing by the Member or the Member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services as defined at 10 C.C.R. 2505-10, Section 8.209.2.

2.1.41. Disaster - An event that makes it impossible for Contractor to perform the Work out of its regular facility or facilities, and may include, but is not limited to, natural disasters, fire or terrorist attacks.

2.1.42. DRAMS – the Department's Drug Rebate Analysis Management System.

2.1.43. Early Periodic Screening, Diagnostic and Treatment (EPSDT) — EPSDT provides a

comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT requirements are defined by 42 C.F.R. § 441.50 to 441.162, 42 C.F.R. § 440.345, 42 U.S.C. 1902(a)(43) and 1905(a)(4)(B), and Medicaid Part V state manual.

2.1.44. Effective Date – The date upon which this Contract will take effect, as defined in the Contract.

2.1.45. Emergency Medical Condition – As defined in 42 C.F.R. § 438.114(a) means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

2.1.45.1. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

2.1.45.2. Serious impairment to bodily functions.

2.1.45.3. Serious dysfunction of any bodily organ or part.

2.1.46. Emergency Services – Covered inpatient and outpatient services that are furnished by a provider that is qualified to deliver these services under 42 C.F.R. § 438, and needed to evaluate or stabilize an emergency medical condition as defined in 42 C.F.R. § 438.114.

2.1.47. Encounter Data – The information relating to the receipt of any item(s) or service(s) by an enrollee under a Contract between the State and a provider as defined in 42 C.F.R. § 438.2.

2.1.48. Essential Behavioral Health Safety Net Provider (Essential Provider) – a licensed behavioral health entity or a behavioral health provider approved by the Behavioral Health Administration to provide care coordination and at least one of the behavioral health safety net services defined in § 27-50-101(13), C.R.S.

2.1.49. Essential Community Provider (ECP) – Providers that historically serve medically needy or medically indigent individuals and demonstrate a commitment to serve low-income and medically indigent populations who comprise a significant portion of the patient population. To be designated an "ECP," the provider must demonstrate that it meets the requirements as defined in 25.5-5-404.2, C.R.S.

2.1.50. Fee-for-Service (FFS) – A payment delivery mechanism based on a unit established for the delivery of that service (e.g., office visit, test, procedure, unit of time).

2.1.51. Federally Qualified Health Center (FQHC) – A hospital-based or free-standing center that meets the FQHC definition found in Section 1905(1)(2)I of the Social Security Act.

2.1.52. Fiscal Agent – A contractor that processes or pays vendor claims on behalf of the Medicaid agency.

2.1.53. Fiscal Year (FY) – The 12 month period beginning on July 1 of a year and ending on June 30 of the following year.

2.1.54. Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to her/himself or some other person. It includes any act that constitutes Fraud under The Colorado Medicaid Fraud Control Act, C.R.S. § 24-31-801 et seq., The Colorado False Claims Act, C.R.S. § 25.5-4-305 et seq. and other applicable federal or state laws and regulations.

2.1.55. Frontier County – A county in Contractor's service area with a population density less than

or equal to 6 persons per square mile.

2.1.56. Grievance – An expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to, quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the Member's rights as defined at 42 C.F.R. § 438.400 (b).

2.1.57. Group of Practitioners – means two or more health care practitioners who practice their profession at a common location, whether or not they share common facilities, common supporting staff, or common equipment.

2.1.58. Health First Colorado – Colorado's Medicaid program. It was renamed July 1, 2016.

2.1.59. Health Neighborhood – A network of Medicaid providers ranging from specialists, hospitals, oral health providers, LTSS providers, home health care agencies, ancillary providers, local public health agencies, and county social/human services agencies that support Members' health and wellness.

2.1.60. Health Needs Survey – A brief tool to assess individual Member's health risks and quality of life issues, and identify high priority Member needs for health care and Care Coordination.

2.1.61. HEDIS – The Healthcare Effectiveness Data and Information Set developed by the National Committee for Quality Assurance.

2.1.62. HIPAA - The Health Insurance Portability and Accountability Act of 1996.

2.1.63. HHS-OIG – The U.S. Department of Health and Human Services Office of Inspector General.

2.1.64. Home and Community Based Services (HCBS) Waivers – Services and supports authorized through 1915(c) waivers of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) as described at 42 CFR 441.300, et seq.

2.1.65. Hospital Transformation Program – A Department initiative to connect hospitals to the Health Neighborhood and align hospital incentives with the goals of the Accountable Care Collaborative Program.

2.1.66. Independent Assessment – A process to assess the strengths and needs of a child or adolescent using the Child and Adolescent Needs and Strengths (CANS) assessment. The CANS is an age-appropriate, evidence-based, validated, functional assessment tool. The assessment determines whether treatment in a Qualified Residential Treatment Program (QRTP) provides the most effective and appropriate level of care for the child in the least restrictive environment, in accordance with Colorado Department of Human Services regulations (10 CCR 2505-10 8.765.1). An Independent Assessment must be conducted by a provider contracted with the Behavioral Health Administration (BHA) or its designee.

2.1.67. Indian health care provider (IHCP) - Means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

2.1.68. Indirect Ownership Interest – Means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in another entity.

2.1.69. I/T/U – Indian Health Service, Tribally operated facility/program, and Urban Indian clinic.

2.1.70. Key Performance Indicators (KPIs) – Performance measures tied to incentive payments for the Accountable Care Collaborative.

2.1.71. Key Personnel - The position or positions that are specifically designated as such in this Contract.

2.1.72. Limited Service Licensed Provider Network (LSLPN) – As defined by 3 CCR 702-2, Regulation 2-1-9, a provider network restricted to (i) a narrowly defined health specialty (e.g., substance abuse, radiology, mental health, pediatrics, pharmacology, etc.) or (ii) services narrowly limited to a single type of licensed health facility (e.g., inpatient hospital, birth center, long-term care facility, hospice, etc.) or (iii) home health care services delivered in the covered person's residence only.

2.1.73. Managed Care Organization (MCO) – An entity that has or is seeking to qualify for, a comprehensive risk contract and that is a federally qualified health maintenance organization that meets the advanced directives requirements; or any public or private entity that meets the advance directives requirements and is determined by the Secretary to make the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity, and meets the solvency standards of 42 C.F.R. § 438.116 as defined in 42 C.F.R. § 438.2.

2.1.74. Managing Employee – Means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control, or who directly or indirectly conducts the day-to-day operation.

2.1.75. Marketing—Means any communication from MCO, PIHP, PAHP, PCCM or PCCM Entity to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular, MCO's, PIHP's, PAHP's, PCCM's or PCCM Entity's, Medicaid product, or either to not enroll in or disenroll from another MCO's, PIHP's, PAHP's, PCCM's or PCCM Entity's and other Medicaid product, as defined in CFR 438.104(a).

2.1.76. Medical Home – An approach to providing comprehensive primary care that facilitates partnerships between individual Members, their providers, and, where appropriate, the Member's family.

2.1.77. Medical Loss Ratio (MLR) – Percent of a premium used to pay for medical claims and activities that improve the quality of care; a basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees.

2.1.78. Medicaid Management Information Systems (MMIS) – The Department's automated computer systems that process Medicaid and CHP+ claims and other pertinent information as required under federal regulations.

2.1.79. Medically Necessary – Also called Medical Necessity, shall be defined as described in 10 CCR 2505-10 § 8.076.1.8, §8.280.4.E.2., 10 CCR 2505-10 § 8.280, and 42 CFR § 441.50 to 441.62.

2.1.80. Medical Record – A document, either physical or electronic, that reflects the utilization of health care services and treatment history of the Member.

2.1.81. MFCU - Colorado Medicaid Fraud Control Unit.

2.1.82. Member – Any individual enrolled in the Accountable Care Collaborative.

2.1.83. Monthly Capitation Payment – A payment the State makes on a monthly basis to a Contractor on behalf of each Member enrolled in its plan under a contract and based on the actuarially sound capitation rate for the provision of services covered under the Contract. For this Contract, the State will make two payments: one for the managed care capitation initiative and one for the Capitated Behavioral Health Benefit.

2.1.84. Network Provider – A Provider who is in the employment of, or who has entered into an agreement with, Contractor to provide medical or specialty behavioral health services to Contractor's Members. Primary care providers who are "Network Providers" are referred to as "Primary Care Medical Providers."

2.1.85. Nursing Facility – A facility that primarily provides skilled nursing care and related services to residents for the rehabilitation of individuals who are injured, disabled, or sick, or on a regular basis above the level of custodial care to other individuals with intellectual or developmental disabilities.

2.1.86. Office of Community Living (OCL) – Office within the Department that provides direction and strategic oversight of Colorado Medicaid's programs, services, and supports for older adults and persons with disabilities.

2.1.87. Office of Community Living Case Management Agency (CMA) - An organization contracted with the Department's Office of Community Living to provide case management services and activities to Members receiving Medicaid Home and Community-Based Services (HCBS) waiver benefits.

2.1.88. Open Enrollment Period – the two months immediately preceding the month in which a Member's birthday occurs.

2.1.89. Operational Start Date – The Effective Date of the Contract, or when the Department authorizes Contractor to begin fulfilling its obligations under the Contract.

2.1.90. Other Personnel - Individuals and subcontractors, in addition to Key Personnel, assigned to positions to complete tasks associated with the Work.

2.1.91. Overpayment - The amount paid to a Provider which is in excess of the amount that is allowable for goods or services furnished and which is required by Title XIX of the Social Security Act to be refunded. An Overpayment may include, but is not limited to, improper payments made as the result of Fraud, Waste, and Program Abuse.

2.1.92. Ownership – Means the possession of equity in the capital, stock, or profits of an entity.

2.1.93. Ownership or Control Interest – Means an individual or entity that: has an ownership interest totaling five percent or more; has an indirect ownership Interest equal to five percent or more; has a combination of direct and indirect ownership interests equal to five percent or more; owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five percent of the value of the property or assets of the other entity; is an officer or director of an entity that is organized as a corporation; or is a partner in an entity that is organized as a partnership.

2.1.94. Patient Abuse – The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical or financial harm or pain or mental anguish, including any acts or omissions that constitute a criminal violation under state law.

2.1.95. Persons with Special Health Care Needs – persons defined in 10 C.C.R. 2505-10, §8.205.9,

et seq.

2.1.96. PHI - Protected Health Information.

2.1.97. Population Management Framework – The Department-developed population stratification framework that includes three levels: complex care coordination and management for members with complex health needs; condition management for members with chronic or Department specified health conditions; and prevention and supportive services for general wellness and member engagement.

2.1.98. Post-Stabilization Care Services – Covered services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Member's condition.

2.1.99. Potential Member – an individual enrolled in Medicaid who is eligible for Contractor's managed care capitation initiative but is not yet enrolled.

2.1.100. Pre-Admission Screening and Resident Review (PASRR) – A federally mandated program through the Omnibus Budget Reconciliation Act to determine medical necessity for placement in a Medicaid certified nursing facility and the need for specialized services for individuals with mental illness and/or an intellectual or developmental disability.

2.1.101. Prepaid Inpatient Health Plan (PIHP) – An entity that provides health and medical services to enrollees under a non-comprehensive risk contract with the Department, and on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates, and provides, arranges for, or is otherwise responsible for the provisions of any inpatient hospital or institutional services for its enrollees as defined in 42 C.F.R. § 438.2.

2.1.102. Prevalent Language(s) – Means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient, as defined in 42 C.F.R. § 438.10(a).

2.1.103. Primary Care Alternative Payment Model (APM) – A Department initiative to transition primary care provider reimbursement from one based on volume to one based on value in the FFS system.

2.1.104. Primary Care Case Management (PCCM) – A system under which a primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Members, or a PCCM entity that contracts with the State to provide a defined set of functions as defined in 42 C.F.R. § 438.2.

2.1.105. Primary Care Case Management Entity (PCCM Entity) – An organization that provides any of the following functions, in addition to PCCM services, for the state: provision of intensive telephonic or face-to-face case management; development of enrollee care plans; execution of contracts with and/or oversight responsibilities for the activities of fee-for-service providers in the Fee-for-Service program; provision of payments to Fee- for-Service providers on behalf of the state; provision of enrollee outreach and education activities; operation of a customer service call center; review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement; implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers; coordination with behavioral health systems/providers; coordination with long-term services and supports

systems/providers as defined in 42 C.F.R. § 438.2.

2.1.106. Primary Care Medical Provider (PCMP) – A primary care provider contracted with a RAE to participate in the Accountable Care Collaborative as a Network Provider.

2.1.107. Primary Diagnosis – The diagnosis the provider either conducted an evaluation for or was the reason for the specific treatment that is requested or submitted for reimbursement on a CMS 1500.

2.1.108. Principal Diagnosis – Condition established after study to be chiefly responsible for a Member's admission to the hospital. It is always the first-listed diagnosis on the health record and the UB-04 claim form.

2.1.109. Program Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medical Assistance program, an Overpayment by the Medical Assistance program, in reimbursement for good or services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

2.1.110. Primary Care Medical Provider Practice Site (PCMP Practice Site) – A single "brick and mortar" physical location where services are delivered to Members under a single Medicaid billing provider identification number.

2.1.111. Private Institution for Mental Diseases (Private IMD) — A hospital, nursing facility, or other institution of more than 16 beds that is not under the jurisdiction of the State's mental health authority that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services as defined in Section 1905(i) of the Social Security Act, 42 CFR 435.1009, and the State Medicaid Manual Section 4390.

2.1.112. Program of All-Inclusive Care for the Elderly (PACE) – A Medicare/Medicaid managed care program that provides health care and support services to individuals 55 years of age and older to assist frail individuals to live in their communities as independently as possible by providing comprehensive services based on their needs, as described at 25.5- 5-412, C.R.S.

2.1.113. Protected Health Information (PHI) – Any protected health information, including, without limitation any information whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes, but is not limited to, any information defined as Individually Identifiable Health Information by the federal Health Insurance Portability and Accountability Act.

2.1.114. Provider – Any health care professional or entity that has been accepted as a provider in the Colorado Medicaid program as determined by the Department.

2.1.115. Provider Dispute – Any administrative, payment, or other dispute between a provider and a Contractor that does not involve a member appeal and does not include routine provider inquires that Contractor resolves in a timely fashion through existing informal processes.

2.1.116. Public Institution for Mental Diseases (Public IMD) — A facility under the jurisdiction of the State's mental health authority that provides services to mentally ill persons as defined in Section 1905(i) of the Social Security Act, 42 CFR 435.1009, and the State Medicaid Manual Section 4390.

2.1.117. Referral or Written Referral – A document from a provider that recommends or provides permission for a Member to receive additional services.

2.1.118. Regional Accountable Entity (RAE) – A single regional entity responsible for implementing the Accountable Care Collaborative within its region.

2.1.119. Rural County – A county in Contractor's service area with a total population of less than 100,000 people.

2.1.120. Rural Health Center (RHC) – A hospital-based or free-standing center that meets the RHC definition found in Section 1905(1)(2)(B) of the Social Security Act.

2.1.121. Specialty Drugs: A list of Outpatient Hospital Physician Administered Drugs maintained by the Department that are subject to special reimbursement terms.

2.1.122. Service Area – the area for which the Department and Contractor have agreed that Contractor will provide Covered Services to Members.

2.1.123. Significant Business Transaction – Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000.00 and five percent of Contractor's total operating expenses.

2.1.124. Single Case Agreement- A written agreement between Contractor and a Provider to deliver services to a Member.

2.1.125. Site Review – The visit of Department staff or its designee to the site or the administrative office(s) of Contractor and/or its Network Providers and/or subcontractors to assess the physical resources and operational practices in place to deliver contracted services and/or health care.

2.1.126. Special Connections – The Special Connections program provides treatment services for pregnant women and women up to 12 months postpartum with substance use disorders who are assessed to be at risk for poor maternal or infant health outcomes. The program is jointly administered by the Colorado Department of Human Services, Behavioral Health Administration, and the Department to provide specialized women's services that are gender responsive and trauma informed.

2.1.127. Stakeholder – any individual, group or organization that is involved in or affected by a course of action related to the Accountable Care Collaborative. Stakeholders may be Members, family members, caregivers, clinicians, advocacy groups, professional societies, businesses, policymakers, or others.

2.1.128. Start-Up Period – The period from the Effective Date until the Operational Start Date.

2.1.129. State Fair Hearing – The process set forth in 42 C.F.R. § 431 subpart E.

2.1.130. Subcontractor – An individual or entity that has a contract with an MCO, PIHP, or PCCM Entity that relates directly or indirectly to the performance of the MCO, PIHP, or PCCM Entity's obligations under its contract with the state. A Network Provider is not a Subcontractor by virtue of the Network Provider agreement with the MCO, or PIHP as defined in 42 C.F.R. § 438.2.

2.1.131. Suspected Fraud – An instance of when an idea, impression, belief, feeling, or thought of an event, behavior or trend exists, but definitive evidence is lacking.

2.1.132. Termination/Terminated – Occurring when a state Medicaid program, CHP+, or the Medicare program has taken action to revoke a Medicaid or CHP+ provider's or Medicare provider's

or supplier's billing ID.

2.1.133. Universal Contract – Provisions required in CRS 27-50-203 to be used by state agencies and their contractors when contracting for behavioral health services in the state.

2.1.134. Urban County – A county in Contractor's Service Area with a total population equal to or greater than 100,000 people.

2.1.135. Urgent Medical Condition – A medical condition that has the potential to become an emergency medical condition in the absence of treatment.

2.1.136. Utilization Management – The function wherein use, consumption, and outcome services, along with level and intensity of care, are reviewed for their appropriateness using Utilization Review techniques.

2.1.137. Utilization Review – A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, Referrals, procedures or settings.

2.1.138. Value-based Payment – A type of payment for healthcare services that links Provider payments to improved Member health outcomes and reduced healthcare expenditures.

2.1.139. Waste – Inappropriate utilization that results in unnecessary cost.

2.1.140. Wholly Owned Supplier – A supplier whose total ownership interest is held by Contractor or by a person, persons, or other entity with an ownership or control interest in Contractor.

2.1.141. Work – The tasks and activities Contractor is required to perform to fulfill its obligations under the Contract, including the performance of any services and delivery of any goods.

2.1.142. Work Product – The tangible and intangible results of the Work, whether finished or unfinished, including drafts. Work Product includes, but is not limited to, documents, text, software (including source code), research, reports, proposals, specifications, plans, notes, studies, data, images, photographs, negatives, pictures, drawings, designs, models, surveys, maps, materials, ideas, concepts, know-how, and any other results of the Work. "Work Product" does not include any Contractor Pre-Existing Material that is used, without modification, in the performance of the Work.

2.1.143. Wrap Around Benefits – Medicaid services which either exceed coverage limitations Contractor is required by this Contract - to provide or, Contractor is not obligated to provide coverage for under this Contract. Wrap Around Benefits are services reimbursable under the Medicaid fee-for-service and must be billed directly to the Department's fiscal agent by the Provider. Wrap Around Benefits include, but are not limited to medical transportation and private duty nursing.

2.2. Any other term used in this Contract that is defined in an Exhibit shall be construed and interpreted as defined in that Exhibit.

3. CONTRACTOR'S GENERAL REQUIREMENTS

3.1. The Department will contract with only one organization, Contractor, and will work solely with that organization with respect to all tasks and deliverables to be completed, services to be rendered and performance standards to be met under the work outlined in this Contract.

3.1.1. Contractor shall not be located outside of the United States, per 42 CFR § 438.602(i).

3.1.2. Claims paid by Contractor to a network provider, out-of-network provider, subcontractor or financial institution located outside of the United States will not be considered in the development of actuarially sound capitation rates per 42 CFR § 438.602(i).

3.2. Contractor may be privy to internal policy discussions, contractual issues, price negotiations, confidential medical information, Department financial information, advance knowledge of legislation and other Confidential Information. In addition to all other confidentiality requirements of the Contract, Contractor shall also consider and treat any such information as Confidential Information and shall only disclose it in accordance with the terms of the Contract.

3.3. Contractor shall work cooperatively with Department staff and, if applicable, the staff of other State contractors to ensure the completion of the Work. The Department may, in its sole discretion, use other contractors to perform activities related to the Work that are not contained in Contractor to perform any of the Department's responsibilities. In the event of a conflict between Contractor and any other State contractor, the State will resolve the conflict and Contractor shall abide by the resolution provided by the State.

3.4. Contractor shall inform the Department on current trends and issues in the healthcare marketplace and provide information on new technologies in use that may impact Contractor's responsibilities under the work outlined in this Contract.

3.5. Contractor shall maintain complete and detailed records of all meetings, system development life cycle documents, presentations, project artifacts and any other interactions or deliverables related to the project described in the Contract. Contractor shall make records available to the Department upon request, throughout the term of the Contract.

3.6. Contractor shall participate in special workgroups created by the Department or other state agencies as directed by the Department and shall provide requested deliverables to support these workgroups in accordance with agreed-upon terms and deadlines established by the workgroups.

3.7. Contractor shall use the Department-developed definition for the following terms, when applicable and when available: appeal; co-payment; durable medical equipment; emergency room care; emergency services; excluded services; grievance; habilitation services and devices; health insurance; home health care; hospice services; hospitalization; hospital outpatient care; medically necessary; network; non-Network Provider; physician services; plan; preauthorization; prescription drug coverage; primary care physician; PCP; Network provider; premium; provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care.

3.8. Contractor Performance Management

3.8.1. Performance Management Process

3.8.1.1. The Department may take action when Contractor is out of compliance in relation to the Work performed under the Contract. Prior to a determination of breach of contract, the Department may initiate components of a multi-step process intended to correct Contractor performance until the Work performed under the Contract has reached a satisfactory level. The multi-step process selected will be dependent on the persistence, severity, and risk of the performance issue and may include informal performance feedback, an action monitoring plan, a corrective action plan, or a recoupment of funds for reimbursement for Department hours spent working on the outstanding issue(s).

3.8.2. Financial accountability

3.8.2.1. The Department may recoup funds from Contractor when Contractor is out of compliance in relation to the Work performed under the Contract when the non-compliance is a high

enough degree of severity, persistence or of significant risk; when a PERFORMANCE STANDARD is not met; or when the performance management process has not resolved the non-compliance

3.8.2.2. The Department may recoup funds from Contractor at a rate of fifty dollars per hour ($50/hr) for the number of Department staff hours engaged on the identified issue(s).

3.8.2.3. These reimbursements shall be deducted from Contractor's profit margin and not from operational expenses. Contractor shall bear the responsibility of proving that reimbursements are deducted from Contractor's profit margin during the quarterly financial review meetings with the Department. Contractor shall not:

3.8.2.3.1. Pass on the cost of this reimbursement to Network Providers or Subcontractors that support the Work, unless it is shown, and the Department agrees, that the Provider or Subcontractor is directly responsible for the PERFORMANCE STANDARD not being met.

3.9. Deliverables

3.9.1. All Deliverables shall meet Department-approved format and content requirements. The Department will specify the number of copies and media for each Deliverable.

3.9.2. Each Deliverable shall follow the Deliverable submission process as follows:

3.9.2.1. Contractor shall submit each Deliverable to the Department for review and approval.

3.9.2.2. For all documentation, creation, review and acceptance cycle:

3.9.2.2.1. Contractor shall gather and document requirements for the Deliverable.

3.9.2.2.2. Contractor shall create a draft in the Department-approved format for the individual Deliverable.

3.9.2.2.3. Contractor shall perform internal quality control review(s) of the Deliverable including, but not limited to:

3.9.2.2.3.1. Readability

3.9.2.2.3.2. Spelling

3.9.2.2.3.3. Grammar

3.9.2.2.3.4. Completion

3.9.2.2.3.5. Adherence to all required templates or development of templates.

3.9.2.3. All modifications shall include version control and tracked changes.

3.9.2.4. The Department will review the Deliverable and may direct Contractor to make changes to the Deliverable. Contractor shall make all changes within ten Business Days following the Department's direction to make the change unless the Department provides a longer period in writing.

3.9.2.5. Changes the Department may direct include, but are not limited to, modifying portions of the Deliverable, requiring new pages or portions of the Deliverable, requiring resubmission of the Deliverable or requiring inclusion of information or components that were left out of the Deliverable.

3.9.2.5.1. The Department may also direct Contractor to provide clarification or provide a walkthrough of any Deliverable to assist the Department in its review. Contractor

shall provide the clarification or walkthrough as directed by the Department.

3.9.2.6. Once the Department has received an acceptable version of the Deliverable, including all changes directed by the Department, the Department will notify Contractor of its acceptance of the Deliverable in writing. A Deliverable shall not be deemed accepted prior to the Department's notice to Contractor of its acceptance of that Deliverable

3.9.3. Contractor shall employ an internal quality control process to ensure that all Deliverables are complete, accurate, easy to understand and of high quality. Contractor shall provide Deliverables that, at a minimum, are responsive to the specific requirements for that Deliverable, organized into a logical order, contain accurate spelling and grammar, are formatted uniformly, and contain accurate information and correct calculations. Contractor shall retain all draft and marked-up documents and checklists utilized in reviewing Deliverables for reference as directed by the Department.

3.9.4. If any due date for a Deliverable falls on a day that is not a Business Day, then the due date shall be automatically extended to the next Business Day, unless otherwise directed by the Department.

3.9.5. All due dates or timelines that reference a period of days, months or quarters shall be measured in calendar days, months and quarters unless specifically stated as being measured in Business Days or otherwise. All times stated in the Contract shall be considered to be in Mountain Time, adjusted for Daylight Saving Time as appropriate, unless specifically stated otherwise.

3.9.6. No Deliverable, report, data, procedure or system created by Contractor for the Department that is necessary to fulfilling Contractor's responsibilities under the Contract, as determined by the Department, shall be considered proprietary.

3.9.7. If any Deliverable contains ongoing responsibilities or requirements for Contractor, such as Deliverables that are plans, policies or procedures, then Contractor shall comply with all requirements of the most recently approved version of that Deliverable. Contractor shall not implement any version of any such Deliverable prior to receipt of the Department's written approval of that version of that Deliverable. Once a version of any Deliverable described in this subsection is approved by the Department, all requirements, milestones and other Deliverables contained within that Deliverable shall be considered to be requirements, milestones and Deliverables of this Contract.

3.9.7.1. Any Deliverable described as an update of another Deliverable shall be considered a version of the original Deliverable for the purposes of this subsection.

3.10. Stated Deliverables and Performance Standards

3.10.1. Any section within this Statement of Work headed with or including the term "DELIVERABLE" or "PERFORMANCE STANDARD" is intended to highlight a Deliverable or performance standard contained in this Statement of Work and provide a clear due date for the Deliverables. The sections with these headings are for ease of reference not intended to expand or limit the requirements or responsibilities related to any Deliverable or performance standard, except to provide the due date for the Deliverables.

3.11. Communication Requirements

3.11.1. Communication with the Department

3.11.1.1. Contractor shall enable all Contractor staff to exchange documents and electronic files

with the Department staff in formats compatible with the Department's systems. The Department currently uses Microsoft Office 2016 and/or Microsoft Office 365 for PC. If Contractor uses a compatible program, then Contractor shall ensure that all documents or files delivered to the Department are completely transferrable and reviewable, without error, on the Department's systems.

3.11.1.2. Contractor shall provide the Department with a listing of the following individuals within Contractor's organization, that includes cell phone numbers and email addresses:

3.11.1.2.1. An individual who is authorized to speak on the record for media, legislative or other requests regarding the work, the Contract or any issues that arise that are related to the work.

3.11.1.2.2. An individual who is responsible for any written communications, surveys, in- person meetings, call center scripting, electronic communication, website, online portals, external newsletters, and distribution lists for Network Providers, Prospective Network Providers, Prospective Members, Members, Prospective Partners and Partners or any marketing related to the work, savings and care coordination utilization reports.

3.11.1.2.3. Back-up communication staff that can respond in the event that the other individuals listed are unavailable.

3.11.1.3. The Department will use a transmittal process to provide Contractor with official direction within the scope of the Contract. Contractor shall comply with all direction contained within a completed transmittal. For a transmittal to be considered complete, it must include, at a minimum, all of the following:

3.11.1.3.1. The date the transmittal will be effective.

3.11.1.3.2. Direction to Contractor regarding performance under the Contract.

3.11.1.3.3. A due date or timeline by which Contractor shall comply with the direction contained in the transmittal.

3.11.1.3.4. The signature of the Department employee who has been designated to sign transmittals.

3.11.1.3.4.1. The Department will provide Contractor with the name of the person it has designated to sign transmittals on behalf of the Department, who will be the Department's primary designee. The Department will also provide Contractor with a list of backups who may sign a transmittal on behalf of the Department if the primary designee is unavailable. The Department may change any of its designees from time to time by providing notice to Contractor through a transmittal.

3.11.1.4. The Department may deliver a completed transmittal to Contractor in hard copy, as a scanned attachment to an email or through a dedicated communication system, if such a system is available.

3.11.1.4.1. If a transmittal is delivered through a dedicated communication system or other electronic system, then the Department may use an electronic signature to sign that transmittal.

3.11.1.5. If Contractor receives conflicting transmittals, Contractor shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, to obtain

direction. If the Department does not provide direction otherwise, then the transmittal with the latest effective date shall control.

3.11.1.6. In the event that Contractor receives direction from the Department outside of the transmittal process, it shall contact the Department's primary designee, or backup designees if the primary designee is unavailable, and have the Department confirm that direction through a transmittal prior to complying with that direction.

3.11.1.7. Transmittals may not be used in place of an amendment, and may not, under any circumstances be used to modify the term of the Contract or any compensation under the Contract. Transmittals are not intended to be the sole means of communication between the Department and Contractor, and the Department may provide day-to- day communication to Contractor without using a transmittal.

3.11.1.8. Contractor shall retain all transmittals for reference and shall provide copies of any received transmittals upon request by the Department.

3.11.2. Communication with Providers and Other External Entities

3.11.2.1. Contractor shall maintain consistent communication, both proactive and responsive, with Network Providers and other partners, and promote communication among Network Providers.

3.11.2.2. Contractor shall create, document, and implement a Communication Plan that specifies how Contractor will maintain necessary communication with all Network Providers and partners in the broader Health Neighborhood. The Communication Plan shall include:

3.11.2.2.1. A description of the purpose and frequency of communications with Network Providers and other partners.

3.11.2.2.2. The communication methods Contractor plans to use. Communication methods may consist of written communications, in-person meetings, one-on one support, electronic communication and any other method Contractor deems appropriate.

3.11.2.2.3. A contingency plan with specific means of immediate communication with Members and Providers and a method for accelerating the internal approval and communication process to address urgent communications or crisis situations.

3.11.2.2.4. A general plan for how Contractor will address communication deficiencies or crisis situations, including how Contractor will increase staff, contact hours or other steps Contractor will take if existing communication methods for Members or providers are insufficient.

3.11.2.3. Contractor shall review and update the Communication Plan at least annually and submit to the Department for review as part of the Annual Network Management Strategic Plan.

3.11.2.3.1. Contractor shall modify the Annual Network Management Strategic Plan as directed by the Department to account for any changes in the work, in the Department's processes and procedures or in Contractor's processes and procedures, or to address any communication related deficiencies determined by the Department.

3.11.3. <u>Accessibility Indemnification</u>

3.11.3.1. The Contractor shall indemnify, save, and hold harmless the Indemnified Parties, against any and all costs, expenses, claims, damages, liabilities, court awards and other

amounts (including attorneys' fees and related costs) incurred by any of the Indemnified Parties in relation to Contractor's failure to comply with §§24-85-101, et seq., C.R.S., or the Accessibility Standards for Individuals with a Disability as established by OIT pursuant to Section §24-85-103 (2.5), C.R.S.

3.11.4. Accessibility

3.11.4.1. The Contractor shall comply with the Work Product provided under this Contract shall be in compliance with all applicable provisions of §§24-85-101, et seq., C.R.S., and the Accessibility Standards for Individuals with a Disability, as established by OIT pursuant to Section §24-85-103 (2.5), C.R.S. Contractor shall also comply with all State of Colorado technology standards related to technology accessibility and with Level AA of the most current version of the Web Content Accessibility Guidelines (WCAG), incorporated in the State of Colorado technology standards.

3.11.4.2. The State may require Contractor's compliance to the State's Accessibility Standards to be determined by a third party selected by the State to attest to Contractor's Work Product and software is in compliance with §§24-85-101, et seq., C.R.S., and the Accessibility Standards for Individuals with a Disability as established by OIT pursuant to Section §24-85-103 (2.5), C.R.S.

3.12. Start-Up and Closeout Periods

3.12.1. Contractor shall have a Start-Up and a Closeout Period.

3.12.2. Start-Up Period

3.12.2.1. The Start-Up Period shall begin on the Effective Date. The Start-Up Period shall end on the Operational Start Date of the Contract.

3.12.2.2. Contractor shall receive no compensation for the Start-Up Period.

3.12.2.3. The Operational Start Date shall not occur until Contractor has completed all requirements of the Start-Up Period, including the completion of the Start-Up Plan.

3.12.3. Start-Up Plan

3.12.3.1. During the Start-Up Period, Contractor shall create a Start-Up Plan that contains, at a minimum, all of the following:

3.12.3.1.1. A description of all activities, timelines and milestones necessary to fully transition the services of the Community Behavioral Health Services program and the Accountable Care Collaborative Program described in the Contract from a prior contractor to Contractor.

3.12.3.1.2. A description of all activities, timelines, milestones and deliverables necessary for Contractor to be fully able to perform all Work by the Operational Start Date.

3.12.3.1.3. A listing of all personnel involved in the Start-Up and what aspect of the Start-Up they are responsible for.

3.12.3.1.4. Contractor shall participate in an operational readiness review in compliance with 42 C.F.R. § 438.66. The readiness review consists of a desk audit and Site Review covering the following:

3.12.3.1.4.1. Administrative staffing and resources.

3.12.3.1.4.2. Delegation and oversight of MCO, PIHP, PAHP or PCCM Entity responsibilities.

3.12.3.1.4.3. Provider communications.

3.12.3.1.4.4. Grievances and Appeals.

3.12.3.1.4.5. Member communication, services and outreach.

3.12.3.1.4.6. Provider Network Management.

3.12.3.1.4.7. Program Integrity/Compliance.

3.12.3.1.4.8. Case management/Care Coordination/service planning.

3.12.3.1.4.9. Quality improvement.

3.12.3.1.4.10. Utilization review.

3.12.3.1.4.11. Financial reporting and monitoring.

3.12.3.1.4.12. Financial solvency.

3.12.3.1.4.13. Claims management.

3.12.3.1.4.14. Encounter Data and enrollment information management.

3.12.3.1.5. Staff hiring and training.

3.12.3.1.6. Infrastructure for data collection and exchanges, billing and reimbursement.

3.12.3.1.7. Test system compatibility.

3.12.3.1.8. Adherence to security protocols.

3.12.3.1.9. Established Provider Networks and agreements.

3.12.3.1.10. Member and provider materials and education.

3.12.3.1.11. Activities to fully transition the services described in the Contract from a prior contractor.

3.12.3.1.12. Policy and Procedures Manual that contains the policies and procedures for all systems and functions necessary for Contractor to complete its obligations under the Contract.

3.12.3.1.13. Business Continuity Plan described in Section 3.13.

3.12.3.1.14. The risks associated with the Start-Up and a plan to mitigate those risks.

3.12.3.1.15. Data as needed for the Department rate setting process.

3.12.3.2. Contractor shall deliver the Start-Up Plan to the Department for review and approval.

3.12.3.2.1. DELIVERABLE: Start-Up Plan

3.12.3.2.2. DUE: Within five Business Days after the Effective Date

3.12.3.3. Contractor shall update the Start-Up Plan based on the Department's request and resubmit the Start-Up Plan for review and approval.

3.12.3.3.1. DELIVERABLE: Start-Up Plan Update

3.12.3.3.2. DUE: Within five Business Days from the Department's request for an update

3.12.3.4. Contractor shall implement the Start-Up Plan upon the Department's approval of the Start-Up Plan.

3.12.3.5. Contractor shall not engage in any Work under the Contract, other than the Work described above in the Start-Up Period, prior to the Operational Start Date.

3.12.3.6. Submit to the Department Contractor's Colorado Division of Insurance license as either a Health Maintenance Organization or Limited Service Licensed Provider Network

3.12.3.6.1. DELIVERABLE: Contractor's Colorado Division of Insurance license

3.12.3.6.2. DUE: Upon the Effective Date

3.12.3.7. Contractor shall ensure that all requirements of the Start-Up Period are complete by the deadlines contained in the Department-approved Start-Up Plan and that Contractor is ready to perform all Work by the Operational Start Date.

3.12.4. Closeout Period

3.12.4.1. The Closeout Period shall begin on the earlier of 90 days prior to the end of the last renewal year of the Contract or notice by the Department of non-renewal. The Closeout Period shall end on the day that the Department has accepted the final deliverable for the Closeout Period, as determined in the Department-approved and updated Closeout Plan, and has determined that the closeout is complete.

3.12.4.2. This Closeout Period may extend past the termination of the Contract. The Department will perform a closeout review to ensure that Contractor has completed all requirements of the Closeout Period. If Contractor has not completed all of the requirements of the Closeout Period by the date of the termination of the Contract, then any incomplete requirements shall survive termination of the Contract.

3.12.4.3. During the Closeout Period, Contractor shall complete all of the following:

3.12.4.3.1. Implement the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department, and complete all steps, deliverables and milestones contained in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

3.12.4.3.2. Provide to the Department, or any other contractor at the Department's direction, all reports, data, systems, deliverables and other information reasonably necessary for a transition as determined by the Department or included in the most recent Closeout Plan or Closeout Plan Update that has been approved by the Department.

3.12.4.3.3. Ensure that all responsibilities under the Contract have been transferred to the Department, or to another contractor at the Department's direction, without significant interruption.

3.12.4.3.4. Notify any Subcontractors of the termination of the Contract, as directed by the Department.

3.12.4.3.5. Notify all Members that Contractor will no longer be the RAE as directed by the Department. Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, Contractor shall deliver these notifications to all Members, but in no event shall Contractor deliver any such notification prior to approval of that notification by the Department.

3.12.4.3.5.1. DELIVERABLE: Member Notifications

3.12.4.3.5.2. DUE: 60 days prior to termination of the Contract

3.12.4.3.6. Notify all providers that Contractor will no longer be the RAE as directed by the Department. Contractor shall create these notifications and deliver them to the Department for approval. Once the Department has approved the notifications, Contractor shall deliver these notifications to all providers, but in no event shall Contractor deliver any such notification prior to approval of that notification by the Department.

3.12.4.3.6.1. DELIVERABLE: Provider Notifications

3.12.4.3.6.2. DUE: 60 days prior to termination of the Contract

3.12.4.3.7. Continue meeting each requirement of the Contract as described in the Department-approved and updated Closeout Plan, or until the Department determines that specific requirement is being performed by the Department or another contractor, whichever is sooner. The Department will determine when any specific requirement is being performed by the Department or another contractor, and will notify Contractor of this determination for that requirement.

3.12.4.4. The Closeout Period may extend past the termination of the Contract. The Department will perform a closeout review to ensure that Contractor has completed all requirements of the Closeout Period. In the event that Contractor has not completed all of the requirements of the Closeout Period by the date of the termination of the Contract, then any incomplete requirements shall survive termination of the Contract.

3.12.5. Closeout Planning

3.12.5.1. Closeout Plan

3.12.5.1.1. Contractor shall create a Closeout Plan that describes all requirements, steps, timelines, milestones and Deliverables necessary to fully transition the services described in the Contract from Contractor to the Department or to another contractor selected by the Department to be the Accountable Care Collaborative Program contractor after the termination of the Contract. The Closeout Plan shall also designate an individual to act as a closeout coordinator, who will ensure that all requirements, steps, timelines, milestones and deliverables contained in the Closeout Plan are completed and work with the Department and any other contractor to minimize the impact of the transition on Members and the Department. Contractor shall deliver the Closeout Plan to the Department for review and approval.

3.12.5.1.1.1. DELIVERABLE: Closeout Plan

3.12.5.1.1.2. DUE: March 31, 2020

3.12.5.1.2. Contractor shall update the Closeout Plan, at least annually, to include any technical, procedural or other changes that impact any steps, timelines or milestones contained in the Closeout Plan, and deliver this Closeout Plan Update to the Department for review and approval.

3.12.5.1.2.1. DELIVERABLE: Closeout Plan Update

3.12.5.1.2.2. DUE: Annually, by July 31st of each year

3.13. Business Continuity

3.13.1. Contractor shall create a Business Continuity Plan that Contractor will follow in order to continue operations after a Disaster or a Business Interruption. The Business Continuity Plan

shall include, but is not limited to, all of the following:

3.13.1.1. How Contractor will replace staff that has been lost or is unavailable during or after a Business Interruption so that the Work is performed in accordance with the Contract.

3.13.1.2. How Contractor will back-up all information necessary to continue performing the Work, so that no information is lost because of a Business Interruption.

3.13.1.2.1. In the event of a Disaster, the plan shall also include how Contractor will make all information available at its back-up facilities.

3.13.1.3. How Contractor will minimize the effects on Members of any Business Interruption.

3.13.1.4. How Contractor will communicate with the Department during the Business Interruption and points of contact within Contractor's organization the Department can contact in the event of a Business Interruption.

3.13.1.5. Planned long-term back-up facilities out of which Contractor can continue operations after a Disaster.

3.13.1.6. The time period it will take to transition all activities from Contractor's regular facilities to the back-up facilities after a Disaster.

3.13.2. Contractor shall deliver the Business Continuity Plan to the Department for review and approval.

3.13.2.1. DELIVERABLE: Business Continuity Plan

3.13.2.2. DUE: Within 30 Business days after the Effective Date

3.13.3. Contractor shall review its Business Continuity Plan at least annually and update the plan as appropriate to account for any changes in Contractor's processes, procedures or circumstances. Contractor shall submit an Updated Business Continuity Plan that contains all changes from the most recently approved prior Business Continuity Plan or Updated Business Continuity Plan or shall note that there were no changes.

3.13.3.1. DELIVERABLE: Updated Business Continuity Plan

3.13.3.2. DUE: July 31st of each year

3.13.4. In the event of any Business Interruption, Contractor shall implement its most recently approved Business Continuity Plan or Updated Business Continuity Plan immediately after Contractor becomes aware of the Business Interruption. In that event, Contractor shall comply with all requirements, Deliverables, timelines and milestones contained in the implemented plan.

3.14. Accreditation

3.14.1. In accordance with 42 C.F.R. § 438.332(a) Contractor shall inform the Department of whether it is accredited by a private independent accrediting entity. If so, Contractor shall allow the accrediting entity to provide the Department a copy of the most recent review, including:

3.14.1.1. Accreditation status, survey type, and level;

3.14.1.2. Accreditation results including recommended actions, corrective action plans, or findings; and

3.14.1.3. Expiration date of the accreditation.

3.15. Federal Financial Participation Related Intellectual Property Ownership

3.15.1. In addition to the intellectual property ownership rights specified in the Contract, the following subsections enumerate the intellectual property ownership requirements Contractor shall meet during the term of the Contract in relation to federal financial participation under 42 CFR §433.112 and 45 CFR §95.617 concerning Mechanized Claim Processing and Information Retrieval Systems ("MCPIRS") to the extent that regulations apply to Contractor's operations under this Contract. CMS Regulations and Guidance, including, but not limited to, the CMS Memorandum RE: Mechanized Claim Processing and Information Retrieval Systems – Enhanced Funding, dated March 31, 2016 (SMD# 16-004) shall be applicable when interpreting requirements of this section 2.10 and only to the extent they apply to Contractor. Intellectual property ownership rights specified in the Contract shall not apply to (1) material created or used by Contractor which is unrelated to federal financial participation funding obtained by the State under 42 CFR §433.112 and 45 CFR §95.617 in connection with its MCPIRS, (2) material created using funds other than Contract Funds or (3) material that would have been developed by Contractor to enhance its own proprietary intellectual property and commercial software used in Contractor's business operations unrelated to the MCPIRS, using funds outside of Contract Funds and regardless of Contractor's performance of work.

3.15.1.1. Contractor shall notify the State before designing, developing, creating or installing any new data, new software or modification of a software using Contract Funds. Contractor shall not proceed with such designing, development, creation or installation of data or software without express written approval from the State.

3.15.1.2. If Contractor uses Contract Funds to develop necessary materials, including, but not limited to, programs, products, procedures, data and software to fulfill its obligations under the Contract, Contractor shall document all Contract Funds used in the development of the Work Product, including, but not limited to the materials, programs, procedures, and any data, software or software modifications.

3.15.1.2.1. The terms of this Contract will encompass sole payment for any and all Work Product and intellectual property produced by Contractor for the State. Contractor shall not receive any additional payments for licenses, subscriptions, or to remove a restriction on any intellectual property Work Product related to or developed under the terms of this Contract.

3.15.1.3. Contractor shall provide the State comprehensive and exclusive access to and disclose all details of the Work Product produced using Contract Funds.

3.15.1.4. Contractor shall hereby assign to the State, without further consideration, all right, interest, title, ownership and ownership rights in all Work Product and deliverables prepared and developed by Contractor for the State, either alone or jointly, under this Contract, including, but not limited to, data, software and software modifications designed, developed, created or installed using Contract Funds, as allowable in the United States under 17 U.S.C.S. §201 and §204 and in any foreign jurisdictions.

3.15.1.4.1. Such assigned rights include, but are not limited to, all rights granted under 17 U.S.C.S §106, the right to use, sell, license or otherwise transfer or exploit the Work Product and the right to make such changes to the Work Product as determined by the State.

3.15.1.4.2. This assignment shall also encompass any and all rights under 17 U.S.C.S §106A,

also referred to as the Visual Artists Rights Act of 1990 (VARA), and any and all moral rights to the Work Product.

3.15.1.4.3. Contractor shall require its employees and agents to, promptly sign and deliver any documents and take any action the State reasonably requests to establish and perfect the rights assigned to the State or its designees under these provisions.

3.15.1.4.4. Contractor shall execute the assignment referenced in Section 3.15.1.4 immediately upon the creation of the Work Product pursuant to the terms of this Contract.

3.15.1.5. The State claims sole ownership and all ownership rights in all copyrightable software designed, developed, created or installed under this Contract using Contract Funds, including, but not limited to:

3.15.1.5.1. Data and software, or modifications thereof created, designed or developed using Contract Funds.

3.15.1.5.2. Associated documentation and procedures designed and developed to produce any systems, programs, reports and documentation.

3.15.1.5.3. All other Work Products or documents created, designed, purchased, or developed by Contractor and funded using Contract Funds.

3.15.1.6. All ownership and ownership rights pertaining to Work Product created in the performance of this Contract will vest with the State, regardless of whether the Work Product was developed by Contractor or any Subcontractor.

3.15.1.7. Contractor shall fully assist in and allow without dispute, both during the term of this Contract and after its expiration, registration by the State of any and all copyrights and other intellectual property protections and registrations in data, software, software modifications or any other Work Product created, designed or developed using Contract Funds.

3.15.1.8. The State reserves a royalty-free, non-exclusive and irrevocable license to produce, publish or otherwise use such software, modifications, documentation and procedures created using Contract Funds on behalf of the State, the Federal Department of Health and Human Services (HHS) and its contractors. Such data and software includes, but is not limited to, the following:

3.15.1.8.1. All computer software and programs, which have been designed or developed for the State, or acquired by Contractor on behalf of the State, which are used in performance of the Contract.

3.15.1.8.2. All internal system software and programs developed by Contractor or subcontractor, including all source codes, which result from the performance of the Contract; excluding commercial software packages purchased under Contractor's own license.

3.15.1.8.3. All necessary data files.

3.15.1.8.4. User and operation manuals and other documentation.

3.15.1.8.5. System and program documentation in the form specified by the State.

3.15.1.8.6. Training materials developed for State staff, agents or designated representatives

3.15.1.8.7. in the operation and maintenance of this software.

3.16. Performance Reviews

3.16.1. The Department may conduct performance reviews or evaluations of Contractor in relation to the Work performed under the Contract.

3.16.2. The Department may work with Contractor in the completion of any performance reviews or evaluations or the Department may complete any or all performance reviews or evaluations independently, at the Department's sole discretion.

3.16.3. Contractor shall provide all information necessary for the Department to complete all performance reviews or evaluations, as determined by the Department, upon the Department's request. Contractor shall provide this information regardless of whether the Department decides to work with Contractor on any aspect of the performance review or evaluation.

3.16.4. The Department may conduct these performance reviews or evaluations at any point during the term of the Contract, or after termination of the Contract for any reason.

3.16.5. The Department may make the results of any performance reviews or evaluations available to the public, or may publicly post the results of any performance reviews or evaluations.

3.17. Renewal Options and Extensions

3.17.1. The Department may, within its sole discretion, choose to not exercise any renewal option in the Contract for any reason. If the Department chooses to not exercise an option, it may reprocure the performance of the Work in its sole discretion.

3.17.2. The Parties may amend the Contract to extend beyond six (6) years, in accordance with the Colorado Procurement Code and its implementing rules, in the event that the Department determines the extension is necessary to align the Contract with other Department contracts, to address State or Federal programmatic or policy changes related to the Contract or to provide sufficient time to transition the Work.

3.17.2.1. In the event that the Contract is extended beyond six (6) years, the annual maximum compensation for the Contract in any of those additional years shall not exceed the Contract maximum amount for the prior State Fiscal Year (SFY) plus the annual percent increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the Denver-Boulder-Greeley metropolitan area for the calendar year ending during that prior SFY. If the CPI-U for Denver-Boulder-Greeley is for some reason not available as specified in this subsection, the increase shall be equal to the percent increase in the CPI-U (U.S.) for the same period.

3.17.3. The limitation on the annual maximum compensation shall not include increases made specifically as compensation for additional work added to the Contract.

3.18. State System Access

3.18.1. If Contractor requires access to any State computer system to complete the Work, Contractor shall have and maintain all hardware, software and interfaces necessary to access the system without requiring any modification to the State’s system. Contractor shall follow all State policies, processes and procedures necessary to gain access to the State’s systems.

3.19. Protection of System Data

3.19.1. In addition to the requirements of the main body of this Contract, if Contractor or any Subcontractor is given access to State Records by the State or its agents in connection with Contractor’s performance under the Contract, Contractor shall protect all State Records in accordance with this Exhibit. All provisions of this Exhibit that refer to Contractor shall apply equally to any Subcontractor performing work in connection with the Contract.

3.19.2. For the avoidance of doubt, the terms of this Exhibit shall apply to the extent that any of the following statements is true in regard to Contractor access, use, or disclosure of State Records:

3.19.2.1. Contractor provides physical or logical storage of State Records;

3.19.2.2. Contractor creates, uses, processes, discloses, transmits, or disposes of State Records;

3.19.2.3. Contractor is otherwise given physical or logical access to State Records in order to perform Contractor's obligations under this Contract.

3.19.3. Contractor shall, and shall cause its Subcontractors, to do all of the following:

3.19.3.1. Provide physical and logical protection for all hardware, software, applications, and data that meets or exceeds industry standards and the requirements of this Contract.

3.19.3.2. Maintain network, system, and application security, which includes, but is not limited to, network firewalls, intrusion detection (host and network), annual security testing, and improvements or enhancements consistent with evolving industry standards.

3.19.3.3. Comply with State and federal rules and regulations related to overall security, privacy, confidentiality, integrity, availability, and auditing.

3.19.3.4. Provide that security is not compromised by unauthorized access to workspaces, computers, networks, software, databases, or other physical or electronic environments.

3.19.3.5. Promptly report all Incidents, including Incidents that do not result in unauthorized disclosure or loss of data integrity, to the State.

3.19.4. Colorado Information Security Policy (CISP) Compliance

3.19.4.1. Contractor shall assess its compliance with the CISPs, in effect at the time of the assessment, issued by the Governor's Office of Information Technology ("OIT") posted at www.oit.state.co.us/about/policies under Information Security.

3.19.4.2. For the purposes of reviewing and assessing compliance with the CISPs, Contractor shall consider itself to be both the Information Technology Service Provider (ITSP) and Business Owner.

3.19.4.3. Contractor shall deliver to the State the signed CISP Attestation, on a form provided by the Department, indicating that Contractor has assessed its compliance with the CISPs and has developed a plan to correct, in a timely manner, any security vulnerabilities identified during the assessment.

3.19.4.4. Contractor shall assess its compliance with the CISPs on an annual basis and deliver to the State the signed CISP Attestation, on a form provided by the Department.

3.19.4.4.1. DELIVERABLE: Annual CISP Attestation

3.19.4.4.2. DUE: Annually, by June 30th of each year

3.19.4.5. Contractor shall cause its Subcontractors to comply with the CISPs and to assess their compliance on at least and annual basis. If any Subcontractor's assessment determines that the Subcontractor is not in compliance, then Contractor shall ensure that Subcontractor corrects, in a timely manner, any security vulnerabilities identified during the assessment.

3.19.5. Health and Human Services HIPAA Security Rule Risk Assessments

3.19.5.1. Contractor shall deliver to the State the signed HHS Attestation, on a form provided by the Department, indicating that Contractor has conducted a risk assessment of its operations related to the services provided under this Contract that satisfies the requirement of 45 CFR. §164.308(a)(1)(ii)(A) (the "HIPAA Security Rule"), and that Contractor has developed a plan to correct, in a timely manner, any vulnerabilities in administrative, technical, or physical safeguards identified during the assessment.

3.19.5.2. Contractor shall conduct an annual risk assessment of its operations related to the services provided under this Contract that satisfies the requirement of the HIPAA Security Rule and deliver to the State the signed HHS Attestation, on a form provided by the Department.

3.19.5.2.1. DELIVERABLE: Annual HHS Attestation

3.19.5.2.2. DUE DATE: Annually, by June 30th of each year

3.19.5.3. Contractor shall cause its Subcontractors to comply with the HIPAA Security Rule and assess their compliance on at least an annual basis. If any Subcontractor's assessment determines that the Subcontractor is not in compliance, then Contractor shall ensure that Subcontractor corrects, in a timely manner, any vulnerabilities in administrative, technical, or physical safeguards identified during the assessment.

3.19.6. Subject to Contractor's reasonable access security requirements and upon reasonable prior notice, Contractor shall provide the State with scheduled access for the purpose of inspecting and monitoring access and use of State Records, maintaining State systems, and evaluating physical and logical security control effectiveness.

3.19.7. Contractor shall perform background checks on all of its respective employees and agents performing services or having access to State Records provided under this Contract. A background check performed during the hiring process shall meet this requirement. Contractor shall perform a background check on any employee if Contractor becomes aware of any reason to question the employability of an existing employee. Contractor shall require all Subcontractors to meet the standards of this requirement.

3.19.7.1. Contractor shall deliver to the State the signed Background Check Attestation, on a form provided by the Department, indicating that background checks have been completed on employees participating in operations related to this Contract.

3.19.7.1.1. DELIVERABLE: Background Check Attestation

3.19.7.1.2. DUE: Annually, by June 30th of each year

3.19.7.2. If Contractor will have access to Federal Tax Information under the Contract, Contractor shall agree to the State's requirements regarding Safeguarding Requirements for Federal Tax Information and shall comply with the background check requirements defined in IRS Publication 1075 and §24-50-1002, C.R.S.

3.20. Data Handling

3.20.1. The State, in its sole discretion, may securely deliver State Records directly to Contractor. Contractor shall maintain these State Records only within facilities or locations that Contractor has attested are secure, including for the authorized and approved purposes of backup and disaster recovery purposes. Contractor may not maintain State Records in any data center or other storage location outside the United States for any purpose without the prior express written consent of the State.

3.20.2. Contractor shall not allow remote access to State Records from outside the United States, including access by Contractor's employees or agents, without the prior express written consent of OIS. Contractor shall communicate any request regarding non-U.S. access to State Records to the Security and Compliance Representative for the State. The State shall have sole discretion to grant or deny any such request.

3.20.3. Upon request by the State made any time prior to 60 days following the termination of this Contract for any reason, whether or not the Contract is expiring or terminating, Contractor shall make available to the State a complete and secure download file of all data that is encrypted and appropriately authenticated. This download file shall be made available to the State within 10 Business Days of the State's request, and shall contain, without limitation, all State Records, Work Product, and system schema and transformation definitions, or delimited text files with documents, detailed schema definitions along with attachments in its native format. Upon the termination of Contractor's provision of data processing services, Contractor shall, as directed by the State, return all State Records provided by the State to Contractor, and the copies thereof, to the State or destroy all such State Records and certify to the State that it has done so. If legislation imposed upon Contractor prevents it from returning or destroying all or part of the State Records provided by the State to Contractor, Contractor shall guarantee the confidentiality of all State Records provided by the State to Contractor and will not actively process such data anymore.

4. CONTRACTOR REGION AND PERSONNEL

4.1. General Requirements and Region

4.1.1. Contractor shall provide the physical health managed care capitation initiative benefits and the Capitated Behavioral Health Benefits outlined in this Contract for the population enrolled with Contractor.

4.1.1.1. The Service Area includes Adams, Arapahoe, Denver, and Jefferson counties.

4.1.2. This Contract operates under the state authority of C.R.S. 25.5-5-415 and is a managed care capitation initiative within the Accountable Care Collaborative program.

4.2. Personnel

4.2.1. Contractor shall possess the organizational resources and commitment necessary to perform the work and successfully implement and operate the program in the - Contractor's Region. Specifically, Contractor shall:

4.2.1.1. Have a defined organizational structure with clear lines of responsibility, authority, communication and coordination throughout the organization.

4.2.1.2. Have a physical office located in Contractor's Region, unless otherwise approved by the Department in writing.

4.2.2. Contractor shall take into consideration the diversity of the community and the members it serves when hiring its Key Personnel and Other Personnel.

4.2.3. Contractor shall provide qualified Key Personnel located in Colorado and Other Personnel as necessary to perform the Work throughout the term of the Contract.

4.2.3.1. Contractor shall provide the Department with a final list of individuals assigned to the Contract and appropriate contact information for those individuals.

4.2.3.1.1. DELIVERABLE: Management/supervisory staff contact information

4.2.3.1.2. DUE: Within five Business Days following the Effective Date

4.2.3.2. Contractor shall update this list upon the Department's request to account for changes in the individuals assigned to the Contract.

4.2.3.2.1. DELIVERABLE: Updated list of management/supervisory staff contact information

4.2.3.2.2. DUE: Within five Business Days following the Department's request for an update

4.2.4. If any of Contractor's Key Personnel or Other Personnel are required to have and maintain any professional licensure or certification issued by any federal, state or local government agency, then Contractor shall make copies of such current licenses and certifications available to the Department upon request.

4.2.5. Contractor shall provide the Department with an Organizational Chart listing all positions within Contractor's organization that are responsible for the performance of any activity related to the Contract, their hierarchy and reporting structure and the names of the individuals fulfilling each position.

4.2.5.1. DELIVERABLE: Organizational Chart

4.2.5.2. DUE: Five Business days after the Effective Date

4.2.6. Contractor shall provide the Department with an updated Organizational Chart with any changes in Key Personnel.

4.2.6.1. DELIVERABLE: Updated Organizational Chart

4.2.6.2. DUE: Within five Business Days from any change in Key Personnel or from the Department's request for an updated Organizational Chart

4.2.7. Contractor shall not change individuals in Key Personnel positions without the prior written approval of the Department. Any individual replacing Key Personnel shall have qualifications that are equivalent to or exceed the qualifications of the individual that previously held the position, unless otherwise approved, in writing, by the Department. Contractor shall submit the Key Personnel Approval Form for Contractor's candidate for the position, along with the candidate's resume and copies of required professional license(s)/certification(s). The Department shall provide feedback on the candidate within five Business Days of Contractor's submission of the required information.

4.2.7.1. DELIVERABLE: Key Personnel Approval Form

4.2.7.2. DUE: Within ten Business Days following Contractor's identification of a potential replacement.

4.2.8. Key personnel may be temporarily replaced due to sickness, family emergencies, or other kinds of approved leave. In such cases, the Department shall be notified of the individual that will be filling in for the employee.

4.2.9. Contractor shall ensure that each Key Personnel position is filled by separate and distinct individuals. No individual shall be allowed to fulfill multiple Key Personnel positions simultaneously.

4.2.10. Personnel Availability

4.2.10.1. Contractor shall ensure Key Personnel and Other Personnel assigned to the Contract are available for meetings with the Department during the Department's normal business

hours, as determined by the Department. Contractor shall also make these personnel available outside of the Department's normal business hours and on weekends with prior notice from the Department.

4.2.10.2. Contractor's Key Personnel and Other Personnel shall be available for all regularly scheduled meetings between Contractor and the Department, unless the Department has granted prior, written approval.

4.2.10.3. Contractor shall ensure that the Key Personnel and Other Personnel attending all meetings between the Department and Contractor have the authority to represent and commit Contractor regarding work planning, problem resolution and program development.

4.2.10.4. At the Department's direction, Contractor shall make its Key Personnel and Other Personnel available to attend meetings as subject matter experts with stakeholders both within the state government and with external or private stakeholders.

4.2.10.5. All of Contractor's Key Personnel and Other Personnel that attend any meeting with the Department or other Department stakeholders shall be physically present at the location of the meeting, unless the Department gives prior, written permission to attend by telephone or video conference. If Contractor has any personnel attend by telephone or video conference, Contractor shall provide all additional equipment necessary for attendance, including any virtual meeting space or telephone conference lines.

4.2.10.6. Contractor shall respond to all telephone calls, voicemails and emails from the Department within one Business Day of receipt by Contractor.

4.2.11. Key Personnel

4.2.11.1. Contractor shall designate individuals, based in the State of Colorado, to hold the following Key Personnel positions:

4.2.11.1.1. Program Officer – One full-time employee. The Program Officer shall be a senior management position.

4.2.11.1.1.1. The Program Officer shall:

4.2.11.1.1.1.1. Serve as Contractor's primary point of contact for the Contract and for Contract performance. The Program Officer shall work out of an office within Contractor's Region, unless otherwise approved by the Department in writing.

4.2.11.1.1.1.2. Be accountable for all other Key Personnel and other personnel and ensure appropriate staffing levels throughout the term of the Contract.

4.2.11.1.1.1.3. Monitor all phases of the project in accordance with work plans or timelines or as determined between Contractor and the Department.

4.2.11.1.1.1.4. Ensure the completion of all work in accordance with the Contract 's requirements. This includes, but is not limited to, ensuring the accuracy, timeliness and completeness of all work.

4.2.11.1.1.1.5. Participate in Department-led meetings to discuss the progress and direction of the Program.

4.2.11.1.1.2. The Program Officer shall have the following qualifications:

4.2.11.1.1.2.1. Experience designing and/or administering health programs and developing health care policy.

4.2.11.1.1.2.2. Experience managing projects or contracts of similar scope and size.

4.2.11.1.1.2.3. Knowledge of and experience with health care delivery system reforms and Medicaid programs, including federal and state regulations.

4.2.11.1.1.2.4. Senior management decision-making authority regarding the Contract.

4.2.11.1.2. Utilization Management Director – One full-time employee.

4.2.11.1.2.1. The Utilization Management Director shall:

4.2.11.1.2.1.1. Lead and develop the utilization management program and manage the medical review and authorization process.

4.2.11.1.2.1.2. Oversee the medical appropriateness and necessity of services provided to Members.

4.2.11.1.2.1.3. Analyze and monitor utilization trends, identify problem areas and recommend action plans for resolution.

4.2.11.1.2.2. The Utilization Management Director shall have the following qualifications:

4.2.11.1.2.2.1. Registered Nurse or equivalent health care professional with necessary behavioral health clinical experience and medical knowledge.

4.2.11.1.2.2.2. Minimum of five years' cumulative experience in utilization management and managed care.

4.2.11.1.2.2.3. Knowledge of quality improvement, disease management, and case management.

4.2.11.1.3. Chief Financial Officer (CFO) – One full-time employee. The CFO shall be a senior management position.

4.2.11.1.3.1. The CFO shall:

4.2.11.1.3.1.1. Be accountable for the administrative, financial, and risk management operations of the organization, to include the development of a financial and operational strategy, metrics tied to that strategy, and the ongoing development and monitoring of control systems designed to preserve company assets and report accurate financial information.

4.2.11.1.3.1.2. Effectively implement and oversee the budget, accounting systems, financial and risk management operations for the organization, development of financial management strategy, including robust monitoring and reporting.

4.2.11.1.3.1.3. Ensure financial compliance with federal and state laws and the requirements.

4.2.11.1.3.2. The CFO shall have the following qualifications:

4.2.11.1.3.2.1. Licensed as Certified Public Accountant or have a Master's degree in accounting or business administration, unless otherwise approved by the Department in writing.

4.2.11.1.3.2.2. Experience and demonstrated success in managed health care, accounting systems and financial operations.

4.2.11.1.4. Chief Clinical Officer (CCO) – One full-time employee. The CCO shall be a senior management position.

4.2.11.1.4.1. The CCO shall:

4.2.11.1.4.1.1. Define the overall clinical vision for the organization and provide clinical direction to network management, quality improvement, utilization management and credentialing divisions.

4.2.11.1.4.1.2. Provide medical oversight, expertise and leadership to ensure the delivery of coordinated, cost-effective services and supports for Members.

4.2.11.1.4.1.3. Participate in strategy development and the design and implementation of innovative clinical programs and interventions with the Health Neighborhood and Community.

4.2.11.1.4.2. The CCO shall have the following qualifications:

4.2.11.1.4.2.1. Be a physician licensed and registered in any state.

4.2.11.1.4.2.2. Have a minimum of five years' experience working at a management level with Medicaid programs spanning both physical and behavioral health.

4.2.11.1.4.2.3. Have knowledge and experience with health care delivery system reform, addressing the social determinants of health and establishing coverage policies based on evidence-based practices.

4.2.11.1.5. Quality Improvement Director – One full-time employee. The Quality Improvement Director shall be a management level position.

4.2.11.1.5.1. The Quality Improvement Director shall:

4.2.11.1.5.1.1. Be accountable for development and implementation of quality improvement programs, and all aspects of measuring and assessing program outcomes.

4.2.11.1.5.1.2. Direct and coordinate all quality improvement activities.

4.2.11.1.5.1.3. Ensure alignment with federal and state guidelines.

4.2.11.1.5.1.4. Set internal performance goals and objectives.

4.2.11.1.5.2. The Quality Improvement Director shall have the following qualifications:

4.2.11.1.5.2.1. Minimum of a bachelor's degree in nursing, public health or strongly

4.2.11.1.5.2.2. related field. Master's level preferred.

4.2.11.1.5.2.3. Minimum of five years of professional experience in healthcare quality improvement.

4.2.11.1.5.2.4. Knowledge and Experience in the following areas:

4.2.11.1.5.2.4.1. Accreditation standards, including National Committee on Quality Accreditation (NCQA).

4.2.11.1.5.2.4.2. Outcomes and performance measurement, including HEDIS and HEDIS-like behavioral health measures.

4.2.11.1.5.2.4.3. Compliance and regulation enforcement.

4.2.11.1.6. Health Information Technology (Health IT) and Data Director – One full-time employee.

4.2.11.1.6.1. The Health IT and Data Director shall:

4.2.11.1.6.1.1. Facilitate data sharing among Contractor, the state, and Network Providers.

4.2.11.1.6.1.2. Ensure the implementation and operation of technological tools required to perform the Work.

4.2.11.1.6.1.3. Identify opportunities to reduce redundancy in workflows and data systems.

4.2.11.1.6.1.4. Assist Network Providers to maximize the use of EHRs and Health Information Exchange.

4.2.11.1.6.1.5. Develop the organization's strategy and be accountable for operations related to the receipt and processing of:

4.2.11.1.6.1.5.1. Client enrollment spans.

4.2.11.1.6.1.5.2. Capitation payments.

4.2.11.1.6.1.5.3. Encounter Data.

4.2.11.1.6.1.5.4. Health needs survey information.

4.2.11.1.6.1.5.5. Admission, discharge, and transfer data.

4.2.11.1.6.1.5.6. BIDM System data.

4.2.11.1.6.2. The Health IT and Data Director shall have the following qualifications:

4.2.11.1.6.2.1. Experience directing a health information technology program.

4.2.11.1.6.2.2. Experience supporting health care practices.

4.2.11.1.6.2.3. Expertise in health data analytics.

4.2.11.1.7. Regional Contract Manager (Optional) – One full-time employee.

4.2.11.1.7.1. If Contractor chooses to have a Regional Contract Manager, the Regional Contract Manager shall:

4.2.11.1.7.1.1. Serve as the primary point of contact for all day-to-day operational issues.

4.2.11.1.7.1.2. Oversee operational procedures, business processes, and reporting.

4.2.11.1.7.1.3. Participate in Department-led meetings to discuss operational issues and solutions.

4.2.11.1.7.1.4. Work collaboratively with the Program Officer to perform program analysis and implement enhancements.

4.2.11.1.7.1.5. Work out of an office within Contractor's Region.

4.2.11.1.7.2. The Regional Contract Manager shall have the following qualifications:

4.2.11.1.7.2.1. Experience in management, contract management, and operations of health programs.

4.2.11.1.7.2.2. Experience managing the operations of projects or contracts of similar scope and size.

4.2.11.1.7.2.3. Knowledge of and experience with Medicaid programs.

4.2.11.2. In order to ensure appropriate administrative expertise in behavioral health, Contractor shall ensure that at least one of the Key Personnel has had the majority of their work experience working for behavioral health organizations, including at least five years'

experience in a leadership role administering behavioral health programs. Key Personnel include: Program Officer, Chief Clinical Officer, or Quality Improvement Director.

4.2.12. Other Personnel Responsibilities

4.2.12.1. Contractor shall use its discretion to determine the number of Other Personnel necessary to perform the Work in accordance with the requirements of this Contract.

4.2.12.2. If the Department has determined that Contractor has not provided sufficient Other Personnel to perform the Work in accordance with the requirements of this Contract , Contractor shall provide all additional Other Personnel necessary to perform the Work in accordance with the requirements of this Contract at no additional cost to the Department.

4.2.12.3. Contractor shall ensure that all Other Personnel have sufficient training and experience to complete all portions of the Work assigned to them. Contractor shall provide all necessary training to its Other Personnel, except for State-provided training specifically described in this Contract.

4.2.13. Subcontractors

4.2.13.1. Contractor may assign the portion of this Contract related to the Capitated Behavioral Health Benefit to Colorado Access, Inc.

4.2.13.2. Contractor may subcontract to complete a portion or portions of the Work required by the Contract.

4.2.13.3. Contractor shall not enter into any subcontract in connection with its obligations under this Contract without providing notice to the Department. The Department may reject any subcontract and Contractor shall terminate any subcontract that is rejected by the Department and shall not allow any Subcontractor to perform any Work after that Subcontractor's subcontract has been rejected by the State.

4.2.13.4. Contractor shall provide the organizational name of each Subcontractor and all items to be worked on by each Subcontractor to the Department.

4.2.13.4.1. DELIVERABLE: Name of each Subcontractor and items on which each Subcontractor will work

4.2.13.4.2. DUE: January 1, 2020

4.2.13.5. Contractor shall obtain prior consent and written approval for any use of Subcontractor(s).

4.2.13.6. Contractor shall ensure that all subcontracts are executed in accordance with 42 C.F.R. § 438.230.

4.2.13.7. Contractor shall notify the Department of the termination of any subcontract.

4.2.13.7.1. DELIVERABLE: Notice of Subcontractor Termination

4.2.13.7.2. DUE: At least 60 calendar days prior to termination for all general terminations and within two Business Days of the decision to terminate for quality or performance issue terminations

5. MANAGED CARE CAPITATION INITIATIVE

5.1. Contractor shall perform all of the functions described in this Contract in compliance with all pertinent state and federal statutes, regulations and rules, including the Department's 1915(b) waiver for the Accountable Care Collaborative.

5.2. Contractor shall be licensed pursuant to Section 10-16-401, et seq., C.R.S., as a Health Maintenance Organization.

5.2.1. Contractor shall notify the Department, within two business days, of any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, denying renewal, or notifying Contractor of any noncompliance pursuant to Section 10-16- 401, et seq, C.R.S. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, insurance, permits, etc. required for Contractor to properly perform this Contract and/or failure to notify the Department as required by this section, may be grounds for the immediate termination of this Contract by the Department for default.

5.2.2. Contractor shall meet the solvency standards set forth in Section 10-16-401, et seq, C.R.S. and its implementing regulations and any other applicable regulations. Contractor shall notify the Department, within two business days, of having knowledge or reason to believe that it does not meet the solvency standards specified herein. Failure to meet the solvency standards and/or failure to notify the Department as required by this section may be grounds for the immediate termination of this Contract by the Department for default.

5.3. Contractor shall administer this managed care initiative in compliance with the requirements for an MCO and a PIHP as set forth in 42 C.F.R. § 438.2.

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

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

5.4.1. Contractor shall select members of the governing body in such a way as to minimize any potential or perceived conflicts of interest.

5.5. Contractor shall publicly list information on Contractor's governing body on Contractor's website, including, but not limited to, the names of the members of the governing body and their affiliations.

5.6. Contractor shall create a written Governance Plan that:

5.6.1. Describes how Contractor will protect against any perceived conflict of interest among its governing body from influencing Contractor's activities under this Contract.

5.6.1.1. 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.

5.6.2. Contractor shall ensure that conflicts of interest include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in Contractor and their immediate families, members of the governing body, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons is posted publicly on Contractor's website.

5.7. Contractor shall submit the managed care capitation initiative Governance Plan to the Department.

5.7.1. DELIVERABLE: Managed Care Capitation Initiative Governance Plan

5.7.2. DUE: March 15, 2020

5.8. Contractor shall submit an Updated Managed Care Capitation Initiative Governance Plan to the Department and post it when a change is made to the plan.

5.9. Contractor shall update the Managed Care Capitation Initiative Governance Plan and shall submit the Updated Managed Care Capitation Initiative Governance Plan to the Department any time a change in governance is discovered by Contractor.

5.9.1. DELIVERABLE: Updated Managed Care Capitation Initiative Governance Plan

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

5.10. Contractor shall comply with all applicable Federal and state laws and regulations, including:

5.10.1. Title VI of the Civil Rights Act (CRA) of 1964;

5.10.2. The Age Discrimination Act of 1975;

5.10.3. The Rehabilitation Act of 1973;

5.10.4. Title IX of the Education Amendments of 1972;

5.10.5. The Americans with Disabilities Act; and

5.10.6. Section 1557 of the Patient Protection and Affordable Care Act.

6. MEMBER ENROLLMENT

6.1. Contractor shall understand the Member enrollment and assignment processes described in this section.

6.1.1. Individuals in the following Program Aid Codes are eligible for enrollment in Contractor's managed care capitation initiative:

6.1.1.1. Universal Waiver – MH (containing the following aid detail):

6.1.1.1.1. HCBS CCT (Colorado Choice Transition) - M7

6.1.1.1.2. HCBS EBD (Elderly, Blind, Disabled) - M8

6.1.1.1.3. HCBS DD (Developmentally Disabled) - M6

6.1.1.1.4. HCBS SLS (Supported Living Services) - MC

6.1.1.1.5. HCBS CMHS (Community Mental Health Supports) - M0

6.1.1.1.6. HCBS BI (Brain Injury) - M1

6.1.1.1.7. HCBS CHCBS (Children's Home and Community Based Services) - M3

6.1.1.1.8. HCBS CLLI (Children with Life Limiting Illness) - MD

6.1.1.1.9. HCBS CHRP (Children's Habilitative Residential Program) - M4

6.1.1.1.10. HCBS CES (Children's Extensive Supports) - M2

6.1.1.1.11. HCBS CWA (Children with Autism)- M9

6.1.1.1.12. HCBS SCI (Spinal Cord Injury) - M5

6.1.1.2. SSI Mandatory - BJ

6.1.1.3. Former Foster Care - FF

6.1.1.4. Pickle - B1

6.1.1.5. DAC (Disabled Adult Child) - BF

6.1.1.6. QDW (Qualified Disabled Widow/er) - BM

6.1.1.7. OAP-A Med > 65 Psych (Old Age Pension) - B8

6.1.1.8. OAP Med-A (Old Age Pension, aged 65+) - BK

6.1.1.9. OAP Med-B (Old Age Pension, aged 60-64) - BL

6.1.1.10. MAGI Pregnant (Modified Adjusted Gross Income, pregnant clients) - HP

6.1.1.11. Qualified Pregnant Woman - H7

6.1.1.12. Expanded Pregnant Woman - H9

6.1.1.13. Legal Immigrant Prenatal – HB

6.1.1.14. Psych <21 - H1

6.1.1.15. Eligible Needy Newborn - H2

6.1.1.16. MAGI Children (Modified Adjusted Gross Income, up through age 18) - HH

6.1.1.17. MAGI Parents/Caretakers (Modified Adjusted Gross Income, clients with children in the home) - HR

6.1.1.18. MAGI Adults (Modified Adjusted Gross Income, age 19-65) - HD

6.1.1.19. Transitional Med - H3

6.1.1.20. 4 Month Extended - H6

6.1.1.21. Buy-In WAwD (Working Adults with Disabilities) - B3

6.1.1.22. Buy-In CBwD (Children's Buy-In with Disabilities) - H5

6.1.1.23. Refugee – HA (choice only)

6.1.1.24. QMB (Qualified Medicare Beneficiary) - F4 Only when combined with another eligible full benefit Program Aid Code

6.1.1.25. SLMB (Specified Low-income Medicare Beneficiary) - F3 Only when combined with another eligible full benefit Program Aid Code

6.1.2. Individuals in the following Foster Care Program Aid Codes are eligible for enrollment in Contractor's managed care capitation initiative:

6.1.2.1. Subsidized and Not Subsidized Adoptions – 10

6.1.2.2. Supplemental Security Income - Foster Care – 11

6.1.2.3. Child Welfare - Foster Care – 12

6.1.2.4. Foster Care - Removed by CT/AF – 13

6.1.2.5. Subsidized Adoption Foster Care – 19

6.1.2.6. Emancipated Foster Care SB07-002 – 20

6.1.2.7. Foster Care - Voluntary – 23

6.1.2.8. DYC and Child Welfare Without Regard to Income – 70

6.1.2.9. Foster Care – Division of Youth Services kids – 30

6.2. 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 Accountable Care Collaborative Program. The Department is the final arbiter for all discrepancies between the various systems utilized for verifying eligibility and enrollment.

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

6.2.2. Contractor shall ensure that Network Providers supply services only to eligible Medicaid Members.

6.2.2.1. Contractor shall ensure that Network Providers verify that the individuals receiving services covered under this Contract are Medicaid eligible on the date of service, whether Contractor or the Department is responsible for reimbursement of the services provided, and whether Contractor has authorized a referral or made special arrangements with a provider, when appropriate.

6.3. The Department will enroll Members into the managed care capitation initiative on the same day that a Member's Medicaid eligibility notification is received in the Colorado interChange from the Colorado Benefit Management System (CBMS), except as follows:

6.3.1. In alignment with the Member Enrollment Policy, the Department will allow retroactive enrollment for up to 90 days from when a Member received Institutions for Mental Diseases (IMD) services within that time period.

6.3.2. Enrollment of a Newborn

6.3.2.1. Contractor shall furnish Covered Services to newborns of determined Medicaid eligible Members, enrolled in the managed care capitation initiative, from the date of enrollment until:

6.3.2.1.1. the Member loses Medicaid eligibility; or

6.3.2.1.2. the Member's parent or guardian requests newborn's disenrollment from Contractor's managed care capitation initiative in accordance with Section 6 of this Contract.

6.3.2.2. If newborn's mother resides in Denver County upon receipt of the newborn's Medicaid identification number, the newborn shall be enrolled into Contractor's managed care capitation initiative.

6.3.2.2.1. If the newborn resides outside of Denver County but in the Service Area covered by this Contract, the mother of the newborn, or a designated representative of the newborn, may request enrollment into Contractor's managed care capitation initiative after the Initial Term.

6.3.2.2.1.1. Contractor shall ensure Covered Services are provided for a newborn from the date of enrollment in Contractor's managed care capitation initiative.

6.3.3. Enrollment During Hospitalization

6.3.3.1. If a Potential Member of Contractor's managed care initiative is an inpatient of a hospital at 11:59 p.m. the day before his/her enrollment is scheduled to take effect, enrollment shall be postponed until the first day of the month following discharge.

6.3.3.2. Contractor shall, within 14 calendar days of the date Contractor discovers the Member or

Potential Member's hospital admission, provide a written request to the Department that the enrollment be delayed. Contractor's request shall include:

6.3.3.2.1. The name of the hospital where the Member or Potential Member was an inpatient.

6.3.3.2.2. The date of admission of the Member.

6.3.3.3. The Department shall respond to Contractor, in writing, within five Business Days of Contractor's request to postpone enrollment or upon confirmation of the hospitalization, whichever is later.

6.4. The Department will automatically re-enroll Members with the managed care capitation initiative or with the PCMP and RAE that was in effect at the time of their loss of Medicaid eligibility if there is a loss of Medicaid eligibility of two months or less.

6.5. Contractor shall not discriminate against individuals eligible to enroll in the managed care capitation initiative 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, and 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 also not discriminate against Members in enrollment and re-enrollment on the basis of health status or need for health care services.

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

6.6.1. The Department will enroll Members with the appropriate aid eligibility category and in Contractor's Service Area until the enrollment cap, as defined in Section 6.12.1.2, has been met.

6.7. All Members enrolled in Contractor's managed care capitation initiative will have 90 days in which to opt out. Those who do not opt out shall be enrolled until the Member's next Open Enrollment Period, at which time the Member shall receive an open enrollment notice. Subsequent enrollment shall be for 12 months and a Member may not disenroll from Contractor's managed care capitation initiative except as provided in section 6.12. Disenrollment.

6.8. All enrollment notices, informational materials and instructional materials relating to enrollment of Members shall be provided in a manner and format that may be easily understood and, wherever possible, at a sixth-grade reading level, and must be shared with the Department's designated Contract manager for approval.

6.9. Contractor may limit enrollment of new Members by notifying the Department, in writing, that it will not accept new Member as long as the enrollment limitation does not conflict with applicable statutes and regulations.

6.10. Contractor shall receive and process an enrollment file from the Department that contains the enrollment information for all of Contractor's Members in addition to any additions, deletions or changes.

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

6.12. Caseload and Enrollment Cap Growth

6.12.1. Contractor shall understand that there will be an enrollment cap for the managed care capitation initiative. The Department will utilize the annual Medicaid Caseload Budget Request to set Contractor's enrollment cap. The annual budget forecasts and caseload trends are selected based on statistical modeling and trend analysis.

6.12.1.1. At a minimum, the Department will review Contractor's enrollment cap in November and February of each state fiscal year. The Department shall inform Contractor, in writing, of any changes to the enrollment cap.

6.12.1.2. Contractor's enrollment cap is set at 100,000 members for SFY 2023-2024.

6.12.1.3. The Department will periodically review Contractor's enrollment cap based on Contractor's request with appropriate supporting data.

6.13. Disenrollment

6.13.1. Contractor may only request disenrollment of a Member for cause. The Department shall review Contractor's requests for disenrollment and may grant or reject Contractor's request at its discretion. A disenrollment for cause may only occur under the following circumstances:

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

6.13.1.2. Receipt of comprehensive health coverage, other than Medicaid, by the Member.

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

6.13.1.4. Member moves out of Contractor's Service Area.

6.13.1.5. Contractor's managed care capitation initiative does not, because of moral or religious reasons, cover the service the Member seeks.

6.13.1.6. The Member needs related services to be performed at the same time, not all related services are available within the network and a physician determines that receiving the services separately would subject the Member to unnecessary risk.

6.13.1.7. Abuse or intentional misconduct consisting of any of the following:

6.13.1.7.1. Behavior of the Member that is disruptive or abusive to the extent that Contractor's ability to furnish services to either the Member or other Members is impaired.

6.13.1.7.2. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.

6.13.1.7.3. Behavior of the Member that poses a physical threat to the provider, to other provider or Contractor staff or to other Members.

6.13.1.7.4. Contractor shall provide one oral warning, to any Member exhibiting abusive behavior or intentional misconduct, stating that continuation of the behavior or misconduct will result in a request for disenrollment. If the Member continues the behavior or misconduct after the oral warning, Contractor shall send a written warning that the continuation of the behavior or misconduct will result in disenrollment from Contractor's managed care capitation initiative. Contractor shall keep a copy of the written warning and a written report of its investigation into the behavior to provide to the Department upon request. If the Member's behavior or misconduct poses an imminent threat to the provider, to other provider or Contractor or to other Members,

Contractor may request an expedited disenrollment after it has provided the Member exhibiting the behavior or misconduct an oral warning.

6.13.1.8. The Member commits Fraud or knowingly furnishes incorrect or incomplete information on applications, questionnaires, forms or statements submitted to Contractor as part of the Member's enrollment in Contractor's managed care capitation initiative.

6.13.1.9. Any other reason determined to be acceptable by the Department.

6.13.2. Disenrollment for cause shall not include disenrollment for the following reasons:

6.13.2.1. Adverse changes in the Member's health status.

6.13.2.2. Change in the Member's utilization of medical services.

6.13.2.3. The Member's diminished mental capacity.

6.13.2.4. Any behavior of the Member resulting from the Member's special needs, as determined by the Department, unless those behaviors seriously impair Contractor's ability to furnish services to that Member or other Members.

6.13.3. The Department may disenroll any Member, whom requests disenrollment, at its sole discretion.

6.13.4. The Department may disenroll a Member from Contractor's managed care capitation initiative upon that Member's request. A Member (or their representative) may request disenrollment to the Department, either written or orally, and the Department may grant the Member's request for the following reasons:

6.13.4.1. For cause, at any time. A disenrollment for cause may occur under the following circumstances:

6.13.4.1.1. The Member moves out of Contractor's Service Area.

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

6.13.4.1.3. The Member needs related services to be performed at the same time, not all related services are available within the network and a physician determines that receiving the services separately would subject the Member to unnecessary risk.

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

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

6.13.4.1.6. Lack of access to covered services, as documented by the Department.

6.13.4.1.7. Lack of access to providers experienced in dealing with the Member's health care needs.

6.13.4.1.8. The Member enrolled in Contractor's managed care capitation initiative with his/her Physician and the Physician leave Contractor.

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

6.13.4.1.10. The Member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than the managed care capitation imitative offered by Contractor and Contractor cannot provide the Member with reasonable access to a Medicare

approved Provider or, if the Member is enrolled in a Medicare managed care plan, Contractor cannot provide the Member with Providers participating in both plans.

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

6.13.4.1.12. The Member is a foster child.

6.13.4.1.13. The Member is an Indian Member and, in accordance with 42 CFR 438.14(b)(5), there is not timely access to an Indian Health Care Provider.

6.13.4.2. A newborn Member's mother, or designated representative, may request Disenrollment with cause of the newborn within 90 days following:

6.13.4.2.1. Enrollment of the newborn or 90 days after the Department sends the notice of Enrollment, whichever is later.

6.13.4.2.1.1. Said request must include mother's current address and a 24 hour phone number, both must be listed on file with the county. The Department may conduct reviews of the requests to determine HIPAA compliance and/ or compliance with this Contract.

6.13.4.2.2. If the mother to a newborn, who is not a member of the managed care capitation initiative, has a newborn that is Enrolled as a Member into the managed care capitation initiative: the mother of the newborn, or Contractor, may request that the Department disenroll the newborn from the managed care capitation initiative.

6.13.4.3. Without cause, under the following circumstances:

6.13.4.3.1. A Member may request disenrollment at any time during the 90 days following the date of the Member's initial enrollment with Contractor.

6.13.4.3.2. A Member may request disenrollment at least once every 12 months after the first 90 day period.

6.13.4.3.3. A Member may request disenrollment upon automatic reenrollment under 42 CFR 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

6.13.4.3.4. A Member may request disenrollment if the Department imposes the intermediate sanction specified in 438.702(a)(3).

6.13.5. In the event that the Department grants a request for disenrollment, the effective date of that disenrollment shall be no later than the first day of the second month following the month in which the Member files the request, or Contractor refers the request to the Department.

6.13.5.1. If the Department or Contractor fails to make a disenrollment determination within this timeframe, the request shall be considered approved and the effective date shall be determined by the aforementioned timeframe.

6.13.6. In the event that a Member is disenrolled from Contractor's managed care capitation initiative because the Member has become ineligible for Medicaid, then the effective date of disenrollment shall be the date on which the Member became ineligible.

6.13.7. In the event that the Department denies a request for disenrollment, the Department will notify the Member of their right to request a State Fair Hearing.

6.13.8. Contractor shall use reports and information from interChange to verify the Medicaid eligibility and enrollment in Contractor's managed care capitation initiative for its Members.

These reports may include some or all of the following:

6.13.8.1. Benefit Enrollment and Maintenance Transaction report (ANSI X 12N 834).

6.13.8.2. Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction report (ANSI X 12N 820) for capitation.

6.14. Effective Date of Disenrollment

6.14.1. In most instances, disenrollment will be effective the first day of the month following the month in which the request for disenrollment was made.

6.14.1.1. If this does not occur, the disenrollment will be no later than the first day of the second month following the month in which the request was made.

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

6.14.2. Disenrollment Postponed Due to Inpatient Hospital Stay

6.14.2.1. If a current Member of Contractor's managed care capitation initiative is an inpatient of a Hospital at 11:59 p.m. the day before his/her Disenrollment from Contractor's Plan is scheduled to take effect, Disenrollment shall be postponed until the last day of the month in which the Member is discharged from the hospital.

6.14.2.1.1. Contractor shall, within ten calendar days of the date Contractor discovers the Member or Potential Member's hospital admission, request in writing to the Department that the disenrollment be delayed. Contractor's request shall include the name of the hospital where the Member or Potential Member was inpatient and the date of admission. The Department shall respond to Contractor in writing within five Business Days of Contractor's request to postpone disenrollment or upon confirmation of the hospitalization, whichever is later.

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

6.14.2.3. The Department shall respond to Contractor in writing within five Business Days of Contractor's request to postpone Enrollment.

7. MEMBER ENGAGEMENT

7.1. Person-and Family Centered Approach

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

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

7.1.1.2. Utilization of various tools to communicate clearly and concisely.

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

7.1.1.4. Promotion of health and wellness, particularly related to preventive and healthy behaviors as outlined in initiatives such as Colorado's 10 Winnable Battles and Colorado's State of Health.

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

7.1.3. Contractor shall be aware of the work being done and recommendations made by the Department's Member Experience Advisory Council, which consists of Medicaid and CHP+ Clients, family members and/or caretakers.

7.2. Cultural Responsiveness

7.2.1. 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).

7.2.2. 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. All materials shall be written in English or Spanish, or any other language, as directed by the Department or as required by 42 CFR 438.10.

7.2.3. Contractor shall provide cultural and disability competency training programs, as needed, to Network Providers and Contractor staff regarding:

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

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

7.2.4. Contractor shall identify Members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by Contractor of the language proficiency of Members during the Member's orientation or while being served by Network Providers.

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

7.2.5.1. Readily accessible is defined as electronic information and services that comply with modern accessibility standards, such as Section 508 of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and Successor versions.

7.2.6. Language Assistance Services

7.2.6.1. Contractor shall provide language assistance services as described in 42 C.F.R. § 438.10, for all Contractor interactions with Members, as well as covered services. Language assistance services include both 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.

7.2.6.2. Contractor shall make oral interpretation available in all languages and written translation available in each Prevalent Language at no cost to any Member.

7.2.6.2.1. Contractor shall ensure the competence of language assistance provided by interpreters and bilingual staff.

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

7.2.6.2.3. 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.

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

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

7.2.6.3.2. Written translation in Prevalent Languages.

7.2.6.3.3. Auxiliary aids and services for Members with disabilities.

7.2.6.4. Contractor shall ensure that language assistance services shall include, but are not limited to, the use of auxiliary aids such as TTY/TDY and American Sign Language.

7.2.6.5. Contractor shall ensure that customer service telephone functions easily access interpreter or bilingual services.

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

7.2.6.6.1. DELIVERABLE: Language Assistance Services Report

7.2.6.6.2. DUE: September 30, 2023, and annually by September 30

7.2.7. Written Materials for Members

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

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

7.2.7.3. Contractor shall ensure that its written materials, which are critical to obtaining services, include, at a minimum:

7.2.7.3.1. Provider directories;

7.2.7.3.2. appeal and grievance notices; and

7.2.7.3.3. denial and termination notices available in the Prevalent Languages in the State.

7.2.7.3.4. Contractor shall include taglines in the Prevalent Languages in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided.

7.2.7.4. Contractor shall notify all Members and potential Members of the availability of alternate formats for information, as required by 42 C.F.R. § 438.10 and 45 C.F.R. § 92.8, and how to access such information.

7.2.7.5. Contractor shall write all materials in easy to understand language and format and shall

comply with all applicable requirements of 42 C.F.R. § 438.10.

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

7.2.7.6. Contractor shall translate all written information into other non-English Prevalent Languages in Contractor's Region.

7.2.7.7. Contractor shall ensure that its written materials for Members are available in alternative formats, through the provision of auxiliary aids and services in an appropriate manner, that take 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.

7.2.7.8. Contractor shall ensure that its written materials for Members include taglines in the Prevalent 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.

7.2.7.9. Contractor shall ensure that all written materials for Members have been tested by Member representatives.

7.3. Member Communication

7.3.1. Contractor shall maintain consistent communication, both proactive and responsive, with Members and ensure that Contractor's Member communications adhere to Colorado Medicaid's brand standards.

7.3.2. Contractor shall staff, publish, and maintain the telephone number for a toll-free line that Members may call regarding customer service and Care Coordination issues. Contractor shall provide both English and Spanish-speaking representatives to assist English and Spanish-speaking Members and Clients, through both telephone and in- person conversations.

7.3.2.1. The Member call line shall have the capability to receive calls and the capability to make outbound calls. The Member call line shall be open to receive and make calls with sufficient staff to support minimum hours of operations during Business Hours. The Member call line shall be capable of managing all contacts, including during fluctuations in call volumes.

7.3.2.1.1. During Business Hours, Contractor shall ensure that no more than five percent 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.

7.3.2.1.2. Contractor shall ensure that the average length of time callers are waiting in the call queue before the call is answered shall be two minutes or less during each calendar month.

7.3.2.1.3. 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.

7.3.2.2. Contractor shall submit a Call Line Statistics Report in a format agreed upon by the Department and Contractor.

7.3.2.2.1. DELIVERABLE: Call Line Statistics Report

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

7.3.3. Contractor shall communicate practice guidelines to Members and potential Members upon request.

7.3.4. Contractor shall assist any Member who contacts Contractor, including Members not in Contractor's region, who require assistance with contacting their PCMP and/or RAE.

7.3.4.1. The Department will provide data to Contractor on all Members for this purpose.

7.3.5. Contractor shall conduct an initial screening of each Member's needs, within 90 days of the effective date of enrollment.

7.3.5.1. Contractor shall make subsequent attempts to conduct an initial screening of each Member's needs if the initial attempt to contact the Member is unsuccessful.

7.3.6. General Member Information Requirements

7.3.6.1. Contractor shall develop electronic and written materials for distribution to both newly enrolled and existing Members, with input and approval from the Department, in accordance with 42 C.F.R. § 438.10 that must include, at a minimum, all of the following:

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

7.3.6.1.2. Contractor's Email address.

7.3.6.1.3. Contractor's website address.

7.3.6.1.4. State relay information.

7.3.6.1.5. The basic features of a PIHP and MCO.

7.3.6.1.6. The Service Area covered by Contractor.

7.3.6.1.7. Medicaid benefits, including State Plan benefits, the physical health benefits that are part of the managed care capitation initiative and those in the Capitated Behavioral Health Benefit.

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

7.3.6.1.9. A directory of Network Providers.

7.3.6.1.9.1. DELIVERABLE: Network Directory

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

7.3.6.1.10. The requirement for Contractor to provide adequate access to physical health services included in the managed care capitation initiative and to the behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards.

7.3.6.1.11. Contractor's shall perform the following responsibilities for the coordination of Member care:

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

7.3.6.1.13. 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.

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

7.3.7. Member Rights

7.3.7.1. Contractor shall possess written policies, subject to Department approval, that guarantee:

7.3.7.1.1. Each Member's right to be treated with respect and due consideration for their dignity and privacy.

7.3.7.2. Contractor shall provide information to Members regarding their Member Rights, as stated in 42 C.F.R. § 438.100, that include, but are not limited to:

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

7.3.7.2.2. 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.

7.3.7.2.3. The right to participate in decisions regarding their health care, to include the right to refuse treatment.

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

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

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

7.3.7.2.7. Their right to freely exercise their rights in regard to Contractor or its providers treating the Member adversely.

7.3.7.3. Contractor shall post and distribute Member rights to, at a minimum, the following individuals:

7.3.7.3.1. Members.

7.3.7.3.2. Member's families.

7.3.7.3.3. Providers.

7.3.7.3.4. Case workers.

7.3.7.3.5. Stakeholders.

7.3.7.4. Contractor shall possess written policies guaranteeing each Member's right to receive information on available treatment options and alternatives.

7.3.7.4.1. All written policies shall be presented in a manner appropriate to the Member's condition and ability to understand.

7.3.8. Member Handbook

7.3.8.1. Contractor shall collaborate with the Department to create a Member Handbook for distribution to both newly enrolled and existing Members. The Member Handbook shall meet the requirements of 42 C.F.R. § 438.10 and will include, at a minimum, all of the following:

7.3.8.1.1. Information that enables the Member to understand how to effectively use the managed care capitation initiative.

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

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

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

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

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

7.3.8.1.6.1. An explanation that describes 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, resulting in serious impairment to bodily functions, or causing serious dysfunction of any bodily organ or part.

7.3.8.1.6.2. An explanation that describes 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.

7.3.8.1.6.3. An explanation that describes 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 initiative physician is not available for consultation.

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

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

7.3.8.1.6.6. 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.

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

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

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

7.3.8.1.9. 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.

7.3.8.1.10. Member rights and responsibilities, as defined in Section 7.3.7.

7.3.8.1.11. Explanation of access to Member benefits available under the State Plan but not covered under the Contract, including cost sharing and how to request transportation and mileage reimbursement.

7.3.8.1.12. How to locate information and updates to Contractor's formulary drug list.

7.3.8.1.13. The transition of care policies for Members and potential Members.

7.3.8.1.14. Information on how to report Suspected Fraud or abuse.

7.3.8.1.15. A section with information specific to Contractor's Service Area.

7.3.8.2. Contractor shall submit all contact information for inclusion in the Member Handbook, as determined relevant by Contractor, to the Department.

7.3.8.2.1. DELIVERABLE: Colorado Medicaid Member Handbook Contractor contact information

7.3.8.2.2. DUE: Five days after the Effective Date of the Contract

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

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

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

7.3.9. Contractor Website

7.3.9.1. Contractor shall develop and maintain a customized and comprehensive website that, at a minimum, meets the following requirements:

7.3.9.1.1. Follows modern principles of optimizing user experience on mobile and personal computer platforms

7.3.9.1.2. Is navigable by individuals who have a low literacy level, disabilities, or require language assistance.

7.3.9.2. Contractor shall ensure that the website provides online access to general customer service information that includes, but is not limited to:

7.3.9.2.1. Contractor's contact information.

7.3.9.2.2. Member rights and handbooks.

7.3.9.2.3. Grievance and Appeal procedures and rights.

7.3.9.2.4. General functions of Contractor.

7.3.9.2.5. Trainings.

7.3.9.2.6. Non-Emergency Medical Transportation benefit information including links for

regional providers and instructions for obtaining rides and submitting requests for mileage reimbursement.

7.3.9.2.7. For PCMPs and specialty health providers, Contractor shall make the following information related to Contractor's network providers available to Members as a provider directory in electronic form and in paper form upon request:

7.3.9.2.7.1. Names, as well as any group affiliations.

7.3.9.2.7.2. Street addresses.

7.3.9.2.7.3. Telephone numbers.

7.3.9.2.7.4. Website URLs, as appropriate.

7.3.9.2.7.5. Specialties, as appropriate.

7.3.9.2.7.6. Whether network providers will accept new Members.

7.3.9.2.7.7. The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

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

7.3.9.2.8. Contractor shall ensure that the electronic provider directory is updated no later than 30 calendar days after Contractor receives updated provider information.

7.3.9.2.9. Contractor shall update the paper provider directory at least quarterly as required by 42 CFR 438.10(h)(3).

7.3.9.2.10. Contractor shall make the provider directory available on its website in a machine-readable file and format, as specified by the Secretary.

7.3.9.2.11. Access to care standards.

7.3.9.2.12. Health First Colorado Nurse Advice Line..

7.3.9.2.13. Colorado Crisis Services information.

7.3.9.2.14. Resources for hospital transplant teams to coordinate services for Members who are transplant recipients with an SUD diagnosis.

7.3.9.3. Contractor shall provide a link to the 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.

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

7.3.9.5. Contractor shall organize the website to allow for the access of information by Members, family members, providers, stakeholders and the general public.

7.3.9.5.1. Contractor shall ensure that the access of information is in compliance with the Americans with Disabilities Act (ADA).

7.3.9.6. Contractor shall ensure that web materials are able to produce printer-friendly copies of information.

7.3.10. Termination of Provider Agreement

7.3.10.1. 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.

7.3.10.1.1. DELIVERABLE: Notice to Members of Network Provider Termination

7.3.10.1.2. DUE: 15 days from the notice of termination

7.3.11. Information on Grievance and Appeals Process

7.3.11.1. Contractor shall provide information to Members on Grievance, Appeals and State Fair Hearing procedures and timelines (as relevant and described in Section 8.0). The information shall include, at a minimum, the following:

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

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

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

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

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

7.3.11.1.6. The method for obtaining a State Fair Hearing.

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

7.3.11.1.8. 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.

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

7.3.11.2. Advance Directives

7.3.11.2.1. Contractor shall work with the 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.

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

7.3.11.3.1. A description of applicable state law.

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

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

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

7.3.11.4. 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.

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

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

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

7.3.12. Other Information

7.3.12.1. Contractor shall provide other necessary information to Members and their families, as determined by the Department. This information shall include, but not be limited to:

7.3.12.1.1. The services provided by Early Periodic Screening, Diagnostic and Treatment (EPSDT) and how to obtain additional information.

7.3.13. Member Material Review Process

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

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

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

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

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

7.3.13.2. The Department may review any Member materials used by Contractor and request changes or redrafting of Member materials, as the Department determines necessary, to ensure that the both the language and the document aligns with the Department communication standards. Contractor shall make any changes to the Member materials requested by the Department. This requirement shall not apply to individualized correspondence that is directed toward a specific Member.

7.3.13.3. Contractor shall ensure that all Member materials have been Member-tested.

7.3.14. Electronic Distribution of Federally Required Information

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

7.3.14.1.1. The format is readily accessible and complies with modern accessibility standards such as Section 508 of the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and W3C's Web content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

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

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

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

7.3.14.1.5. 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.

7.3.15. Contractor shall follow their Department-approved PHE Unwind Plan to identify high-risk Members that are going to lose their Medicaid enrollment due to the PHE unwind and outreach these Members prior to their eligibility redetermination date.

7.3.15.1. Contractor shall remind these Members to update their contact information with the Department. 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 (mobile application is free and available in the Apple and Google Play stores), depending on Member access to these options.

7.3.15.2. Contractor shall conduct outreach to these Members to assist them in responding to Department renewal requests for additional information and submitting necessary renewal forms. Contractor shall use multiple modalities when conducting such outreach, including telephone, email, and text.

7.3.15.3. Contractor shall not be limited to the requirements of sections 7.4.7 for purposes of the Public Health Emergency unwind and continuity of care for members disenrolling from Medicaid.

7.4. Marketing

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

7.4.2. During the Contract phase, Contractor may engage in Marketing Activities at its discretion. Contractor shall not distribute any marketing materials without the Department's approval.

7.4.3. Contractor shall submit all materials relating to Marketing Activities to the Department and shall allow the 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.

7.4.3.1. Based on this review, the Department may require changes to any materials before Contractor distributes those materials or may disallow the use of any specific materials in its sole discretion.

7.4.4. Contractor shall specify methods of assuring the Department that Marketing, including plans and materials, is accurate and is not misleading, confusing or defraud Members or the Department.

7.4.5. Contractor shall distribute all marketing materials to the entire Service Area as defined by this Contract.

7.4.6. Contractor shall not seek to influence enrollment in conjunction with the sale or offering of

any private insurance.

7.4.7. Contractor and any Subcontractors shall not, directly or indirectly, engage in door- to-door, telephone or other cold call marketing activities.

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

7.4.9. Contractor shall not create marketing materials that contain any assertion or statement, whether written or oral, that a potential Member must enroll with Contractor to obtain or retain benefits.

7.4.10. 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.

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

7.5. Health Needs Survey

7.5.1. The 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.

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

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

7.5.3.1. Contractor shall review the Member responses to the Health Needs Survey on a regular basis to identify Members who may benefit from timely contact and support from Contractor and/or network providers.

7.5.4. The Department reserves the right to adjust the Health Needs Survey during the term of the contract. Contractor will assist the Department in improving this survey and its ability to meet the objectives of the Accountable Care Collaborative to identify chronic conditions, emerging health risks and opportunities for intervention, care coordination, and cost control.

7.5.4.1. Contractor shall work with the Department to implement any new tools and aggregate member information to better meet the objectives of the Needs Survey and the Accountable Care Collaborative.

7.6. Member Onboarding and EPSDT Outreach

7.6.1. Contractor shall onboard enrolled Members to Medicaid and the Accountable Care Collaborative.

7.6.2. 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.

7.6.2.1. 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.

7.6.2.2. Contractor shall inform Members about the EPSDT program generally within 60 days of identification of the Member being pregnant.

7.6.2.3. 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".

7.6.3. Contractor shall provide EPSDT-eligible Members, including children involved with child welfare, with the following minimum information:

7.6.3.1. The benefits of preventive health care, including the American Association of Pediatrics' Bright Futures Guidelines

7.6.3.2. The services available to Members under the EPSDT program;

7.6.3.3. Where the EPSDT services are available,

7.6.3.4. How to obtain EPSDT services;

7.6.3.5. How the EPSDT services are available without cost to the Member;

7.6.3.6. How to request necessary transportation, reimbursement for mileage, and scheduling assistance.

7.6.4. Contractor shall be accountable for providing information on EPSDT at least once to households with multiple EPSDT-Eligible Members residing in the household. Contractor will not be held accountable for providing EPSDT information to each individual EPSDT-Eligible Member residing in the household.

7.6.4.1. 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.

7.6.5. Contractor's communications about EPSDT shall be delivered using easy-to- understand, non-technical language.

7.6.6. Contractor shall use a combination of oral and written materials to outreach EPSDT-eligible Members, including but not limited to:

7.6.6.1. Mailed letters, brochures or pamphlets.

7.6.6.2. Face-to-face interactions.

7.6.6.3. Telephone calls.

7.6.6.4. Video-conferencing.

7.6.6.5. Automated calls.

7.6.6.6. Email messages.

7.6.6.7. Text/SMS messaging.

7.6.7. 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.

7.6.7.1. Contractor shall monitor EPSDT-eligible Members' receipt of screenings and examinations in accordance with American Association of Pediatrics' Bright Futures

Guidelines.

7.6.8. Contractor shall employ proven best practices for outreach including:

7.6.8.1. Using multiple methods of communication.

7.6.8.2. Staggering message delivery to different das of the week or hours of the day.

7.6.8.3. 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.

7.6.8.4. Attempt to reach members more than once through multiple methods.

7.6.8.5. Target outreach activities to particular "at risk" groups, to be defined in collaboration with the Department. For example, mothers with babies to be added to assistance units, families with infants, or adolescents, first time eligibles, and those not using the program for over 2 years might benefit most from oral methods.

7.6.9. 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: Head Start; Early Intervention under the Individuals with Disabilities 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); and social services programs under Title XX.

7.6.9.1. Contractor shall collaborate with the Department to develop and share best practices for educating Members about EPSDT and outreaching EPSDT-Eligible Members to improve adherence to the American Association of Pediatrics (AAP) “Bright Futures Guidelines”.

7.6.9.1.1. Contractor shall consider professional standards of care for children, which may include the American Association of Pediatrics, specialty societies, and consensus expert opinion, when determining medically necessary services for EPSDT.

7.6.10. Contractor shall actively participate with the Department and other RAEs in creating a mutually-agreed upon document establishing evidence-based standards for communication and outreach related to EPSDT.

7.6.10.1. Contractor shall submit a quarterly EPSDT Outreach Report to the Department, in a format to be determined by the Department. The Quarterly EPSDT Outreach Report will include descriptions of Contractor’s communication methods for outreach and individual member reporting of completed outreach activities and attempted outreach activities.

7.6.10.1.1. DELIVERABLE: EPSDT Outreach Report

7.6.10.1.2. DUE: Quarterly, 45 days after the end of the reporting period

7.6.11. Contractor shall submit to the 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.

7.6.11.1. DELIVERABLE: EPSDT Outreach Plan

7.6.11.2. DUE: Annually, on July 31

7.7. Promotion of Member Health and Wellness

7.7.1. 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.

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

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

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

7.7.5. EPSDT Program

7.7.5.1. Contractor shall ensure the delivery of EPSDT services for Contractor Covered Services.

7.7.5.2. Contractor shall have written policies and procedures for providing EPSDT services, to include, at a minimum:

7.7.5.2.1. Lead testing; and

7.7.5.2.2. immunizations to the eligible population.

7.7.5.3. Contractor shall comply with all EPSDT regulations set forth in 1905(a), 42 USC 1396d(r)(5) and 42 USC 1396d(a), 42 C.F.R. Sections 441.50 through 441.62, as amended, and performance will be verified by paid claims, CAP audits and ad hoc reporting.

7.7.5.4. Contractor shall provide all required components of periodic health screens, as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule.

7.7.5.5. Efforts related to providing the required components of periodic health screens shall include, at a minimum:

7.7.5.5.1. Education and outreach to eligible Members of the importance of EPSDT services.

7.7.5.5.2. A proactive approach to ensure that eligible Members obtain EPSDT services including but not limited to:

7.7.5.5.2.1. EPSDT exceptions to all care limitations and must be determined on a case by case basis. Prior authorization is allowed for services but must not impede the delivery of necessary services.

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

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

7.7.5.5.5. Per 42 C.F.R 438.210, a process to assure that medically necessary services not covered by Contractor are referred to the correct provider with the appropriate referral information for action.

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

7.7.5.5.7. Contractor shall apply the Department's definition of Medical Necessity to all members ages 20 and under.

7.7.5.6. All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions, with the exception of services expressly excluded in this Contract, are covered for EPSDT-eligible beneficiaries ages birth to twenty-one, in

accordance with 1905(r) of the Social Security Act. Any excluded EPSDT services shall be covered as a wrap- around benefit by the State.

7.7.5.7. Contractor shall complete and submit an annual EPSDT Report to the Department.

7.7.5.7.1. Contractor shall provide the EPSDT Report to the Department on the Form CMS-416 and it will contain all information required for that form for the most recent period from October 1st through September 30th.

7.7.5.7.1.1. DELIVERABLE: EPSDT Report

7.7.5.7.1.2. DUE: Annually by February 1st for the prior period from October 1st through September 30th

7.8. Prevention, Wellness, and Member Engagement Report

7.8.1.1. Contractor shall submit a bi-annual report to the Department describing how Contractor engaged Members and Community stakeholders in the Accountable Care Collaborative, in a format determined by the Department. The Prevention, Wellness, and Member Engagement Report shall include number of population health educational outreach contacts in alignment with the Department's Population Management Framework. DELIVERABLE: Prevention, Wellness, and Member Engagement Report

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

8. GRIEVANCES AND APPEALS

8.1. In accordance with 42 C.F.R. § 438 Subpart F and 10 CCR 2505-10, Section 8.209 of the Medicaid state rules for Managed Care Grievances and Appeals Processes, Contractor shall have a Grievance and Appeal system in order to:

8.1.1. Handle Grievances about any matter related to this Contract other than an adverse benefit determination.

8.1.2. Handle Appeals of an adverse benefit determination for the physical health services related to the managed care capitation initiative and for the Capitated Behavioral Health Benefit.

8.1.3. Contractor shall also have processes to collect and track information about both Grievances and Appeals.

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

8.3. Contractor shall understand the Department's procedures for handling Appeals of physical health and behavioral health adverse benefit determinations and shall assist Members in following the Department's procedures.

8.4. Contractor shall provide Members assistance in completing forms and other procedural steps in the Grievance and Appeals process, including, but not limited to:

8.4.1. Providing interpreter services and toll-free numbers with a Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability.

8.5. Contractor shall inform Network Providers and subcontractors, at the time they enter into a contract about the following, in compliance with 42 CFR 438.414 and 42 CFR 438.10(g)(2)(xi)(A) - (B):

8.5.1. The Member's right to file an Appeal, including:

8.5.1.1. The requirements and timeframes for filing.

8.5.1.2. The availability of assistance with filing.

8.5.1.3. The toll-free number to file orally.

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

8.5.3. The Member's right to request a continuation of benefits during an Appeal or State Fair Hearing filing, although the Member may be liable for the cost of any continued benefits if the adverse benefit determination is upheld.

8.5.4. The Member's right to file Grievances related to Contractor or services provided through Contractor.

8.5.5. Any rights the Provider has to Appeal or otherwise challenge the failure of Contractor to cover a service.

8.5.6. Any timeliness considerations in filing a Grievance, filing for an Appeal, filing for a State Fair Hearing, or seeking a Continuation of Benefits.

8.6. Grievances

8.6.1. Contractor shall both establish and maintain a Grievance process through which Members may express dissatisfaction about any matter related to this Contract other than an Adverse Benefit Determination.

8.6.1.1. The grievance process will provide Members sufficient time to disenroll, no later than the first (1st) day of the second month following the month in which the member or Contractor files the request to disenroll, based on the timeframe specified in 42 CFR 438.56(e)(1), if Contractor approves a disenrollment in response to a grievance.

8.6.2. Contractor shall ensure that information about the Grievance process, including how to file a Grievance, is available to all Members and is given to all Network Providers and subcontractors.

8.6.3. Contractor shall allow a Member to file a Grievance either orally or in writing, at any time, and shall acknowledge receiving the Grievance.

8.6.4. Contractor shall ensure that decision makers in the Grievance process were not involved in previous levels of review or decision-making, nor were they a subordinate of anyone who was. 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:

8.6.4.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

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

8.6.4.3. The Grievance or Appeal involves clinical issues.

8.6.5. Contractor shall make a decision regarding the Grievance and provide notice to the Member of its decision within 15 Business Days of when the Member files the Grievance.

8.6.6. Contractor may extend the timeframe for processing a Grievance by up to fourteen(14) calendar days if a Member requests; or Contractor shows (to the satisfaction of the Department, upon its request) that there is a need for additional information and that the delay

is in the Member's best interest.

8.6.7. If Contractor extends the timeline for a Grievance not at the request of a Member, Contractor shall:

8.6.7.1. Make reasonable efforts to give the Member prompt oral notice of the delay;

8.6.7.2. Give the Member written notice, within two calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

8.6.8. Contractor shall notify a Member of the resolution of a Grievance and ensure such methods meet, at a minimum, the standards described at 42 C.F.R § 438.10

8.6.9. If a Member is dissatisfied with the disposition of a Grievance, the Member may bring the unresolved Grievance to the Department. The Department's decision is final.

8.6.10. Contractor shall document problems a Network Provider submits to Contractor, and the solutions Contractor has offered to the Network Provider. The Department may review any of the documented solutions. If the Department determines the solution to be insufficient or otherwise unacceptable, it may direct Contractor to find a different solution or follow a specific course of action.

8.6.10.1. If the Department is contacted by a Member, family members or caregivers of a Member, advocates, the Ombudsman for Medicaid Managed Care, or other individuals/entities with a Grievance regarding concerns about the care or lack of care a Member is receiving, Contractor shall address all issues as soon as possible after the Department has informed Contractor of the concerns. Contractor shall keep the Department informed about progress on resolving concerns in real time, and shall advise the Department of final resolution.

8.7. Notice of Adverse Benefit Determination

8.7.1. When a Contractor denies coverage of or payment for a covered service, Contractor shall send to the Member a notice of Adverse Benefit Determination that meets the following requirements:

8.7.1.1. Is in writing.

8.7.1.2. Is available in the state-established Prevalent Languages in its region.

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

8.7.1.4. Is in an easily understood language and format.

8.7.1.5. Explains the Adverse Benefit Determination Contractor or its subcontractor has taken or intends to take.

8.7.1.6. Explains the reasons for the Adverse Benefit Determination.

8.7.1.7. 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.

8.7.1.8. 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.

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

8.7.1.10. Describes how a Member can Appeal or file a Grievance.

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

8.7.1.12. Explains the Member's right to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of continued services.

8.7.1.13. 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.

8.7.1.14. 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.

8.7.2. Contractor shall ensure that decision makers take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

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

8.7.3.1. 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.

8.7.3.2. As least five days prior to the date of Adverse Benefit Determination if Contractor has verified information indicating probable Member Fraud.

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

8.7.3.3.1. The Member has died.

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

8.7.3.3.3. 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.

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

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

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

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

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

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

8.7.3.4. On the date of Adverse Benefit Determination when the Adverse Benefit Determination is a denial of payment.

8.7.3.5. 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.

8.7.3.5.1. Contractor shall take no longer than 14 calendar days for standard authorizations that deny or limit residential services for members under the age of 21 and that require an Independent Assessment.

8.7.3.5.2. Contractor may extend the 10 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.

8.7.3.5.2.1. Contractor may extend the 14 calendar day service authorization notice timeframe for up to 14 additional days for residential services for members under the age of 21 that require an Independent Assessment if the Member or the Provider requests extension; or if the Contractor justifies a need for additional information and shows how the extension is in the Member's best interest.

8.7.3.5.3. If Contractor extends the 10 day or 14 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.

8.7.3.6. 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.

8.7.4. 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.

8.7.5. 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.

8.8. Handling Appeals

8.8.1. Contractor shall handle Appeals of adverse benefit determination, in compliance with 42 C.F.R. § 438.400 and 42 C.F.R. § 438.228(a).

8.8.2. 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.

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

8.8.4. 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:

8.8.4.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

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

8.8.4.3. The Grievance or Appeal involves clinical issues.

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

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

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

8.8.6.1. 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.

8.8.7. 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.

8.8.7.1. 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.

8.8.8. Contractor shall give the Member and the Member's representative an opportunity, 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.

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

8.8.10. Contractor shall take not punitive action against a Provider who requests an expedited resolution.

8.8.11. Continuation of Benefits and Services During an Appeal

8.8.11.1. Contractor shall continue the Member's benefits while an Appeal is in the process if all of the following are met:

8.8.11.1.1. The Appeal is filed on or before the later of:

8.8.11.1.1.1. Ten days after Contractor mailed the notice of adverse benefit determination.

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

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

8.8.11.1.3. The services were ordered by an authorized Provider.

8.8.11.1.4. The authorization period has not expired.

8.8.11.1.5. The Member requests an extension of benefits.

8.8.11.2. 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:

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

8.8.11.2.2. 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.

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

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

8.8.11.3. Contractor may recover the cost of the continued services furnished to the Member while the Appeal was pending if the final resolution of the Appeal upholds Contractor's adverse

benefit determination.

8.8.11.4. 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.

8.8.11.5. 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.

8.8.11.6. Contractor shall notify the requesting Provider and give the Member written notice 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.

8.8.12. Resolution and Notification of Appeals

8.8.12.1. 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:

8.8.12.1.1. 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.

8.8.12.2. 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 the Department, upon its request) that there is a need for additional information and that the delay is in the Member's best interest.

8.8.12.2.1. 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.

8.8.12.2.2. 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.

8.8.12.2.3. 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.

8.8.12.2.4. 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.

8.8.12.2.5. 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.

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

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

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

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

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

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

8.8.12.4.4. Notice that the Member may be liable for the cost of any continued benefits if Contractor's adverse benefit determination is upheld in the hearing.

8.8.13. State Fair Hearing

8.8.13.1. Contractor shall allow a Member to request a State Fair Hearing after the Member has exhausted Contractor's Appeal process.

8.8.13.1.1. The Member has 120 calendar days from the date of a notice of an adverse Appeal resolution to request a State Fair Hearing.

8.8.13.2. 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.

8.8.13.3. 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.

8.8.13.4. 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.

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

8.8.14. Expedited State Fair Hearing

8.8.14.1. When the Appeal is heard first through Contractor's Appeal process, the Department's Office of Appeals will 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 the Department's receipt of a hearing request for a denial of service that:

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

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

8.9. Ombudsman for Medicaid Managed Care

8.9.1. Contractor shall utilize and refer Members to the Ombudsman for Medicaid Managed Care to assist with problem-solving, Grievance resolution, in-plan and administrative law judge

hearing level Appeals, and referrals to Community resources, as appropriate.

8.9.1.1. Contractor shall share PHI, with the exception of psychotherapy notes and substance use disorder-related information, with the Ombudsman upon request from the Ombudsman, 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.

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

8.10. Grievance and Appeals Report

8.10.1. Contractor shall create a quarterly Grievance and Appeals Report that includes the following information about Member Grievances and Appeals:

8.10.1.1. A general description of the reason for the Grievance or Appeal.

8.10.1.2. The date received.

8.10.1.3. The date of each review or, if applicable review meeting.

8.10.1.4. Resolution at each level of the Appeal or Grievance, if applicable.

8.10.1.5. Date of resolution at each level, if applicable.

8.10.1.6. Name of the covered Member for whom the Appeal or Grievance was filed.

8.10.2. Contractor shall submit the quarterly Grievance and Appeals Report to the Department.

8.10.2.1. DELIVERABLE: Grievance and Appeal Report

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

9. NETWORK DEVELOPMENT AND ACCESS STANDARDS

9.1. Establishing a Network

9.1.1. Contractor shall create, administer, and maintain a network of Network Providers that is sufficient to provide adequate access to all Covered Services.

9.1.2. 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.

9.1.2.1. Contractor may create networks based on quality indicators, credentials, and price.

9.1.3. Contractor shall ensure that its contracted network is capable of serving all Members, including contracting with Providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities.

9.1.4. Contractor's network shall include, but not be limited to, the following:

9.1.4.1. Public and Private providers, including independent practitioners.

9.1.4.2. Federally Qualified Health Centers (FQHC).

9.1.4.3. Rural Health Clinics (RHC).

9.1.4.4. Community Mental Health Centers (CMHC).

9.1.4.5. Substance Use Disorder Clinics

9.1.4.6. School Based Health Centers (SBHC).

9.1.4.7. Indian Health Care Providers.

9.1.4.8. Essential Community Providers (ECP).

9.1.4.9. Providers capable of billing both Medicare and Medicaid.

9.1.4.10. Comprehensive Providers.

9.1.4.11. Essential Providers.

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

9.1.5.1. The anticipated number of Members.

9.1.5.2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented.

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

9.1.5.4. The number of Network Providers who are accepting new Members.

9.1.5.5. 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.

9.1.6. 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 deaf and hard of hearing community; and the disability community and other culturally diverse communities who may be served.

9.1.7. Contractor may use mechanisms, such as telemedicine, to address geographic barriers to accessing clinical providers from diverse backgrounds.

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

9.1.8.1. 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.

9.1.8.2. Contractor shall not discriminate against any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

9.1.8.3. Contractor shall comply with any additional provider selection requirements as established by the Department.

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

9.1.8.4. 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.

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

9.1.8.5.1. The contracting and credentialing 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 to Contractor's network. The practice of contract back-dating does not constitute compliance to this process for the purpose of reporting or meeting the measurement period standards.

9.1.8.5.1.1. 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 credentialing application has been approved.

9.1.8.5.2. 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.

9.1.8.5.3. Contractor shall respond to all Provider inquiries related to their credentialing and contracting within two business days.

9.1.8.5.4. The Contractor shall complete the credentialing and contracting processes or deny network admission within sixty (60) days of receiving a completed application for at least ninety percent (90%) of all Providers.

9.1.8.5.5. The Contractor shall submit a monthly RAE Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department.

9.1.8.5.5.1. DELIVERABLE: RAE Credentialing and Contracting Report

9.1.8.5.5.2. DUE: Monthly, on the 15th of the month following the reporting period

9.1.8.6. 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.

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

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

9.1.8.6.3. Beginning January 1, 2024, Contractor shall ensure that the single case agreement process is executed within 14 calendar days of at least eighty percent 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.

9.1.8.6.3.1. 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.

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

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

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

9.1.8.7. 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 455.100-106 and 42 CFR 455.400-470.

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

9.1.9.1. 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.

9.1.10. Contractor shall ensure that its network provides Contractor's Members with a reasonable choice of Providers.

9.1.11. Contractor shall not be required to contract with more providers than necessary to meet the needs of its Members.

9.1.12. Contractor shall allow each Member to choose a PCMP to the extent possible and appropriate.

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

9.1.14. Contractor shall continually work to expand and enhance the Medicaid networks. Work related to continually working to expand and enhance Medicaid networks shall include, but not be limited to:

9.1.14.1. Recruiting new Providers and encouraging Network Providers to expand their capacity to serve more Members.

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

9.1.16. Contractor shall document its relationship with, and requirements for, each provider participating in Contractor's network in a written contract.

9.1.17. Contractor shall offer contracts to all willing and qualified FQHCs, RHCs, Comprehensive Providers, and IHCPs, located in the Contract Region.

9.1.18. Contractor shall retain and update contracts with all Network Providers who become enrolled as Comprehensive or Essential Providers.

9.1.19. 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.

9.1.20. Contractor shall terminate any providers of services or persons terminated (as described in section 1902(kk)(8) of the Social Security Act) from participation under title XIX, title XVIII, or title XXI from participating as a provider in Contractor's network.

9.1.21. Contractor shall permit an out- of-network IHCP to refer an Indian enrollee to a Network Provider in accordance with 42 C.F.R. § 438.14(b)(6).

9.1.22. Contractor shall permit Indian Members to obtain covered services from out-of- network I/T/U providers from whom the Member is otherwise eligible to receive such services.

9.1.23. Contractor shall permit Indian Members to access out-of-state IHCPs, in accordance with 42 CFR 438.14(b)(5), in a state where timely access to covered services cannot be ensured due to few or no Indian Health Care Providers.

9.2. Provider Credentialing and Re-credentialing

9.2.1. Contractor shall have documented procedures for credentialing and re-credentialing Network Providers that are publicly available to providers upon request. The documented procedures shall include Contractor's timeframes for the credentialing and re- credentialing processes.

9.2.2. Contractor shall use NCQA credentialing and re-credentialing standards and guidelines as the uniform and required standards for all contracts.

9.2.3. Contractor shall submit the Provider Credentialing Policies and Procedures to the Department.

9.2.3.1. DELIVERABLE: Provider Credentialing Policies and Procedures

9.2.3.2. DUE: January 1, 2020

9.2.4. Contractor shall ensure that all Network Providers are credentialed.

9.2.5. Contractor may accept accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organization (JCAHO) to satisfy individual credentialing elements required by this Contract or NCQA credentialing standards, if the Department deems the elements to be substantially equivalent to the NCQA elements and/or standards.

9.2.6. Contractor shall credential all contracted Providers and ensure that re-credentialing of all individual practitioners occurs at least every three years.

9.2.7. 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.

9.2.8. Primary Care Network

9.2.8.1. Contractor shall ensure that all primary care providers in its network meet the following criteria:

9.2.8.1.1. Enrolled as a Colorado Medicaid provider.

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

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

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

9.2.8.1.4.1. Community mental health centers and HIV/infectious disease practitioners may

qualify with Contractor's approval if all other criteria are met.

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

9.2.8.1.5.1. Physician (Code 05).

9.2.8.1.5.2. Osteopath (Code 26).

9.2.8.1.5.3. Federally Qualified Health Center (Code 32).

9.2.8.1.5.4. Rural Health Clinic (Code 45).

9.2.8.1.5.5. School Health Clinic (Code 51).

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

9.2.8.1.5.7. Clinic-Practitioner Group (Code 16).

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

9.2.8.1.6. Provides Care Coordination.

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

9.2.8.1.8. 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.

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

9.2.8.1.10. 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.

9.2.8.1.11. 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.

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

9.2.8.1.13. Uses an electronic health record or are working with Contractor to share data with the Department.

9.2.8.2. 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.

9.2.8.2.1. For example, Contractor provides 24/7 phone coverage for a practice or provides Care Coordination for a practice.

9.2.8.2.2. Contractor shall partner with these primary care providers to identify practice goals and support them in working toward achieving these goals.

9.2.8.3. Contractor shall consider practice site within a health organization, group, or system, as a separate practice site for the purposes of the Contactor's network.

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

supplies providers.

9.2.8.3.2. 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.

9.2.8.3.3. Contractor shall not impose any limitation on a Member's ability to select or change that Member's PCMP that is more restrictive than the Member's right to disenroll from Contractor's managed care capitation initiative.

9.2.8.3.4. Contractor shall permit any American Indian/Alaska Native Member eligible to receive services from a participating I/T/U provider, to elect that I/T/U as his or her primary care provider, if that I/T/U participates in Contractor's network as a primary care provider and has the capacity to provide the services.

9.2.8.3.5. Contractor shall exempt any American Indian/Alaska Native Member, who is eligible to receive or has received an item or Covered Service under this Contract, through an I/T/U provider or through referral from premiums and copays.

9.3. Specialty Behavioral Health Provider Network

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

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

9.3.3. Contractor shall enter into contracts with any willing and qualified in the Contract Region to enable Member choice and promote continuity of care.

9.3.3.1. When developed by the Department and the Behavioral Health Authority, Contractor shall use the Universal Contracting provisions as established in CRS 25.5-5-402 on a timeline agreed upon by Contractor and the Department. Per CRS 25.5-5-402 inclusion of the Universal Contracting provisions does not preclude Contractor to have other terms to drive value and accountability.

9.3.3.2. The Department will engage Contractor in the stakeholder process for developing the Universal Contracting provisions.

9.3.3.3. Contractor shall offer a Value-based Payment arrangement to all in-network Comprehensive Providers located in the Contract Region.

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

9.3.5. Behavioral Health Provider Credentialing and Re-credentialing

9.3.5.1. Contractor shall have documented procedures for credentialing and re- credentialing Network behavioral health providers that is publicly available to providers upon request. The documented procedures shall include Contractor's timeframes for the credentialing and re-credentialing processes.

9.3.5.2. Contractor shall submit the Provider Credentialing Policies and Procedures to the Department.

9.3.5.2.1. DELIVERABLE: Provider Credentialing Policies and Procedures

9.3.5.2.2. DUE: January 1, 2020

9.3.5.3. Contractor shall ensure that all Network Behavioral Health Providers are credentialed.

9.3.5.3.1. Contractor shall use NCQA credentialing and re-credentialing standards and guidelines as the uniform and required standards for all contracts.

9.3.5.3.1.1. Providers who are issued a provisional license and are enrolled with Medicaid are considered to be in good standing.

9.3.5.3.1.2. Contractor may contract with and reimburse providers with provisional licenses who are enrolled with Medicaid.

9.3.5.3.1.3. Contractor shall use the Council for Affordable Quality Healthcare (CAQH) ProView® application throughout the life of the Contract to collect data from individual Providers as necessary to complete the credentialing and recredentialing processes.

9.3.5.3.1.4. Contractor shall use the CAQH VeriFide™ application throughout the life of the Contract to perform Provider primary source verification for the credentialing and recredentialing processes.

9.3.5.3.1.5. Contractor may not require any additional documentation from individual Providers for the purposes of credentialing, unless the purpose of the request is to obtain a clean file.

9.3.5.3.2. Contractor may accept accreditation of primary care clinics by the JCAHO to satisfy individual credentialing elements, required by this Contract or NCQA credentialing standards, if the Department deems the elements to be substantially equivalent to the NCQA elements and/or standards.

9.3.5.4. Contractor shall credential all contracted Providers and ensure that re- credentialing of all individual behavioral health practitioners occurs at least every three years.

9.3.6. 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.

9.3.7. 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 14.5 and Exhibit I. When Medicaid services are sought from IHS/Tribal 638 providers, those providers shall bill the Department's fiscal agent.

9.4. Access to Care Standards

9.4.1. Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care in order to:

9.4.1.1. Serve all primary care and care coordination needs;

9.4.1.2. Serve all specialty and ancillary care needs, including but not limited to, behavioral health needs; and

9.4.1.3. Allow for adequate Member freedom of choice amongst Providers.

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

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

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

9.4.5. 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.

9.4.6. Contractor shall implement a network management process and maintain an up-to- date database or directory of contracted Providers approved to deliver services, which includes all the information listed in Section 7.3.6 of this contract. Contractor shall ensure that the directory is updated at least monthly and shall be made available to the Department.

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

9.4.8. Contractor shall ensure that its physical health network complies with the time and distance standards as described the following tables:

PHYSICAL HEALTH NETWORK TIME AND DISTANCE STANDARDS

	Urban County		Rural County		Frontier County	
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Adult Primary Care Providers	30	30	45	45	60	60
Pediatric Primary Care Providers	30	30	45	45	60	60
Gynecology, OB/GYN	30	30	45	45	60	60
Specialists, Adult	30	30	60	60	100	100
Specialists, Pediatric	30	30	60	60	100	100
Hospitals (acute care)	20	20	30	30	60	60
Pharmacy	10	10	30	30	60	60

9.4.8.1. Contractor shall ensure that its primary care network has a sufficient number of Providers so that each Member has their choice of at least two primary care providers within the maximum time or the maximum distance for their county classification. For Rural and Frontier areas, the Department may adjust this requirement based on the number and location of available Providers.

9.4.8.1.1. In the event that there are less than two practitioners that meet the primary care provider 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.

9.4.8.1.2. Contractor shall use GeoAccess, or a comparable service, to measure the distance between the Members and the Providers in Contractor's Service Area.

BEHAVIORAL HEALTH NETWORK TIME AND DISTANCE STANDARDS

	Urban County		Rural County		Frontier County	
Required Providers	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Hospitals (acute care)	20	20	30	30	60	60
Psychiatrists and other psychiatric prescribers, for adults	30	30	60	60	90	90
Psychiatrists and other psychiatric prescribers; serving children	30	30	60	60	90	90
Mental Health Provider; serving adults	30	30	60	60	90	90
Mental Health Provider; serving children	30	30	60	60	90	90
Substance Use Disorder Provider; serving adults	30	30	60	60	90	90
Substance Use Disorder Provider; serving children	30	30	60	60	90	90

9.5. Contractor shall ensure that its behavioral health network has a sufficient number of Providers so that each Member has their choice of at least two behavioral health providers within the maximum time or the maximum distance for their county classification. For Rural and Frontier areas, the Department may adjust this requirement based on the number and location of available providers.

9.5.1. In the event that there are no behavioral health providers who meet the behavioral health provider standards within the defined area for a specific Member, then Contractor shall not be bound by the time and distance requirements of the prior table for that Member.

9.5.2. Contractor shall use GeoAccess, or a comparable service, to measure the distance between the Members and the behavioral health providers in Contractor's Region.

9.6. Contractor shall ensure that its networks meet the following Practitioner to Member

ratios:

9.6.1. Adult primary care providers: One practitioner per 1,800 adult Members.

9.6.2. Mid-level adult primary care providers: One practitioner per 1,200 adult Members.

9.6.3. Pediatric primary care: One practitioner per 1,800 child Members.

9.6.4. Physician specialist (includes Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology): One Physician specialist per 1,800 Members.

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

9.6.5. Adult mental health providers: One practitioner per 1,800 adult Members.

9.7. Pediatric mental health providers: One practitioner per 1,800 child Members.

9.8. Substance use disorder providers: One practitioner per 1,800 Members.

9.9. Contractor shall maintain sufficient IHCPs in the network to ensure timely access to care 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.

9.9.1. Indian or Tribal Members eligible to receive services from an IHCP in the network are permitted to choose that IHCP as their PCMP, as long as that IHCP has the capacity to provide services.

9.10. Contractor shall ensure its network is sufficient so as to provide services to Members on a timely basis, as follows:

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

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

9.10.3. Non-urgent, symptomatic care visit – within seven days after the request.

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

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

9.10.4.2. Contractor shall not place Members on waiting lists for initial routine service requests.

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

9.11.1. 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.

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

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

9.11.3. Contractor shall not place Members on waiting lists for initial routine service requests.

9.11.4. Contractor shall take actions necessary to ensure that all Covered Services under this Contract are provided to Members with reasonable promptness, including but not limited to the following:

9.11.4.1. Utilizing out-of-network Providers.

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

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

9.11.6. 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.

9.11.7. Contractor shall provide a List of Credentialed Early Intervention Qualified Providers to the Department, annually, by October 30th, and assure that there are adequate providers to serve the eligible children. Contractor shall use the template provided by the Department.

9.11.7.1. DELIVERABLE: List of Credentialed Early Intervention Qualified Providers

9.11.7.2. DUE: Annually by October 30th

9.11.8. Contractor shall provide service for a Member to receive a second opinion from a qualified health care professional, within its network, or arrange for the Member to obtain one outside the network if there is no other qualified health care professional within its network, at no cost to the Member.

9.12. Network Changes and Deficiencies

9.12.1. Contractor shall notify the 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:

9.12.1.1. Information describing how the change will affect service delivery.

9.12.1.2. Availability, or capacity of covered services.

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

9.12.1.4. A plan to correct any network deficiency.

9.12.1.4.1. DELIVERABLE: Network Changes and Deficiencies

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

9.13. Network Adequacy Plan and Report

9.13.1. Contractor shall create a Network Adequacy Plan as part of the Network Management Strategic Plan that contains, at a minimum, the following information for its provider networks:

9.13.1.1. 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.

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

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

9.13.1.3.1. Adult primary care providers.

9.13.1.3.2. Pediatric primary care providers.

9.13.1.3.3. OB/GYN.

9.13.1.3.4. Family planning providers.

9.13.1.3.5. Gerontologists.

9.13.1.3.6. Internal Medicine providers.

9.13.1.3.7. Physician Specialists.

9.13.1.3.7.1. Contractor and the Department shall specify specialty groups that require further reporting on an ongoing basis, as determined by Contractor and the Department.

9.13.1.3.8. Adult mental health providers.

9.13.1.3.9. Pediatric mental health providers.

9.13.1.3.10. Substance use disorder providers.

9.13.1.3.11. Psychiatrists.

9.13.1.3.12. Child psychiatrists.

9.13.1.3.13. Psychiatric prescribers.

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

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

9.13.1.6. Cultural and language expertise of providers.

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

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

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

9.13.2. Contractor shall create a Network Adequacy Report that contains, at a minimum, the following information:

9.13.2.1. Number and percent of primary care providers accepting new Medicaid Members.

9.13.2.2. Number and percent of specialty providers accepting Medicaid Members.

9.13.2.2.1. The Department, in collaboration with Contractor, will determine specific specialty groups that require further reporting on an ongoing basis.

9.13.2.3. Number and percent of primary care providers offering after-hours appointment

availability to Medicaid Members.

9.13.2.4. Performance meeting timeliness standards.

9.13.2.5. New providers contracted during the quarter.

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

9.13.2.7. Additional information, as requested by the Department.

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

9.13.3.1. DELIVERABLE: Network Adequacy Report

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

9.13.4. Member complaints on appointment wait times shall be addressed immediately on a patient-specific basis and researched to determine solutions to any causal systemic issues.

10. HEALTH NEIGHBORHOOD AND COMMUNITY

10.1. Contractor shall promote Members' physical and behavioral well-being by creating a Health Neighborhood and Community consisting of a diverse network of health care providers and Community organizations providing services to residents within Contractor's geographic Service Area.

10.1.1. As Members living within Contractor's geographic region may be attributed to a RAE, Contractor shall collaborate with RAEs in the same Service Area to assist them in leveraging Contractor's Health Neighborhood and Community to address Members' social and other health needs.

10.1.2. Contractor shall collaborate with the RAEs in order to leverage their Health Neighborhoods and Communities in order to help serve any of Contractor's enrolled Members.

10.1.3. Contractor's efforts shall include increasing Member access to timely and appropriate Medicaid services and benefits that can positively impact the conditions in which Members live.

10.1.4. Contractor shall notify the Department upon becoming aware of new construction of an emergency department, hospital, or hospital expansion.

10.1.4.1. DELIVERABLE: Notice of New Construction

10.1.4.2. DUE: Within five Business Days of becoming aware of new construction of an emergency department, hospital or hospital expansion

10.2. Health Neighborhood

10.2.1. Contractor shall recognize the value that all Medicaid providers offer to improving Member health and functioning. The successful engagement and utilization of the full range of Health Neighborhood providers, including specialty care, LTSS providers, Managed Service Organizations and their networks of substance use disorder 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, is 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.

10.2.2. Contractor shall establish and strengthen relationships among its Network Providers and the

Health Neighborhood in the Service Area by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts.

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

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

10.2.4.1. 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. Programs may include, but are not limited to:

10.2.4.1.1. Sharing of claims data as appropriate.

10.2.4.1.2. Care Coordination, particularly coordinating travel and following up with Members that miss specialty care appointments.

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

10.2.4.1.4. Providing support in implementing and utilizing telehealth solutions.

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

10.2.5.1. Contractor shall promote the use of the Department-adopted electronic consultation software when adopted, through which specialists consult with PCMPs via a telecommunication platform. Electronic consultations allow specialists to receive reimbursement for timely review of clinical information and providing Member specific recommendations on how a PCMP may manage a condition and whether a specialty visit is required. Electronic consultations have been shown to increase appropriate access to specialty care, improve both physician satisfaction and Member experience, and improve overall quality of care.

10.2.5.1.1. 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.

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

10.2.6.1. Contractor shall establish arrangements with the Colorado Crisis Services vendors for the coordination of follow-up care for Medicaid Members.

10.2.7. Contractor shall coordinate care with Colorado's Managed Service Organizations to ensure Member access to appropriate substance use disorder treatments.

10.2.8. 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.

10.2.8.1. Contractor shall educate hospital discharge planners on processes that support LTSS Members and non-institutional discharge options.

10.2.9. Contractor shall utilize and disseminate, to appropriate Network Providers, admit/discharge/transfer 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 admit/discharge/transfer Data.

10.2.9.1. Contractor shall follow-up with discharged Members to:

10.2.9.1.1. Ensure the Member understood discharge instructions;

10.2.9.1.2. Schedule a follow-up physician or PCMP visit in accordance with the discharge plan; and

10.2.9.1.3. Ensure the Member filled related prescriptions in accordance with the discharge plan.

10.2.10. 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 Accountable Care Collaborative Program.

10.2.10.1. Contractor shall work with the Department to understand how the Hospital Transformation Program will work in Colorado, and the hospitals' role and responsibilities.

10.2.10.2. Contractor shall help hospitals determine priorities and select projects, interventions and performance goals for the Hospital Transformation Program.

10.2.11. Contractor shall collaborate with LTSS providers and care coordinators/case managers, No Wrong Door Entities, Area Agencies on Aging, and Aging and Disability Resources for Colorado to develop holistic approaches to assisting LTSS Members achieve their health and wellness goals.

10.2.11.1. Contractor shall work to improve coordination of long-term services and supports with Members' physical and behavioral health needs through a variety of methods, such as developing policies and/or means of sharing Member information.

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

10.2.13. Contractor shall establish relationships and communication channels with the entities administering the Department's Non-Emergency Medical Transportation benefit in order to ensure Members are able to attend their medical appointments on time. Contractor shall designate a single point of contact to lead non-emergency medical transportation work. Contractor shall share feedback with the Department on transportation issues.

10.2.13.1. Members' health is often negatively impacted when they miss appointments, particularly with specialty care providers, and can result in over utilization of the emergency department. Strengthening the relationship of the Non-Emergency Medical Transportation administrative entities with members of the Health Neighborhood and implementing initiatives to increase efficiency can significantly improve provider satisfaction, Member experience, and Member health.

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

dental benefits.

10.2.15. Contractor shall collaborate with local public health agencies by:

10.2.15.1. Designing opportunities for integration of local public health activities into the Accountable Care Collaborative.

10.2.15.2. Identifying any specific target activities to meet the health needs of Members in the region, such as enrollment, health promotion, population health initiatives, and dissemination of public health information.

10.2.15.3. Exploring appropriate funding approaches to support collaborative activities.

10.3. Community and the Social Determinants of Health

10.3.1. 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.

10.3.2. Recognizing that the conditions in which Members live also impact their health and well-being, Contractor shall establish relationships and collaborate with economic, social, educational, justice, recreational and other relevant organizations to promote the health of local communities and populations.

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

10.3.4. Contractor shall establish relationships and communication channels with Community organizations that provide resources such as food, housing, energy assistance, childcare, education, and job training in the region.

10.3.4.1. 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.

10.3.5. Contractor shall establish access to a centralized regional resource directory listing all Community resources available to Members and share the information with providers and Members.

10.3.5.1. Contractor shall not duplicate Community efforts to create a directory. Instead, Contractor shall integrate, leverage, and/or participate in any existing state or regional efforts to build a regional resource directory, when possible.

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

10.3.7. 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.

10.3.8. Contractor shall share information with Community organizations in the region about identified Community social service gaps and needs.

10.3.9. Contractor shall engage with hospitals and local public health agencies regarding their community health needs assessments in order to develop and implement collaborative strategies to reduce health inequities and disparities in the Community.

10.3.10. Contractor shall collaborate with the Department, other state agencies, and regional and local

efforts in order to expand the Community resources available to Members.

10.3.11. Health Equity Plan

10.3.11.1. Contractor shall provide a Health Equity Plan to identify and address specific and targeted health disparities that impact Members within their respective 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 for COVID-19 vaccination rates, maternity and perinatal health, and behavioral health and prevention.

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

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

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

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

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

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

10.3.11.2.6. DELIVERABLE: Health Equity Plan

10.3.11.2.7. DUE: December 31, 2023

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

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

10.3.11.4.1. DELIVERABLE: Health Equity Report

10.3.11.4.2. DUE: Annually, by December 31

10.4. Statewide Health Infrastructure

10.4.1. Contractor shall participate in and align its activities with advisory groups, existing programs and statewide initiatives designed to strengthen the health care system, including:

10.4.1.1. Managed Service Organizations (MSOs): funded by the Behavioral Health Administration to provide specialized substance abuse services to vulnerable populations.

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

10.4.1.2.1. Contractor shall promote the Colorado Crisis System to Members and Providers for confidential, immediate support for mental health, substance use, or emotional help.

10.4.1.3. Comprehensive Primary Care Initiative (CPC+): a CMS led, multi-payer effort fostering collaboration between public and private health care payers to strengthen primary care.

10.4.1.4. Community Living Advisory Group: recommended LTSS system changes to enhance community living options and provided direction to Office of Community Living as changes are implemented.

10.4.1.5. Benefits Collaborative: The Department's formal process to establish the amount, scope, and duration of fee-for-service benefits, ensure that covered services are evidence-based and guided by best practices, and develop working relationships and collaborate with stakeholders.

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

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

10.4.1.7. Utilization Management Vendor: Contractor shall establish a relationship and communication channels with the Department's utilization management (UM) vendor to leverage Member programs and services, such as the Nurse Advice Line.

10.5. Health Neighborhood and Community Report

10.5.1. Contractor shall submit a bi-annual report to the Department describing Contractor's activities to collaborate with and build the Health Neighborhood and Community to support Members' health care and social needs, in addition to articulating plans for the Health Neighborhood and Community in the Annual Network Management Strategic Plan.

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

10.5.2.1. Contractor shall ensure that efforts and strategies outlined in the Health Neighborhood and Community Report are a part of Contractor's Population Management Strategic Plan.

10.5.3. The Health Neighborhood and Community Report shall include:

10.5.3.1. Collaboration with hospitals, including with the Hospital Transformation Program.

10.5.3.2. Activities to increase regional specialty provider Medicaid network and access

10.5.3.3. Recruitment efforts and training for utilization of electronic consultation

10.5.3.4. Efforts to utilize data to improve transitions of care and results of those efforts

10.5.3.5. Activities to engage LTSS providers

10.5.3.6. Collaboration with Local Public Health Agencies

10.5.3.7. Activities to engage Members with evidence-based/promising practice programs in the Community to address social determinants of health.

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

10.5.5. Contractor shall update and submit the Health Neighborhood and Community Report twice a year to the Department and reflect any revisions in Contractor's Population Management Strategic Plan when applicable.

10.5.5.1. DELIVERABLE: Health Neighborhood and Community Bi-annual Report

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

10.6. COVID-19

10.6.1. Contractor shall establish and strengthen relationships among Health Neighborhood and Community providers and organizations within the region to address the negative impacts of COVID-19.

10.6.2. Contractor shall facilitate health data sharing among providers in the Health Neighborhood to support improved COVID-19 vaccination rates and address other identified health risks associated with COVID-19.

10.6.3. Contractor shall work with Health Neighborhood and Community providers and organizations to remove roadblocks to Member access to COVID-19 vaccinations and other resources addressing disparities in health equity.

10.6.4. Contractor shall engage, partner, use financial or nonfinancial incentives as available, and collaborate with organizations such as providers, hospitals, pharmacies and local public health agencies to address COVID-19.

11. POPULATION MANAGEMENT AND CARE COORDINATION

11.1. Contractor shall manage the health of all its Members.

11.1.1. Contractor shall use the Population Management Framework to inform, assess, track and manage the health needs and outcomes of all its Members in order to improve health, control costs and improve the experience of care. Contractor shall use the Population Management Framework to guide work in the areas of care coordination, condition management, prevention support and member engagement, Health Neighborhood and community development, practice support and financial support.

11.1.2. Contractor shall understand that population management requires a detailed understanding of the distribution of health conditions and health related behaviors, and is strengthened by the consideration of social determinants of health, such as income, culture, race, age, family status, housing status, and education level. Contractor shall possess capabilities to leverage and build upon the Department's data systems and perform analytics to successfully implement an information-based approach to delivering and coordinating care and services across the continuum.

11.1.3. Data from the Department indicates a high need for wellness interventions in the following areas:

11.1.3.1. Weight;

11.1.3.2. Tobacco use;

11.1.3.3. Family planning education;

11.1.3.4. Anxiety and depression;

11.1.3.5. Pre- and post-natal care.

11.1.3.6. Immunizations

11.1.4. Contractor shall focus in these areas and the Department will continue to direct information and insights to guide Contractor focus. 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 at all life stages and levels of health, with a particular focus

on Complex Members. Contractor shall ensure that Care Coordination is one of the interventions available to Members.

11.1.5. Contractor shall monitor and participate in the Department's effort to make the Diabetes Prevention Program a Medicaid benefit. Once a covered benefit Contractor shall coordinate the delivery of the Diabetes Prevention Program consistently during the term of this Contract. Contractor shall identify those who meet program criteria and outreach to those participants.

11.1.6. Contractor shall outreach to women in the perinatal period to improve education and outcomes around maternity support and benefits and advantages. Contractor shall focus particularly on high-risk pregnant women in the first trimester as well as during the post-partum period as a goal of this outreach.

11.1.7. Contractor shall educate providers on tools available to assist physicians on best practices for population management and care coordination as tools become available in partnership with the Department.

11.1.8. Contractor shall provide outreach, education, and access to Members in need of routine and emergent immunizations and leverage data to focus these efforts on priority populations.

11.2. Population Management

11.2.1. Contractor shall develop and submit to the Department a Population Management Strategic Plan in a format determined by the Department.

11.2.1.1. Contractor shall place a particular focus on Members identified as Complex Members for outreach and interventions, including care coordination.

11.2.1.2. Contractor may substitute their own population management approach for serving Complex Members with Department approval.

11.2.1.2.1. Contractor shall leverage data and resources to risk stratify beyond the Complex Member population to effectively meet the unique needs of their assigned members more broadly.

11.2.2. Contractor shall use the Population Management Framework and risk stratification methodology to support population management including focused outreach, programming, and care coordination for members utilizing Medicaid services. The Department's risk stratification methodology captures both the physical and behavioral health needs of Members and allows for further customization by Network Providers, RAEs and Contractor to effectively meet the unique needs of their assigned Members.

11.2.2.1. Contractor shall collaborate with the Department to evolve the Population Management Framework and risk stratification methodology as appropriate.

11.2.3. Contractor shall facilitate the transition of Members from their region to another RAE when appropriate.

11.2.4. Contractor shall ensure that its Population Management Strategic Plan is designed in alignment with the Population Management Framework and risk stratification methodology includes, at a minimum, the strategies, interventions, and evidence to support the following:

11.2.4.1. Wellness promotion and member engagement

11.2.4.2. Programs for health conditions identified by the Department and implemented by Contractor.

11.2.4.3. Care Coordination strategy.

11.2.4.4. A description of how Contractor will engage and support Network Providers and the Health Neighborhood in Contractor's strategies, including, incentives and financial structures to reward increased value and improved outcomes.

11.2.4.5. A description of milestones and outcomes for how Contractor will monitor the implementation and success of interventions.

11.2.4.6. Addressing identified health disparities among enrolled Members.

11.2.5. Contractor shall incorporate evidence-based practices, and promising local initiatives that address the social determinants of health.

11.2.6. Contractor shall engage Members and Network Providers in the development and revising of the Population Management Strategic Plan and shall share the final plan with Network Providers, and assist them in delivering care coordination for Complex Members, condition management, prevention and wellness activities and other interventions based on the Population Management Strategic Plan.

11.2.7. Contractor shall submit the Population Management Strategic Plan to the Department for review and integrate feedback as appropriate.

11.2.7.1. DELIVERABLE: Population Management Strategic Plan

11.2.7.2. DUE: July 1, 2020

11.2.8. Contractor shall review the Population Management Strategic Plan at least annually and submit a revised Plan to the Department detailing progress made, lessons learned, and planned adjustments based on evidence from implementation of the previous year's strategic plan.

11.2.8.1. DELIVERABLE: Population Management Strategic Plan Update

11.2.8.2. DUE Annually, July 1.

11.3. Care Coordination

11.3.1. Contractor shall effectively coordinate care for all Members and focus on Complex Members. Contractor shall use its own resources and Department insights to ensure active coordination of these high-cost and high-need members.

11.3.2. Contractor shall have a specific process to ensure that Specialty Drugs are managed away from outpatient hospitals into home infusion, where appropriate.

11.3.3. Contractor shall use the Population Management Framework to inform Contractor's strategy to provide Care Coordination to its members. Contractor shall ensure that Care Coordination is part of Contractor's Population Management Strategic Plan. Care Coordination shall comprise:

11.3.3.1. A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support Member health and well-being.

11.3.3.2. Activities targeted to specific members who require more intense and extended assistance and includes interventions such as care plans.

11.3.4. Contractor shall use a person- and family-centered approach to Care Coordination, which takes into consideration the preferences and goals of Members and their families, and then connects them to the resources required to carry out needed care and follow up.

11.3.5. Contractor shall ensure that care is coordinated for the Member within a practice, as well as

between the practice and other Health Neighborhood providers and Community organizations.

11.3.5.1. In the event Contractor allows a PCMP or other Subcontractor to perform any Care Coordination activities, the agreement with that PCMP or other Subcontractor shall comply with all applicable requirements of this Contract.

11.3.6. Contractor shall not duplicate Care Coordination provided through LTSS and HCBS waivers and other programs designed for special populations; rather, Contractor shall work to link and organize the different Care Coordination activities to promote a holistic approach to a Member's care.

11.3.7. Contractor shall ensure that Care Coordination:

11.3.7.1. Is accessible to Members.

11.3.7.2. Is provided at the point of care whenever possible.

11.3.7.3. Addresses both short and long-term health needs.

11.3.7.4. Is culturally responsive.

11.3.7.5. Respects Member preferences.

11.3.7.6. Supports regular communication between care coordinators and the practitioners delivering services to Members.

11.3.7.7. Reduces duplication and promotes continuity 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.

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

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

11.3.7.10. Contractor shall ensure Care Coordination is documented in the form of a care plan for Members who require more intense or extended assistance including Complex Members.

11.3.7.10.1. Contractor shall ensure Care Coordination care plans are regularly and sufficiently monitored and include the following:

11.3.7.10.2. A lead care coordinator.

11.3.7.10.3. Goals and outcomes.

11.3.7.10.4. Be member and/or caregiver driven.

11.3.7.11. Aligns with Contractor's Population Management Strategic Plan.

11.3.7.12. Protects Member privacy.

11.3.8. Contractor shall ensure that care coordinators in Contractor's network reach out and connect with other service providers and communicate information appropriately, consistently and without delay.

11.3.9. Contractor shall reasonably ensure that all Care Coordination, including interventions provided by Network Providers and Subcontractors, meet the needs of the Member.

11.3.10. Contractor shall ensure that Care Coordination is provided to Members who are transitioning between health care settings and populations who are served by multiple systems, including, but not limited to, children involved with child welfare, Medicaid- eligible individuals transitioning out of the criminal justice system, Members receiving LTSS services, Members transitioning out of inpatient, residential, and institutional settings, and Members residing in the community who are identified as at-risk for institutionalization. To meet the needs of these Members, Contractor shall:

11.3.10.1. Designate staff persons to serve as Contractor's single point of contact with the different systems and settings.

11.3.10.2. Give designated staff persons 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 10 CCR 2505-10 8.013, and out-of-state NEMT as described in 10 CCR 2505-10 8.014.7.

11.3.10.3. Provide specific guidance to care coordinators about each setting, regarding how to identify Members in the system/setting; how to provide Care Coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and Member concerns.

11.3.10.4. Participate in special workgroups created by the Department or other state agencies to improve services and coordination of activities for populations served by multiple systems.

11.3.10.4.1. Contractor shall partner with the Department and the Colorado Department of Corrections (CDOC) to identify and provide services to Medicaid-eligible individuals being released from incarceration to enable them to transition successfully to the community. Services shall include, but are not limited to, in- reach services, care transition support, and care coordination.

11.3.10.4.2. Contractor shall receive and process a list from the Colorado Department of Corrections containing information about incarcerated individuals who have recently been released or will be released in the near future.

11.3.10.4.2.1. Contractor shall process the list to identify individuals who are assigned to Contractor or will be released to Contractor's region and are likely to be assigned to Contractor.

11.3.10.4.2.2. 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.

11.3.10.4.2.3. Contractor shall coordinate transitional support between CDOC and other RAEs for individuals who were likely to but ultimately were not assigned to Contractor.

11.3.10.4.2.4. Contractor shall safely destroy the Department of Corrections list following processing to ensure privacy protections.

11.3.10.5. Implement programs and/or procedures to reduce unnecessary utilization of the emergency department for Members residing in Nursing Facilities and Members receiving end of life care.

11.3.10.6. Contractor shall utilize the admission/discharge/transfer (ADT) data from the Colorado Health Information Exchange to identify hospitalized Members.

11.3.10.7. Contractor shall ensure that follow-up engagement with Members occurs within 30 days after a physical health inpatient discharge and within 7 days after a behavioral health inpatient discharge.

11.3.11. For Members with intellectual and developmental disabilities who require services for conditions other than a mental health or substance use disorder, Contractor shall assist the Member in locating appropriate services.

11.3.12. For Members with substance use disorders who require services not covered by Medicaid, Contractor shall coordinate care with the state's Managed Service Organizations.

11.3.13. Contractor shall coordinate care with the Colorado Crisis System to ensure timely follow-up outreach and treatment for enrolled Members who accessed crisis services.

11.3.14. Contractor shall comply with requirements for coordinating care for Members identified by the Department as at-risk for institutionalization resulting from an agreement with the Department of Justice.

11.3.14.1. Contractor shall process a list from the Department of Members who are identified as at-risk for institutionalization.

11.3.14.2. Contractor shall outreach and provide Care Coordination services to Members identified as at-risk for institutionalization to support them in remaining in the community.

11.3.14.3. Contractor's Care Coordination activities for Members identified as at-risk for institutionalization shall include, but not be limited to, in-reach services, care transition support, and referrals to HCBS services.

11.3.15. For Members who are transplant recipients with an SUD diagnosis, Contractor shall follow the Transplant Patients with SUD Diagnosis protocol developed by the Department.

11.3.15.1. Contractor shall make resources easily accessible on the Contractor's website for hospital transplant teams to coordinate services for Members who are transplant recipients with an SUD diagnosis.

11.3.16. Contractor shall assist care coordinators within Contractor's network with bridging multiple delivery systems and state agencies.

11.3.17. Contractor shall require additional support and guidance when the systems and providers engaged with a Member's complex care require leadership and direction.

11.3.18. Contractor shall ensure that Care Coordination tools, processes, and methods are available to and used by Network Providers as described in Section 15.2.1.

11.3.19. Contractor shall ensure that clinical and claims data feeds, including but not limited to admission/discharge/transfer (ADT) data received from a Colorado health information exchange, monthly claims data, the Nurse Advice Line data feed, and the Inpatient Hospital Transitions data feed are actively used in providing Care Coordination for Members.

11.3.20. Creative solutions and complex solutions

11.3.20.1. Contractor shall lead and facilitate complex solutions meetings for adults and creative solutions meetings for children that include the Member's care team, needed community partners, and State Department staff as applicable in order to identify solutions for Members experiencing significant barriers to care, including but not limited to difficult placements.

11.3.20.2. Contractor shall use templates provided by the Department to refer, track, and monitor Members involved in creative solutions and complex solutions.

11.3.20.2.1. Contractor shall develop a plan to bridge support for Members between discharge from higher levels of care and waitlists for step-down services.

11.3.20.2.1.1. When solutions are unsuccessful, summarize the reasons and any missed opportunities or future plans to prevent similar outcomes.

11.3.20.3. Contractor shall report creative solutions and complex solutions data in a format and at a frequency determined by the Department.

11.4. Care Coordination and Complex Care Management Report

11.4.1.1. Contractor shall provide a Care Coordination and Complex Care Management Report in a format agreed to by the Department and Contractor. The report shall include extended care coordination activities for Complex Members performed by Contractor, Network Providers and Partners, and Subcontractors, and include Care Coordination activities for members at-risk for institutionalization. The report shall contain, at a minimum, narrative and statistics that include the following:

11.4.1.1.1. The number of unique Complex Members for whom extended care coordination was provided by Contractor, PCMPs, and other contracted care coordination entities during the reporting period.

11.4.1.1.2. Narrative descriptions of successes, challenges and improvement opportunities for overall extended care coordination strategy and for subpopulations identified by the Department.

11.4.1.2. Contractor shall submit the Care Coordination and Complex Care Management Report to the Department.

11.4.1.2.1. DELIVERABLE: Care Coordination and Complex Care Management Report

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

11.5. Condition Management

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

11.5.2. Contractor shall utilize existing programs among its Network Providers to manage and support Members with specific health conditions.

11.5.3. Contractor shall develop programs to manage and support Members with specific health conditions identified by the Department for which Contractor's Network Providers do not have existing programs.

11.5.4. Contractor shall use the Population Management Framework to inform Contractor's strategy and progress on programs to address members with specific health conditions as outlined in the Condition Management Report.

11.5.5. Contractor shall incorporate condition management into Contractor's Population Management Strategic Plan.

11.5.6. Condition Management Report

11.5.6.1. Contractor shall provide information about their strategy and progress on programs to

address Members with specific health conditions as identified by the Department in the Condition Management Report.

11.5.6.2. Contractor shall submit a Condition Management Report in a format agreed upon by the Department and Contractor.

11.5.6.3. Contractor shall update and submit the Condition Management Report twice a year to the Department and reflect any revisions in Contractor's Population Management Strategic Plan when applicable.

11.5.6.3.1. DELIVERABLE: Condition Management Report

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

11.6. Immunization Activity Report

11.6.1. Contractor shall create and deliver an Immunization Activity Report in a format agreed to by the Department and Contractor. The report shall contain, at a minimum, narrative and statistics to describe the following categories:

11.6.1.1. Outreach and education efforts provided to Members and financial contributions towards this work.

11.6.1.2. Efforts to access to immunization services for priority populations.

11.6.1.3. How Contractor has created and/or strengthened relationships with immunization partners.

11.6.1.3.1. DELIVERABLE: Immunization Activity Report

11.6.1.3.2. DUE: February 12, 2024

11.7. Collaboration with Office of Community Living Case Management Agencies (CMAs)

11.7.1. Contractor shall ensure collaboration with CMAs occurs for all shared Members that need care coordination services for physical, mental and behavioral health services in addition to the HCBS case management services provided by a CMA.

11.7.1.1. Contractor shall collaborate with CMAs to avoid duplication of efforts and to comply with guidelines from the Department that outline how the Contractor will work with CMAs to coordinate care for Members receiving services from a CMA.

11.7.2. Contractor shall identify which CMAs are responsible for providing HCBS case management services to their shared Members and shall work with these CMAs to coordinate care for those Members.

11.7.3. Contractor shall coordinate with CMAs when a Member is admitted to a hospital, including, but not limited to, communication about the reason for admission, the Member's hospital status, and discharge plans.

11.7.3.1. Contractor shall collaborate with CMAs when a shared Member is discharged from the hospital to ensure the Member is connected to the necessary services.

11.7.4. Contractor may explore data sharing agreements with all CMAs supporting their shared Members to share information needed to assist those Members in accessing physical and behavioral health services.

11.7.5. Contractor shall honor Member preferences for case management and care coordination.

11.7.6. Contractor shall implement the following best practices:

11.7.6.1. Contractor shall participate in regular collaboration meetings between the Contractor and CMAs serving shared Members.

11.7.6.2. Contractor shall draft, with the CMAs, policies and procedures for their collaboration for shared Member Care Coordination.

11.7.6.3.

12. PROVIDER SUPPORT AND PRACTICE TRANSFORMATION

12.1. Contractor shall serve as a central point of contact for Network Providers regarding Medicaid services and programs, regional resources, clinical tools, and general administrative information.

12.2. Contractor shall support Network Providers that are interested in integrating primary care and behavioral health services; enhancing the delivery of team-based care by leveraging all staff and incorporating patient navigators, peers, promoters, and other lay health workers; advancing business practices and use of health technologies; participating in APM; and other activities designed to improve Member health and experience of care.

12.3. 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.

12.4. Contractor shall ensure that Contractor's Provider communications adhere to Colorado Medicaid's brand standards.

12.5. Contractor shall use the Population Management Framework to inform Contractor's strategy to provide Practice Support to Network Providers.

12.5.1. Contractor shall ensure that Practice Support is part of Contractor's Population Management Strategic Plan.

12.6. Contractor shall support the delivery of evidence-based medicine by Network Providers.

12.7. Contractor shall include a written Practice Support Strategy as part of the Annual Network Management Plan that includes, but is not limited to, the following information:

12.7.1. The types of information and administrative support, provider trainings, and data and technology support Contractor will offer and make available to Network Providers.

12.7.2. The practice transformation strategies it will offer to help practices progress along the Framework for Integration of Whole-Person Care as well as strategies to help practices engage with Contractor's efforts to implement their Population Management Strategy.

12.7.3. Contractor shall submit the Annual Network Management Strategic Plan to the Department

12.7.3.1. DELIVERABLE: Annual Network Management Strategic Plan

12.7.3.2. DUE: Annually, August 1

12.8. Contractor shall submit a Practice Support, Transformation and Communication Report to the Department.

12.8.1. DELIVERABLE: Practice Support, Transformation and Communication Report

12.8.2. DUE: Annually, by July 22

12.9. General Information and Administrative Support

12.9.1. Contractor shall ensure adequate informational support for Network Providers, while being

mindful of not duplicating existing materials.

12.9.2. Contractor shall maintain, staff, and publish the number for a toll-free telephone line and general Provider relations asynchronous electronic communication format that Providers may contact regarding general information, administrative support, and complaints , including, but not limited to, contracting, credentialing, claims, and payment.

12.9.2.1. Contractor shall post their Provider relations asynchronous electronic communication format and phone number on their website.

12.9.2.2. Contractor shall respond to all Provider inquiries within two (2) business days.

12.9.2.3. Contractor shall have an automated response to their Provider relations asynchronous electronic communication format that states the expected response time.

12.9.2.4. For inquiries that cannot be resolved within five (5) business days, the Contractor shall document a process for how they are working to resolve the issue and provide an update to the Department, either in writing or during a regularly scheduled meeting upon request.

12.9.2.4.1. For inquiries that take longer than 5 business days to resolve, the Contractor shall provide a specific name and contact information for a staff person the Provider will work with to resolve the issue. Contractor shall provide the staff member name and contact information via the method of communication the Provider used to contact the Contractor.

12.9.2.5. During Business Hours, Contractor shall ensure that no more than five percent of calls are abandoned in any consecutive thirty (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.

12.9.2.6. Contractor shall ensure that the average length of time callers are waiting in the call queue before the call is answered shall be two minutes or less during each calendar month.

12.9.2.7. 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.

12.9.2.8. Contractor shall submit monthly response time data from its Provider telephone line in the Call Line Statistics Report.

12.9.3. Contractor shall create an information strategy to connect and refer Network Providers to existing resources, and fill in any information gaps, for the following topics:

12.9.3.1. General information about Medicaid, the Accountable Care Collaborative Program, and Contractor's role and purpose.

12.9.3.2. Contractor's process for handling appeals of physical health adverse benefit determinations.

12.9.3.3. Available Member resources, including the Member provider directory.

12.9.3.4. Clinical resources, such as screening tools, clinical guidelines, practice improvement activities, templates, trainings and any other resources Contractor has compiled.

12.9.3.5. Community-based resources, such as child care, food assistance, services supporting elders, housing assistance, utility assistance and other non-medical supports.

12.9.4. Contractor shall make Network Providers aware of the following Colorado Medicaid

program information:

12.9.4.1. Medicaid eligibility.

12.9.4.2. Medicaid covered benefits.

12.9.4.3. State Plan services.

12.9.4.4. Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

12.9.4.5. HCBS waiver services.

12.9.4.6. American Society of Addiction Medicine (ASAM) criteria.

12.9.4.7. Capitated Behavioral Health Benefit.

12.9.4.8. Claims and billing procedures.

12.9.4.9. Prior authorization referral requirements.

12.9.4.10. Out-of-state medical care as described in 10 CCR 2505-10 8.013.

12.9.4.11. Out-of-state NEMT as described in 10 CCR 2505-10 8.014.7.

12.9.5. Contractor shall inform Network Providers of key Department contractors, their roles and responsibilities, including:

12.9.5.1. Business Intelligence Data Management.

12.9.5.2. Colorado Medicaid's fiscal agent.

12.9.5.3. Enrollment broker.

12.9.5.4. Pharmacy Benefit Management System.

12.9.5.5. Utilization Management.

12.9.5.6. Oral Health contractor.

12.9.5.7. Non-Emergent Medical Transportation administrators.

12.9.5.8. Case Management Agencies.

12.9.5.9. Community Center Boards.

12.9.5.10. Single Entry Points.

12.9.5.11. Nurse Advice Line.

12.9.5.12. Crisis Services System.

12.9.6. Contractor shall act as a liaison between the Department and its other contractors, partners and providers.

12.9.7. Contractor shall outreach to and educate specialists and other Medicaid providers regarding the Accountable Care Collaborative Program, its structure, the role of Contractor and the supports it will offer to providers in its network.

12.9.8. Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including:

12.9.8.1. Medicaid provider enrollment.

12.9.8.2. Member eligibility and coverage policies.

12.9.8.3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

12.9.8.4. Service authorization and referral.

12.9.8.5. Member and PCMP assignment and attribution.

12.9.8.6. PCMP designation.

12.9.9. Contractor shall establish a timely process for responding to and resolving barriers and problems reported by behavioral health providers related to Contractor's payment and benefits systems, including but not limited to the following:

12.9.9.1. Billing and claims payment.

12.9.9.2. Provider credentialing.

12.9.9.3. Provider contracting.

12.9.9.4. Service authorization.

12.9.10. 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.

12.9.10.1. The Department will provide data to Contractor on all Members for this purpose.

12.9.11. Contractor shall use, and recommend to Network Providers, medical management, clinical and operational tools to ensure optimal health outcomes and control costs for Members. The suite of tools and resources should offer a continuum of support for Network Providers and the broader Health Neighborhood.

12.9.11.1. Contractor shall promote fidelity to evidence-based practices in order to assure effectiveness of the services provided.

12.9.12. Contractor shall have a designated IPN work lead that the Department can engage in efforts to support the Behavioral Health Independent Provider Network (IPN).

12.9.12.1. The Contractor's designated IPN work lead shall have the role of representing the IPN's concerns and considerations to inform the Contractor's policies and procedures.

12.9.12.2. The Contractor's designated IPN work lead shall attend workgroups, forums, and meetings in which the IPN is the focus.

12.10. Provider Training

12.10.1. Contractor shall, at a minimum, develop trainings and host forums for ongoing training regarding the Program and the services Contractor offers.

12.10.2. Contractor shall promote participation of Network Providers in state, local, and Contractor specific training programs.

12.10.3. Contractor shall ensure that trainings and updates on the following topics are made available to Contractor's Network Providers every six (6) months:

12.10.3.1. Colorado Medicaid eligibility and application processes.

12.10.3.2. Medicaid benefits.

12.10.3.3. Access to Care standards.

12.10.3.4. EPSDT.

12.10.3.5. Contractor's Population Management Strategy.

12.10.3.6. Cultural responsiveness.

12.10.3.7. Member rights, Grievances, and Appeals.

12.10.3.8. Quality improvement initiatives, including those to address population health.

12.10.3.9. Trauma-informed care.

12.10.3.10. Other trainings identified in consultation with the Department.

12.10.3.11. Non-emergency medical transportation.

12.10.3.12. Contractor shall develop a training on how to request assistance from RAEs in discharging Members to care in the community, for hospital staff with whom Contractor works to discharge Members.

12.10.3.13. Use and proper submission of mental health and substance use disorder treatment data reporting tools (including but not limited to the most current Colorado Client Assessment Record and the Drug and Alcohol Coordinated Data System data model); proper use of the Behavioral Health Administration's referrals and bed tracking tool; proper use of the Central Registry Medication Assisted Treatment tool.

12.10.3.13.1. On a quarterly basis the Contractor shall distribute the care discharges training to hospital care discharge teams with whom they work.

12.10.4. Contractor shall maintain a record of training activities it offers and submit to the Department upon request.

12.11. Interoperability Rule

12.11.1. Contractor shall implement and maintain a secure, standards-based application program interface (API) aligning with the Department's implementation timeline. The API shall:

12.11.1.1. Be available through a public-facing digital endpoint on Contractor's website.

12.11.1.2. Include complete and accurate provider directory information.

12.11.1.2.1. The provider directory must meet the same technical standards as the patient access API, excluding the security protocols related to user authentication and authorization.

12.11.1.2.2. The provider directory information shall be updated no later than 30 calendar days after the Department or Contractor receives the provider directory information or updates to provider directory information.

12.11.1.2.3. Comply with the requirements of 42 CFR § 438.242, 45 CFR § 170.215, as well as the provider directory information specified in § 438.10.

12.11.1.2.4. Provide current members, or their personal representatives, with access to claims and Encounter Data within one business day of receipt, including:

12.11.1.2.4.1. Adjudicated claims, including data for payment decisions that may be appealed, were appealed, or in the process of appeal.

12.11.1.2.4.2. Provider remittances and beneficiary cost-sharing pertaining to adjudicated claims.

12.11.1.2.4.3. Services and Items Provided in Treatment

12.11.1.2.5. Clinical information within one business day of receipt, if collected and maintained

by Contractor, including:

12.11.1.2.5.1. Diagnoses and Related Codes.

12.11.1.2.5.2. Medical Records and Reports.

12.11.1.2.5.3. Statements of Medical Necessity.

12.11.1.2.5.4. Laboratory Test Results.

12.11.1.2.6. Information about covered outpatient drugs within one business day after the effective date of any update, including:

12.11.1.2.6.1. Formulary of prescription drugs and costs to the member.

12.11.1.2.6.2. Preferred drug list information.

12.11.2. 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.

12.11.3. Contractor shall incorporate the USCDI data classes and elements received from other plans about the member.

12.11.4. Contractor shall, upon request by a member:

12.11.4.1. 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.

12.11.4.2. 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.

12.12. Data Systems and Technology Support

12.12.1. 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.

12.12.2. 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.

12.12.3. Contractor shall make available technical assistance and training for Network Providers on how to use the following state-supported HIT systems:

12.12.3.1. Contractor's Care Coordination Tool.

12.12.3.2. The BIDM System.

12.12.3.3. Colorado interChange (MMIS).

12.12.3.4. Behavioral Health Administration's Colorado Client Assessment Record and the Drug and Alcohol Coordinated Data System data collection tool.

12.12.3.5. PEAK website and PEAKHealth mobile app.

12.12.3.6. Regional health information exchange.

12.12.3.7. Electronic consultation and referral tools.

12.12.4. Contractor shall offer the following supports to Network Providers on managing and utilizing data:

12.12.4.1. Provide practice-level data/reports.

12.12.4.2. Assist providers with data analysis and reporting.

12.12.4.3. Train practices on how to utilize data to:

12.12.4.3.1. Improve care for Complex Members.

12.12.4.3.2. Improve care for Members with Department identified health conditions.

12.12.4.3.3. Implement wellness and prevention strategies.

12.12.4.3.4. Understand how their practice is performing on Key Performance Indicators and other health outcome measures.

12.12.4.3.5. Identify Members who require additional services.

12.12.4.4. Contractor shall possess the expertise and establish the infrastructure to support outbound raw claims data extracts to the PCMPs, both behavioral health claims from Contractor's internal system and physical health claims data from the Department.

12.12.4.4.1. Contractor shall establish a process for PCMPs to request raw claims data extracts from Contractor.

12.12.4.5. Contractor shall facilitate clinical information sharing by supporting Network Providers in connecting electronic health records (EHRs) with the regional health information exchange (HIE) for exchanging clinical alerts and clinical quality measures (CQM) data.

12.12.4.6. 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 can be found at https://www.healthit.gov/policy-researchers-implementers/interoperability.

12.12.4.7. Contractor shall identify and address gaps in information sharing or data quality.

12.13. Practice Transformation

12.13.1. Contractor shall offer practice transformation support to Network Providers interested in improving performance as a Medical Home and participating in alternative payment models, including the Department's APM. Practice transformation efforts may include activities such as: coaching practices in team-based care; improving business practices and workflow; increasing physical and behavioral health integration; incorporation of lay health workers, such as promotors, peers, and patient navigators; and implementing health programming to advance Contractor's Population Management Strategy.

12.13.2. Contractor shall identify the existing strengths of a Network Provider and partner with the interested Network Provider to design and implement practice transformation strategies that build on these strengths and support the Network Provider in achieving its individualized practice goals.

12.13.3. Contractor shall offer expertise and resources necessary for practice transformation ranging from assistance with efficiency and performance enhancements to comprehensive practice redesign.

12.13.4. 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.

12.13.5. Contractor shall partner with practices to establish feasible 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:

12.13.5.1. Connect Network Providers to practice transformation resources that are readily available in the Service Area.

12.13.5.2. Educate Network Providers about the methods, principles, best practices, and benefits of practice transformation.

12.13.5.3. Provide technical assistance, tools and resources as appropriate.

12.13.6. Contractor shall use existing practice transformation organizations in the region and the state and coordinate with existing practice transformation efforts, when appropriate, to reduce duplication of efforts and overburdening practices.

12.13.7. 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 achieving advanced Medical Home standards.

12.13.8. Contractor assist the Department with implementing the Alternative Payment Model and support network providers impacted by this payment model.

12.14. Financial Support

12.14.1. The Contractor shall align with the Center for Medicare & Medicaid Innovation's (CMMI's) Making Care Primary program by reflecting the principles of each of the design elements in the Making Care Primary payer guide.

12.14.1.1. DELIVERABLE: Making Care Primary Payer Alignment Plan

12.14.1.2. DUE: July 31, 2024

13. CAPITATED PHYSICAL HEALTH BENEFIT

13.1. Covered Services

13.1.1. Health Coverage

13.1.1.1. Contractor shall provide or shall arrange to have provided all Covered Services specified in this Contract. Contractor shall provide Care Coordination, Utilization Management and Medical Management for Members to promote the appropriate and cost-effective utilization of Covered Services. Contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

13.1.1.1.1. Contractor may cover services or settings that are in lieu of State Plan services if the following criteria are met:

13.1.1.1.1.1. The Department deems the alternative service or setting as a medically necessary appropriate substitute for the covered service or setting.

13.1.1.1.1.2. The Department deems the alternative service or setting as a cost-effective substitute for the covered service or setting.

13.1.1.1.1.3. Contractor does not require the Member to use the alternative service or setting.

13.1.1.1.1.4. The alternative services and settings are offered to Members during the enrollment process.

13.1.1.2. Contractor shall provide the same standard of care for all Members regardless of eligibility category and shall make all Covered Services available in terms of timeliness, amount, duration and scope, to Members in an amount no less than those services are available to non-Member Medicaid recipients within the same area.

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

13.1.1.4. Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service if Contractor objects to the service on moral or religious grounds.

13.1.1.5. Any cost sharing imposed on Members is in accordance with Medicaid FFS requirements at 42 CFR 447.50 through 42 CFR 447.82.

13.1.2. Covered Services Through Network Providers

13.1.2.1. Covered Services shall be made available in the Service Area only through Network Providers or non-Network Providers authorized by Contractor. A Network Provider is any Physician, Hospital, or other healthcare professional or facility that has entered into a professional service agreement with Contractor to provide clinical services to Contractor's Members.

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

13.1.2.2.1. Special arrangements or Referrals are made by a Network Provider or Contractor, as specified in the Member handbook.

13.2. Coverage of Specific Services and Responsibilities

13.2.1. Emergency Services

13.2.1.1. Emergency services that are:

13.2.1.1.1. Furnished by a provider that is qualified to administer these services according to 42 CFR 438.

13.2.1.1.2. Needed to evaluate or stabilize an Emergency Medical Condition.

13.2.1.2. Contractor shall be responsible for coverage and payment of Emergency Services and Post-Stabilization Care Services as specified in 42 CFR 438.114(b) and 42 CFR 422.113(c). Contractor:

13.2.1.2.1. Shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor.

13.2.1.2.1.1. Shall pay non-contracted providers for emergency services no more than the amount that would be paid if the service had been provided under the State's FFS Medicaid program.

13.2.1.2.1.2. Shall not deny payment for treatment obtained under either of the following circumstances:

13.2.1.2.1.2.1. 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.

13.2.1.2.1.2.2. A representative of Contractor instructs the Member to seek Emergency Services.

13.2.1.2.1.3. 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.

13.2.1.2.1.4. 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 to stabilize the Member.

13.2.1.2.1.5. The attending emergency Physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Contractor for coverage and payment.

13.2.1.2.1.6. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's Provider Network that are pre-approved by Contractor.

13.2.1.2.1.7. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's network that are not pre- approved by Contractor, but that are administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

13.2.1.2.1.7.1. Contractor does not respond to a request for pre-approval within one hour of receiving the request.

13.2.1.2.1.7.2. Contractor cannot be contacted.

13.2.1.2.1.7.3. 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 patient until a plan Provider is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

13.2.1.2.1.7.4. 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.

13.2.1.2.1.8. Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved ends when:

13.2.1.2.1.8.1. A plan Provider with privileges at the treating Hospital assumes responsibility for the Member's care.

13.2.1.2.1.8.2. A plan Provider assumes responsibility for the Member's care through transfer.

13.2.1.2.1.8.3. Contractor and the treating Provider reach an agreement concerning the Member's care.

13.2.1.2.1.8.4. The Member is discharged.

13.2.1.2.2. Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a 24 hour per day, seven day per week basis.

13.2.1.3. Emergency Ambulance Transportation

13.2.1.3.1. Contractor shall make reasonable efforts to ensure that Members within the Service Area shall have access to emergency ambulance transportation on a 24 hour per day, seven day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.

13.2.1.4. Verification of Medical Necessity for Emergency Services

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

13.2.1.5. Poststabilization Care Services

13.2.1.5.1. Contractor shall provide coverage for Poststabilization Care Services in compliance with 42 C.F.R. § 438.114(e) and 42 CFR §422.113(c).

13.2.1.6. Coverage of Prescription Drugs

13.2.1.6.1. Effective January 1, 2024, Contractor shall not allow the use of spread pricing, as defined by CMS, by Contractor's Pharmacy Benefit Management System.

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

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

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

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

13.2.1.6.3. Contractor shall provide coverage for prescription drugs approved for use and reimbursed by the Medicaid Program, including those products that require prior authorization by the Medicaid Program. Contractor's internal prior authorization criteria shall not apply to prescription drugs carved out of this Contract. Such Covered Drugs must be prescribed and dispensed within Contractor's parameters for pharmaceuticals, and as follows:

13.2.1.6.3.1. Contractor shall establish a drug formulary, for all Medically Necessary Covered Drugs with its own prior authorization criteria, provided Contractor includes each therapeutic drug category in the Medicaid program. Contractor shall ensure that the formulary requires the following:

13.2.1.6.3.1.1. Information in electronic or paper form about which generic and name brand medications are covered, as well as which tier each medication is on.

13.2.1.6.3.1.2. The formulary drug list on Contractor's website in a machine-readable file and format as specified by the Secretary.

13.2.1.6.3.2. Contractor shall develop and maintain a prior authorization program to provide Covered Drugs for any Medically Necessary conditions unmet by Contractor's formulary product. Contractor shall ensure that the program includes the following criteria:

13.2.1.6.3.2.1. Provision of a telephonic or telecommunication response within 24 hours of a request for prior authorization; and

13.2.1.6.3.2.2. Prescription of at least a 72-hour supply of outpatient Covered Drugs in an Emergency situation, with the exception of drugs referred to in section 42 USC 1396r-8(d)(2) of the Act. Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the Member's well-being.

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

13.2.1.6.5. Outpatient Drug Coverage & Drug Utilization

13.2.1.6.5.1. Contractor shall develop and maintain a Drug Utilization Review (DUR) program that complies with the requirements described in Sections 1927(g) and 1927(d)(5)(A) of the Act, Section 1004 of the Support for Patient and Communities Act, and 42 CFR part 456, subpart K. Contractor's DUR program shall perform the following functions:

13.2.1.6.5.1.1. Prospective drug review, including:

13.2.1.6.5.1.1.1. A prospective safety edit regarding:

13.2.1.6.5.1.1.2. Days' supply for patients not currently receiving opioid therapy for initial prescription fills.

13.2.1.6.5.1.1.3. Early refills, for subsequent prescription fills.

13.2.1.6.5.1.1.4. Therapeutically-duplicative initial and subsequent opioid prescription fills.

13.2.1.6.5.1.1.5. Quantity of prescription dispensed for initial and subsequent prescription fills.

13.2.1.6.5.1.1.6. The maximum daily morphine equivalent for treatment of pain.

13.2.1.6.5.1.2. Retrospective drug use review, including:

13.2.1.6.5.1.2.1. An automated claims review process that indicates when an individual is prescribed the morphine milligram equivalent for such treatment in excess of any limitation that may be identified by the State.

13.2.1.6.5.1.2.2. An automated claims review process that indicates fills of opioids in excess of limitations identified by the State.

13.2.1.6.5.1.2.3. An automated claims review process that monitors when an individual is

concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

13.2.1.6.5.1.3. Processes to monitor and manage the appropriate use of antipsychotic medications by all children 18 and under who receive Medicaid services through Contractor, including foster children.

13.2.1.6.5.1.4. Processes to identify potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies.

13.2.1.6.5.1.5. Establish and operate a DUR Board.

13.2.1.6.5.1.6. An educational program.

13.2.1.6.5.2. Contractor shall exclude encounters for Covered Drugs that are subject to discounts under the 340B Drug Pricing Program from drug utilization data reports submitted to the Department.

13.2.1.6.5.3. Contractor shall provide the Department with a detailed report of its drug utilization review program activities on an annual basis, within 45 days after receiving a written request from the Department. Contractor shall ensure that the report includes information as required by the Secretary of Health and Human Services, CMS Medicaid Drug Utilization Review report, and the Department.

13.2.1.6.5.3.1. DELIVERABLE: DUR Program Activities Report

13.2.1.6.5.3.2. DUE: Within 45 days after receiving a written request from the Department

13.2.1.6.5.4. Contractor shall cover all outpatient drugs as defined in 42 USC 1396r-8 and section 1927(k)(2) of the Act based on medical necessity.

13.2.1.6.5.5. Contractor shall either cover only those outpatient drugs that are eligible for rebate, or that are purchased through the 340B Drug Pricing Program pursuant to 42 USC 1396r-8 and Section 1927(j)(1) of the Act.

13.2.1.6.5.6. Contractor shall not cover drugs purchased through the federal 340B Pricing Program when dispensed by 340B contract pharmacies pursuant to Section 1927(a)(5) of the Act.

13.2.1.6.5.7. Contractor shall not cover non-rebateable drugs purchased outside of the Federal 340B Drug Pricing Program, pursuant to Sections 1927(a)(1) and (b)(1)(A) of the Act.

13.2.1.6.5.8. Contractor shall provide a formulary for covered outpatient drugs that is no more restrictive than the Department's formulary for coverage, pursuant to 42 CFR 438.210.

13.2.1.6.5.9. Contractor shall report the following drug utilization data and information necessary for the Department to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period:

13.2.1.6.5.9.1. Total number of units of each dosage form, strength, and package size by National Drug Code of all outpatient drugs covered and dispensed by Contractor.

13.2.2. Inpatient Hospital Services

13.2.2.1. Contractor shall be responsible for inpatient hospital stays based on the Principal

Diagnosis that requires inpatient care.

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

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

13.2.2.1.3. Contractor shall not be responsible for the hospital stay when the Principal Diagnosis is for substance abuse rehabilitation.

13.2.2.2. Coverage for Emergency Services

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

13.2.2.3. Contractor shall not be responsible for Emergency Services when the Primary or Principal Diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis.

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

13.2.2.3.2. For any procedure billed in a UB-92/ANSI 837I, Health Care Claim Institutional (ANSI 837I) format, Contractor shall be responsible for all Covered Services associated with a Member's outpatient Hospital Services Covered Services, including all psychiatric, medical and facility Covered Services, if:

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

13.2.2.3.2.2. The Principal Diagnosis is a medical diagnosis.

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

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

13.2.2.3.3.2. The Covered Services are not listed as a required capitated behavioral health benefit covered service as defined in 10 C.C.R. 2505-10, Section 8.212.4.A. Diagnoses and procedures listed in Exhibit I.

13.2.2.4. Early Intervention Services

13.2.2.4.1. Contractor shall provide Early Intervention (EI) Services and Supports as described in CRS 27-10.5 part 7. These services shall be provided in natural environments as defined in 34 CFR 303.126. If Contractor does not meet the requirements specified in CRS 27-10.5-709, Contractor shall develop a process in coordination with the Department and the Colorado Department of Human Services to ensure EI Services and Supports are provided in accordance with CRS 27-10.5 part 7. Contractor shall contract with providers who meet the qualifications for early intervention providers, as defined in CCR 2509-10-7.951, and as noted on the EI Colorado Website.

13.2.2.5. Wrap Around (Fee For Service) Benefits

13.2.2.5.1. Contractor shall communicate to its Network Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this Contract - but are available to Members under Medicaid fee for service (FFS).

13.2.2.5.2. Contractor shall instruct its Network Providers on how to refer a Member for such services. Contractor shall advise Network Providers of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) support services that are available through other entities, including, but not limited to local public health departments. Contractor shall also advise post-partum or breast- feeding or pregnant women of the special supplemental food program (Women, Infants, and Children), state's special assistance program for substance abusing pregnant women, and enhanced prenatal care services.

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

13.2.2.5.4. Contractor shall inform its Network Providers of the services provided by the RAEs.

13.2.3. Coverage of Abortions

13.2.3.1. Contractor shall cover abortions in the following situations, in accordance with 42 CFR 441.202 and the Consolidated Appropriations Act of 2008:

13.2.3.1.1. When the pregnancy is the result of an act of rape or incest.

13.2.3.1.2. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

13.3. Exclusions

13.3.1. Acupuncture

13.3.2. Air ambulance services when a Client could be safely transported by ground ambulance or by means other than ambulance.

13.3.3. Ambulatory surgical procedures not listed on the state approved list.

13.3.4. Ambulance services when a Client could be safely transported by means other than ambulance.

13.3.5. Audiology and Speech Pathology: With the exception of EPSDT Covered Services, diagnostic procedures performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids are not covered under this Contract - but may be provided to children under the age of 21 through the Health Care Program for Children with Special Needs. Simple articulation or academic difficulties that are not medical or surgical in origin are also excluded.

13.3.6. Autopsy charges

13.3.7. Biofeedback, stress management, behavioral testing and training, and counseling for sexual

dysfunction.

13.3.8. Chiropractic services unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.

13.3.9. Cosmetic Procedures or corrective plastic surgery performed solely to improve appearance. Cosmetic surgery exclusions include, but are not limited to, surgery for sagging or extra skin, any augmentation procedures, rhinoplasty and associated surgery, and any procedures utilizing an implant which does not alter physiologic functions, unless Medically Necessary and/or to correct disfigurement.

13.3.10. Counseling for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders or chronic situational reactions.

13.3.11. Dental services:

13.3.11.1. Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.

13.3.11.2. For adults, surgical correction of malocclusion, maxillofacial orthognathic surgery, oral surgery (except as otherwise provided under the Surgical Services), orthodontia treatment and procedures involving osteotomy of the jaw including hospital outpatient or ambulatory, anesthesia and related costs resulting from the services when determined by Contractor to relate to a dental condition.

13.3.12. The following types of Durable Medical Equipment: wheelchair lifts for vans or automobiles, continuous glucose monitors for Members that are 21 years old and older, hot tubs, jacuzzies, exercise bikes or equipment, treadmills, stair glides, ramps for use with vehicles or homes, memberships in health clubs, or fees for swimming or other exercise or activities.

13.3.13. Experimental or investigational services or pharmaceuticals.

13.3.14. Government-sponsored care

13.3.14.1. Items and services provided by federal programs, such as a Veteran’s Hospital.

13.3.14.2. Services provided in facilities that serve a specific population, such as prisoners.

13.3.14.3. Care for conditions that federal, state, or local laws require to be treated in a public facility.

13.3.14.4. Services for which treatment is provided under any government law now existing or subsequently enacted or amended, including but not limited to Workmen's Compensation Act, Employer Liability Law or Colorado "No-Fault" automobile insurance.

13.3.15. Fertility procedures or services that render the capability to produce children, except when that capability is a side effect of Medically Necessary surgery for another purpose/diagnosis.

13.3.16. FQHC Services: Inpatient hospital stays are not covered under FQHC Services but may be a benefit under Inpatient Hospital Care.

13.3.17. HCBS Services. Includes wrap around services such as case management (for Model 200 children), home modification, electronic monitoring, personal care, non-medical transportation & all other waiver services.

13.3.18. Hearing Aids - With the exception of EPSDT Covered Services, diagnostic procedures

performed for the purposes of determining general hearing levels, screening, or for the distribution of a hearing device are not covered. Hearing aids, repairs and batteries are not covered under this Contract but may be provided to children under the age of 21 as a Wrap Around Benefit. Simple articulation or academic difficulties that are not medical or surgical in origin are not covered under this Contract.

13.3.19. High colonics

13.3.20. Holistic or homeopathic care including drugs and ecological or environmental medicine.

13.3.21. Home delivery: Services associated with non-emergent home delivery, unless prior authorized by Contractor are excluded.

13.3.22. Home Health Services: Services provided specifically as benefits of the Home and Community Based Services Programs (HCBS), which include unskilled personal care, home modification, electronic monitoring, adult day services, alternative care facility services, homemaker services and respite care are not included under this Contract.

13.3.22.1. Long Term Home as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.

13.3.22.2. Home Health Services provided by a person who ordinarily resides in the Client's home or is an immediate family member are not covered.

13.3.23. Hospice services. Clients need not be disenrolled from their HMO to receive hospice services, but may continue to get care not related to the terminal illness from the HMO. Clients may request disenrollment.

13.3.24. Hospital back up level of care. Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470 is excluded.

13.3.25. Hypnosis

13.3.26. Immunizations related to foreign travel.

13.3.27. Imaging (Radiology or X-ray) Services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

13.3.28. Infertility treatment, including but not limited to embryo transplants, in vitro fertilization, and low tubal transfers, gamete intrafallopian tube transfer and zygote intrafallopian tube transfer.

13.3.29. Inpatient hospital excluded services include:

13.3.29.1. Psychiatric/psychological care included and covered as part of the RAE Capitated Behavioral Health Benefit.

13.3.29.2. Discharge medications and experimental drugs.

13.3.29.3. Inpatient hospital services defined as experimental by the Medicare program.

13.3.29.4. For Medicaid approved benefits, Medicare patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities.

13.3.30. Institutional care when provided for the primary purpose of controlling or changing Client's environment, or if custodial care, domiciliary care, convalescent care (other than extended care) respite care, rest cures or hospice care.

13.3.31. Isometric exercise

13.3.32. Expenses for medical reports, including presentation and preparation.

13.3.33. Laboratory services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

13.3.34. Long Term Home Health as defined at 10 CCR 2505-10, Sections 8.520 is excluded.

13.3.35. Newborn hospitalizations: Continued stay of healthy newborns for any other reason after the mother's discharge is not a benefit under the medical assistance program.

13.3.36. Nurse Home Visitor Program - Home visiting program for first time mothers by Registered Nurses, with sites approved by and contracted with CDHS.

13.3.37. Portable and liquid oxygen according to the procedure codes and descriptions listed below:

PROC_CD	Description
A4617	Mouth piece
S8121	O2 contents liquid lb
A4619	Face tent
E0425	Gas system stationary compre
E0441	Oxygen contents, gaseous
E0550	Humidif extens supple w ippb
E1353	Oxygen supplies regulator
E0444	Portable 02 contents, liquid
E1392	Portable oxygen concentrator, rental
K0738	Portable gas oxygen system
E0434	Portable liquid 02
E0439	Stationary liquid 02
E1405	O2/water vapor enrich w/heat
E1406	O2/water vapor enrich w/o he
S8120	O2 contents gas cubic ft
E0430	Oxygen system gas portable
E0435	Oxygen system liquid portable
E0443	Portable 02 contents, gas
E1355	Oxygen supplies stand/rack
A4615	Cannula nasal
A4616	Tubing (oxygen) per foot
E0455	Oxygen tent excl croup/ped t
E1390	Oxygen concentrator
A4483	Moisture exchanger
A4620	Variable concentration mask
E0424	Stationary compressed gas 02
E0431	Portable gaseous 02
E0440	Oxygen system liquid station
E0442	Oxygen contents, liquid
E1391	Oxygen concentrator, dual
E1354	Wheeled oxygen cart
K0740	Repair/ srv oxygen eq
K0739	Repair/ svc DME non-oxygen eq

13.3.38. Paternity Testing. Such services shall be reimbursed by the Medicaid Program and recouped through the court system. Personal comfort or convenience items. Includes items such as hospital television, telephone, private room (except as Medically Necessary), modifications and alterations in homes, vehicles, or place of residence.

13.3.39. Personal comfort or convenience items. Includes items such as hospital television, telephone, private room (except as Medically Necessary), modifications and alterations in homes, vehicles, or place of residence.

13.3.40. Physical examinations of the following nature are excluded:

13.3.40.1. Examinations required by the county departments for the purpose of qualifying applicants for assistance or for the re-certification of recipients for assistance in the following

categories: AND, AB, AFDC, or placement of children in Foster Care.

13.3.40.2. Physical examinations for employment, licensing, marriage, insurance, school, camp, sports, or adoption purposes or requests by any institution, agency, or person other than the recipient's county department or the state department. Examination or treatment ordered by a court except when such treatment may be Medically Necessary and is provided by a network provider and/or authorized by the primary care physician.

13.3.41. Prenatal Plus - Enhanced program for high risk pregnant women that provides a care coordinator, dietitian and mental health professional. The program is offered through four packages with approved services as listed in 10 C.C.R. 2505 – 10 §8.748.

13.3.42. Private Duty Nursing (PDN). Private duty nursing services are a Wrap Around Benefit.

13.3.43. Psychiatric/psychological care as follows:

13.3.43.1. Milieu therapy

13.3.43.2. Play therapy

13.3.43.3. Day care

13.3.43.4. Electroshock treatment rehabilitation

13.3.43.5. Night care

13.3.43.6. Family therapy

13.3.43.7. Biofeedback

13.3.44. Reversal of surgically performed sterilization or subsequent re-sterilization.

13.3.45. Skilled Nursing Facility Services are a Wrap Around Benefit.

13.3.46. Substance or alcohol abuse, inpatient or residential rehabilitation.

13.3.47. Surrogate Mother Services or supplies received in connection with a Client acting as or utilizing the services of a surrogate mother.

13.3.48. Transportation, non-emergent, to medical appointments.

13.3.49. Travel, whether or not recommended or prescribed by a Physician or other medical practitioner.

13.3.50. Vision correction procedures for the purpose of vision correction that can be treated by corrective lenses, such as refractive keratoplasty, or radial and laser keratotomies.

13.3.51. Wrap Around Benefits are services that are Medicaid benefits not paid by Contractor. Wrap Around Benefits are paid for by the State of Colorado Medicaid program on a fee- for-service basis upon determination of Medical Necessity. Wrap-around services include, but may not be limited to the following:

13.3.51.1. Auditory Services for children. Contractor Covered Services include screening and Medically Necessary ear exams and audiological testing. Wrap Around Benefits include hearing aids, auditory training, audiological assessment and hearing evaluation.

13.3.51.2. Cavity Free at Three dental services.

13.3.51.3. Comprehensive dental assessment, care and treatment for children.

13.3.51.4. Adult Dental services consisting of diagnostic procedures, preventative procedures,

restorative procedures, periodontal care, endodontic treatment and oral surgery.

13.3.51.5. Doula services.

13.3.51.6. Drug/Alcohol Treatment for pregnant women, to include assessment and treatment, is covered through the Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only.

13.3.51.7. HCBS Services including case management (for Model 200 children); home modification, electronic monitoring, personal care and non-medical transportation.

13.3.51.8. Hospice services, however client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested.

13.3.51.9. Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470.

13.3.51.10. Inpatient substance abuse rehabilitation treatment for individuals aged 20 and under, DRG 772, as set forth in 10 CCR 2505-10, Section 8.300.4.5.

13.3.51.11. Intestinal Transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (i.e., liver); coordinated by Department & HMO Case Manager; provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai.

13.3.51.12. Non-emergency transportation to medical appointments for Covered Services only, through the Department's contracted NEMT vendor.

13.3.51.13. Pediatric Behavioral Therapies.

13.3.51.14. Private Duty Nursing (PDN), nursing services only.

13.3.51.15. Skilled Nursing Facility Services (skilled nursing and rehabilitation services) if client meets level of care certification. Wrap-around skilled nursing facility services include those services set forth at 10 CCR 2505-10, Section 8.440.1, notwithstanding the list of Covered Services set forth above. Wrap-around skilled nursing facility services also include any Medicare cross-over benefits.

13.4. Service Limits

13.4.1. Contractor shall provide covered services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under Fee-for-Service Medicaid.

13.4.2. Contractor shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

13.4.3. Contractor shall ensure that services supporting beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

13.4.4. 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.

13.4.5. Contractor may place appropriate limits on a service as follows:

13.4.5.1. On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity.

13.4.5.2. For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose.

13.4.6. Contractor shall ensure that any decision to deny a service authorization request or to

authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease.

13.4.7. 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.

13.4.8. Contractor shall establish clear and specific criteria for discharging Members from treatment.

13.4.8.1. Contractor shall include this criteria in Member materials and information.

13.4.8.2. 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.

13.4.9. 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.

13.4.10. Contractor shall not hold a Member liable for Covered Services:

13.4.10.1. Provided to the Member, for which the Department does not pay Contractor

13.4.10.2. Provided to the Member, for which the Department or Contractor does not pay the provider that furnishes the service under a contract, referral, or other arrangement

13.4.10.3. 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

13.4.11. Contractor shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

13.4.11.1. Contractor's network shall provide Contractor's Members with a meaningful choice in selecting a PCMP. Contractor shall allow, to the extent possible and appropriate, each Member to choose a PCMP.

13.4.11.2. 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.

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

13.4.11.4. Contractor shall document its relationship with and requirements for each PCMP in Contractor's network in a written contract.

13.4.11.5. Contractor shall offer contracts to all FQHCs, RHCs, and Indian Health Care Providers located in the Contract Service Area.

13.4.11.6. 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.

13.4.11.7. Contractor shall terminate any providers of services or persons terminated (as described in section 1902(kk)(8) of the Social Security Act) from participation under title XIX, title

XVIII, or title XXI from participating as a provider in Contractor's network.

13.5. Service Planning, Coordination and Care Transitions

13.5.1. Based on the Member's needs and level of care required, Contractor shall ensure they have procedures for the following:

13.5.1.1. Intake and Assessment: Contractor shall ensure that each Member receives an individual intake and assessment appropriate for the level of care needed.

13.5.1.2. Service Planning: Contractor shall have a service planning system that uses the information gathered in the Member's intake and assessment to produce such a treatment or service plan or care plan in a timely manner.

13.5.1.3. 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.

13.5.1.3.1. Contractor shall regularly report on Members experiencing challenges to discharge from hospitals, in a format determined by the Department.

13.5.1.3.1.1. DELIVERABLE: Weekly Hospital Discharge Status Report

13.5.1.3.1.2. DUE: Weekly, on a day of the week determined by the Department

13.5.1.4. 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 enrollment with Contractor to a RAE or enrollment from a RAE to Contractor as required in 42 C.F.R. § 438.62.

13.5.2. 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:

13.5.2.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

13.5.2.2. Any information the Member needs to decide among all relevant treatment options.

13.5.2.3. The risks, benefits, and consequences of treatment or non-treatment.

13.6. Utilization Management

13.6.1. Contractor shall ensure access to and appropriate utilization of covered health services.

13.6.2. Contractor shall establish and maintain a documented Utilization Management Program and Procedures, in compliance with 42 CFR 438.905 and 438.910, that includes, at a minimum, the following:

13.6.2.1. Description of its utilization management program structure and assignment of responsibility for utilization management activities to appropriate individuals.

13.6.2.2. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

13.6.2.2.1. For children under the age of 21, identification of a designated, appropriately licensed medical professional responsible for utilization management review 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.

13.6.2.3. Evidence of a behavioral health practitioner's involvement in program development and implementation.

13.6.2.4. Identification of the type of personnel responsible for each level of utilization management decision-making.

13.6.2.5. Standards for utilization management personnel to consult with the ordering provider prior to denial or limitation of requested/provided services.

13.6.2.6. Policies and procedures for the use and periodic review of written clinical decision-making criteria based on clinical evidence.

13.6.2.7. Provider dispute resolution.

13.6.2.8. Description of a Provider Dispute Resolution process which follows Division of Insurance Provider Dispute Resolution requirements and timelines.

13.6.2.9. Description of how Contractor shall provide or arrange for the provision of all medically necessary behavioral health services for diagnoses listed in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses for children under the age of 21 without regard to any Contractor-established service limitations, 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.

13.6.2.9.1. DELIVERABLE: Utilization Management Program and Procedures

13.6.2.9.2. DUE: 30 days after any significant change is made.

13.6.3. Contractor shall implement Contractor's documented Utilization Management Program and Procedures.

13.6.4. Contractor's utilization management process shall in no way impede timely access to services.

13.6.4.1. Contractor shall not require prior authorization for the non-pharmaceutical components of MAT.

13.6.5. Contractor shall have mechanisms for providers and Members on how they can obtain the utilization management decision-making criteria upon request.

13.6.6. 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.

13.6.7. Contractor shall use the Department's established clinical coverage criteria and/or coverage standards for determinations of coverage for Specialty Drugs. When no Department coverage criteria and/or coverage standards exists, Contractor shall make the determination in consultation in collaboration with the Department, based on medical necessity and clinical evidence for use.

13.6.8. Contractor shall prior-authorize Specialty Drugs, in advance and in consultation with the Department, in accordance with the Department's coverage criteria and medical necessity standards.

13.6.9. Contractor shall disseminate practice guidelines to Members and potential Members upon request.

13.6.9.1. Contractor shall adopt practice guidelines that consider the needs of Members.

13.6.9.2. Contractor shall adopt practice guidelines in consultation with Network Providers.

13.6.9.3. Contractor shall review and update practice guidelines periodically as appropriate.

13.6.10. In compliance with CRS 25.5-5-422, on or after January 1, 2020 Contractor shall not:

13.6.10.1. Impose any prior authorization requirements on any prescription medication approved by the Food and Drug Administration (FDA) for the treatment of substance use disorders.

13.6.10.2. Impose any step therapy requirements as a prerequisite to authorizing coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

13.6.10.3. Exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associate counseling or wraparound services solely on the grounds that the medications that the medications and services were court ordered.

13.6.11. Contractor shall use the Department's established clinical coverage criteria and/or coverage standards for determinations of coverage of Specialty Drugs. When no Department coverage criteria and/or coverage standards exists, Contractor shall make the determination in consultation with the Department, based on medical necessity and clinical evidence for use.

13.6.12. Contractor shall prior-authorize Specialty Drugs, in advance and in consultation with the Department, in accordance with the Department's coverage criteria and medical necessity standards.

13.6.13. Contractor shall ensure that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply are consistent with such practice guidelines.

13.6.14. Contractor shall provide education and ongoing guidance to Members and Providers about its utilization management program and protocols.

13.7. FQHC And RHC Encounter Reimbursement

13.7.1. 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. The Department reserves the right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

13.7.1.1. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505-10 § 8.700.6C.

13.7.1.2. The Department shall notify Contractor of changes to the FQHC and RHC rates and rules.

13.7.1.3. The Department conducts quarterly accuracy audits with FQHCs and RHCs. Should the 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.

13.7.2. If multiple 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 least the encounter rate.

13.7.3. Contractor shall submit the Encounter Data for FQHC and RHC visits to the Department per the specifications provided in Section 15.2.2.

13.7.3.1. DELIVERABLE: FQHC and RHC Encounter Data

13.7.3.2. DUE: Within 30 days before the end of each calendar year quarter

13.7.4. Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs as directed by the Department.

13.8. IHCP Reimbursement

13.8.1. Contractor shall reimburse any IHCP enrolled in Medicaid as an FQHC but not a Network Provider at least the encounter rate.

13.8.2. Contractor shall reimburse IHCPs not enrolled in Medicaid as an FQHC, regardless of whether they are Network Providers, the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.

13.8.3. The Contractor shall participate in the Department's accuracy audits process for IHCPs, as directed by Department staff.

13.8.4. Contractor shall pay ninety percent (90%) of all clean claims from I/T/U Network Providers (whether in individual or group practice or who practice in shared health facilities) within thirty (30) days of the date of receipt and pay ninety-nine percent (99%) of all clean claims from practitioners (who are in individual or group practice or who practice in shared health facilities) within ninety (90) days of the date of receipt.

13.9. Physician Incentive Plans

13.9.1. Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

13.9.1.1. 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.

13.9.2. 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.

13.9.3. 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.

13.9.3.1. DELIVERABLE: Physician Incentive Plan

13.9.3.2. DUE: Effective Date or upon implementation of a physician incentive plan

13.10. Third Party Payer Liability

13.10.1. 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 the

Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

13.10.1.1. 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 the Department to provide information to the Department regarding commercial third party resources.

13.10.1.2. In the case of commercial health coverage, Contractor shall notify the 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 the 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, Contractor shall submit to the Department's fiscal agent the following information:

13.10.1.2.1. Member's Medicaid identification number 1

13.10.1.2.2. Member's full name

13.10.1.2.3. Identification of the health carrier or health plan

13.10.1.2.4. Member's health plan identification and group numbers

13.10.1.2.5. Policy holder's full name

13.10.1.2.5.1. DELIVERABLE: Third Party Resource Identification

13.10.1.2.5.2. 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

13.10.2. 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.

13.10.3. 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.

13.10.4. Contractor shall not restrict access to covered services due to the existence of possible or actual third-party liability.

13.10.5. 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.

13.10.6. 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.

13.10.6.1. Contractor shall limit recoveries to the amount that Medicaid would have paid under

Medicaid Fee-for-Service.

13.10.7. 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.

13.10.8. With the exception of Section 13.10.9. 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:

13.10.8.1. The sum of reported third party coinsurance and/or deductible or

13.10.8.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

13.10.9. 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. 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.

13.11. Medical Loss Ratio (MLR)

13.11.1. 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).

13.11.2. Annual measurement periods will align with the state fiscal year, beginning on July 1 and ending on June 30 of the subsequent calendar year.

13.11.3. Contractor shall submit an MLR report to the Department, for each MLR reporting year, that includes:

13.11.3.1. Total incurred claims.

13.11.3.2. Expenditures on quality improvement activities.

13.11.3.3. Expenditures related to activities compliant with program integrity requirements.

13.11.3.4. Non-claims costs.

13.11.3.5. Premium revenue.

13.11.3.6. Taxes.

13.11.3.7. Licensing fees

13.11.3.8. Regulatory fees.

13.11.3.9. Methodology(ies) for allocation of expenditures.

13.11.3.10. Any credibility adjustment applied if the MLR reporting year experience is partially credible.

13.11.3.10.1. Any credibility adjustment shall be added to the reported MLR calculation before calculating any remittances.

13.11.3.10.2. Contractor shall not add a credibility adjustment to the calculated MLR if the MLR reporting year experience is fully credible.

13.11.3.11. The calculated MLR.

13.11.3.12. Any remittance owed to the state, if applicable.

13.11.3.13. A comparison of the information reported with the audited financial report.

13.11.3.14. A description of the aggregation method used to calculate total incurred claims.

13.11.3.15. The number of member months.

13.11.4. All data provided by Contractor for the purpose of MLR calculation shall use actual costs.

13.11.4.1. Contractor shall allow for three months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five months.

13.11.4.2. Contractor shall submit the completed MLR calculation on the 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 the Department guidelines, for the measurement period by January 15. Contractor shall submit encounter claims in compliance with requirements in Section 15.2.2.

13.11.4.2.1. DELIVERABLE: Adjusted MLR Calculation Report and supporting data and documentation

13.11.4.2.2. DUE: Annually, by January 15th of each year

13.11.4.3. 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 the Department deems it appropriate for such Encounter Data submissions to be sent through the State's Colorado interchange.

13.11.4.4. MLR Target: Contractor shall have an MLR of at least eighty-nine percent (89%). Contractor will calculate a cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department.

13.11.4.5. 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)).

13.11.4.5.1. 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.

13.11.4.5.2. Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

13.11.4.5.3. 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.

13.11.4.5.4. 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.

13.11.4.5.5. 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. The numerator does not include the MLR remittance per 42 C.F.R. § 438.8(f)(2)(vi).

13.11.4.6. 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%.

13.11.4.6.1. Contractor shall aggregate data for all Medicaid eligibility groups covered under this Contract.

13.11.4.7. If Contractor's MLR does not meet or exceed the MLR Target, then Contractor shall reimburse the Department the difference using the following formula:

13.11.4.7.1. Reimbursement amount shall equal the 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).

13.11.4.7.2. Contractor shall reimburse the Department within 30 days of the Department finalizing the MLR validation. The 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.

13.11.4.7.2.1. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

13.11.4.7.3. Adjusted MLR Target: The MLR Target will be decreased by one percent for each quality measure target (MLR Quality Target) that Contractor meets or exceeds (see 13.11.5.2 Quality Target Table). The lowest possible Adjusted MLR Target is four percent lower than the MLR Target, or 85%. If Contractor does not meet any MLR Quality Targets, then the Adjusted MLR Target is equal to the MLR Target, 89%.

13.11.5. MLR Quality Targets

13.11.5.1. Contractor shall participate in the measurement and reporting of MLR quality metrics required by the Department for Contractor's Adjusted MLR, with the expectation that this information will be placed in the public domain.

13.11.5.2. The Department will provide to Contractor documented calculation methodology for all metrics.

13.11.5.2.1. The 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.

13.11.5.2.2. The Department will determine the final Adjusted MLR metric criteria.

13.11.5.3. Contractor shall provide data, as requested, to enable the Department or its designee to

calculate the quality metrics, unless the data is already in the Department's possession.

13.11.5.4. Contractor shall support Network Providers to collect and report information required to calculate the quality metrics.

13.11.5.5. Contractor shall be held to the following four quality metrics in relation to the Adjusted MLR Target:

13.11.5.5.1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (1%)

13.11.5.5.2. Prenatal and Postpartum Care: Prenatal Care (NQF1517); Prenatal and Postpartum Care: Postpartum Care (NQF1517) (1%)

13.11.5.5.3. Well-Child Visits in the first 30 Months of Life (NQF1392) (0.5%); Child and Adolescent Well-Care Visits (NQF1516) (0.5%)

13.11.5.5.4. Depression Screening and Follow-Up (1%)

13.11.5.6. Quality Targets Table

13.11.5.6.1. Contractor shall be held to the following four (4) quality metrics and their respective risk allocations in relation to the Adjusted MLR Target.

Quality Metric	Percentage Adjustment Made to the MLR
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Subtract one percent (-1%)
Prenatal and Postpartum Care: Prenatal Care (NQF1517); Prenatal and Postpartum Care: Postpartum Care (NQF1517)	Subtract one percent (-1%)
Well-Child Visits in the first 30 Months of Life (NQF1392) (0.5%); Child and Adolescent Well-Care Visits (NQF1516) (0.5%)	Subtract one percent (-1%)
Depression Screening and Follow-Up	Subtract one percent (-1%)
Total Percentage Points	Subtract four percent (-4%)

13.11.5.6.2. If Contractor's MLR does not meet or exceed the MLR Target, then Contractor shall reimburse the Department the difference using the following formula:

13.11.5.6.2.1. Reimbursement amount shall equal the 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).

13.11.5.6.2.2. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

13.11.5.6.2.3. Contractor shall submit all encounters, audited financial statements and reporting, and flat files for the measurement period, before the Department can validate the

MLR.

13.11.5.6.2.4. Contractor's Medical Spend shall be verified using both Encounter Data submitted through the State's Colorado InterChange, as well as audited supplemental data provided in Contractor's annual financial reporting.

13.11.5.6.2.5. Contractor shall reimburse the Department within 30 days of the Department finalizing the MLR validation. The 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.

13.11.5.6.3. Subcontracted Claims Adjudication Activities

13.11.5.6.3.1. 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.

13.11.5.6.4. In any instance where the Department makes a retroactive change to the capitation payments for an MLR reporting year where the MLR report has already been submitted to the Department, Contractor shall:

13.11.5.6.4.1. Re-calculate the MLR for all MLR reporting years affected by the change; and

13.11.5.6.4.2. Submit a new MLR report meeting the applicable requirements.

13.11.5.6.5. DELIVERABLE: Adjusted MLR Calculation Report and supporting data and documentation

13.11.5.6.6. DUE: Annually, within 30 Business Days following the Department providing repriced internal claims data.

13.12. Medicaid Reporting Template

13.12.1. 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.

13.12.1.1. The Department will provide the Annual Certified Rate Setting Financial Template and an information request list (IRL) to Contractor no less than 60 days in advance of the due date.

13.12.1.2. Contractor shall not modify the Annual Certified Rate Setting Financial Template, unless written approval is provided by the Department, and shall submit supporting data and documentation as outlined in the IRL to provide clarity and detail.

13.12.1.3. The Department may modify the Annual Certified Rate Setting Financial Template and will notify Contractor within five business days of the modification.

13.12.2. Contractor shall submit any requested supporting data and documentation to the Department and the designated outside vendor within seven business days of the Department's request.

13.12.2.1. DELIVERABLE: Annual Certified Rate Setting Financial Template with supporting data and documentation listed in the IRL

13.12.2.2. DUE: Annually, by November 15 of each year

13.13. Medicaid Payment in Full

13.13.1. 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.

13.13.2. 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.

13.13.3. 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.

13.13.4. 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.

13.13.5. 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. The Department will deduct from the penalty the amount of overcharge and return it to the affected Members.

13.13.6. Contractor shall not charge Members co-pays for the following services:

13.13.6.1. Inpatient hospital services.

13.13.6.2. Outpatient Hospital Services.

13.13.6.3. Optometrist Visits.

13.13.6.4. Podiatrist Visits.

13.13.6.5. Primary Care Physician and specialist services.

13.13.6.6. Rural Health Clinic Visits.

13.13.6.7. Federally Qualified Healthcare Center (FQHC) Visits.

13.13.6.8. DME/Disposable Supply Services.

13.13.6.9. Laboratory services.

13.13.6.10. Radiology services.

13.13.6.11. Prescription drugs or refill services.

13.13.7. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 C.F.R. §§ 95.1 and 95.7, the Department shall file all claims for reimbursement of payments to Contractor with CMS within two years after the calendar

quarter in which the Department made the expenditure. Contractor and the Department shall work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file Contractor's claims or capitation payments within two years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 C.F.R. § 95.19, no claims or capitations will be paid to Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from Contractor all claims and capitations paid to Contractor for any period of time disallowed by CMS.

13.13.8. 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.

13.13.9. 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.

13.13.9.1. 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 the 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.

13.13.9.1.1. DELIVERABLE: Timely Clean Claims Payment Report

13.13.9.1.2. DUE: Quarterly, within 45 days following the end of the quarter for which the report covers

13.14. Capitated Physical Health Metric Reporting

13.14.1. Contractor shall report on metrics selected by the Department no later than 45 calendar days after the end of each quarter. Contractor shall collaborate with the Department to define the reporting specifications.

13.14.1.1. DELIVERABLE: Capitated Physical Health Metric Report

13.14.1.2. DUE: Within 45 days after the end of each quarter

14. CAPITATED BEHAVIORAL HEALTH BENEFIT

14.1. Contractor shall administer and deliver the Capitated Behavioral Health Benefit and increase access to Behavioral Health services for all Medicaid Members, which means that Contractor shall:

14.1.1. Receive a Capitated Payment for each Member.

14.1.2. Assume comprehensive risk for all covered inpatient and outpatient Behavioral Health services.

14.1.3. Take full responsibility for providing, arranging for or otherwise taking responsibility for the provision of all Medically Necessary covered Behavioral Health services.

14.1.4. Ensure the Capitated Payments support Members achieving behavioral health and wellbeing

and are not diverted for meeting Contractor's physical health responsibilities.

14.2. As the administrator of a capitated benefit, Contractor shall 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.

14.3. Contractor shall administer the Capitated Behavioral Health Benefit in a manner that is fully integrated with the entirety of the Work outlined in the Contract thereby creating a seamless experience for Members and Providers.

14.4. Contractor shall demonstrate a commitment to the following principles in administering the Capitated Behavioral Health Benefit:

14.4.1. 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.

14.4.2. Trauma-informed: Treatment that acknowledges and understands the vulnerabilities or triggers of past traumatic experiences on Members' health.

14.4.3. 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.

14.4.4. 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.

14.4.4.1. Contractor shall develop policies and procedures, as needed, on how Contractor shall respond to requests from participating Providers for interpreter services.

14.4.5. 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:

14.4.5.1. Improving the public's understanding of mental health and substance use disorders.

14.4.5.2. Normalizing mental health and substance use disorders as legitimate and treatable health issues.

14.4.5.3. Actively promoting emotional health.

14.4.5.4. Promoting education and public awareness of mental health and substance use disorder symptoms.

14.4.5.5. Increasing access to effective treatment and supporting individual recovery.

14.4.5.6. Evidence-based: Treatment is provided in accordance with the best available research and clinical expertise.

14.4.6. 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 on the strengths and needs of the entire family or community.

14.4.7. Contractor shall furnish information about the services that Contractor does not cover because of moral or religious objections to the Department whenever it adopts such a policy

during the term of the contract.

14.4.8. Contractor would otherwise be required to provide, reimburse for, or provide coverage of a counseling or referral service is not required to do so if Contractor objects to the service on moral or religious grounds.

14.4.9. If Contractor does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information on how and where to obtain such services, the Department shall provide that information to Members.

14.4.10. Contractor shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

14.5. Covered Services.

14.5.1. 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. Guidance for how Contractor may considering evaluating and treating mental illness in individuals with developmental disabilities and individuals with traumatic brain injury is provided in Exhibit H.

14.5.1.1. Contractor shall incorporate lessons learned from the Cross-System Crisis Response Pilot Program established by House Bill 15-1368 to improve the delivery and coordination of behavioral health services for individuals with intellectual and developmental disabilities. The goal of the Cross-System Crisis Response Pilot Program is to provide crisis intervention, stabilization, and follow-up services to individuals who have both an Intellectual or Developmental Disability and a mental health or behavioral health condition and who also require services not available through an existing Home and Community Based Services (HCBS) waiver or covered under the Colorado behavioral health care system.

14.5.2. Contractor shall provide or arrange for the provision of all medically necessary covered services as detailed in Section 14.5, represented by procedures listed in the State Behavioral Health Services Billing Manual (the State Behavioral Health Services Billing Manual can be found on the Department's website), for all Primary and Principal Diagnosis indicated in Exhibit I Capitated Behavioral Health Benefit Covered Services and Diagnoses.

14.5.3. Contractor shall provide or arrange for the provision of all medically necessary behavioral health services for Primary and Principal Diagnosis listed in Exhibit I Capitated Behavioral Health Benefit Covered Services and 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 regulatory guidance.

14.5.3.1. For Members also enrolled in a managed care capitation initiative, Contractor shall provide mental health or substance use disorder services within the scope of benefits stipulated in the Contract.

14.5.3.2. 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.

14.5.4. 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.

14.5.5. Contractor shall understand that in addition to the State Plan Services included in the Capitated Behavioral Health Benefit listed below, the Department now allows and encourages the provision of up to six sessions of short-term behavioral health services in a primary care setting per episode of care. (Exhibit J Short-term Behavioral Health Services in Primary Care). These short-term behavioral health services must be provided by a licensed behavioral health provider. These services will be reimbursed Fee-for- Service when billed by the primary care provider.

14.5.6. State Plan Services

14.5.6.1. Contractor shall manage the delivery of the following State Plan Services for Members:

14.5.6.1.1. Individual psychotherapy: One-to-one therapeutic contact with a Member for at least 30 minutes but not to exceed two hours.

14.5.6.1.2. Individual brief psychotherapy: Therapeutic contact with one Member up to and including 30 minutes.

14.5.6.1.3. Group psychotherapy: Therapeutic contact with more than one Member, up to and including two hours.

14.5.6.1.4. Family psychotherapy: Face-to-face therapeutic contact with a Member and family Member(s), or other persons significant to the Member, for improving Member-family functioning.

14.5.6.1.5. Behavioral health assessment: Face-to-face clinical assessment of a Member by a behavioral health professional that determines the nature of the Member's problem(s); factors contributing to the problem(s); a Member's strengths, abilities and resources to help solve the problem(s); and any existing diagnoses.

14.5.6.1.6. 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.

14.5.6.1.7. Intensive Outpatient Program for substance use disorders: services provided in an outpatient setting and are focused on maintaining and improving functional abilities for a member through time-limited, multi-faceted approach to treatment as defined by the ASAM criteria.

14.5.6.1.8. Outpatient day treatment: Therapeutic contact with a Member 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.

14.5.6.1.9. School-based services: State Plan outpatient behavioral health services provided to pre-school and school-aged children and adolescents on site in their schools, with the cooperation of the schools.

14.5.6.1.10. Targeted case management: Medically Necessary services to assist and support a Member in gaining access to or to develop his/her skills for gaining access to needed medical, social, educational, and other services essential to meeting basic human needs, as appropriate.

14.5.6.1.11. Rehabilitative services: Any remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for maximum reduction of behavioral health symptoms and restoration of a recipient to his/her best possible functional level.

14.5.6.1.12. Substance use disorder assessment: An evaluation designed to determine the most appropriate level of care, based on criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug/alcohol use, abuse or dependence and related problems, and the comprehensive treatment needs of a Member with a drug or alcohol diagnosis.

14.5.6.1.13. Alcohol/drug screen counseling: Substance use disorder counseling services are provided along with screening to discuss results with a Member.

14.5.6.1.14. 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.

14.5.6.1.14.1. Contractor shall establish a single reimbursement rate for methadone administration (Code H0020) regardless of place of service, including for take-home doses.

14.5.6.1.15. 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.

14.5.6.1.15.1. 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 psychiatric diagnosis.

14.5.6.1.15.2. 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.

14.5.6.1.16. 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.

14.5.6.1.17. *Crisis* Services: Services provided during a behavioral health emergency, which can involve unscheduled, immediate, or special interventions in response to a crisis with a Member.

14.5.6.1.17.1. 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.

14.5.6.2. Emergency and Post-Stabilization Care Services

14.5.6.2.1. 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).

14.5.6.2.2. Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with Contractor.

14.5.6.2.3. 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.

14.5.6.2.4. Contractor shall not be responsible for outpatient emergency room services billed on a UB-04 for the treatment of a primary substance use disorder.

14.5.6.2.5. 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 principal diagnosis is a covered behavioral health diagnosis when a diagnosis is required.

14.5.6.2.6. Contractor shall not refuse to cover treatment obtained under either of the following circumstances:

14.5.6.2.6.1. 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.

14.5.6.2.6.2. A representative of Contractor instructs the Member to seek Emergency Services.

14.5.6.2.7. 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 furnished the services.

14.5.6.2.8. 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.

14.5.6.2.9. 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.

14.5.6.2.10. Contractor shall acknowledge 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 shall be binding on Contractor for coverage and payment.

14.5.6.2.11. Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside Contractor's provider network that are pre- approved by Contractor.

14.5.6.2.12. Contractor shall be financially responsible for Post-Stabilization Care Services 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:

14.5.6.2.12.1. Contractor does not respond to a request for pre-approval within one hour.

14.5.6.2.12.2. Contractor cannot be contacted.

14.5.6.2.12.3. 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.

14.5.6.2.13. 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.

14.5.6.2.14. Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved shall end when:

14.5.6.2.14.1. A plan provider with privileges at the treating hospital assumes responsibility for the Member's care.

14.5.6.2.14.2. A plan provider assumes responsibility for the Member's care through transfer.

14.5.6.2.14.3. Contractor and the treating provider reach an agreement concerning the Member's care.

14.5.6.2.14.4. The Member is discharged.

14.5.6.2.15. Nothing in this section shall preclude Contractor from conducting a retrospective review consistent with these rules regarding emergency and Post- Stabilization Care Services.

14.5.6.2.16. 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.

14.5.6.2.17. Contractor shall not be financially responsible for Emergency Services when the Primary or Principal diagnosis is physical in nature even when procedures are provided to treat a secondary behavioral health diagnosis.

14.5.6.3. Inpatient Psychiatric Hospital Services

14.5.6.3.1. Contractor shall cover and pay for Inpatient Psychiatric Hospital Services which are defined as follows:

14.5.6.3.1.1. For Members under 21 years old. A program of care for Members age 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 twenty-first birthday are entitled to receive inpatient benefits until discharged from the facility or until their twenty-second birthday, whichever is earlier, as outlined in 42 C.F.R. § 441.151.

14.5.6.3.1.2. For adults ages 21 to 64 years. A program of psychiatric care in which the Member remains 24 hours a day in a facility licensed as a hospital by the state, excluding state institutes for mental disease (IMDs).

14.5.6.3.1.3. For Members age 65 years and over. A program of care for Members age 65 and over in which the Member remains 24 hours a day in an institution for mental diseases, or other facility licensed as a hospital by the State.

14.5.6.3.2. Contractor's responsibility for all inpatient hospital services is based on the Principal Diagnosis that requires inpatient level of care and is being managed within the treatment plan of the Member.

14.5.6.3.2.1. Contractor shall be financially responsible for the hospital stay when the Member's Principal Diagnosis is a covered psychiatric diagnosis, even when the psychiatric diagnosis includes some physical health procedures (including labs and ancillary services).

14.5.6.3.2.2. Contractor shall not be financially responsible for inpatient hospital services when the Member's Principal Diagnosis is physical in nature, even when the physical health hospitalization includes some covered psychiatric conditions or procedures to treat a secondary covered psychiatric diagnosis.

14.5.6.3.3. Contractor shall be financially responsible for a Member's admission to any free standing inpatient psychiatric facility, when the Member is presenting with psychiatric symptoms, for the purposes of acute stabilization, safety and assessment to determine whether or not the Principal Diagnosis occasioning the Member's admission to the hospital is a mental health disorder or substance use disorder.

14.5.6.3.3.1. If a mental health disorder is determined to be the Principal Diagnosis, Contractor shall be financially responsible for the remainder of the inpatient hospital services, as Medically Necessary in accordance with 10 CCR 2505- 10 § 8.076.1.8. The assessment period shall generally not exceed 72 hours.

14.5.6.3.4. Contractor may cover, but may not require the Member to use, Institutions for Mental Disease (IMDs) in lieu of short-term inpatient psychiatric hospital care when determined medically appropriate and cost-effective, in compliance with 42 CFR 438.3(e)(2).

14.5.6.3.4.1. 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. When members are in an IMD for more than 15 days, the Department will recoup the capitation. This length of stay limit does not apply to inpatient stays associated with SUD diagnoses.

14.5.6.3.4.2. Contractor shall receive a monthly capitation payment for retroactively enrolled Members who received IMD services up to 90 days prior to their eligibility determination.

14.5.6.3.5. Transitioning Members from Colorado Mental Health Institutes and Hospitals

14.5.6.3.5.1. Contractor shall maintain policies, procedures, and strategies for helping to transition Members from Colorado Mental Health Institutes to safe and alternative environments. Contractor shall participate in discussions and care coordination with the Colorado Mental Health Institutes, and Contractor shall have plans in place to provide medically necessary covered services once the Member has been discharged from the Colorado Mental Health Institute.

14.5.6.3.5.2. Contractor shall work with appropriate treatment providers in their region in order to transition children from hospitals to safe and alternative step-down environments (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.

14.5.6.3.5.3. Contractor shall work with the Colorado Mental Health Institutes to execute communication and transition plans for Members.

14.5.6.3.5.4. Contractor shall assign a liaison to serve as a regular point of contact with the Colorado Mental Health Institute staff and Members who will return to or enter Contractor's geographic service area. Contractor's liaison, or their designee, shall engage in the following activities:

14.5.6.3.5.4.1. Monthly treatment planning meetings, when requested by the Department or Colorado Mental Health Institute.

14.5.6.3.5.4.2. Discharge planning meetings.

14.5.6.3.5.4.3. Face-to-face planning with client.

14.5.6.3.5.4.4. Prompt in-person, email, telephone, and fax communication with treatment Providers sufficient to arrange a successful discharge from the Colorado Mental Health Institute.

14.5.6.3.5.5. Once Contractor's Members are discharged from a Colorado Mental Health Institute, Contractor shall be responsible for arranging and coordinating medically necessary on-going treatment.

14.5.6.3.5.6. Contractor who was responsible for that Member upon admission to the Colorado Mental Health Institute shall remain Contractor until the Member is reassigned by the Department to a new Regional Accountable Entity.

14.5.6.4. Residential and Inpatient Substance Use Disorder Services

14.5.6.4.1. Contractor shall cover inpatient SUD services and residential SUD services which are defined as follows:

14.5.6.4.1.1. Inpatient SUD services: SUD services that provide a planned and structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting.

14.5.6.4.1.2. Residential SUD services: SUD services that are delivered in settings that provide 24-hour structure, support and clinical interventions for patients. These services are appropriate for patients who require time and structure to practice and integrate their recovery and coping skills in a residential, supportive environment. Higher levels of residential treatment provide safe, stable living environments for patients who need them to establish or maintain their recovery apart from environments that promote continued use in the community.

14.5.6.4.2. Contractor's responsibility for all residential SUD services is based on the presence of a Primary SUD Diagnosis and demonstration of medical necessity based on the ASAM Criteria for the level of care provided.

14.5.6.4.3. Contractor shall be financially responsible for the hospital stay when the Member's Primary or Principal Diagnosis is a covered SUD diagnosis, even when the treatment includes some physical health procedures (including labs and ancillary services).

14.5.6.4.3.1. Contractor shall not be financially responsible for ASAM level 4 services.

14.5.6.4.4. 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.

14.5.7. Non-State Plan 1915(b)(3) Waiver Services

14.5.7.1. 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.

14.5.7.1.1. 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.

14.5.7.1.2. Intensive Case Management – Community-based services averaging more than one hour per week, provided to children and adults with serious behavioral health needs who are at risk of a more intensive 24 hour placement and who need extra support to live in the community.

14.5.7.1.3. 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.

14.5.7.1.4. 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.

14.5.7.1.5. Mental Health Residential Services – Any type of twenty-four (24) hour psychiatric care, excluding room and board, provided in a non-hospital, non-nursing home setting, where Contractor provides supervision in a therapeutic environment. Residential services are appropriate for children, youth, adults and older adults who need twenty-four (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.

14.5.7.1.5.1. Contractor shall not be financially responsible for covering mental health residential treatment services for children and youth in the custody of the Colorado Department of Human Services—Division of Child Welfare or the Division of Youth Corrections who are placed by those agencies into either a Psychiatric Residential Treatment Facility (as defined in C.R.S. 25.5-4-103) or a Residential Child Care Facility (as defined in C.R.S. 26-6-102).

14.5.7.1.5.2. Contractor shall be responsible for the payment of residential substance use disorder treatment services delivered for all youth enrolled with Contractor, 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.

14.5.7.1.6. 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, seven days a week, 365 days a year.

14.5.7.1.7. 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 include, but are not limited to, peer counseling and support services, peer-run employment services, peer mentoring for children and adolescents, recovery groups, warm lines and advocacy services. Contractor may consider utilizing the competency-based guidelines included Exhibit K: Peer Specialist Core Competencies for training peer support specialists and recovery coaches.

14.5.7.1.8. 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.

14.5.7.2. Contractor shall regularly evaluate the effectiveness of the 1915(b)(3) Waiver services over the life of the contract. Contractor shall propose any changes to the 1915(b)(3) Waiver services to the Department and the Department shall approve any changes prior to implementation of the changes.

14.6. Service Limits

14.6.1. Contractor shall provide covered services in an amount, duration, and scope that is no less than the amount, duration, and scope furnished under Fee-for-Service Medicaid.

14.6.2. 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.

14.6.2.1. 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.

14.6.3. Contractor shall ensure that services supporting beneficiaries with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

14.6.4. 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.

14.6.5. Contractor may place appropriate limits on a service as follows:

14.6.5.1. On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity.

14.6.5.1.1. 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.

14.6.5.2. For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose.

14.6.5.2.1. 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.

14.6.5.2.2. For Members also enrolled in a physical health MCO, Contractor shall only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or substance use disorder 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.

14.6.5.2.3. For Utilization Management, 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.

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

14.6.7. 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.

14.6.8. Contractor shall establish clear and specific criteria for discharging Members from treatment.

14.6.8.1. Contractor shall include above criteria in Member materials and information.

14.6.8.2. 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.

14.6.9. 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.

14.6.10. Contractor shall not hold a Member liable for Covered Services:

14.6.10.1. Provided to the Member, for which the Department does not pay Contractor

14.6.10.2. Provided to the Member, for which the Department or Contractor does not pay the provider that furnishes the service under a contract, referral, or other arrangement

14.6.10.3. 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

14.6.11. 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 9.4.

14.6.11.1. 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

14.6.11.2. Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder 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.

14.7. Service Planning, Coordination and Care Transitions

14.7.1. Based on the Member's needs and level of care required, Contractor shall ensure they have procedures for the following:

14.7.1.1. Intake and Assessment: Contractor shall ensure that each Member receives an individual intake and assessment appropriate for the level of care needed.

14.7.1.2. Service Planning: Contractor shall have a service planning system that uses the information gathered in the Member's intake and assessment to build a service or care plan.

14.7.1.3. 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.

14.7.1.3.1. Contractor shall regularly report on Members experiencing challenges to discharge from hospitals, in a format determined by the Department.

14.7.1.3.1.1. DELIVERABLE: Weekly Hospital Discharge Status Report

14.7.1.3.1.2. DUE: Weekly, on a day of the week determined by the Department

14.7.1.4. 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

14.7.2. Contractor's Provider Network shall comply with the Behavioral Health Administration's data collection policies and procedures, including the following:

14.7.2.1. <u>The use of Behavioral Health Administration technology related to inpatient and residential behavioral health bed availability and placement.</u>

14.7.2.2. Changes to and compliance with the Colorado Client Assessment Record and the Drug and Alcohol Coordinated Data System reporting requirements.

14.7.2.3. <u>Changes to and compliance with the Medication Assisted Treatment Central Registry for individuals receiving medication assisted treatment.</u>

14.7.2.4. At the Department's request, Contractor shall collect from their Provider Network the required Drug/Alcohol Coordinated Data System for Members with a substance use disorder diagnosis.

14.7.3. 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:

14.7.3.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

14.7.3.2. Any information the Member needs to decide among all relevant treatment options.

14.7.3.3. 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.

14.8. Utilization Management

14.8.1. Contractor shall ensure access to and appropriate utilization of covered behavioral health services.

14.8.2. Contractor shall establish and maintain a documented Utilization Management Program and Procedures, in compliance with 42 CFR 438.905 and 438.910, that includes, at a minimum, the following:

14.8.2.1. Description of its utilization management program structure and assignment of responsibility for utilization management activities to appropriate individuals.

14.8.2.2. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

14.8.2.3. Evidence of a behavioral health practitioner's involvement in program development and implementation.

14.8.2.4. Identification of the type of personnel responsible for each level of utilization management decision-making.

14.8.2.5. Standards for utilization management personnel to consult with the ordering provider prior to denial or limitation of requested/provided services.

14.8.2.6. Policies and procedures for the use and periodic review of written clinical decision-making criteria based on clinical evidence.

14.8.2.7. Provider dispute resolution

14.8.2.8. Description of a Provider Dispute Resolution process which follows Division of Insurance Provider Dispute Resolution requirements and timelines.

14.8.2.8.1. DELIVERABLE: Utilization Management Program and Procedures

14.8.2.8.2. DUE: 30 days after any significant change is made.

14.8.3. Contractor shall only utilize ASAM criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.

14.8.3.1. Contractor shall prior authorize residential and inpatient SUD services except as stated herein.

14.8.3.2. Contractor shall utilize the following preauthorization timeframes with regard to the following ASAM levels for inpatient SUD services:

ASAM Level	Initial Authorization Timeframe
3.1,	30 days minimum
3.3, 3.5	20 days minimum
3.7	10 days minimum
3.2WM	5 days minimum before concurrent auth
3.7WM	4 days minimum before concurrent auth

14.8.3.3. Contractor shall authorize a minimum of 30 days of care for services under the Special Connections Program.

14.8.3.4. Contractor shall not require prior authorization for admission to a 3.2 WM or 3.7 WM 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. Contractor shall perform a continued stay authorization for stays longer than 5 days for 3.2WM and longer than 4 days for 3.7WM will require a continued stay authorization.

14.8.4. Contractor shall consider the following factors, at a minimum, when determining medical necessity or the appropriate level of care for a Member diagnosed with an eating disorder:

14.8.4.1. The Member's eating behaviors

14.8.4.2. The Member's need for supervised meals and support interventions

14.8.4.3. Laboratory results, including but not limited to, the Member's heart rate, renal or cardiovascular activity, and blood pressure

14.8.4.4. The recovery environment

14.8.4.5. Co-occurring disorders the individual may have

14.8.4.6. Contractor shall not utilize the body mass index, ideal body weight, or any other standard requiring an achieved weight when determining medical necessity or the appropriate level of care for a Member diagnosed with an eating disorder, including but not limited to, bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the diagnostic and statistical manual of mental disorders.

14.8.4.6.1. Contractor shall not be required to follow these requirements when determining medical necessity or the appropriate level of care for a Member diagnosed with anorexia nervosa, restricting subtype.

14.8.4.6.2. The .Contractor shall not use body mass index, ideal body weight, or any other standard requiring an achieved body weight as the determining factor when assessing medical necessity or the appropriate level of care for a Member diagnosed with anorexia nervosa, restricting subtype

14.8.5. Contractor shall program and design a utilization management tracking system to meet data submission guidelines established by the Department.

14.8.5.1. Contractor shall submit Utilization Management Data to the Department or its contractor in a format determined by the Department.

14.8.5.1.1. DELIVERABLE: Utilization Management Data

14.8.5.1.2. DUE: Monthly, within 15 calendar days of the month for which the data covers

14.8.6. Contractor shall use the Diagnostic Manual – Intellectual Disability, 2nd Edition (DM-ID-2) to inform medical necessity determinations for Members with intellectual or developmental disabilities, as outlined in Exhibit H..

14.8.6.1. Contractor shall have policies and procedures that align with best practices in assessment of need, diagnosis, and authorization or services as outlined in Exhibit H.

14.8.7. Contractor shall use the most current edition of the Statewide Standardized Utilization Management (SSUM) Guidelines in conjunction with national standard guidelines when making medical necessity determinations for members under the age of 21 effective July 1, 2023.

14.8.8. Contractor shall refer the youth for an Independent Assessment to inform their medical necessity determination according to Colorado Code of Regulations (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.

14.8.8.1. Contractor shall only use an Independent Assessment for initial authorization purposes. Contractor shall not use an Independent Assessment for continuing authorizations.

14.8.8.1.1. Contractor shall determine continued stay authorizations by the youth's presentation, benefit of treatment, medical need as outlined in the SSUM Guidelines, and EPSDT requirements.

14.8.8.2. 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.

14.8.8.3. Contractor shall issue an administrative denial when an Independent Assessment is cancelled due to a member’s family or guardian not responding to requests for documents within 72 hours.

14.8.8.4. Contractor shall not pay for an Independent Assessment for which Contractor did not initiate the referral.

14.8.8.5. Contractor shall accept for consideration an Independent Assessment completed at the request of another payer dated within 30 days of a request made to Contractor.

14.8.8.6. Contractor may wait for the Independent Assessment to be completed before placing a youth in a QRTP, and then respond to the Independent Assessment findings.

14.8.8.7. Contractor may place a youth in a QRTP while the Independent Assessment is being completed.

14.8.8.7.1. 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 Independent Assessment.

14.8.8.7.2. If the Independent Assessment 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.

14.8.8.8. 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.

14.8.8.9. If Contractor denies a request for QRTP services due to non-covered diagnosis, Contractor shall refer the youth for an Independent Assessment and pay for the assessment which is required for QRTP services to be covered via Fee-For-Service.

14.8.8.9.1. Contractor shall refer the youth for an Independent Assessment within 24 hours of the denial due to non-covered diagnosis.

14.8.8.9.2. Contractor shall coordinate the most effective and appropriate level of care for the youth in the least restrictive environment.

14.8.9. Contractor shall implement Contractor’s documented Utilization Management Program and Procedures.

14.8.10. Contractor's utilization management process shall in no way impede timely access to services.

14.8.10.1. Contractor shall not require prior authorization for the non-pharmaceutical components of MAT.

14.8.10.2. Contractor shall respond to 95% of authorization requests for inpatient and residential SUD services not associated with the Special Connections program within 72 hours following the initial request, and 100% of authorizations requests within 96 hours following the initial request.

14.8.10.3. Contractor shall respond to 95% of authorization requests for the Special Connections program within 24 hours following the initial request, and 100% of authorization requests within 48 hours following the initial request.

14.8.10.4. Contractor shall not require prior authorization for outpatient psychotherapy services, in accordance with 25.5-5-406.1., C.R.S.

14.8.11. Contractor shall have mechanisms for providers and Members on how they can obtain the utilization management decision-making criteria upon request.

14.8.12. 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.

14.8.13. If Contractor determines that the Member does not meet standards of Medical Necessity for behavioral health services, Contractor shall inform the Member about alternate 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 CCBs, SEPs, and Managed Service Organizations.

14.8.14. Contractor shall disseminate practice guidelines to Members and potential Members upon request.

14.8.14.1. Contractor shall adopt practice guidelines that consider the needs of Members.

14.8.14.2. Contractor shall adopt practice guidelines in consultation with Network Providers.

14.8.14.3. Contractor shall review and update practice guidelines periodically as appropriate.

14.8.15. Contractor shall provide education and ongoing guidance to Members and providers about its utilization management program and protocols.

14.9. FQHC And RHC Encounter Reimbursement

14.9.1. 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. The Department reserves the right to change the minimum requirement payment to FQHCs to align with FQHC payment reforms in the future.

14.9.1.1. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505-10 § 8.700.6C.

14.9.1.2. The Department notifies Contractor of the FQHC and RHC rates on a quarterly basis.

14.9.1.3. The Department conducts quarterly accuracy audits with FQHCs and RHCs. Should the Department recognize any discrepancy in FQHC or RHC payments (less than the full encounter rate), Contractor shall be 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.

14.9.2. 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 least the encounter rate.

14.9.3. Contractor shall submit the Encounter Data for FQHC and RHC visits to the Department per the specifications provided in Section 15.2.2.

14.9.4. Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs as directed by the Department.

14.10. Reimbursements

14.10.1. Contractor shall reimburse practitioners for the provision of Covered Services within Contractor's established Utilization Management policies and agreed upon payment arrangements.

14.10.2. 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.

14.10.3. Required Reimbursement Strategies

14.10.3.1. Community Mental Health Center and Comprehensive Provider Reimbursement

14.10.3.1.1. Contractor shall reimburse CMHCs and Comprehensive Providers as licensed by the BHA the Department established encounter rate for services identified for allowable costs. The Department reserves the right to change the minimum requirement payment to CMHCs and Comprehensive Providers to align with behavioral health safety net reforms in the future.

14.10.3.1.2. Contractor shall reimburse each CMHC and Comprehensive Provider the encounter rate calculated in accordance with Department documented procedures.

14.10.3.1.3. Contractor shall update the CMHC and Comprehensive Provider encounter rates upon Department notification.

14.10.3.1.4. Contractor shall participate in quarterly accuracy audits with CMHCs and Comprehensive Providers. Should the Department recognize any discrepancy in CMHC and Comprehensive Provider payments (less than the full encounter rate), Contractor is responsible for reimbursing the CMHCs and Comprehensive Provider the difference of the encounter payment and the initial reimbursement amount.

14.10.3.1.5. Contractor shall submit the encounter data for CMHCs and Comprehensive Provider visits to the Department per the specifications provided by the Department.

14.10.3.2. Essential Provider Reimbursement

14.10.3.2.1. Contractor shall reimburse Essential Providers, at a minimum, the rates reflected on the Directed Payment Fee Schedule in the State Behavioral Health Services Billing Manual.

14.10.3.2.1.1. The Department reserves the right to change the minimum requirement payment to Essential Providers to align with behavioral health safety net reforms in the future.

14.10.3.2.2. Contractor shall reimburse Essential Providers for identified essential services in accordance with the rates established by the Department in the Directed Payment Fee Schedule in the State Behavioral Health Services Billing Manual.

14.10.3.2.3. The Contractor shall submit the encounter data for Essential Provider visits to the Department per the specifications provided by the Department.

14.10.3.2.4. The Contractor shall participate in the Department's accuracy audits process for Essential Providers and is required to complete any necessary documentation upon the Department's request.

14.11. Institutions for Mental Diseases (IMDs)

14.11.1. 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 Inpatient Psychiatric Hospitals that includes Public IMDs and Private IMDs and negotiate in good faith.

14.11.2. Contractor shall offer value-based payment agreements with a statewide network of Private IMDs and negotiate in good faith.

14.11.2.1. Contractor's value-based payment agreement with an individual Private IMD shall:

14.11.2.1.1. Incentivize quality care and outcomes that may include follow-up after discharge, average length of stay, readmission rates, and stabilization of symptoms.

14.11.2.1.2. Adhere to the principle of serving members in the least restrictive environment.

14.11.2.1.3. Require proactive, collaborative management of members.

14.11.2.1.4. Support the timely transition of members to outpatient, community-based care.

14.11.2.1.5. Be a signed contract or legal agreement.

14.11.2.2. Contractor shall submit confirmation of an executed value-based payment agreement with an individual Private IMD and the payment details and associated metrics to the Department.

14.12. Physician Incentive Plans

14.12.1. Contractor shall disclose to the Department at the time of contracting, or at the time any incentive Contract is implemented thereafter, the terms of any physician incentive plan.

14.12.1.1. 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.

14.12.2. 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.

14.12.3. 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.

14.12.3.1. DELIVERABLE: Physician Incentive Plan

14.12.3.2. DUE: On the Effective Date or upon implementation of a Physician Incentive Plan.

14.13. Third Party Payer Liability

14.13.1. 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 the Department and agree to cooperate with the Department in identifying third parties who may be liable for all or part of the costs of providing services to the Member, as a condition of participation in the Medicaid program.

14.13.1.1. 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 the Department to provide information to the Department regarding commercial third-party resources.

14.13.1.2. In the case of commercial health coverage, Contractor shall notify the 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 the 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, Contractor shall submit to the Department's Fiscal Agent the following information:

14.13.1.2.1. Member's Medicaid identification number

14.13.1.2.2. Member's full name.

14.13.1.2.3. Identification of the health carrier or health plan

14.13.1.2.4. Member's health plan identification and group numbers

14.13.1.2.5. Policy holder's full name

14.13.1.2.5.1. DELIVERABLE: Third Party Resource Identification

14.13.1.2.5.2. 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.

14.13.2. 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.

14.13.3. 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.

14.13.4. Contractor shall not restrict access to covered services due to the existence of possible or actual third party liability.

14.13.5. 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.

14.13.6. 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.

14.13.7. 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.

14.13.8. With the exception of Section 14.12. 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:

14.13.8.1. The sum of reported third party coinsurance and/or deductible or

14.13.8.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

14.13.9. 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.

14.13.10. 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.

14.14. Medical Loss Ratio (MLR)

14.14.1. 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).

14.14.2. The first measurement period will begin upon the start of the Operational Period of the Contract and end on June 30, 2020.

14.14.3. 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.

14.14.4. Contractor shall submit an MLR report to the Department, for each MLR reporting year, that includes:

14.14.4.1. Total incurred claims.

14.14.4.2. Expenditures on quality improvement activities.

14.14.4.3. Expenditures related to activities compliant with program integrity requirements.

14.14.4.4. Non-claims costs.

14.14.4.5. Premium revenue.

14.14.4.6. Taxes.

14.14.4.7. Licensing fees

14.14.4.8. Regulatory fees.

14.14.4.9. Methodology(ies) for allocation of expenditures.

14.14.4.10. Any credibility adjustment applied.

14.14.4.11. The calculated MLR.

14.14.4.12. Any remittance owed to the state, if applicable.

14.14.4.13. A comparison of the information reported with the audited financial report.

14.14.4.14. A description of the aggregation method used to calculate total incurred claims.

14.14.4.15. The number of member months.

14.14.5. All data provided by Contractor for the purpose of MLR calculation shall use actual costs.

14.14.5.1. Contractor shall allow for four months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five months.

14.14.5.2. Contractor shall submit the completed Adjusted MLR Calculation Report and supporting data and documentation by January 15 in compliance with the Department guidelines, for the measurement period. The supporting data and documentation includes, but is not limited to, all encounters, certified financial statements and reporting, and flat files. Contractor shall submit encounter claims in compliance with requirements in Section 15.2.2.

14.14.5.2.1. DELIVERABLE: Adjusted MLR Calculation Report and supporting data and documentation

14.14.5.2.2. DUE: Annually, by January 15th of each year.

14.14.5.3. Contractor's Medical Spend will be calculated using audited supplemental data provided in Contractor's annual financial reporting will be verified using Encounter Data submitted through submission on a secure server, until such time that the Department deems it appropriate for such Encounter Data submissions to be sent through the State's Colorado interchange.

14.14.5.4. MLR Target: Contractor shall have an MLR of at least 85%. Contractor will calculate a cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department.

14.14.5.5. 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).

14.14.5.5.1. 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.

14.14.5.5.2. Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

14.14.5.5.3. 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.

14.14.5.5.4. 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.

14.14.5.5.5. 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.

14.14.5.6. 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%.

14.14.5.6.1. Contractor shall aggregate data for all Medicaid eligibility groups covered under this Contract.

14.14.5.7. If Contractor's MLR does not meet or exceed the MLR Target, then Contractor shall reimburse the Department the difference using the following formula:

14.14.5.7.1. Reimbursement amount shall equal the 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).

14.14.5.7.2. Contractor shall reimburse the Department within 30 days of the Department finalizing the MLR validation. The 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.

14.14.5.7.2.1. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with Contractor any adjustments that must be made to Contractor's calculated MLR.

14.14.6. Subcontracted Claims Adjudication Activities

14.14.6.1. 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.

14.14.7. In any instance where the Department makes a retroactive change to the capitation payments for an MLR reporting year where the MLR report has already been submitted to the Department, Contractor shall:

14.14.7.1. Re-calculate the MLR for all MLR reporting years affected by the change; and

14.14.7.2. Submit a new MLR report meeting the applicable requirements.

14.14.8. DELIVERABLE: Adjusted MLR Calculation Report and supporting data and documentation

14.14.9. DUE: Annually, on January 15

14.15. Medicaid Payment in Full

14.15.1. 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.

14.15.2. 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.

14.15.3. 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.

14.15.4. 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.

14.15.5. 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. The Department will deduct from the penalty the amount of overcharge and return it to the affected Members.

14.15.6. As a precondition for obtaining federal financial participation for payments under this agreement, per 45 C.F.R. §§ 95.1 and 95.7, the Department must file all claims for reimbursement of payments to Contractor with CMS within two years after the calendar quarter in which the Department made the expenditure. Contractor and the Department shall work jointly to ensure that reconciliations are accomplished as required by CMS for timely filing. If the Department is unable to file Contractor's claims or capitation payments within two years after the calendar quarter in which the Department made the expenditure due to inadequate or inaccurate Contractor records, and the Department does not meet any of the exceptions listed at 45 C.F.R. § 95.19, no claims or capitations will be paid to Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from Contractor all claims and capitations paid to Contractor for any period of time disallowed by CMS.

14.15.7. Institutions for Mental Disease (IMD) Identification Report

14.15.7.1. Contractor shall submit a monthly report notifying the Department and the Department's Fiscal Agent of any Member stays in an IMD for inpatient psychiatric treatment, spanning more than 15 days during a capitation payment period for the purposes of capitation recoupment, in compliance with 42 CFR 438.6(e).

14.15.7.2. Contractor shall submit a monthly report notifying the Department and the Department's Fiscal Agent of any Member stays in an IMD spanning more than 15 days during a capitation payment period for the purposes of capitation recoupment, in compliance with 42 CFR 438.6(e).

14.15.7.3. For each Member identified in accordance with Section 14.15.7.1., the report shall

include:

14.15.7.3.1. Member's Medicaid ID

14.15.7.3.2. Date of Admission

14.15.7.3.3. Date of Discharge

14.15.7.3.4. Billing Provider Name

14.15.7.3.5. Billing Provider ID

14.15.7.4. DELIVERABLE: Institutions for Mental Disease (IMD) Identification Report

14.15.7.5. DUE DATE: No later than ten Business Days following the reporting month.

14.16. Parity

14.16.1. Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

14.16.1.1. 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.

14.16.2. 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.

14.16.2.1. 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 438.910(d).

14.16.3. Contractor shall provide to the 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:

14.16.4. Contractor shall provide all documentation necessary for determination of Contractor's compliance with Federal parity requirements. Contractor shall provide this documentation upon request for the Department's annual report as required by C.R.S. 25.5-5-421.

14.16.4.1. DELIVERABLE: Parity Benefits Table

14.16.4.2. DUE: Within 21 calendar days of the Department documentation request.

15. DATA, ANALYTICS AND CLAIMS PROCESSING SYSTEMS

15.1. Central Role of Data and Analytics

15.1.1. Contractor shall use data and analytics to successfully operate the Accountable Care Collaborative Program. Data and information are used for a range of management, coordination and care activities, such as process improvement, population health management, federal compliance, claims processing, outcomes tracking and cost control.

15.1.1.1. Contractor shall understand the key cost drivers within its Service Area and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

15.1.1.1.1. Contractor shall be responsible for monitoring utilization of low value services and analyzing cost categories that are growing faster than would normally be expected.

15.1.1.1.2. Contractor shall incorporate risk adjusted utilization expectations into its analytic procedures as Members with more complex conditions and needs are expected to use more resources.

15.1.1.2. 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.

15.1.1.3. Contractor shall use existing tools provided by the Department and other available resources to establish performance benchmarks and monitor provider performance across key cost and utilization metrics. The existing tools provided by the Department include, but are not limited to, the following:

15.1.1.3.1. Colorado interChange (MMIS)

15.1.1.3.1.1. Contractor shall maintain an interface that enables Contractor to use the Colorado interChange Provider Portal to retrieve eligibility, enrollment and attribution information for Members.

15.1.1.3.1.2. At a minimum, Contractor shall have the capabilities to utilize and process HIPAA standard transactions, such as the 834 Form.

15.1.1.3.2. Business Intelligence and Data Management System (BIDM System), to the extent appropriate:

15.1.1.3.2.1. Contractor shall use the BIDM System's Data Analytic Portal and MoveIt server to access Medicaid claims and Encounter Data for physical, behavioral and dental services. The BIDM System will directly interface with existing and future Medicaid data systems (interChange, AxisPoint Vital (LTSS care coordination tool) and Pharmacy Benefit Management System) while building capacity to exchange health information with other data sources, including clinical data.

15.1.1.3.2.2. Contractor shall have the capability to use data to create meaningful and actionable information, and interpret such information to provide leadership and guidance to providers, partners and the Department.

15.1.1.3.2.3. Contractor shall access standard analytics and reports, including trended Key Performance Indicator data, nationally recognized quality and utilization measures, and cost data.

15.1.1.3.2.4. Contractor shall design queries and searches it requires and interpret the results of the queries and searches it conducts.

15.1.1.3.2.5. Contractor shall share with the Network Providers, the BIDM System and with the Department any specific findings or important trends discovered through Contractor's analysis of the available data and information.

15.1.1.3.2.6. 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.

15.1.1.3.2.7. Contractor shall support and encourage Network Provider use of the BIDM System's Data Analytic Web Portal.

15.1.1.3.2.8. The 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.

15.1.1.3.2.8.1. Contractor shall only use the Part 2 Data for three specific purposes:

15.1.1.3.2.8.2. To assess calculation and payment for performance measures.

15.1.1.3.2.8.3. To provide care coordination and/or case management services in support of payment or health care operations.

15.1.1.3.2.8.4. 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.

15.1.1.3.3. Contractor shall receive direct admission, discharge, and transfer (ADT) data feeds from one of Colorado's regional health information exchanges.

15.1.1.3.4. Contractor shall receive the Nurse Advice Line data feed from the Nurse Advice Line contractor when it becomes available.

15.1.1.3.5. Contractor shall receive the Inpatient Hospital Transitions data feed from the Department.

15.1.1.4. Contractor shall work with the 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 the Department.

15.1.1.5. 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.

15.1.1.6. 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.

15.1.1.7. Contractor shall create a data governance policy.

15.1.1.7.1. Contractor shall ensure that the data governance policy describes in what circumstances Contractor will allow other entities, including providers and Community organizations, full access to Member level data, including how behavioral health data will be shared.

15.1.1.7.2. Contractor shall update the data governance policy annually, and provide to the Department upon request.

15.2. Required Systems

15.2.1. Care Coordination Tool

15.2.1.1. 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.

15.2.1.2. Contractor shall ensure that the Care Coordination Tool:

15.2.1.2.1. Works on mobile devices.

15.2.1.2.2. Supports HIPAA and 42 CFR Part 2 compliant data sharing.

15.2.1.2.3. Provides role-based access to providers and care coordinators.

15.2.1.3. Contractor shall ensure the Care Coordination Tool can collect and aggregate, at a minimum, the following information:

15.2.1.3.1. Name and Medicaid ID of Member for whom Care Coordination interventions were provided.

15.2.1.3.2. Age.

15.2.1.3.3. Gender identity.

15.2.1.3.4. Race/ethnicity.

15.2.1.3.5. Name of entity or entities providing Care Coordination, including the Member's choice of lead care coordinator if there are multiple coordinators.

15.2.1.3.6. Care Coordination notes, activities and Member needs.

15.2.1.3.7. Stratification level.

15.2.1.4. 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.

15.2.1.5. Contractor shall collect and be able to report the information identified in Section 15.2.1.3 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.

15.2.1.6. Contractor shall work with the Department to plan for how the Care Coordination Tool can exchange data with other Department tools such as the BIDM System and the LTSS Case Management system.

15.2.2. Claims Processing System for Capitated Behavioral Health Benefit and Medical Services

15.2.2.1. Contractor shall maintain a claims processing system to reimburse providers for medical covered and covered services under the Capitated Behavioral Health Benefit and produce encounter claims.

15.2.2.2. Contractor shall maintain a claims processing system to reimburse providers for covered medical services.

15.2.2.2.1. Medical encounter claims include paid services delivered by any Provider. These claims shall include, but are not limited to services delivered by medical groups, practices, clinics, Physicians, mid-level practitioners, medical equipment suppliers,

family planning clinics, independent laboratories, optometrists, podiatrists, FQHCs, freestanding rehabilitation centers, or any other Providers.

15.2.2.2.2. When a Member receives services from multiple Providers in the same day, Contractor shall submit separate encounter claims for each visit for each Provider.

15.2.3. 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 the Department's website.

15.2.4. Encounter Data Reporting through the MMIS

15.2.4.1. Contractor shall submit all Encounter Data on all State Plan and 1915(b)(3) Waiver services included within the Capitated Behavioral Health Benefit and for covered medical services 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.

15.2.4.2. Contractor shall collaborate with the Department or the Department's Pharmacy Benefit Management (PBM) vendor to ensure compliance as set forth in the Colorado Pharmacy Benefit Management System (PBMS) Batch Pharmacy Encounters Companion Guide.

15.2.4.3. Contractor shall submit Encounter Data in the ANSI ASC X12N 837 format directly to the Department's fiscal agent using the 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:

15.2.4.3.1. Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

15.2.4.3.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

15.2.4.3.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

15.2.4.4. Contractor shall use the enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. Such data transmissions and enrollment reports shall include:

15.2.4.4.1. Medicaid Management Information System (MMIS) reports, which verify Medicaid eligibility

15.2.4.4.2. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction

15.2.4.4.3. HIPAA compliant X12N 834 Health Care Enrollment and Maintenance standard transaction

15.2.4.5. Contractor shall submit 95% of all clean encounter claims within 30 calendar days after the month the claim was paid or denied, and 100% of all clean encounter claims within 120 calendar days after the month the claim was paid or denied, following the methodology developed by the Department. Contractor shall submit Encounter Data into the MMIS each month. The Department will measure performance on a monthly basis.

15.2.4.6. 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 the 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 the Department.

15.2.4.7. Contractor shall meet or exceed a 98% reported clean encounter claims acceptance rate for the measurement quarter, following the methodology developed by the Department. The Department will measure performance on a quarterly basis. At the discretion of the Department, or at the request of the Contractor, the accuracy rate may be adjusted to account for Department system changes. Contractor shall develop and implement a plan to meet this standard.

15.2.4.8. 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.

15.2.4.8.1. DELIVERABLE: Certified Encounter Data submission

15.2.4.8.2. DUE: Monthly, on the last Business Day of the month

15.2.4.9. 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.

15.2.4.10. 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.

15.2.4.11. Contractor shall comply with changes in Department data format requirements as necessary. The 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.

15.2.5. Flat File Submission

15.2.5.1. Contractor shall on a quarterly basis 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 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.

15.2.5.1.1. The Department will provide Contractor with the specifications for the Flat File Submission using a Flat File Specifications document. The Department will collaborate on proposed changes to the Flat File Specifications document with Contractor at least 90 days in advance of implementation. In the event that collaborative agreement cannot be achieved, the Department retains the right to make the final decision regarding format submission requirements.

15.2.5.1.2. The Department shall conduct a quality review of the submission to determine if flat

file meets the required specifications.

15.2.5.1.3. The Department will notify Contractor within 45 Business Days if it discovers errors or incomplete data on a submitted flat file encounter claim upon validation. Contractor shall correct and resubmit the encounter claim within 14 calendar days of notification by the Department.

15.2.5.2. DELIVERABLE: Certified Flat File Submission

15.2.5.3. DUE: For Capitated Behavioral Health Benefit, quarterly, 21 days after the state fiscal year quarter ends.

15.2.5.4. DUE: For covered medical services, quarterly, 15 calendar days after the state fiscal quarter year ends.

15.2.5.5. Contractor shall submit a flat file that contains 95% of paid claim lines within 30 days of the claim paid quarter.

15.2.5.6. Contractor shall submit a flat file that contains 100% of paid claim lines within 60 days of the claim paid quarter.

15.2.5.7. Contractor shall be responsible for the accuracy of flat file submissions.

15.2.5.8. Flat file accuracy is determined monthly for completeness of data fields, and annually for completeness of inclusion of all claims.

15.2.5.9. Annual Submission

15.2.5.9.1. 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.

15.2.5.9.1.1.1. The Department will provide Contractor with the specifications for the annual flat file submission.

15.2.5.9.1.1.2. The Department will conduct a quality review of the annual submission to determine if the flat file meets the required specifications.

15.2.5.9.2. DELIVERABLE: Certified Annual Flat File

15.2.5.9.3. DUE: For capitated behavioral health benefit, annually, by October 31

15.2.5.9.4. DUE: For covered medical services, annually, by October 31

16. OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

16.1. Continuous Quality Improvement

16.1.1. 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.

16.1.2. 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.

16.1.3. Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for both the MCO and PIHP.

16.2. Quality Improvement Program

16.2.1. 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.

16.2.2. Contractor's Quality Improvement Program for the managed care capitation initiative shall align with the 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 the following:

16.2.2.1. Performance improvement projects.

16.2.2.2. Collection and submission of performance measurement data, including Member experience of care.

16.2.2.3. Mechanisms to detect both underutilization and overutilization of services.

16.2.2.4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs, as defined by the Department, and in accordance with any applicable state quality assurance and utilization review standards.

16.2.2.4.1. Mechanisms to review and revise reassessment of functional need for Members with special health care needs, at least every 12 months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

16.2.2.4.2. Mechanisms to allow Members with special health care needs to directly access a specialist as appropriate for the Member's condition and identified needs.

16.2.2.5. Quality of care concerns.

16.2.2.6. External Quality Review.

16.2.2.7. Advisory committees and learning collaboratives.

16.2.3. Contractor shall develop and submit a Quality Improvement Plan to the 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 the Department's direction.

16.2.3.1. DELIVERABLE: Quality Improvement Plan

16.2.3.2. DUE: January 1, 2020

16.2.4. Upon Department approval, Contractor shall implement the Quality Improvement Plan.

16.2.5. Contractor shall review and update the Quality Improvement Plan at least one time annually.

16.2.5.1. DELIVERABLE: Quality Improvement Plan Update

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

16.2.6. Contractor shall create an Annual Quality Report to the Department and/or designee,

detailing the progress and effectiveness of each component of its Quality Improvement Program. Contractor shall include the following in the report:

16.2.6.1. A description of the techniques Contractor used to improve its performance

16.2.6.2. A description of the qualitative and quantitative impact the techniques had on quality

16.2.6.3. The status and results of each Performance Improvement Project conducted during the year

16.2.6.4. Opportunities for improvement

16.2.7. Contractor shall submit the Annual Quality Report to the Department.

16.2.7.1. DELIVERABLE: Annual Quality Report

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

16.2.8. Contractor shall publicly post its Annual Quality Report.

16.3. Performance Improvement Projects

16.3.1. 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.

16.3.2. Contractor shall complete Performance Improvement Project annual reports 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.

16.3.3. Contractor shall have a minimum of two Performance Improvement Projects chosen in collaboration with the Department: one clinical project that may include physical health integration into behavioral health and one non-clinical project.

16.3.3.1. Contractor shall conduct Performance Improvement Projects on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a particular topic.

16.3.4. Contractor shall have the capacity to conduct up to two additional Performance Improvement Projects upon request from CMS.

16.3.5. Contractor shall ensure that Performance Improvement Projects include the following:

16.3.5.1. Measurement of performance using objective quality indicators.

16.3.5.2. Implementation of system interventions to achieve improvement in quality.

16.3.5.3. Evaluation of the effectiveness of the interventions.

16.3.5.4. Planning and initiation of activities for increasing or sustaining improvement.

16.3.6. Contractor shall participate in a Performance Improvement Project learning collaborative at the end of each Performance Improvement Project cycle hosted by the Department that includes sharing of data, outcomes, and interventions.

16.3.7. Contractor shall submit Performance Improvement Projects for validation by the 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. These requirements include:

16.3.7.1. Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction

16.3.7.2. Mechanisms to detect both under-utilization and over-utilization of services

16.3.7.3. Mechanisms designed to assess the quality and appropriateness of care furnished to Members with special health care needs

16.3.7.4. Measurement of performance using objective valid and reliable quality indicators

16.3.7.5. Implementation of system interventions to achieve improvement in quality

16.3.7.6. Empirical evaluation of the effectiveness of the interventions

16.3.8. Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report described in 16.2.6.

16.4. Performance Measurement

16.4.1. As applicable to the managed care capitation initiative, Contractor shall participate in the measurement and reporting of performance measures required by the Department, with the expectation that this information will be placed in the public domain.

16.4.2. Contractor shall consult with the Department to develop measurement criteria, reporting frequency and other performance measurement components. The Department will determine the final measurement and pay for performance criteria.

16.4.3. Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

16.4.4. Contractor shall provide data, as requested, to enable the Department or its designee to calculate the performance measures, unless the data is already in the Department's possession.

16.4.5. Contractor shall support Network Providers and care coordinators to collect and report information required to calculate the performance measures.

16.4.6. Contractor shall track their performance on identified measures monthly through the BIDM System and other data resources as appropriate.

16.4.7. Contractor shall have the opportunity to provide comments regarding any and all of the Department's documented calculation methodologies for pay for performance measures prior to the first distribution of funds.

16.4.8. Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

16.4.8.1. Healthcare Effectiveness Data and Information Set (HEDIS)

16.4.8.1.1. Contractor shall calculate and submit specified HEDIS measures, and core set measures as required by the Department, as updated by CMS annually. Contractor shall track the CMS core measure set development to ensure reporting on the current measure set. The Department will collaborate with Contractor's quality improvement committee to designate the required measures.

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

16.4.8.1.3. Contractor shall contract with a NCQA (National Committee for Quality Assurance) certified individual entity to perform an external audit of the HEDIS measures

according to HEDIS protocols.

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

16.4.8.1.4.1. During any HEDIS year in which more than three required HEDIS measures are considered not compliant, Contractor shall re-calculate and submit the previously invalid measure rates within 30 days from the date of the invalid measure. Contractor shall ensure those measure rates are audited by an NCQA certified individual entity.

16.4.9. Alignment with the RAE Accountable Care Collaborative Pay for Performance

16.4.9.1. Contractor shall work to improve performance for up to nine Key Performance Indicators (KPIs). KPIs will be established at the Department's discretion to align with new statewide initiatives and through consultation with the Department, RAEs, and stakeholders.

16.4.9.1.1. Following the first year of the Contract, the Department may include a public health measure as a KPI, reflecting the RAE's role in the Health Neighborhood and Community addressing social determinants of health.

16.4.9.1.2. Contractor shall calculate and report quarterly to the Department performance on the KPIs.

16.4.9.1.2.1. DELIVERABLE: KPI Performance Reporting

16.4.9.1.2.2. DUE: Quarterly, within 150 calendar days following the reporting quarter

16.4.9.1.3. The KPIs are:

16.4.9.1.3.1. Emergency Department (ED) Visits – A ratio of the number of Emergency Room Visits per-set-member-count per-performance-period

16.4.9.1.3.2. Behavioral Health Engagement – Percent of Members who received a behavioral health service delivered either in primary care settings or under the Capitated Behavioral Health Benefit within the evaluation period

16.4.9.1.3.3. Child and Adolescent Well Visits – Percent of child and adolescent Members who received the appropriate minimum number of well visits within the evaluation period

16.4.9.1.3.4. Prenatal Care – Percent of women who gave birth who received a prenatal visit during pregnancy

16.4.9.1.3.5. Dental Visit – Percent of Members who received professional dental services

16.4.9.1.3.6. Detailed KPI specifications can be found in the data specifications document developed and maintained by the Department. This specifications document may be updated at any time by the Department in collaboration with Contractor.

16.4.9.2. Behavioral Health Incentive Program

16.4.9.2.1. Subject to available funding, Contractor may be eligible to participate in a Behavioral Health Incentive Program as described in, Exhibit E.

16.4.9.2.2. Detailed Behavioral Health Incentive Program measure specifications can be found in the data specifications document developed and maintained by the Department.

This specifications document may be updated at any time by the Department in collaboration with Contractor.

16.4.10. Additional Performance Measurement

16.4.10.1. Public Reporting

16.4.10.1.1. 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:

16.4.10.1.2. Clinical and Utilization Measures as relevant, including CMS Core Measures and HEDIS measures that align with CPC+ and other state and federal initiatives

16.4.10.1.3. Member experience of care as described in Section 16.5.

16.4.10.1.4. Operational and financial data including member enrollment and summary financial information.

16.4.10.2. Contractor will not be eligible to earn payments for performance on the Public Reporting measures unless, the Department, at its discretion, allows Contractor to earn performance payments on one or more of the Public Reporting measures.

16.4.10.3. Contractor may, at its discretion, use any of the Public Reporting measures to establish a pay for performance program for Contractor's Network Providers.

16.4.10.4. Health Equity and Performance Improvement

16.4.10.4.1. 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 the Department and stakeholders upon request.

16.4.10.4.2. Contractor shall collaborate with the Department and stakeholders in the development of health equity measures, which may require the addition of new measures or the adjustment of existing measures.

16.4.10.4.3. Over the performance period for any or all performance measures, Contractor shall collaborate with the 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.

16.5. Member Experience of Care

16.5.1. 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.

16.5.2. 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.

16.5.2.1. Contractor shall submit monthly average speed of answer data from its Member contact center in the Call Line Statistics Report.

16.5.3. Contractor shall administer an annual Consumer Assessment of Health Plan Survey (CAHPS) with Department identified survey supplements, for both adults and children to measure satisfaction with their enrollees.

16.5.3.1. Contractor shall administer the CAHPS through a certified survey vendor in compliance with appropriate survey protocols.

16.5.3.2. Contractor shall share the survey results with the Department immediately following NCQA annual submission.

16.5.4. Contractor shall develop and implement a comprehensive assessment for those Members identified by the State as requiring long-term support services or having special health care needs. The comprehensive assessment shall identify any special conditions that necessitate a special treatment and care coordination plan or regular care monitoring, pursuant to 42 CFR 438.208(c)(2).

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

16.5.5.1.

16.5.6. Contractor shall inform the Department if they conduct any additional surveys of Members and share findings through the Operational Learning Collaborative.

16.5.7. Contractor shall use the results and data from CAHPS and all other surveys conducted by Contractor to inform Contractor's Quality Improvement Plan.

16.5.8. Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

16.5.8.1. Contractor shall monitor interventions and report on them at least one time annually at the Operational Learning Collaborative.

16.5.8.2. 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.

16.6. Mechanisms to Detect Overutilization and Underutilization of Services

16.6.1. 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.

16.7. Quality of Care Concerns

16.7.1. Contractor shall investigate any alleged Quality of Care (QOC) concerns, which are defined as concerns raised by the Department or Providers, or concerns discovered by Contractor. Contractor shall not consider Member complaints about care to be QOC concerns and should process these complaints as Grievances, unless the Department instructs otherwise.

16.7.1.1. Contractor shall have a system for identifying and addressing all alleged QOC concerns.

16.7.2. When a QOC concern is raised, Contractor shall investigate, analyze, track, trend and resolve QOC concerns by doing the following, but not limited to:

16.7.2.1. Investigate the QOC issue(s).

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

16.7.2.3. Refer QOC issues to Contractor's peer review committee, when appropriate.

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

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

16.7.2.6. Notify the Department that Contractor has received a QOC.

16.7.2.7. Document the incident in a QOC summary to be sent to the Department. This summary shall include, at a minimum:

16.7.2.7.1. The name and contact information of the originator of the QOC concern.

16.7.2.7.2. A description of the QOC concern including issues, dates and involved parties.

16.7.2.7.3. All steps taken during the QOC investigation and resolution process.

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

16.7.2.7.5. Evidence of the QOC resolution.

16.7.2.7.6. A copy of the acknowledgement letter.

16.7.2.7.7. Any referral made by Contractor to peer review, a regulatory agency or a licensing board or agency.

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

16.7.2.7.9. Any outcome of the review as determined by Contractor.

16.7.2.8. For QOC concerns involving Network Providers, Contractor may use the process of its professional review committee, as set forth in Sections 12-36.5-104 and 12-36.5- 104.4, C.R.S.

16.7.2.9. Contractor shall submit a letter to the Department, upon request, that includes a brief description of the QOC concern, the efforts that Contractor took to investigate the concern and the outcome of the review as determined by Contractor.

16.7.2.9.1. Contractor shall include a description of whether the issue was found to be a QOC issue and what action Contractor intends to take with the Provider(s) involved.

16.7.2.9.2. Contractor shall not include in its letter the names of the persons conducting the investigation or participating in a peer review process.

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

16.7.2.9.4. Contractor shall send the complete letter within ten Business Days of the Department's request. Upon request from Contractor, the Department may allow additional time to investigate and report.

16.7.2.9.5. DELIVERABLE: QOC Letter

16.7.2.9.6. DUE: Within ten Business Days of the Department's request

16.8. External Quality Review

16.8.1. 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.

16.8.2. Contractor shall participate in an external quality review that includes a review of the:

16.8.2.1. Contractor’s activities in its role as a MCO.

16.8.2.2. Contractor's activities in its role as a PIHP for the Capitated Behavioral Health Benefit.

16.8.2.3. Contractor’s administration of the Contract as an integrated program.

16.8.3. Contractor shall participate in an annual external review that may include, but is not limited to, the following:

16.8.3.1. 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 the Department or its vendors.

16.8.3.2. Performance improvement projects and studies.

16.8.3.3. Surveys.

16.8.3.4. Network adequacy during the preceding 12 months.

16.8.3.5. Calculation and audit of quality and utilization indicators.

16.8.3.6. Administrative data analyses.

16.8.3.7. Review of individual cases.

16.8.3.8. Care Coordination record review.

16.8.3.9. Provider site visits.

16.8.3.10. Encounter Data validation.

16.8.4. 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 the Department.

16.9. Advisory Committees and Learning Collaboratives

16.9.1. 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.

16.9.2. Program Improvement Advisory Committees (PIAC)

16.9.2.1. Contractor shall participate in both a regional and local PIAC to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Members and providers in the Program.

16.9.2.2. Contractor shall ensure that the local PIAC includes, at a minimum, the following stakeholder representatives:

16.9.2.2.1. Members.

16.9.2.2.2. Members’ families and/or caregivers.

16.9.2.2.3. PCMPs.

16.9.2.2.4. Behavioral health providers.

16.9.2.2.5. Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

16.9.2.2.6. Other individuals who can represent advocacy and Community organizations, local public health, and child welfare interests.

16.9.2.3. For the regional PIAC, Contractor shall:

16.9.2.3.1. Designate one of Contractor's Key Personnel to attend monthly meetings.

16.9.2.3.2. Nominate one representative from Contractor's local PIAC to serve as members of the regional PIAC and ensure they consistently attend and participate in monthly meetings. The representative cannot be employed by Contractor.

16.9.2.3.3. The Department may, at its own discretion, direct greater alignment and engagement between Contractor's local PIAC and the regional PIAC.

16.9.2.4. Contractor shall create a local PIAC with the following responsibilities:

16.9.2.4.1. Review Contractor's deliverables.

16.9.2.4.2. Discuss program policy changes and provide feedback.

16.9.2.4.3. Provide representatives for the statewide PIAC.

16.9.2.4.4. Review Contractor's and Program's performance data.

16.9.2.4.5. Review Member materials and provide feedback.

16.9.2.5. Contractor shall ensure that its local PIAC:

16.9.2.5.1. Be directed and chaired by one of Contractor's Key Personnel.

16.9.2.5.2. Have a formal, documented membership and governance structure that is posted on Contractor's website for public viewing.

16.9.2.5.3. Have a formal budget for the operations of the local PIAC.

16.9.2.5.4. 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.

16.9.2.5.4.1. Contractor shall ensure that Members and their family or caregivers feel safe providing feedback and, depending on the needs of the region, may develop additional opportunities for Members and their family or caregivers to provide their feedback.

16.9.2.5.5. Open all scheduled meetings to the public.

16.9.2.5.6. Post the minutes of each meeting on Contractor's website within 30 days of each meeting.

16.9.2.5.7. Accommodate individuals with disabilities.

16.9.3. Quality Improvement Committee

16.9.3.1. Contractor shall have its Quality Improvement Director participate in the 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.

16.9.4. Operational Learning Collaborative

16.9.4.1. Contractor shall participate in Department Operational Learning Collaborative meetings to monitor and report on Contractor and Accountable Care Collaborative activities including, but not limited to, the following.

16.9.4.1.1. Wellness activities.

16.9.4.1.2. Provider payment models.

16.9.4.1.3. Health Promotion and Population Stratification and Management.

16.9.4.1.4. Member engagement.

16.9.4.1.5. Health Neighborhood and Community development.

16.9.4.1.6. Provider support and practice transformation.

16.9.4.1.7. Data analytics.

16.9.4.1.8. Care Coordination, including cross-agency, cross-system activities.

16.9.4.1.9. Health information initiatives and technologies.

16.9.4.1.10. Strategies used to address social determinants of health.

16.9.4.1.11. Transitions of care, including hospital discharge and LTSS Members transitioning to the community.

16.9.4.1.12. Contractor shall participate in annual and ad hoc learning collaboratives to monitor specific program activities and share lessons learned.

16.10. Quarterly Leadership Meeting

16.10.1. Contractor shall host a quarterly meeting with Department leadership (to include the Executive Director) to review the following:

16.10.1.1. Performance reports that summarize Contractor performance, including:

16.10.1.1.1. Care Coordination.

16.10.1.1.2. Population Health Management Report.

16.10.1.1.3. Network Adequacy Report.

16.10.1.1.4. Grievances and Appeals.

16.10.1.1.5. Member Engagement.

16.10.1.1.6. Administrative Payment Arrangements.

16.10.1.1.7. Client Over-Utilization Program.

16.10.1.2. Areas of opportunity and challenge to be addressed for Contractor to improve performance, including barriers to properly address those opportunities and challenges.

16.10.1.3. Provider areas of opportunity and where the Department can be of assistance.

16.11. Ad Hoc Quality Reports

16.11.1. Contractor shall provide to the Department or its agents any information or data relative to the Contract. In such instances, and at the direction of the 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.

16.11.1.1. Contractor shall have at least 30 calendar days, or a timeframe mutually agreed upon between the Department and Contractor, to fulfill such requests.

16.11.1.2. Contractor shall certify that data and information it submits to the Department is accurate.

16.11.1.3. DELIVERABLE: Ad Hoc Quality Reports

16.11.1.4. Due: At the direction of the Department

16.12. Health Plan Management Metrics

16.12.1. Contractor shall collaborate with the Department in establishing a set of health plan management metrics that are based on industry standards to improve administration of the ACC program. Health plan management metrics may include, but are not limited to, the following:

16.12.1.1. Claim payment statistics.

16.12.1.2. Member grievance reporting.

16.12.1.3. Provider response statistics.

16.12.1.4. Provider contracting status reporting.

16.12.2. Contractor shall partner with the Department in good faith to incorporate the agreed upon health plan management metrics into ongoing ACC program monitoring and performance accountability.

17. COMPLIANCE AND PROGRAM INTEGRITY

17.1. Program Integrity Compliance Program Requirements

17.1.1. 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.

17.1.2. Contractor shall comply with all applicable CMS regulations in 42 C.F.R. § 438.

17.1.3. Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by Contractor for coverage of services and payment of claims under the Contract, shall have a compliance program to implement and maintain arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Program Abuse.

17.1.4. The compliance program shall be approved by Contractor's Chief Program Officer and Compliance Officer.

17.1.5. Contractor shall ensure that the compliance program, at a minimum includes:

17.1.5.1. Written policies and procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements.

17.1.5.2. 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.

17.1.5.3. 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.

17.1.5.4. 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.

17.1.5.4.1. Contractor shall ensure that this training is conducted in a manner that allows the Department to verify that the training has occurred.

17.1.5.5. Effective lines of communication between the Compliance Officer and Contractor's employees.

17.1.5.6. Enforcement of standards through well publicized disciplinary guidelines.

17.1.5.7. Establishment and implementation of procedures and a program integrity infrastructure that includes adequate systems and staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, 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:

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

17.1.5.7.2. Processes to screen all provider claims processed or paid by Contractor collectively and individually, for Suspected Fraud, Waste or Program Abuse.

17.1.5.7.3. Processes to identify 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.

17.1.5.7.4. Processes to recover Overpayments to providers.

17.1.5.7.5. Processes to identify and promptly report to the Department instances of Suspected Fraud, Waste and Program Abuse.

17.1.5.7.6. Processes for 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.

17.1.5.8. Requirements for Network Providers to report to Contractor when they have received an Overpayment, to return the Overpayment to Contractor, and to notify Contractor in writing of the reason for the Overpayment within 60 calendar days after the date on which the Overpayment was identified.

17.1.5.8.1. Contractor shall have a process for Network Providers to report and return Overpayments to Contractor.

17.1.5.8.2. Contractor shall have a process for notifying the Department of an identified Overpayment within five business days. Contractor shall supply the Department the

information submitted by a Network Provider related to an identified Overpayment within 30 calendar days of receiving the same information.

17.1.5.9. 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.

17.1.5.10. Contractor shall comply with the Department policies related to recoveries of Overpayments.

17.1.5.10.1. For the capitated behavioral health benefit described in Section 14, Contractor shall not retroactively recover provider payments if:

17.1.5.10.1.1. 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

17.1.5.10.1.2. Contractor makes an error processing the claim, but the claim is otherwise accurately submitted by the provider.

17.1.5.10.2. For the capitated behavioral health benefit described in Section 14, Contractor shall not retroactively recover provider payments after 12 months from the date a claim was paid, except:

17.1.5.10.2.1. When Medicare, Commercial insurance, or third-party liability is the primary payer for a claim.

17.1.5.10.2.2. The claim is the subject of a state or federal audit, including audits contractually required by the Department.

17.1.5.10.2.3. The claim is subject to a law enforcement investigation.

17.1.5.10.2.4. The claim submitted was a duplicate.

17.1.5.10.2.5. The claim is fraudulent.

17.1.5.10.2.6. The provider improperly billed the claim.

17.1.5.10.2.7. The claim was submitted with a billing code or diagnosis code that inaccurately or incorrectly resulted in reimbursement or bypassed prior authorization requirements.

17.1.5.10.3. For the capitated behavioral health benefit described in Section 14, 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.

17.1.6. Contractor shall have a process for the prompt referral to the Department and the State Medicaid Fraud Control Unit 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 Section.

17.1.6.1. 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.

17.1.6.2. 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.

17.1.6.3. False representation is any inaccurate statement that is relevant to a claim for reimbursement and is made by a provider or client who has actual knowledge of the truth or false nature of the statement, or by a provider or client who has actual knowledge of the truth or false nature of the statement, or by a provider or client acting in deliberate ignorance of or with reckless disregard for the truth of the statement.

17.1.6.4. DELIVERABLE: Compliance Program documents and information

17.1.6.5. DUE: Annually, by July 31

17.1.7. Contractor shall modify the Compliance Program as requested by the Department within ten Business Days following the receipt of the Department's requested changes.

17.1.7.1. DELIVERABLE: Compliance Program revisions and changes

17.1.7.2. DUE: Within ten Business Days following the Department's request

17.2. Compliance Plan Requirements

17.2.1. Contractor shall have a documented Compliance Plan that implements all elements of the Compliance Program.

17.2.2. Contractor shall ensure adequate and dedicated staffing and resources needed in order to successfully implement the Compliance Plan and routinely monitor providers and clients to detect and prevent aberrant billing practices, potential Fraud, Waste, Program Abuse and promptly address potential compliance issues and problems.

17.2.3. Contractor shall ensure the Compliance Plan, at minimum, includes:

17.2.3.1. A risk assessment of Contractor's various Fraud, Waste, and Program Abuse and program integrity processes.

17.2.3.2. An outline of activities proposed for the next reporting year regarding compliance and audit activities, including, but not limited to:

17.2.3.2.1. Conducting prospective, concurrent, and/or post-payment reviews of claims, including, but not limited to medical records reviews, data mining, and desk audits;

17.2.3.2.2. Verifying provider adherence to professional licensing and certification requirements;

17.2.3.2.3. Verifying provider records and other documentation to ensure services billed by providers were actually rendered;

17.2.3.2.4. Reviewing goods provided and services rendered for Fraud, Waste and Program Abuse;

17.2.3.2.5. 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).

17.2.3.2.5.1. Contractor shall not include activities related to administrative billing issues, such as financial statement audits.

17.2.3.3. An outline of activities proposed for the next reporting year regarding 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.

17.2.3.4. An outline of activities proposed for the next reporting year regarding 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.

17.2.3.5. 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:

17.2.3.5.1. Automated pre-payment claims edits.

17.2.3.5.2. Automated post-payment claims edits.

17.2.3.5.3. Desk audits on post-payment review of claims.

17.2.3.6. 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.

17.2.4. Contractor shall submit its Compliance Plan to the Department for review and approval. Contractor shall only submit finalized Compliance Plans; the Department will not accept draft versions.

17.2.4.1. DELIVERABLE: Compliance Plan

17.2.4.2. DUE: July 31, 2020

17.2.5. On an annual basis, Contractor shall review its Compliance Plan and make any necessary revisions for the following reporting year. Contractor shall submit revised Compliance Plans to the Department for review and approval.

17.2.5.1. DELIVERABLE: Compliance Plan documents and information

17.2.5.2. DUE: Annually, by July 31

17.2.6. Contractor shall modify the Compliance Plan as requested by the Department within ten Business Days following the receipt of the Department's requested changes.

17.2.6.1. DELIVERABLE: Compliance Plan revisions and changes

17.2.6.2. DUE: Within ten Business Days following the Department's request

17.3. Reports and Disclosures

17.3.1. Contractor shall follow all requirements in this Statement of Work Section 17.3 to notify the Department of all work, activities, and events occurring under the requirements of Statement of Work Section 17.1.

17.3.1.1. Reports Requiring Monthly Notification

17.3.1.1.1. 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.

17.3.1.1.2. Contractor shall report, at minimum:

17.3.1.1.2.1. All 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;

17.3.1.1.2.2. All suspended claim reimbursements and payments to a provider, including information whether the suspension is related to an audit or Fraud case and dates of when reimbursements and payments were suspended;

17.3.1.1.2.3. 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;

17.3.1.1.2.4. Any provider terminations not based on quality or performance or for cause, including but not limited to:

17.3.1.1.2.4.1. A change in ownership or control of a provider.

17.3.1.1.2.4.2. A provider voluntarily withdrawing from the MCE's network; and

17.3.1.1.2.4.3. The death of a provider.

17.3.1.1.2.4.3.1. Contractor shall provide the following:

17.3.1.1.2.4.3.2. Date of removal.

17.3.1.1.2.4.3.3. Reason for the termination.

17.3.1.1.2.4.3.4. Numbers of members served by the provider; and

17.3.1.1.2.4.3.5. Plan to ensure that members receive continuous services.

17.3.1.1.2.5. Any other information as specified by the Department.

17.3.1.1.3. Contractor shall use the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

17.3.1.1.3.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report

17.3.1.1.3.2. DUE: Within ten Business Days after the end of each month.

17.3.1.1.4. Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten Business Days following the receipt of the Department's requested changes.

17.3.1.1.4.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

17.3.1.1.4.2. DUE: Within ten Business Days following the Department's request

17.3.1.2. Reports Requiring Semi-Annual Notification

17.3.1.2.1. 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.

17.3.1.2.2. The six month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

17.3.1.2.3. Contractor shall use the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

17.3.1.2.4. Contractor shall report, at minimum:

17.3.1.2.4.1. All audits or reviews which have been started, are on-going or completed as part of the Compliance Program and Compliance Plan, including issue(s) being reviewed or audited, the status of the review or audit, the start and end dates of services covered by the review or audit, and the start and end dates of the review or audit;

17.3.1.2.4.2. All instances of Suspected Fraud, Waste and Program Abuse, discovered and reported to the Department and the MFCU, including the suspected issue, the start and end dates of the services suspected to involve Fraud, the approximate amount of the claims affected and the date of report to the Department and the MFCU;

17.3.1.2.4.3. All verification conducted of member services, including the number of notices sent to Members to verify and report whether services billed by providers were actually received by Members, the number of responses received, number of responses warranting further action.

17.3.1.2.4.4. All identified and 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, dates of when Overpayments were identified, and dates when Overpayments were recovered; and

17.3.1.2.4.5. Any other information as specified by the Department.

17.3.1.2.5. Contractor shall not include activities related to administrative billing issues, such as reviews of financial statements or credit balances.

17.3.1.2.5.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Report

17.3.1.2.5.2. DUE: Within 45 days of the end of the six month reporting period

17.3.1.2.6. Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten Business Days following the receipt of the Department's requested changes.

17.3.1.2.6.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

17.3.1.2.6.2. DUE: Within ten Business Days following the Department's request

17.3.1.3. Disclosures Requiring Prompt Notification

17.3.1.3.1. Provider Terminations

17.3.1.3.1.1. Contractor shall notify the Department of its 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

17.3.1.3.1.2. Contractor shall provide the following:

17.3.1.3.1.2.1. Provider’s name and identification number.

17.3.1.3.1.2.2. Date of removal.

17.3.1.3.1.2.3. Number of members served by the provider.

17.3.1.3.1.2.4. Reason for the termination.

17.3.1.3.1.2.5. Narrative describing how Contractor intends to provide or services for affected members after the termination; and

17.3.1.3.1.2.6. Any information as required by the Department.

17.3.1.3.1.2.7. DELIVERABLE: Notice of Network Provider Termination for Quality of Performance or For Cause

17.3.1.3.1.2.8. DUE: Within two Business Days of the decision to terminate for quality or performance issue terminations or terminations for cause

17.3.1.3.2. Changes in Member Circumstances Affecting Eligibility

17.3.1.3.2.1. In accordance with 42 C.F.R. 438.608 (a)(3), Contractor shall promptly notify the 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:

17.3.1.3.2.1.1. Changes in the Member’s residence.

17.3.1.3.2.1.2. The death of a Member.

17.3.1.3.2.2. Contractor shall use the Provider/Member Change in Circumstance Disclosure template.

17.3.1.3.2.3. Contractor shall provide the following:

17.3.1.3.2.3.1. The member’s name.

17.3.1.3.2.3.2. Medicaid ID number.

17.3.1.3.2.3.3. Date of change.

17.3.1.3.2.3.4. Description of the change; and

17.3.1.3.2.3.5. Any information as required by the Department.

17.3.1.3.2.3.6. DELIVERABLE: Monthly Member Change in Circumstance Disclosure Report

17.3.1.3.2.3.7. DUE: Within ten Business Days after the end of each month.

17.3.1.4. Disclosures Requiring Notification within 30 Days

17.3.1.4.1. Provider Licensure and Professional Review Actions

17.3.1.4.1.1. 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 list of reportable actions:

17.3.1.4.1.1.1. Malpractice payments.

17.3.1.4.1.1.2. Licensure and certification actions.

17.3.1.4.1.1.3. Negative actions or findings.

17.3.1.4.1.1.4. Adverse actions.

17.3.1.4.1.1.5. Health Care-related Criminal Convictions.

17.3.1.4.1.1.6. Health Care-related Civil Judgments.

17.3.1.4.1.1.7. Exclusions from Federal or state health care programs; and

17.3.1.4.1.1.8. Other adjudicated actions of decisions.

17.3.1.4.1.1.8.1. DELIVERABLE: Notification of Adverse Licensure of Professional Review

17.3.1.4.1.1.8.2. DUE: Must be submitted to the Department and National Practitioner Data Bank within 30 days following the action being reported.

17.3.1.5. Disclosures Requiring Notification within 60 days

17.3.1.5.1. Overpayments and Excess Capitation Payments

17.3.1.5.1.1. 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 the Department.

17.3.1.5.1.2. Contractor shall provide the following:

17.3.1.5.1.2.1. Client information.

17.3.1.5.1.2.2. Claims information.

17.3.1.5.1.2.3. Encounter Data information.

17.3.1.5.1.2.4. Paid amounts.

17.3.1.5.1.2.5. Provider information.

17.3.1.5.1.2.6. Dates of when Overpayment was identified and recovered.

17.3.1.5.1.2.7. Recovery amounts.

17.3.1.5.1.2.8. Capitation information; and

17.3.1.5.1.2.9. Any information as required by the Department.

17.3.1.5.1.3. Contractor shall use the Overpayment and Recovery Disclosure template.

17.3.1.5.1.3.1. DELIVERABLE: Overpayment and Recovery Notification Disclosure

17.3.1.5.1.3.2. DUE: Within 60 calendar days of identifying capitation or other payments.

17.4. Fraud, Waste, and Program Abuse

17.4.1. Contractor shall participate in joint meetings, no less than quarterly, held by the Department and the MFCU 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 the Department.

17.4.2. Contractor shall temporarily suspend all review activities or actions related to any provider upon request of the Department.

17.4.3. Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

17.4.4. Contractor shall provide expert assistance to the Department, its Recovery Audit Contractor, and the MFCU, as requested by the 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.

17.4.5. Contractor shall provide expert assistance that includes, but is not limited to, the following topics:

17.4.5.1. Any reports made pursuant to this section.

17.4.5.2. Any medical records review or Medical Necessity findings or determinations made pursuant to this Contract.

17.4.5.3. Provider treatment and business practices.

17.4.5.4. Provider billing practices and patterns.

17.4.5.5. Contractor shall meet with the Department, its contractors or the MFCU to explain any reports or findings made pursuant to the section. It shall cooperate with and provide assistance with any review, recovery effort, informal reconsideration, Appeal or investigation conducted by the federal or state government, law enforcement, the Program Integrity Section, the Department's contractors, federal or state auditors, or any other entity engaged in program integrity functions.

17.4.6. Contractor shall not take any kind of recovery action or initiate any kind of activity against a Network Provider when possible Fraud is suspected without the approval of the Department.

17.4.7. Contractor shall not take any action that might interfere with an investigation of possible Fraud by the Department, the Medicaid Fraud Control Unit (MFCU), or any other law enforcement entity. Contractor shall assist the Department, the MFCU or any other law enforcement entity as requested with any preliminary or full investigation.

17.4.8. 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 the Department.

17.5. Provider Fraud

17.5.1. Contractor shall notify the 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.

17.5.2. Upon identification or suspicion of suspected provider Fraud, Contractor shall use the MCO Suspected Fraud Written Notice template to notify the Department and the MFCU in writing.

17.5.3. Contractor shall provide the following, at minimum:

17.5.3.1. Written documentation of the findings.

17.5.3.2. Information on any verbal or written reports.

17.5.3.3. Copies of any written reports.

17.5.3.4. All details of the findings and concerns, including a chronology of Contractor actions which resulted in the reports, in a mutually agreed upon format.

17.5.3.5. Information on the identification of any affected claims that have been discovered.

17.5.3.6. Any claims data associated with its report (in a mutually agreed upon format, if possible).

17.5.3.7. Any information as required by the Department.

17.5.3.7.1. DELIVERABLE: Managed Care Suspected Fraud Written Notice

17.5.3.7.2. DUE: Within three Business Days from the initial discovery to the Department and the MCFU

17.5.4. 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 the Department or MFCU.

17.5.4.1. DELIVERABLE: Managed Care Suspected Fraud Written Notice Revisions and Additional Information

17.5.4.2. DUE: Within three Business Days following the Department's or the MFCU's request

17.6. Member Fraud

17.6.1. Contractor shall notify the 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.

17.6.2. 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 the Department at report.clientfraud@state.co.us.

17.6.3. Contractor shall provide the following, at minimum:

17.6.3.1. All verbal and written reports related to the Suspected Fraud;

17.6.3.2. 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;

17.6.3.3. Information regarding the identification of any affected claims that have been discovered;

17.6.3.4. Any claims data associated with its report (in a mutually agreed upon format, if possible); and

17.6.3.5. Any information as required by the Department.

17.6.3.5.1. DELIVERABLE: Managed Care Suspected Member Fraud Written Notice

17.6.3.5.2. DUE: Within three Business days from the initial discovery to the Department

17.7. Suspension of Payments Due to a Credible Allegation of Fraud

17.7.1. Contractor shall suspend payments due to a Credible Allegation of Fraud in full or in part only at the direction of the Department, in accordance with 42 C.F.R. § 455.23.

17.7.2. Contractor shall release suspended payment amounts to the provider within one payment cycle when directed to do so by the Department.

17.7.3. 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.

17.7.4. The Department may suspend payments to Contractor if Contractor is under investigation for a Credible Allegation of Fraud.

17.7.5. When Contractor has suspended payments to a provider due to a Credible Allegation of

Fraud, Contractor shall create and provide to the Department a monthly report of payments which have been suspended.

17.7.5.1. DELIVERABLE: Suspended Payments Report

17.7.5.2. 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

17.8. Quality Improvement Inspection, Monitoring and Site Reviews

17.8.1. Contractor shall enable and support the Department or its designee to conduct site reviews of Contractor's, Subcontractors' or providers' locations on an annual basis or more frequently if the 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.

17.8.2. Site Reviews may include but are not limited to determining compliance with state and federal requirements, contracts and Provider agreements, Medicaid service provision and billing procedures, and Medicaid Bulletins and Provider Manuals. Contractor shall cooperate with Department site review activities to monitor Contractor performance.

17.8.3. Contractor shall allow the Department or State to inspect and review Contractor operations for potential risks to the State of Colorado operations or data.

17.8.4. Contractor shall allow the 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. The Department may determine when an emergency review is required in its sole discretion.

17.8.5. Contractor shall fully cooperate with any annual, external, independent review performed by an EQRO or other entity designated by the Department.

17.8.6. 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 the Department or its designee for mutually agreed upon dates for a site review. Final notice of the Site Review schedule and a copy of the monitoring instrument will be mailed to Contractor at least three weeks prior to the visit. Contractor shall submit copies of policies, procedures, manuals, handbooks, reports and other requested materials to facilitate the Department and/or designee's desk audit prior to the Site Review. Contractor has a minimum of 30 days to submit the required materials for non- emergency reviews.

17.8.7. Contractor shall make available, to the Department and its agents for Site Review, all records and documents related to the execution of this Contract, either on a scheduled basis, or immediately on an emergency basis. 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.

17.8.8. The 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 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.

17.8.9. Contractor shall respond to any required actions identified by the 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 the Department or its agents and time frames to implement these remedies. The corrective action plan is subject to approval by the Department. The Department will monitor progress on the corrective action plan until Contractor is found to be in complete compliance. The 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 the Contract.

17.8.9.1. The Department may extend the time frame for corrective action in its sole discretion. The Department may also reduce the time frame for corrective action if delivery of covered services for Members is adversely affected or if the time reduction is in the best interests of Members, as determined by the Department.

17.8.9.2. 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.

17.8.9.3. The Department will not accept any data submitted by Contractor to the Department or its agents after the last site visit day towards compliance with the visit in the written report. The Department will only apply this data toward the corrective action plan.

17.8.10. 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.

17.8.11. In the event that the Site Reviewers wish to inspect a Network Provider location, Contractor shall ensure that:

17.8.11.1. Network Providers make staff available to assist in the audit or inspection effort.

17.8.11.2. Network Providers make adequate space on the premises to reasonably accommodate Department, state or federal personnel conducting the audit or inspection effort.

17.9. Prohibitions

17.9.1. 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.

17.9.1.1. Contractor shall create a Provider Preventable Conditions Report that includes all provider-preventable conditions. Contractor shall submit this report to the Department on an annual basis.

17.9.1.1.1. DELIVERABLE: Provider Preventable Conditions Report

17.9.1.1.2. DUE: Annually, no later than July 31 of each year.

17.9.2. Contractor shall ensure all Network Providers are enrolled with the 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.

17.9.3. The Department will not make payment to Contractor, if Contractor is:

17.9.3.1. An entity that could be excluded from under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual.

17.9.3.2. 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.

17.9.3.3. 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:

17.9.3.3.1. Any individual or entity excluded from participation in federal health care programs.

17.9.3.3.2. Any individual or entity that would provide those services through an excluded individual or entity.

17.9.3.4. Contractor shall not pay a provider or Subcontractor, directly or indirectly, for the furnishing of any good or service if:

17.9.3.4.1. The provider or Subcontractor is excluded from participation in federal health care programs.

17.9.3.4.2. The provider of Subcontractor has a relationship described in the section on prohibited affiliations.

17.9.4. Prohibited Affiliations

17.9.4.1. 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.

17.9.4.2. Contractor shall not knowingly have a relationship with:

17.9.4.2.1. 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.

17.9.4.2.2. 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.

17.9.4.2.3. A person with ownership or more than five percent 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.

17.9.4.2.4. 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.

17.9.4.2.5. 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.

17.9.4.3. Contractor shall provide written disclosure to the 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).

17.9.4.4. If the 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, the Department:

17.9.4.4.1. Must notify the Secretary of the Department of Health and Human Services (Secretary) of the noncompliance.

17.9.4.4.2. May continue an existing agreement with Contractor unless the Secretary directs otherwise.

17.9.4.4.3. May not renew or extend the existing agreement with Contractor unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation.

17.9.5. Prohibited Payments

17.9.5.1. Contractor shall not make payments:

17.9.5.1.1. 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:

17.9.5.1.1.1. 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);

17.9.5.1.1.2. 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

17.9.5.1.1.3. By an individual or entity to whom the 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 the Department determines there is a good cause not to suspend such payments; or

17.9.5.1.2. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;

17.9.5.1.3. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; or

17.9.5.1.4. For home health care services provided by an agency or organization, unless the agency provides the Department with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

17.10. General Compliance and Program Integrity Requirements

17.10.1. Business Transaction Disclosures

17.10.1.1. Contractor shall submit, full and complete information about:

17.10.1.1.1. 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

17.10.1.1.2. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the five year period ending on the date of the request.

17.10.1.2. DELIVERABLE: Disclosure of Business Transactions

17.10.1.3. DUE: Within 35 calendar days following a request by the Department or by the Secretary of the Department of Health and Human Services.

17.10.2. Ownership or Control Disclosures

17.10.2.1. Contractor shall disclose to the 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 the Department.

17.10.2.2. Contractor shall include the following ownership and control disclosure information in a form to be provided by the Department:

17.10.2.2.1. 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.

17.10.2.2.2. Date of birth and Social Security Number of any individual with an ownership or control interest in Contractor.

17.10.2.2.3. 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 five percent or more interest.

17.10.2.2.4. 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 five percent or more interest is related to another person with ownership or control interest in Contractor as a spouse, parent, child, or sibling.

17.10.2.2.5. 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.

17.10.2.2.6. The name, title, address, date of birth, and Social Security Number of any Managing Employee of Contractor.

17.10.2.2.6.1. DELIVERABLE: Ownership or Control Disclosures

17.10.2.2.6.2. DUE: Annually on July 31, and within thirty-five (35) calendar days of either a change of ownership or a written request by the Department.

17.10.3. Conflict of Interest

17.10.3.1. 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.

17.10.3.2. The term "conflict of interest" means that:

17.10.3.2.1. Contractor maintains a relationship with a third party and that relationship creates competing duties on Contractor.

17.10.3.2.2. The relationship between the third party and the Department is such that one party's interests could only be advanced at the expense of the other's interests.

17.10.3.2.3. A conflict of interest exists even if Contractor does not use information obtained from one party in its dealings with the other.

17.10.3.3. Contractor shall submit a full disclosure statement to the Department, setting forth the details that create the appearance of a conflict of interest.

17.10.3.3.1. DELIVERABLE: Conflict of Interest Disclosure Statement

17.10.3.3.2. DUE: Within ten Business Days of learning of an existing appearance of a conflict of interest situation.

17.10.4. Subcontracts and Contracts

17.10.4.1. Contractor shall disclose to the Department copies of any existing subcontracts and contracts with providers upon request.

17.10.4.2. 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.

17.10.4.2.1. DELIVERABLE: Subcontracts and Provider Contracts

17.10.4.2.2. DUE: Within five Business Days of the Department's Request.

17.10.5. Screening of Employees and Contractors

17.10.5.1. Contractor shall not employ or contract with any individual or entity who has been excluded from participation in Medicaid by the HHS-OIG.

17.10.5.2. 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.

17.10.5.3. 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 the Department.

17.10.5.3.1. DELIVERABLE: Notification of Discovery of Excluded Employee or Subcontractor

17.10.5.3.2. DUE: Within five Business Days of discovery

17.10.6. Disclosure of Information on Persons Convicted of Crimes

17.10.6.1. 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 the Department, Contractor shall disclose the identity of any person who:

17.10.6.1.1. Has an ownership or control interest in Contractor, or who is a managing employee of Contractor; and

17.10.6.1.2. 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.

17.10.6.1.2.1. DELIVERABLE: Disclosure of Information on Persons Convicted of Crimes

17.10.6.1.2.2. DUE: Within 35 calendar days of either a change of ownership or a written request by the Department.

17.10.7. Security Breaches and HIPAA Violations

17.10.7.1. In the event of a breach of the security of sensitive data Contractor shall immediately notify the 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 the Department regarding recovery and remediation.

17.10.7.2. Contractor shall comply with the requirements of C.R.S. § 6-1-716 and any other applicable state and federal laws and regulations.

17.10.7.3. Contractor shall report all HIPAA violations as described in the HIPAA Business Associates Addendum.

17.10.7.3.1. DELIVERABLE: Security and HIPAA Violation Breach Notification

17.10.7.3.2. DUE: Within five Business Days of becoming aware of the breach

17.10.8. Maintenance of Records

17.10.8.1. Contractor shall ensure that all Subcontractors and providers comply with all record maintenance requirements of the Contract.

17.10.8.2. 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 ten years.

17.10.9. Inspection and Audits

17.10.9.1. Contractor shall allow the 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.

17.10.9.2. Notwithstanding any other provision in the Contract, Contractor shall allow the Department, CMS, the HHS-OIG, the Comptroller General and their designees this authority for ten years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

17.10.9.3. Contractor shall allow CMS or its agent or designated contractor and the Department or its agent to conduct unannounced, on-site inspections for any reason.

17.10.9.4. In the event that right of access is requested, Contractor and/or its Subcontractors or providers shall:

17.10.9.4.1. Make staff available to assist in any audit or inspection under the Contract.

17.10.9.4.2. Provide adequate space on the premises to reasonably accommodate Department, state or federal or their designees' personnel conducting all audits, Site Reviews or inspections.

17.10.9.4.3. The Secretary of Health and Human services, the Department of Health and Human Services, and the 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.

17.10.9.4.4. 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.

17.10.9.4.5. Contractor shall allow access to Contractor's claims system and claims data by Department staff for program integrity activities.

17.10.9.4.6. In consultation with the 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). The Department may request other information or analyses needed for compliance monitoring.

17.10.9.5. Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five Business Days.

17.10.9.6. Must have staff available to assist in any audit or inspection under the Contract.

17.11. Financial Reporting

17.11.1. To achieve the Accountable Care Collaborative's objective of greater accountability and transparency, Contractor shall participate in a robust financial reporting program.

17.11.2. Contractor shall submit financial information to the Department on both a quarterly and annual basis, and attend in-person quarterly meetings to review and discuss Contractor's financial information as follows:

17.11.2.1. Contractor shall quarterly compile financial information that shall include, but not be limited to, the following:

17.11.2.1.1. Quarterly internal financial statements, including balance sheet and income statement

17.11.2.1.2. Quarterly trial balance listing all account numbers, descriptions and amounts

17.11.2.1.3. Crosswalk and/or allocation schedule(s) to link the quarterly trial balance to the quarterly financial report

17.11.2.1.4. Quarterly financial report using a template that has been mutually agreed upon by Contractor and the Department. The report shall contain a detailed accounting of the total revenue received from the Department during the quarter and how payments were spent, including but not limited to, the following information:

17.11.2.1.4.1. The amount and percentage of PMPM payments spent during the reporting period to support the following categories of work:

17.11.2.1.4.1.1. 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).

17.11.2.1.4.1.2. Care Coordination, with a break-down of dollars spent on contracted Care Coordination and that provided by Contractor.

17.11.2.1.4.1.3. Practice support to include specific information about the types of practices supported.

17.11.2.1.4.1.4. Administration.

17.11.2.1.4.1.5. Network development.

17.11.2.1.4.1.6. Community infrastructure and Health Neighborhood participants.

17.11.2.1.4.1.7. Systems support and capital infrastructure investments.

17.11.2.1.4.1.8. Subcontractors.

17.11.2.1.4.1.9. The categories listed above may be expanded as a result of the process of developing the reporting template.

17.11.2.1.4.1.10. A breakdown of how the PMPM payments were spent for each category of work.

17.11.2.1.4.1.11. Incurred but not reported reserves, defined as the financial reserves held by Contractor to cover services or claims that have been incurred but not reported as of the evaluation date.

17.11.2.2. Contractor shall submit the Quarterly Financial Information to the Department.

17.11.2.2.1. DELIVERABLE: Quarterly Financial Information

17.11.2.2.2. DUE: No later than 45 days from the end of the state fiscal quarter.

17.11.3. Contractor shall compile an Audited Annual Financial Statement that includes, at a minimum, the following:

17.11.3.1. Annual internal financial statements, including balance sheet and income statement

17.11.3.2. 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.

17.11.4. Contractor shall submit the Audited Annual Financial Statement to the Department in a

template provided by the Department and modified as needed. The Department will provide 60 days advance notice to Contractor prior to requiring the use of a modified template.

17.11.4.1. DELIVERABLE: Audited Annual Financial Statement

17.11.4.2. DUE: No later than six months from the end of the fiscal year that the statement covers.

17.11.5. Contractor shall participate in quarterly meetings with the Department to formally present and review the quarterly financial reports submitted to the Department. These meetings will be held by the 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.

17.11.6. Contractor shall submit other financial reports and information as requested by the Department or its designee.

17.11.7. Contractor shall assist the Department in verifying any reported information upon the Department's request. The Department may use any appropriate, efficient or necessary method for verifying this information including, but not limited to:

17.11.7.1. Fact-checking.

17.11.7.2. Auditing reported data.

17.11.7.3. Performing site visits.

17.11.7.4. Requesting additional information.

17.11.8. If the 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 the Department within ten days from the Department's request for the updated report.

17.11.8.1. DELIVERABLE: Updated Financial Reports or Statements

17.11.8.2. DUE: Ten days from the Department's request for the updated report or statement.

17.11.9. Contractor shall report to the Department, at least quarterly, costs incurred by Contractor for Specialty Drugs with supporting invoice(s) from hospital, authorization data and Encounter Data.

17.11.10. Contractor shall use the Department-developed template for the Specialty Drugs Cost Report.

17.11.10.1. DELIVERABLE: Specialty Drugs Quarterly Cost Report

17.11.10.2. DUE: Quarterly on July 31, October 31, January 31, and April 30.

17.12. Graduate Medical Education (GME) Hospital Report

17.12.1. Contractor shall submit data quarterly according to the specifications provided by the 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.

17.12.1.1. DELIVERABLE: Graduate Medical Education Report

17.12.1.2. DUE: Quarterly on July 31, October 31, January 31, and April 30.

17.13. Solvency

17.13.1. Contractor shall notify the 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.

17.13.2. Contractor shall not hold liable any Member for Contractor's debts, in the event Contractor becomes insolvent.

17.13.3. Contractor shall not hold liable any Member for covered services provided to the Member, for which the Department does not pay Contractor, or for which the Department or Contractor does not pay the provider that furnished the service under a contractual, referral, or other arrangement.

17.13.4. 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.

17.13.5. Contractor shall provide assurances satisfactory to the 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.

17.13.5.1. DELIVERABLE: Solvency Notification

17.13.5.2. DUE: Within two Business Days of becoming aware of a possible solvency issue.

17.14. Warranties and Certifications

17.14.1. Contractor shall disclose to the Department if it is no longer able to provide the same warranties and certifications as required at the Effective Date of the Contract.

17.15. Actions Involving Licenses, Certifications, Approvals and Permits

17.15.1. Provider Insurance

17.15.1.1. 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:

17.15.1.1.1. 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 one mi$1,500,000.00 in aggregate per year.

17.15.1.1.2. 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.

17.15.1.1.3. Sections 17.17.1.1.1 and 17.17.1.1.2 shall not apply to Physicians and facilities in Contractor's network which meet any of the following requirements:

17.15.1.1.3.1. 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.

17.15.1.1.3.2. 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.

17.15.1.1.4. Contractor shall provide the Department with acceptable evidence that such insurance is in effect upon the Department's request. In the event of cancellation of any such

coverage, Contractor shall notify the Department of such cancellation within two Business Days of when the coverage is cancelled.

17.15.2. Contractor shall notify the Department of:

17.15.2.1. 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.

17.15.2.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

17.15.2.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract -.

17.15.2.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

17.15.2.3.2. DUE: Within two Business Days of Contractor's notification.

17.16. Federal Intermediate Sanctions

17.16.1. The Department may implement any intermediate sanctions, as described in 42 CFR 438.702, if Contractor:

17.16.1.1. Fails substantially to provide medically necessary services that Contractor is required to provide, under law or under its Contract –with the Department, to a Member covered under the Contract –.

17.16.1.2. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

17.16.1.3. Acts to discriminate among Members on the basis of their health status or need for health care services.

17.16.1.4. Misrepresents or falsifies information that it furnishes to CMS or to the Department.

17.16.1.5. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider.

17.16.1.6. Fails to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210.

17.16.1.7. 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.

17.16.1.8. Has violated any of the other applicable requirements of sections 1903(m), 1932, or 1905(t) of the Act and any implementing regulations.

17.16.2. Notice of Sanction and Pre-Termination Hearing

17.16.2.1. 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.

17.16.2.2. Before terminating any contracts with Contractor, the State must provide Contractor a pre-termination hearing.

17.16.2.3. Prior to a pre-termination hearing, the State must provide Contractor with the following:

17.16.2.4. Written notice of its intent to terminate, the reason for termination, and the time and place of the hearing,

17.16.2.5. 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

17.16.2.6. 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.

17.16.3. 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.

17.17. Termination Under Federal Regulations

17.17.1. The 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 the Department determines that Contractor has failed to:

17.17.1.1. Carry out the substantive terms of its contracts.

17.17.1.2. Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act (42 U.S.C. 401).

17.17.2. Before terminating Contractor's Contract as described in this section, the Department shall:

17.17.2.1. Provide Contractor a cure notice that includes, at a minimum, all of the following:

17.17.2.1.1. The Department's intent to terminate.

17.17.2.1.2. The reason for the termination.

17.17.2.1.3. The time and place for the pre-termination hearing.

17.17.2.2. Conduct a pre-termination hearing.

17.17.2.3. Give Contractor written notice of the decision affirming or reversing the proposed termination of the Contract.

17.17.2.4. If the Department determines, after the hearing, to terminate the Contract for cause, then the Department shall send a written termination notice to Contractor that contains the effective date of the termination.

17.17.2.4.1. 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.

17.17.3. Once the Department has notified Contractor of its intent to terminate under this section, the Department may give Members enrolled with Contractor written notice of the Department's intent to terminate the Contract.

17.17.4. The 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:

17.17.4.1. Allow Members enrolled with Contractor to Disenroll immediately, without cause;

17.17.4.2. Suspend all new enrollments to Contractor's managed care capitation initiative, after the date the Secretary or the Department notifies Contractor of a determination of violation of any requirement under sections 1903(m) or 1932 of the Act; and

17.17.4.3. Suspend payments for all new enrollments to Contractor's managed care capitation initiative until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur

17.17.5. 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 will 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.

18. COMPENSATION AND INVOICING

18.1. Summary of Compensation to Contractor

18.1.1. Compensation to Contractor will consist of the following:

18.1.1.1. Two actuarially certified monthly Capitated Payments, as specified in Exhibit E, 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. The Department will set the monthly Capitated Payment rates at the actuarially certified point estimate in accordance with 42 C.F.R. § 438.

18.1.2. Compensation to Contractor may also consist of the following:

18.1.2.1. An annual behavioral health incentive payment based on Contractor's performance on defined behavioral health metrics.

18.1.3. The Department will not make physical health Capitation Payments to Contractor for any Member who has a stay in an Institution for Mental Disease that exceeds 15 days in a single month. The Department will recoup partial Behavioral Health Capitated Payments for short term stays in an IMD that exceed 15 days during the period of a monthly capitation payment.

18.2. Process for Capitated Payments

18.2.1. The Department will calculate the number of active Members enrolled in Contractor's managed care capitation initiative based on the enrollment information in the Colorado interChange.

18.2.2. The Department will remit all Capitated Payments through the Colorado interChange (MMIS) via electronic funds transfer to a bank account designated by Contractor. The Department will provide Contractor with a monthly payment report through the Colorado interChange.

18.2.2.1. Contractor shall ensure the accuracy of direct deposit information provided to the Department and update such information as needed.

18.2.3. The Department will remit all Capitated Payments to Contractor within the month for which the payment applies.

18.2.3.1. In the event that Contractor is not compensated for a Member in a month for which Contractor should have been compensated, the Department will compensate Contractor for that Member retroactively.

18.3. Special Provisions

18.3.1. The monthly Capitated Payment shall be considered payment in full for all covered services set forth in this Contract.

18.3.2. In the event of conflict or inconsistency, or alleged conflict or inconsistency, between Section 14.5 and any other provision of the Contract, Section 14.5 shall prevail over other provisions of this Contract.

18.3.3. Contractor shall acknowledge that in State Fiscal Year 2020 the Colorado Legislature built a two percent rate increase for behavioral health providers (excluding FQHCs and hospitals). This one-time rate increase is built into the behavioral health rate model year over year and Contractor is required to continue passing this amount on to all eligible providers in its entirety.

18.3.4. Specialty Drug Reimbursements

18.3.4.1. The Department will reimburse Contractor in accordance with the deductions stated below after the drug cost of the Specialty Drugs exceeds $100,000.00 per treated client

18.3.4.2. No payments to Contractor for Specialty Drugs will exceed State reimbursement levels set forth in the Department's approved State Plan with CMS.

18.3.4.3. The Department will reimburse Contractor for the invoice cost of the drugs, after all the following have been deducted:

18.3.4.3.1. Any discounts available to the requesting provider pursuant to the federal 340B drug program.

18.3.4.3.2. Any rebates available to the requesting provider through the federal Medicaid Drug Rebate Program.

18.3.4.3.3. Any amounts received by Contractor, or Contractor's parent company for Contractor's Medicaid business, pursuant to reinsurance settlements for any private catastrophic cost policies maintained by Contractor, or Contractor's parent company for Contractor's Medicaid business, for the current Performance Period. If reinsurance is an umbrella policy, the Department will calculate the pharmacy settlement amount by pharmacy/Medical service ratio.

18.3.4.3.4. Any Contractor offsets attributable to substitution effects that will occur during the State fiscal year due to member treatment with the requested Specialty Drugs, as calculated on an actuarially sound basis.

18.3.4.4. For the purpose of executing the substitution effect requirement stated above, the Department, with assistance from its contracted actuary and with review and comment from Contractor's actuary, will apply appropriate method(s) to review the cost associated with the Specialty Drugs treatment, including but not limited to diagnosis code-based

review, other identification code-based review, member-specific case-by-case review, episode cost to determine the following:

18.3.4.4.1. The calculated trended historical cost embedded in capitation rate, associated with the treated member, or the diagnoses and other codes related treatment;

18.3.4.4.2. The cost in the current State Fiscal year associated with the treated member, or the diagnoses and other codes related treatment, excluding Specialty Drugs.

18.3.4.4.3. The value of appropriate cost adjustments to covered services, delivered under this Contract, is calculated as the difference between the calculations in Sections 18.3.5.4.1. and 18.3.5.4.2., whether they are lower or higher, on an actuarially sound basis.

18.3.4.5. The Department will pay Contractor for Specialty Drugs quarterly, within 60 days of the end of the quarter or the receipt of appropriate documentation, whichever is later.

18.3.4.5.1. In accordance with the special reimbursement term set forth herein, payment by the Department is subject to annual reconciliation as necessary, within 180 days of the end of State Fiscal year or the receipt of appropriate documentation, whichever is later.

18.3.4.6. The Department, with assistance from its contracted actuary, will decide to include prospective risk-based coverage for Specialty Drugs when sufficient cost and utilization experience accumulates within the base data available for the calculation of actuarially sound rates. The Department will communicate the inclusion with Contractor.

18.3.4.6.1. The Department determines drug selection, substitution effect calculation, and payment reconciliation.

18.3.5. Actions Impacting Existing Rates

18.3.5.1. Contractor shall inform the 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.

18.3.6. Behavioral Health Incentive Program Payment

18.3.6.1. The 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 E, Payment.

18.3.6.2. The Behavioral Health Incentive Program will be implemented in accordance with 42 CFR 438.6(b)(2) ensuring that the arrangement with Contractor:

18.3.6.2.1. Does not provide for payment in excess of 105% of the approved capitation payments.

18.3.6.2.2. 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.

18.3.6.2.3. Is not renewed automatically.

18.3.6.2.4. Is made available to both public and private contractors under the same terms of performance.

18.3.6.2.5. Is not conditioned on Contractor entering into or adhering to intergovernmental transfer agreements.

18.3.6.2.6. Is necessary to support program initiatives as specified in the state's quality strategy.

18.3.6.3. The Department will calculate the Behavioral Health Incentive Program payment as described in Exhibit E, Payment.

18.3.6.4. The Department will provide to Contractor documented calculation methodology for all measures prior to the first distribution of funds. The 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. The Department will determine the final measurement and pay for performance criteria.

18.3.6.5. The 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.

18.4. Deliveries

18.4.1. Contractor shall receive payment for delivery services provided to Members through a supplemental payment. The payment, which is set forth in this Contract, includes facility and professional service costs related to the delivery and post-partum care. One payment shall be made for each delivery regardless of the number of births associated with that delivery.

18.4.2. In order to receive payment for deliveries, Contractor shall submit, to the Department, a cover letter and an electronic Excel spreadsheet in the format designated by the Department. Documentation of the delivery, e.g., a claim record of delivery, must accompany the request for payment. The request for payment shall be submitted to the Department no later than 150 days following the delivery.

18.4.3. Contractor shall certify all data submitted is 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 the Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

18.4.4. The Department shall adjudicate Contractor’s request for payment within 35 days of receipt of all documentation of the delivery.

18.5. Payment Calculation Disputes

18.5.1. In the event that Contractor believes that the calculation or determination of any payment is incorrect, Contractor shall notify the Department of its dispute within 30 days of the receipt of the payment. The Department will review calculation or determination and may make changes based on this review. The determination or calculation that results from the Department’s review shall be final. No disputed payment shall be due until after the Department has concluded its review.

18.6. Recoupments

18.6.1. The Department will recoup any capitation payment made to Contractor for Members who have a stay in an Institution for Mental Disease that exceeds 15 days in a single month.

18.6.2. 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 the Department, by check or warrant, with a letter explaining the nature of the payment, within 90 days of termination.

18.6.3. Payments made by the Department to Contractor due to Contractor's omission, Fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

18.6.4. Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any Capitated Payments. Contractor's obligation to refund all calculated MLR rebates continues subsequent to termination of the Contract.

18.7. Contractor's obligation to refund all calculated rebates continues subsequent to the termination of the Contract. Closeout Payments

18.7.1. 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 ten days after the Department has determined that Contractor has completed all of the requirements of the Closeout.

EXHIBIT C, SAMPLE OPTION LETTER

OPTION LETTER

State Agency Department of Health Care Policy and Financing	**Option Letter Number** Insert the Option Number (e.g. "1" for the first option)
Contractor Insert Contractor's Full Legal Name, including "Inc.", "LLC", etc...	**Original Contract Number** Insert CMS number or Other Contract Number of the Original Contract
Current Contract Maximum Amount Initial Term State Fiscal Year 20xx $0.00 Extension Terms State Fiscal Year 20xx $0.00 State Fiscal Year 20xx $0.00 State Fiscal Year 20xx $0.00 State Fiscal Year 20xx $0.00 Total for All State Fiscal Years $0.00	**Option Contract Number** Insert CMS number or Other Contract Number of this Option **Contract Performance Beginning Date** The later of the Effective Date or Month Day, Year **Current Contract Expiration Date** Month Day, Year

1. Options

A. Option to extend for an Extension Term.
B. Option to change the quantity of Goods under the Contract.
C. Option to change the quantity of Services under the Contract.
D. Option to modify the Contract rates.
E. Option to initiate next phase of the Contract.
F. Option to amend a Data Sharing Appendix.

2. Required Provisions

A. **For use with Option 1(A):** In accordance with Section(s) Number of the Original Contract referenced above, the State hereby exercises its option for an additional term, beginning Insert start date and ending on the current contract expiration date shown above, at the rates stated in the Original Contract, as amended.

B. **For use with Options 1(B and C):** In accordance with Section(s) Number of the Original Contract referenced above, the State hereby exercises its option to Increase/Decrease the quantity of the Goods/Services or both at the rates stated in the Original Contract, as amended.

C. **For use with Option 1(D):** In accordance with Section(s) Number of the Original Contract referenced above, the State hereby exercises its option to modify the Contract rates specified in Exhibit/Section Number/Letter. The Contract rates attached to this Option Letter replace the rates in the Original Contract as of the Option Effective Date of this Option Letter.

D. **For use with Option 1(E):** In accordance with Section(s) Number of the Original Contract referenced above, the State hereby exercises its option to initiate Phase indicate which Phase: 2, 3, 4, etc, which shall begin on Insert start date and end on Insert ending date at the cost/price specified in Section Number.

E. **For use with Option 1(F):** In accordance with Section Number of Exhibit B, Statement of Work of the Original Contract referenced above, the State hereby exercises its option to amend an existing Datasharing Appendix, labeled as Appendix Number. The amended Data Sharing Appendix is attached to this Option Letter and is labeled Appendix Number.

F. **For use with all Options that modify the Contract Maximum Amount:** The Contract Maximum Amount table on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Maximum Amount table shown above.

3. Option Effective Date

a. The Effective Date of this Option Letter is upon approval of the State Controller or the Effective Date of this Option Letter, whichever is later.

STATE OF COLORADO John W. Hickenlooper, Governor Department of Health Care Policy and Financing Kim Bimestefer, Executive Director _____ By: Kim Bimestefer, Executive Director Date: _____	In accordance with §24-30-202 C.R.S., this Option is not valid until signed and dated below by the State Controller or an authorized delegate. **STATE CONTROLLER** **Robert Jaros, CPA, MBA, JD** By:_____ Greg Tanner, Controller; Department of Health Care Policy and Financing Option Effective Date:_____

EXHIBIT E-13, Payment

1. MONTHLY PAYMENT FOR CAPITATED PHYSICAL HEALTH BENEFIT

1.1. Effective July 1, 2024 – June 30, 2025, the Contractor shall earn the following Full Risk Rates shown in the following table:

Category of Aid	FY24-25 Rates
AFDC-A-F	$289.05
AFDC-A-M	$172.04
BCKC-A	$375.16
CHILD-C	$141.92
CHILD-U	$413.39
FC	$283.31
OAP-A	$168.40
OAP-B/AND - N	$1,123.95
OAP-B/AND - T	$115.36
AwDC	$350.62
AFDC Expansion Adults - F	$357.91
AFDC Expansion Adults - M	$199.24
Delivery	$6,492.68

2. MONTHLY PAYMENT FOR CAPITATED BEHAVIORAL HEALTH BENEFIT

2.1.
Effective July 1, 2024 - June 30, 2025, the Contractor shall earn Full Risk Rates that are actuarially sound and meet the requirements specified in 42 CFR § 438.4 for that certification period. The Parties acknowledge that the actual rates are unknown as of the Effective Date of Amendment 15 due to delays caused by the end of the Public Health Emergency and the need to recertify the FY23-24 rates. Once the actual rates for July 1, 2024, through June 30, 2025, are complete, the Department will add those rates to this contract through the use of an Option Letter or amendment. If the MMIS pays the FY 23-24 rates prior to the actual rates being included in this Contract, then, once the actual rates are included in the Contract, the Department will reconcile the payments to the actual rates and will recover any overpayments from the Contractor or make additional supplemental payments to the Contractor for any underpayments.

	Behavioral Health Rate – to be negotiated
Elderly	
Disabled	
Non-Expansion Adult	
Expansion Parent	
Children	
Foster Care	
MAGI Adult	

2.2. The Contractor shall assume risk for the cost of services covered under the contract and incurs loss if the cost of furnishing the services exceeds the

payments under the contract. The entity must accept as payment in full, the amount paid by the State plus any cost sharing from the members. Payments for carrying out contract provisions, including incentive payments, are medical assistance costs.

3. RISK CORRIDOR AND RECONCILIATION FOR PROSPECTIVE PAYMENT SYSTEMS EFFECTIVE JULY 1, 2024 – JUNE 30, 2025

3.1. Due to uncertainty associated with the implementation of a Prospective Payment System (PPS) model, all cohorts for this time period shall be subject to a reconciliation calculation.

3.2. The reconciliation will apply to all the Contractor, Comprehensive Providers, and Community Mental Health Centers operating within the state of Colorado.

3.2.1. The Contractor must meet with each Comprehensive Provider and CMHC within 30 days of the end of each quarter to review the Comprehensive Provider's or CMHC's costs to determine if adjustments should be made to the payment arrangement between the provider and the Comprehensive Provider or CMHC.

3.3. The Department, under a State Directed Payment authority (42 CFR 438.6), shall engage in a risk corridor with the contractor on services provided by Comprehensive Providers and Community Mental Health Centers under the PPS model.

3.4. The Safety Net Expansion Risk Corridor shall be calculated by the Department, or its designee, prior to the calculation MLR, and any payments or recoupments shall be incorporated in the MLR calculation as an adjustment to revenue.

3.5. DIRECTED PAYMENT RECONCILIATION

3.5.1. The Contractor shall engage in a reconciliation with any Comprehensive Providers and Community Mental Health Centers where at least 1 of the Contractor's Members has received services to incur a PPS encounter during the SFY 2025.

3.5.2. The reconciliation shall be calculated independent of any Value-Based-Purchasing (VBP) amounts that the Contractor pays outside of the State Directed Payment Amount.

3.6. DIRECTED PAYMENT RECONCILIATION PROCESS

3.6.1. The Contracted Comprehensive Providers and Community Mental Health Centers will be paid directly by the Contractor for the services described in **1.5.1** at their designated **State Directed Payment PPS Rate** determined by the Department as outlined in Ex. B, Section 14.

3.6.2. No later than April 1, 2026, the Department will use the audited or adjusted cost reports submitted by Comprehensive Providers and Community Mental Health Centers to calculate and publish the **Actual Cost PPS Rate** that reflects the actual experience for SFY 2025.

3.6.3. The Contractor will be responsible for reconciling the difference between Comprehensive Provider's or Community Mental Health Center's **State Directed Payment PPS Rate** and the **Actual Cost PPS Rate** for the Comprehensive Provider or Community Mental Health Center for SFY 2025 through the date the Department publishes the **Actual Cost PPS Rate**.

3.6.3.1. PPS encounters are defined by the Department's PPS definition using the assigned procedure codes and trigger logic.

3.6.3.2. The count of PPS encounters for reconciliation with Comprehensive Providers and Community Mental Health Centers will be the count of applicable encounters for each Comprehensive Provider and Community Mental Health Center incurred by the Contractor with dates of service within the SFY 2025 as provided within the submitted encounter data with three months of runout.

3.6.4. In the event of a discrepancy between the Contractor and a Comprehensive Provider or Community Mental Health Center as to the correct count of encounters, the Contractor shall attempt to resolve the discrepancy directly with the Comprehensive Providers and Community Mental Health Centers. If the discrepancy cannot be resolved within 10 business days, the Department will have final say in the allowable count of PPS encounters for the purposes of the reconciliation.

3.7. DIRECTED PAYMENT RECONCILIATION

3.7.1. After finalizing the reconciliation calculation, the Contractor will present and explain the calculations to the Comprehensive Provider or Community Mental Health Center, as well as issue a demand letter, if the Comprehensive Provider or Community Mental Health Centers or notification letter for any amount due from, or due to, the Contracted Comprehensive Providers and Community Mental Health Centers.

3.7.2. The Contractor shall recoup funds from the Contracted Comprehensive Providers and Community Mental Health Centers under the Directed Payment reconciliation, where applicable, within 30 days of the contractor issuing the demand letter.

3.7.3. The Contractor shall reimburse the Contracted Comprehensive Providers and Community Mental Health Centers for any reconciliation, where applicable, within 30 days of the contractor issuing the notification letter.

3.8. SAFETY NET EXPANSION RISK CORRIDOR CALCULATION PROCESS

3.8.1. For each rating cohort, the Department or its designee shall calculate a **Safety Net PMPM** as the portion of the actuarially sound PMPM composed of the comprehensive services to be paid under the PPS payment model.

3.8.2. The Department or its designee shall calculate a **Target Safety Net PMPM** as the weighted average of the **Safety Net PMPMs** by cohort weighted by the actual member months for SFY 2025, with sufficient runout, as reported in the Department's system of record.

3.8.3. The Department, or its designee, will calculate an **Adjusted Actual Safety Net PMPM** as incurred costs divided by member months, weighted by cohort.

3.8.3.1. The numerator will be calculated by the Department, or its designee, as the PPS payment expenditures by cohort, exclusive of value-based payments, reported through the annual encounter data and financial reporting services, incurred within the SFY 2025 with sufficient runout paid under the PPS payment model.

3.8.3.2. The denominator will be calculated by the Department, or its designee, as the actual member months for SFY 2025, with sufficient runout, as reported in the Department's system of record.

3.8.4. The Department will then calculate the ratio between the **Adjusted Actual Safety Net PMPM** and the Contractor's **Target Safety Net PMPM** to determine the risk corridor range and the share of cost, based on the calculation table listed below.

3.8.4.1. The actuarially determined **Target Safety Net PMPM** is equivalent to one hundred percent (100%) in the risk corridor structure.

3.8.5. Risk corridor calculations will be made according to the following:

Corridor #	Risk Corridor Min	Risk Corridor Max	MCE Share	State Share
A	0.00%	94.99%	0%	100%
B	95.00%	98.99%	50%	50%
C	99.00%	100.99%	100%	0%
D	101.00%	104.99%	50%	50%
E	105.00%	+	0%	100%

3.9. RECOUPMENTS OR ADDITIONAL REIMBURSEMENT

3.9.1. In the above table, a ratio of greater than 100% represents a payment from the Department to the Contractor. A ratio of less than 100% represents a payment from the Contractor to the Department.

3.9.2. After finalizing the risk corridor calculation, the Department, or its designee, will present and explain the calculations to the Contractor, as well as issue a demand/notification letter for any amount due from (or due to) the Contractor.

3.9.3. The Contractor shall remit any funds due under the risk corridor structure, where applicable, to the Department within 60 days of the Department issuing the demand letter.

3.9.4. The Department shall reimburse the Contractor for any funds due under the risk corridor structure, where applicable, within sixty (60) days of the Department issuing the notification letter.

3.9.5. The risk corridor shall be calculated independent of any Value-Based-Purchasing (VBP) amounts that the contractor pays outside of the State Directed Payment Amount.

4. RETROSPECTIVE RATE CHANGES

4.1. In relation to unique circumstances and when the Contractor and the Department agree to retrospectively change the rates, the Department will reconcile the rates accordingly.

4.2. The rates for the following time periods will be adjusted according to the tables below, Contract amendment or an Option Letter issued by the Department.

Category of Aid	SFY2023-24 Physical Health Capitation Rates - REVISED
AFDC-A-F	$ 264.68
AFDC-A-M	$ 182.58
BCKC-A	$ 428.17
CHILD-C	$ 128.43
CHILD-U	$ 445.64
FC	$ 143.82
OAP-A	$ 277.41
OAP-B/AND - N	$ 1,098.94
OAP-B/AND - T	$ 160.31
AwDC	$ 283.75
AFDC Expansion Adults - F	$ 233.21
AFDC Expansion Adults - M	$ 140.40
Delivery	$ 6,462.91

COHORT	FY2023-2024 Behavioral Health Rates – REVISED
Elderly	$ 54.61
Disabled	$ 235.90
Non-Expansion Adult	$ 48.03
Expansion Parent	$ 30.17
Children	$ 31.21
Foster Care	$ 109.03
MAGI Adult	$ 84.17

5. PAY FOR PERFORMANCE: KEY PERFORMANCE INDICATOR INCENTIVE PROGRAM AND PERFORMANCE POOL

5.1. The Department will determine the proportion of funds associated with the KPI Incentive Program and the Performance Pool so that the total incentive payment the Contractor may earn equals four dollars and forty three cents ($4.43) PMPM, effective July 1, 2024. The Contract can earn sixty-four and seven-tenths percent (64.7%) of this funding on Key Performance Indicators and thirty-five and

three-tenths percent (35.3%) on Performance Pool measures. Any unearned KPI dollars will be added to the Performance Pool.

6. PAY FOR PERFORMANCE: BEHAVIORAL HEALTH INCENTIVE PROGRAM

6.1. The amount of the incentive payment is limited by federal regulation and available state funding.

Activity	Percent of Funds Allocated to Activity	Requirements
All corrective action plan submissions and activities are in accordance with Contract provisions for duration of the Contract term	50%	100% compliance
The quarterly flat file encounter data submitted for duration of Contract term, in addition to the annual flat file	50%	Submission of flat file that is 100% accurate for a minimum of three (3) quarterly flat files and one (1) annual flat file for a total of four (4) submissions during the State Fiscal Year to receive 100% of funds Submission beyond due date for up to two (2) months: Contractor eligible for participation at 20% reduction for each submission beyond due date. Contractor shall continue to resubmit inaccurate flat file submissions until corrected and accepted by the Department.

6.2. If the Contractor meets the abovementioned minimum requirements, the Contractor may qualify for incentive payments based on minimum improvements in incentive performance measures and by percentage of compliance with incentive process measures.

6.3. Minimum improvement for each incentive performance measure is defined as the Contractor "closing their performance gap by 10%" from a Contractor-specific benchmark as specified in the Behavioral Health Incentive Program specification document released annually by the Department.

6.4. The table below lists each of the incentive performance measures and the percentage of incentive funding allocated for each measure. The Department will work with the Contractor to negotiate what the appropriate baselines will be.

	Incentive Performance Measure	Percentage of Funding Allocated for Measure
Indicator 1	Engagement in Outpatient Substance Use Disorder (SUD) Treatment	20%
Indicator 2	Follow-up Appointment Within 7 Days After an Inpatient Hospital Discharge for a Mental Health Condition	20%
Indicator 3	Follow-up Appointment Within 7 Days After an Emergency Department (ED) Visit for a Substance Use Disorder	20%
Indicator 4	Follow-up After a Positive Depression Screen	20%
Indicator 5	Behavioral Health Screening or Assessment for Children in the Foster Care System	20%

COLORADO
Department of Health Care Policy & Financing

EXHIBIT F
RAE REASSIGNMENT APPROVAL FORM

RAE Reassignment Approval Form

Date: _____

Member Name: _____ DOB: _____

Medicaid ID # _____

Current RAE: _____

Requested RAE: _____

Treating Community Mental Health Center: _____

Provide a written summary of the request, supporting documentation and recommendation to approve or not approve:

RAE Reassignment: _____Effective Date: _____

Contract Manager: _____ Extension: _____

APPROVALS:

- ☐ Approved
- ☐ Not Approved

Section Manager_____Date_____

Division Manager_____Date_____

EXHIBIT H
DEVELOPMENTAL DISABILITY AND TRAUMATIC BRAIN INJURY GUIDANCE

DEVELOPMENTAL DISABILITY (DD)

Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD)

Providing services to individuals with both a mental illness and a developmental disability is a complicated challenge to the provider community in meeting a DD/MI individual's behavioral health needs. Co-occurring mental health disorders and developmental disabilities are relatively common. People with developmental disabilities should be afforded the same access to mental health services as the general population. The intent of this document is to ensure that the presence of a diagnosis of developmental disability does not decrease the diagnostic significance of any accompanying mental illness. A misdiagnosis could result in the use of inappropriate or ineffective interventions.

Although behavioral problems are not universal among the DD population, many individuals with a developmental disability do show problems with impulse control, self-management of their behavior, and may have problems with mood swings, which may or may not be part of their developmental delay. The high rate of co-occurring neurological and general medical conditions can further complicate the diagnostic profile for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual's developmental disability, organic brain pathology, and/or mental illness covered under the Accountable Care Collaborative is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document was developed by the Behavioral Health Organizations (BHOs) in collaboration with Community Center Boards (CCBs), developmental disability professionals, member advocates and other key stakeholders, in the interest of fulfilling their responsibilities under the Colorado Medicaid Program, and to meet their contractual requirements. The document is an attempt to define these criteria for use by evaluating clinicians. It is not intended to fully describe the collaboration between providers, and Regional Accountable Entities (RAEs) and CCBs, that is both required and embraced as values (and in most cases as a reality) by those organizations, by families, and by advocates for individuals with DD/MI. The Colorado Behavioral Health Organizations adopted the following Practice Standards for their Medicaid members with a developmental disability and the RAEs shall also adopt them:

1. In no circumstance, does the presence of DD preclude an assessment for co-occurring mental illness covered under the Accountable Care Collaborative. The RAEs and their contracted providers will not deny services for a covered diagnosis on the basis of that covered diagnosis not being primary. The presence of a covered diagnosis and the RAE's determination that the

issues requiring treatment are related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A RAE provider will complete a face-to-face assessment on any child, youth, or adult with DD who is referred for evaluation for covered mental illness according to that RAE's regular intake and admission procedures and standards. The RAE will provide a mental health assessment for any child, youth or adult with a developmental disability who is referred for evaluation of a covered mental illness. For members whose developmental disability and/or level of functioning precludes the use of standard evaluation protocols, the RAE will solicit the participation and/or assistance from someone, such as the CCB case manager, or family member, who can provide information needed to conduct the assessment. Evaluations will be conducted in a secure setting to ensure the safety of a member who is behaviorally out of control.

3. The RAE will complete a new face-to-face assessment on any re-referred member in which its last assessment is greater than 120 days old.

4. In the specific circumstance in which a RAE provider has assessed a member with DD within the past 120 days and services have been denied, and the member is re-referred for another assessment within that 120-day window, the RAE will re-assess whether there has either been a change in the member's mental status or if new and relevant information has been provided.

5. Referral for evaluation of Medicaid members with DD can be made 24 hours a day, 7 days a week through the RAE's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the RAE. Emergency referrals may be evaluated either within a RAE network site or by RAE staff in a hospital Emergency Department or other safe environment. After-hours emergency referrals are evaluated in a safe environment, usually in a hospital Emergency Department.

7. All evaluations during regular working hours are reviewed by an experienced licensed professional within the RAE provider network if there are diagnostic uncertainties. Any decision to deny services to a member with a developmental disability will be reviewed by the RAE Medical Director or physician designee. All after-hours evaluations are reviewed with the on-call psychiatrist prior to a denial being issued. In all RAEs, an initial appeal of any decision to deny a request for services requires that the denial be reviewed a psychiatrist not involved in previous levels of review or decision-making nor a subordinate of anyone who was.

8. RAEs may also utilize courtesy evaluations from other RAEs, and/or delegate emergency assessment to hospital emergency department personnel for Medicaid members requiring assessment outside their network areas. If treatment is medically necessary (as defined in item #9 below) outside the network area, the RAE will negotiate a single-case agreement or other non-network arrangement with a qualified provider to deliver that medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Accountable Care Collaborative; and, evidence that the referring symptoms are associated with that covered mental illness, that treatment of the symptoms is medically necessary, and that it is provided within the least restrictive environment.

10. Services may be authorized either in whole or in part based upon the relative contribution of covered and non-covered (DD and/or organic brain pathology) conditions, and any collaborative arrangements in place between the RAE and the CCB involved with the individual.

11. At the time of evaluation, the RAE will review all relevant and available information including records of past diagnoses and treatments; however, the RAE will evaluate the provider's diagnostic formulation based on a preponderance of the medical evidence available at the time. If there is not adequate evidence available upon which to accept or challenge the diagnostic formulation of the provider, the RAE may defer its final authorization decision until sufficient information is received. 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.

12. Cases in which the RAE evaluator disagrees with previously assigned "by history" diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary, the member, family member, CCB Case Manager and/or authorized representative will be given detailed written information, in accordance with HIPAA regulations, about the clinical rationale for the denial as well as information about all available appeal rights and assistance with filing an appeal through the RAE.

14. The RAEs acknowledge that diagnoses often "evolves" over a period of time as the natural progression of a disorder further defines itself; and, as new, better, or more complete clinical data is received and integrated into a comprehensive diagnostic formulation. In all situations in which the provider changes a previous diagnostic formulation, they will clearly document both the clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the RAE Medical Director will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the RAE contract is the DSM-5 criteria for that diagnosis. RAEs follow conventional diagnostic practice in considering whether DSM-5 criteria are met, and consider that DSM-5 symptomatology may present atypically in individuals with a developmental disability. However, a DSM-5 diagnosis cannot be made in the absence of reasonably meeting such criteria in the context of an atypical presentation. Diagnostic evaluations will include a review of prior treatment and evaluations, past and current response to prescribed medications, and past and current behavioral presentation as described by care providers, family members and other information sources.

2. Other diagnoses, including the developmental disability, must be present to explain variances from DSM-5 criteria.

3. Consideration is given to the member's abilities or disabilities in how DSM-5 criteria present themselves. The diagnostic process must be developmentally sensitive.

4. Additional diagnoses will not be considered in authorizing services when other known and clearly documented diagnoses sufficiently explain the clinical presentation of the member.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the member, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the member, and are provided in the least restrictive setting where services can safely be provided.

7. RAE enrolled Medicaid members with developmental disability have access to the full spectrum of appeal rights under the Accountable Care Collaborative for adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary.

RAE Practice Standards: Evaluation and Treatment of Covered Mental Illness (MI) in People with Traumatic Brain Injury (TBI).

People with traumatic brain injuries should be given the same access to mental health services as the general Medicaid population. The intent of this document is to make sure that a diagnosis of traumatic brain injury does not preclude an individual from receiving a diagnosis and treatment of a covered mental illness, if appropriate. As with any other population, individuals with TBI are at risk for increased symptoms, impairment, and disability without accurate assessment and appropriate treatment.

Although behavioral problems are not universal in the TBI population, many individuals with a TBI do experience problems with impulse control and self-management of their behavior. Clients may have problems with mood swings, depression, anxiety and psychosis. These problems can be related to the traumatic brain injury, reactive psychological processes and/or co-occurring mental illness diagnoses.

The high rate of co-occurring general medical conditions can further complicate the diagnostic profile and management for these individuals.

The distinction between emotional and behavioral symptoms deriving from an individual’s organic brain pathology, and/or mental illness covered under the Accountable Care Collaborative is frequently difficult, and at times controversial and contentious. For this reason, it is inherently difficult to sort out treatment and payment responsibilities in these situations, as these criteria attempt to do.

This document was developed by several organizations with experience in this area. They include Behavioral Health Organizations (BHOs), the Department of Health Care Policy and Financing, traumatic brain injury treatment professionals, member advocates and other key stakeholders.

This document attempts to define criteria for service access and appropriate billing (capitation vs. fee for service) for use by evaluating clinicians and RAE/Community Mental Health Center (CMHC) administrators. It is not intended to fully describe the collaboration between providers, or between RAEs and other providers. All contributors to this document, including family members and advocates, embrace the value of systems working together.

The Colorado BHOs adopted the following Practice Standards for Medicaid members with a traumatic brain injury and the RAEs have also adopted them:

1. Under no circumstance does the presence of TBI preclude an assessment for and treatment of co-occurring mental illness covered under the Accountable Care Collaborative. RAEs will not deny services for a covered diagnosis on the basis that the covered diagnosis is not primary, and regardless of etiology. For example, a client presenting with post-traumatic stress disorder which developed as a result of a brain injury will be treated for the PTSD, regardless of whether or not the PTSD was caused from incident in which the brain injury occurred. The presence of a covered diagnosis and the RAE's determination that the issues requiring treatment are related to that covered diagnosis shall be the basis for authorizing appropriate, covered services.

2. A RAE provider will complete a face-to-face assessment with any child, youth, or adult with TBI who is referred for evaluation for covered mental illness according to the provider's regular intake and admission procedures and standards. For clients whose traumatic brain injury or level of functioning does not allow for the use of standard assessment procedures, the RAE will request needed information from other sources such as the client's providers, case manager, or family member when available. When these resources are not available, the RAE shall consult outside professionals with expertise in brain injury.

3. The RAE will ensure assessment on any re-referred client for whom the last assessment is older than 120 days.

4. If a member is referred for a second assessment within 120 days of being denied services as a result of the determination that their symptoms are not covered under the current contract, the RAE will consider the following when determining medical necessity:

    a. There has been a change in the member's mental status, or

    b. New and relevant information has been provided.

If so, the RAE will arrange for another mental health assessment based on the new information and/or mental status changes reported.

5. Referral for evaluation of Medicaid members with TBI can be made 24 hours a day, 7 days a week through the RAE's regular access telephone numbers.

6. Routine and urgent referrals are evaluated within the network resources of the RAE. Emergency referrals may be evaluated either within a RAE network site or by RAE staff in a hospital Emergency Department or other safe environment. After hours emergency referrals are to be evaluated in a safe environment, usually in a hospital Emergency Department. RAE providers shall make reasonable efforts to contract with an expert in TBI in order to provide consultation.

7. If there are diagnostic uncertainties, all evaluations during regular working hours are reviewed by an experienced licensed professional within the RAE provider network. Any decision to deny services to a member with a traumatic brain injury will be reviewed by the RAE Medical Director or physician designee. All after hours evaluations will be reviewed with the on-call psychiatrist prior to a denial being issued. In addition, RAE policy dictates that an initial appeal of any decision to deny a request for services requires that the denial be reviewed by a psychiatrist other than the psychiatrist who issued the first denial.

8. RAEs may utilize courtesy emergency evaluations from other RAEs. RAEs may also utilize hospital emergency department personnel to conduct an evaluation on a client outside the network area. If treatment is medically necessary (as defined in item #9 below) outside the network area, the RAE will negotiate an arrangement with a qualified provider to deliver the medically necessary clinical care.

9. All treatment decisions are based upon the presence of covered mental illness as defined under the Accountable Care Collaborative and this contract at Exhibit XXX. Evidence that the referring symptoms are associated with that covered mental illness, evidence that treatment of the symptoms is medically necessary, and an assurance that treatment is provided within the least restrictive environment is necessary.

10. Services may be authorized either in whole or in part based upon determination of the underlying cause of the symptoms presented at the time. If it is determined that the individual does not have a covered diagnosis, the RAE will refer the individual to a specialist provider covered under the Medicaid fee for service program.

11. At the time of evaluation, the RAE will review all relevant and available information including records of past diagnoses and treatments. However, the RAE does not recognize “by history” diagnoses and will evaluate the provider’s diagnostic formulation based on the prevalence of the medical evidence available at the time. If there is not enough evidence available to accept or challenge the diagnostic formulation of the provider, the RAE may defer its final authorization decision until sufficient information has been received. 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.

12. Cases in which the RAE evaluator disagrees with previously assigned “by history” diagnoses will be reviewed and approved by the Medical Director or physician designee before any denial is issued.

13. If the physician determines that requested services are not medically necessary or not covered by the RAE, the member, family member, Case Manager and/or authorized representative will be given detailed written information about the clinical rationale for the denial. The RAE will also provide information about all available appeal rights and assistance with filing an appeal through the RAE.

14. The RAEs acknowledge that diagnoses often "evolve" over a period of time as the natural progression of a disorder further defines itself. Often, new, better, or more complete clinical data is received and integrated into a comprehensive diagnostic formulation. In situations in which the provider changes a previous diagnostic formulation, the provider will clearly document both the clinical evidence and rationale for so doing, and the clinical support for the new diagnosis. In addition, the RAE Medical Director or physician designee will review all changes in diagnosis that result in a denial of services before they take effect.

Guiding Principles for Diagnostic Formulation:

1. The basis for determining the presence of a behavioral health diagnosis covered by the RAE contract is the DSM-5 criteria for that diagnosis. While currently the ICD-10 is the standard by which diagnoses are coded for billing and reporting purposes, the DSM-5 remains the clinical standard by which diagnostic criteria are met and diagnoses are established. DSM-5 criteria must be met to support diagnoses even though billing and reporting will ultimately be submitted under ICD-10 codes. RAE contracted providers follow conventional diagnostic practice in considering whether diagnostic criteria are met, and consider that symptomatology may present atypically in individuals with a TBI. However, a diagnosis cannot be made in the absence of reasonably meeting criteria even in the context of an atypical presentation. Diagnostic evaluations will include a review of preexisting conditions, premorbid functioning, family medical and psychiatric history, prior treatment and evaluations, past and current response to treatment including prescribed medications, and past and current symptomatology and behavioral presentation as described by the individual, care providers, family members and other information sources.

2. Other diagnoses, including the traumatic brain injury, must be present to explain variances from diagnostic criteria.

3. Consideration is given to the member's abilities or disabilities in how diagnostic criteria present themselves.

4. Upon completion of a diagnostic evaluation as described in Guiding Principle #1, if a specific diagnosis is established with a reasonable degree of certainty, additional diagnoses will not be considered in authorizing services.

5. When a specific diagnosis cannot be clearly established (e.g., early in the course of an evolving disorder), the diagnosis with the best prognosis, and that best explains the clinical presentation of the member, is assumed over those with poorer prognoses until there is sufficient evidence to clearly document the poorer prognosis conditions. This conservative practice in

making a diagnosis is standard in medicine and presumes the individual has the strength and resources to overcome or optimally recover from their disability.

6. Diagnostic services, like treatment services, are driven by the best interests of the member, and are provided in the least restrictive setting where services can safely be provided.

7. RAE enrolled Medicaid members with traumatic brain injury have access to the full spectrum of appeal rights under the Accountable Care Collaborative for adverse decisions rendered with regard to clinical services for the treatment of covered mental illnesses.

8. These guidelines will be reviewed no less than annually and revised if necessary. Future review could involve expanding these guidelines.

EXHIBIT I-7, CAPITATED BEHAVIORAL HEALTH BENEFIT COVERED SERVICES & DIAGNOSES

Reimbursed under the behavioral health capitation, when the service is for a covered behavioral health diagnosis and is billed by a Behavioral Health Specialty Provider, non-physician practitioner group, behavioral health group provider, or an FQHC or RHC using revenue code 0900.

A covered diagnosis is not required for services with a primary category of Assessment, Screening, Crisis, or Prevention/Intervention, as indicated in the State Behavioral Health Services billing manual.

Starting January 1, 2024, the Contractor shall be responsible for covering psychotherapy services (90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, and 90853) with a primary diagnosis of Autism Spectrum Disorder (F84.0-F84.9) for Members under the age of 21.

Specialty Behavioral Health Codes

00104	Anesthesia for ECT
90785	InteractiveComplexity*
90832	Psychotherapy-30 minutes
90833	Psytx pt &/or family w/e&m 30 mins
90834	Psychotherapy-45 minutes
90836	Psytx pt &/or family w/e&m 45 mins
90837	Psychotherapy-60 minutes
90838	Psytx pt &/or family w/e&m 60 mins,
90839	Psychotherapy for crisis, first 60 mins
90840	Psychotherapy for crisis add-on, each add'l 30 mins
90846	Family psychotherapy (w/o patient)
90847	Family psychotherapy (with patient)
90849	Multiple family group psytx
90853	Group psychotherapy
90870	ECT
90875	Indv psychotherapy biofeedback 30min
90876	Indv Psychotherapy biofeedback 45min
96372	Ther/proph/diag inj, sc/im
97535	Self-care management training
97537	Community/work reintegration
G0176	Activity therapy 45 min or more
G0177	Training re: care of mh problem
H0004	Behavioral Health counseling and therapy, per 15 mins
H0005	Alcohol and/or drug services; group counseling by a clinician
H0006	Alcohol/Drug case management
H0010	Clinically managed residential withdrawal management: ASAM level 3.2WM, per diem
H0011	Clinically managed residential withdrawal management: ASAM level 3.7WM, per diem
H0015	Alcohol/Drug intensive outpatient
H0016	Alcohol/Drug partial hospitalization
H0017	BH residential w/o room/board
H0018	BH short term res w/o room/board
H0019	BH long term red w/o room/board
H0020	Methadone admin/service
H0033	Oral med admin observation
H0034	Med training/support per 15 min
H0039	Assertive Comm treatment per15min
H0035	MH Partial Hospitalization less 24hr.
H0036	Comm psych treatment per 15 min
H0037	Comm psych treatment, per diem
H0038	Self-help/peer services per 15 min
H0040	Assertive Comm treatment, per diem
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite not-in-home per diem
H2001	Rehab program 1/2 day
H2012	BH day treatment, per hour
H2014	Skills train and dev, 15 min
H2015	Comprehen comm support per 15 min
H2016	Comprehen comm support, per diem
H2017	Psysoc rehab svc, per 15 min
H2018	Psysoc rehab svc, per diem
H2021	Com wrap-around sv, 15 min
H2022	Com wrap-around sv, per diem
H2023	Supported employ, per 15 min
H2024	Supported employ, per diem
H2025	Supp maint employ, 15 min
H2026	Supp maint employ, per diem
H2027	Psycho ed service, per 15 min
H2030	MH clubhouse per 15 min
H2031	MH clubhouse per diem
H2032	Activity therapy per 15 min
H2033	Multisys ther/juvenile 15 min
H2036	Alcohol and/or other drug treatment program, per diem
S5150	nskilled respite care, per 15m
S5151	Unskilled respite care, per diem
S9445	Patient ed non-phys, indv
S9480	Intens Outpatient psych per diem
S9485	Crisis Interv MH per diem
T1005	Respite care service 15 min
T1017	Targeted case management

* must be billed with psychotherapy code

** listed separately in addition to primary procedure code

Reimbursed under the behavioral health capitation, when the service is for an appropriate diagnosis that supports Medical Necessity and is billed by a Behavioral Health Specialty Provider, non-physician practitioner group, behavioral health group provider, or an FQHC or RHC using revenue code 0900.			
Behavioral health codes			
90791	Diagnostic Eval w/o Medical Services	H0023	BH outreach
90792	Diagnostic Eval with Medical Service	H0025	BH prevention education
90887	Interpretation/explanation of psych/medical exam/data	H0031	MH assessment by non-phys
96116	Neurobehavioral status exam; first hr	H0032	MH service plan devel bynon-phys
96121	Neurobehavioral status exam; add'lhrs**	H0046	Drop-in
96130	Psych testing eval services; first hr	H2000	Comprehensive multidiscipline edu
96131	Psych testing eval services; add'l hrs**	H2011	Crisis intervention per 15 min
96132	Neuropsych testing eval services; firsthr	S9453	Smoking cess class, non-phys, per ses
96133	Neuropsych testing eval services; add'lhrs**	S9454	Stress manage, non-phys, per ses
96136	Psych or neuropsych test admin & scoring; 30min		
96137	Psych or neuropsych test admin; add'l 30 min**		
96138	Psych or neuropsych test admin, by tech; first 30min		
96139	Psych or neuropsych test admin, by tech; add'l 30min**		
96146	Psych or neuropsych test - automated		
98966	Hc pro phone call 5-10 min		
98967	Hc pro phone call 11-20 min		
98968	Hc pro phone call 21-30 min		
H0001	Alcohol and/or drug assessment		
H0002	Alcohol and/or drug screening		

Reimbursed under the behavioral health capitation when the service is provided for a covered behavioral health diagnosis, regardless of the billing provider.			
Evaluation & Management Consultation Codes			
99242	Outpatient Consultation, at least 20 minutes	99252	Hospital Consultation, at least 35 minutes
99243	Outpatient Consultation, at least 30 minutes	99253	Hospital Consultation, at least 45 minutes
99244	Outpatient Consultation, at least 40 minutes	99254	Hospital Consultation, at least 45 minutes
99245	Outpatient Consultation, at least 55 minutes	99255	Hospital Consultation, at least 80 minutes
Evaluation & Management Emergency Department Codes			
99281	Emergency department visit for problem that may not require health care professional	99284	Emergency department visit with moderate level of medical decision making
99282	Emergency department visit with straightforward medical decision making	99285	Emergency department visit with high level of medical decision making
99283	Emergency department visit with low level of medical decision making		

Reimbursed through the behavioral health capitation for a covered behavioral health diagnosis when the service is billed by a Behavioral Health Specialty Provider.			
Evaluation & Management Codes			
99202	Office or OP – New, 15 – 29 mins	99307	Subseq nursing facility, 10m
99203	Office or OP – New, 30 – 44 mins	99308	Subseq nursing facility, 15m
99204	Office or OP – New, 45 – 59 mins	99309	Subseq nursing facility, 30m
99205	Office or OP – New, 60 – 74 mins	99310	Subseq nursing facility, 45m
99211	Office or OP – other	99315	Nursing facility discharge, 30m
99212	Office or OP – Est, 10 – 19 mins	99316	Nursing facility discharge, 30+m
99213	Office or OP – Est, 20 – 29 mins	99341	Residence visit – New, at least 15 minutes
99214	Office of OP – Est, 30 – 39 mins	99342	Residence visit – New, 30m
99215	Office or OP – Est, 40 – 45 mins	99344	Residence visit – New, 60m
99221	Initial hospital care at least 40 minutes	99345	Residence visit – New, 75m

99222	Initial hospital care at least 55 minutes	99347	Residence visit – Est, 15m
99223	Initial hospital care at least 75 minutes	99348	Residence visit – Est, 30m
99231	Subsequent hospital care at least 25 minutes	99349	Residence visit – Est, 40m
99232	Subsequent hospital care at least 35 minutes	99350	Residence visit – Est, 60m
99233	Subsequent hospital care at least 50 minutes	99366	Team conf w/patient by hc pro
99234	Same day admit/DC, at least 45 minutes	99367	Team conf w/o patient byphys.
99235	Same day admit/DC, at least 70 minutes	99368	Team conf w/patient by hc pro
99236	Same day admit/DC, at least 85 minutes	99441	Telephone by phys 5-10 min
99238	Hospital discharge day 30 minutes or less	99442	Telephone by phys 11-20 min
99239	Hospital discharge more than 30 minutes	99443	Telephone by phys 21-30 min
99304	Initial nursing facility, 25m		
99305	Initial nursing facility, 35m		
99306	Initial nursing facility,45m		

Evaluation & Management Add-On Codes- Reimbursed under the behavioral health capitation when billed with an Evaluation & Management code covered under the behavioral health capitation.			
90836	Psychotherapy, 45 min with pt and /or family mbr when performed with anE&M	90838	Psychotherapy, 60 min with pt and /or family mbr when performed with an E&M
90833	Psychotherapy, 30 min with pt and /or family mbr when performed with anE&M		

The following revenue codes (in addition to those represented in Appendix Q on the Department's website) may be covered under the capitated behavioral health benefit:	
0510	CLINIC PSYCHIATRIC CLINIC PSYCH CLINIC
0513	CLINIC PSYCHIATRIC CLINIC PSYCH CLINIC
0902	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENSION OF 090X) MILIEU THERAPY BEHAVIORAL HEALTH/MILIEU THERAPY
0903	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENTION OF 090X) PLAY THERAPY BEHAVIORAL HEALTH/PLAY THERAPY
0904	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENSION OF 090X) ACTIVITY THERAPY BEHAVIORAL HEALTH/ACTIVITY THERAPY
0905	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X – AN EXTENSION OF 090X) INTENSIVE OUTPATIENT SERVICES – PSYCHIATRIC BEHAVIORAL HEALTH/INTENS OP/PSYCH*
0906	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X - AN EXTENSION OF 090X) INTENSIVE OUTPATIENT SERVICES - CHEMICAL DEPENDENCY BH/INTENS OP/CHEM DEP**
0907	BEHAVIORAL HEALTH TREATMENTS/SERVICES (ALSO SEE 091X - AN EXTENSION OF 090X) COMMUNITY BEHAVIORAL HEALTH PROGRAM (DAY TREATMENT) BH/COMMUNITY
0911	BEHAVIORAL HEALTH TREATMENT/SERVICES – EXTENSION OF 090X***
0912	BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION OF 090X PARTIAL HOSPITALIZATION - LESS INTENSIVE BH/PARTIAL HOSP
0913	BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION OF 090X PARTIAL HOSPITALIZATION - INTENSIVE BH/PARTIAL INTENS
0916	BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION OF 090X FAMILY THERAPY BH/FAMILY RX
0917	BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION OF 090X BIO FEEDBACK BH/BIOFEED
0918	BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION OF 090X TESTING BH/TESTING
0919	BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION OF 090X OTHER BEHAVIORAL HEALTH TREATMENTS/SERVICES BH/OTHER
0960	PROFESSIONAL FEES (ALSO SEE 097X AND 098X) GENERAL CLASSIFICATION PRO FEE
0961	PROFESSIONAL FEES (ALSO SEE 097X AND 098X) PSYCHIATRIC PRO FEE/PSYCH
1000	BEHAVIORAL HEALTH ACCOMMODATIONS GENERAL CLASSIFICATION
1001	BEHAVIORAL HEALTH ACCOMMODATIONS RESIDENTIAL - PSYCHIATRIC
1003	BEHAVIORAL HEALTH ACCOMMODATIONS SUPERVISED LIVING*
1005	BEHAVIORAL HEALTH ACCOMMODATIONS GROUP HOME***

* For mental health diagnoses only
** For Substance Use Disorder (SUD) diagnoses only
*** For members under the age of 2

Behavioral Health Specialty Provider Types		
Provider Type (PT)	*Specialty Type (ST)*	*Provider Type Description*
35	360	Community Mental Health Center
64	371	ASAM 1.0
64	372	ASAM 1 WM
64	373	ASAM 2.1 - IOP
64	XXX	ASAM 2.5 - PHP
64	374	ASAM 2 WM
64	XXX	ASAM 2.7 - OTP
64	XXX	ASAM 2.7 - OTP
64	477	Substance Use Disorder Clinics
64	871	ASAM level 3.1
64	872	ASAM level 3.3
64	873	ASAM level 3.5
64	874	ASAM level 3.7
64	875	ASAM level 3.2WM
64	876	ASAM level 3.7WM
78	887	Comprehensive Provider

Behavioral Health ICD-10-CM Code Ranges	
Substance Use Disorder	
Start Value	*End Value*
F10.10	F19.99
Mental Health Disorders	
Start Value	*End Value*
F20.0	F69
F90.0	F98.4
F98.8	F99
R45.1	R45.2
R45.5	R45.82

SDOH Diagnoses for Members Under 21
When Billing 90785, 90832, 90834, 90837, 90846, 90847, 90849, 90853, 90875, 90876, H0004, H0005, H0038, H2014, H2017, H2023, H2027, S9445

Start	**End**
R45.0	R45.7
R45.81	R45.84
R45.850	R45.89
R69 and Z03.89	
Z55.0	Z55.9
Z56.0	Z56.6

Z56.81	Z56.9
Z58.81	Z58.9
Z59.00	Z59.02
Z59.10	Z59.3
Z59.41	Z59.7
Z59.811	Z59.9
Z60.0	Z60.9
Z62.0	Z62.1
Z62.21	Z62.6
Z62.810	Z62.819
Z62.820	Z62.823
Z62.831	Z62.833
Z62.890	Z62.9
Z63.0	Z63.1
Z63.31	Z63.6
Z63.71	Z63.9
Z64.0	Z64.4
Z65.0	Z65.9

EXHIBIT J-2, SHORT-TERM BEHAVIORAL HEALTH SERVICES IN A PRIMARY CARE SETTING

In order to see the availability of a full continuum of behavioral health services, the Department is promoting the provision of short-term behavioral health services within primary care settings. These services are not intended for crisis services.

Short-term behavioral health services billed by a contracted Primary Care Medical Provider• (PCMP) may be reimbursed Fee-for-Service (FFS) for up to six (6) visits per state fiscal year. Multiple procedure codes may be billed during a visit as long as they are in compliance with the National Correct Coding Initiative standards. These visits will not require a covered behavioral health diagnosis or authorization. Additional sessions will require authorization from the Contractor and must be reimbursed under the capitated behavioral health benefit.

Short-term behavioral health services must be provided by licensed behavioral health practitioners and candidates for licensure (supervised in accordance with the rules of the Colorado Board of Psychotherapists).

Short-term Behavioral Health Service Procedure Codes

90791	Diagnostic Evaluation without Medical Services
90832	Psychotherapy-30 minutes
90834	Psychotherapy-45 minutes
90837	Psychotherapy-60 minutes
90846	Family Psychotherapy (w/o patient)
90847	Family Psychotherapy (with patient)

* This excludes any primary care provider that is on the same site as a Medicaid enrolled community mental health center CMHC.

Exhibit K Combined Core Competencies for Colorado's Peer Specialists / Recovery Coaches And Family Advocates / Family Systems Navigators

Knowledge of Mental Health/Substance Use Conditions and Treatments - Recognize signs and coping strategies, including the grief process - Know when to refer to a clinician - Know when to report to a supervisor - Understand interactions of physical and behavioral health
Clients Rights/Confidentiality/Ethics/Roles - Understand scope of duties and role - Understand HIPAA / protected health information / confidentiality - Maintain professional boundaries - Recognize potential risks - Advocate when appropriate
Interpersonal Skills - Communication - Diversity and cultural competency - Relationship development - Use guiding principles pertinent to population served - Model appropriate use of personal story and self-advocacy - Goal-setting, problem-solving, teamwork, & conflict resolution
Resiliency, Recovery and Wellness - Understand principles and concepts of resiliency, recovery, and a wellness oriented lifestyle - Assist others with their own resiliency and recovery - Encourage options and choices - Understand impacts of labels, stigma, discrimination, and bullying - Understand person-centered resiliency and recovery planning for all ages and stages - Promote shared decision-making
Resources - Knowledge of community resources and those specific to behavioral health and physical Health and how to navigate the benefits system - Help individuals and families recognize their natural supports ***** Knowledge of public education and special education system and other child-serving systems
Self-care - Recognize when health may compromise the ability to work - Acknowledge that personal wellness is a primary responsibility - Set boundaries between work and personal life
Teaching Skills - Demonstrate wellness and teach life skills - Encourage the development of natural supports - Assist people to find and use psycho-education materials
Basic Work Competencies - Seek supervision and/or ask for direction - Accept feedback - Demonstrate conflict resolutions skills - Navigate complex work environments
Trauma-Informed Support - Understand impact of trauma and responses to trauma - Demonstrate sensitivity and acceptance of individual experiences - Practice cultural sensitivity - Promote shared decision-making

* Item pertains specifically to Family Advocates / Family Systems Navigators

Sources of Information and Input:

1. Advocates for Recovery – Colorado *Core Competencies for Recovery Coaches*, (2010)

2. Blanch, A., Filson, B., & Penney, D. *Engaging Women in Trauma-Informed Peer Support: A Guidebook* (2012)

3. *Colorado Mental Health Advocates' Forum Peer Specialist Core Competencies*, as adopted by the Colorado Department of Health Care Policy and Financing (HCPF) in its *Medicaid Community Mental Health ServicesProgram Request for Proposals* released December 2008.

4. *Colorado Mental Health Advocates' Forum Consensus Statement on Resiliency* (2012)

5. Colorado *Mental Health Advocates' Forum Consensus Statement on Trauma-Informed Care* (2012)

6. National Federation of Families for Children's Mental Health *Certified Parent Support Specialist Self-Assessment Training Checklist*, Sept. 2011, from the National Federation website.

7. *SAMHSA's Working Definition of Recovery* (Dec. 2011), retrieved from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration website

8. House Bill 1193 – Concerning Integrated System-of-Care Family Advocacy Programs for Mental Health Juvenile Justice Populations. (2011)

EXHIBIT L, ADDITIONAL STATEMENT OF WORK

SECTION 1.0 WRAPAROUND PROGRAM FOR CHILDREN AND YOUTH WITH SIGNIFICANT MENTAL HEALTH CONDITIONS

1.1. The Contractor shall administer a Wraparound Program to improve the health, well-being, and functioning of children and youth with significant mental health conditions and their families, and should seek, when possible, to reduce potentially-preventable emergency room, inpatient, or residential child care facilities utilization.

1.2. The Contractor's Wraparound Program shall consist of high-fidelity Wraparound Care Coordination and parent/caregiver peer support in alignment with the state's System of Care and the evidence-based model detailed within the book Building Systems of Care: A Primer (2010).

1.3. Population Served

1.3.1. The Contractor shall administer the Wraparound Program for children and youth from birth to age twenty-one (21) who are assessed as likely to benefit from the Program and who meet all of the following Medical Necessity criteria:

1.3.1.1. The child or youth met at any time during the past 12 months the diagnostic criteria for Serious Emotional Disturbance (SED) or Serious and Persistent Mental Illness (SPMI) as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.) with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable condition.

1.3.1.2. The child's or youth's diagnosable disorder substantially interferes or limits the child's or youth's role or functioning in family, school, employment, relationships, or community activities.

1.3.1.3. The child or youth is taking multiple psychotropic medications outside of recommended guidelines and/or is identified as having a high likelihood of any of the following:

1.3.1.3.1. Placement in a Residential Child Care Facility;

1.3.1.3.2. A psychiatric hospitalization; or

1.3.1.3.3. Commitment in the Youth Corrections system.

1.3.1.4. The child or youth needs or receives multiple services from the same or multiple providers or state child serving systems (i.e., child welfare, juvenile justice, or special education) and needs a care planning team to coordinate services.

1.3.1.5. The person(s) with authority to consent to medical treatment for the child or youth voluntarily agrees to participate in the Wraparound Program. The assent of the child or youth who is not authorized under applicable law to consent to medical treatment is desirable but not required.

1.3.2. The Contractor may assess for appropriateness children or youth in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting who meet the Systems of Care Medical Necessity criteria described in Section 6.3.3.1 who are within 180 days of discharge.

1.3.3. The Contractor shall not administer the Wraparound Program for children or youth who are determined as not being likely to benefit from the Wraparound Program or who meet either of the following criteria:

1.3.3.1. The person(s) with authority to consent to medical treatment for the child or youth does not voluntarily consent to participate in Wraparound Program.

1.3.3.2. The child or youth is in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting at the time of referral and is unable to return to a family home environment or community setting with community-based supports.

1.3.4. The Contractor shall continue administering the Wraparound Program for children or youth who meet all of the following criteria:

1.3.4.1. The child or youth's clinical condition(s) continues to warrant the Wraparound Program in order to coordinate the child or youth's involvement with state agencies or multiple service providers.

1.3.4.2. Progress toward identified care plan goals have been documented.

1.3.5. The Contractor shall discontinue administering the Wraparound Program for children and youth who meet any of the following criteria:

1.3.5.1. The child or youth no longer meets the criteria for a significant mental health condition

1.3.5.2. The Child and Family Care Team determine the child or youth has met the care plan objectives and continued services are not necessary to prevent worsening of the child or youth's behavioral health condition.

1.3.5.3. Consent for treatment is withdrawn.

1.3.5.4. The child/youth and parent/caregiver are not engaged in treatment despite multiple documented attempts to address engagement.

1.3.5.5. The child/youth is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting and is unable to return to a family home environment or community setting with community-based supports.

1.3.5.6. The youth turns 21 years old.

1.4. The Contractor shall create and submit to the Department a monthly Wraparound Program Enrollment Report that contains, at a minimum, the following information:

1.4.1. Name and Medicaid ID for all new Members enrolled in the Wraparound Program during the past month.

1.4.2. Name and Medicaid ID for all Members who remain enrolled in the Wraparound Program.

1.4.3. Name and Medicaid ID for all Members whose enrollment in the Wraparound Program was terminated during the past month.

1.4.3.1. DELIVERABLE: Wraparound Program Enrollment List

1.4.3.2. DUE: Monthly, by the last day of the month.

1.5. The Contractor shall accept, monitor and report on all referrals of potentially eligible children and youth and the final determination. Referrals may come from the state's Crisis Hotline, child welfare, probation, Network Provider, school or other source.

1.5.1. The Contractor shall identify children and youth enrolled with the Contractor that might benefit from the Wraparound Program by examining past hospitalizations, overuse of the crisis system, and prescriptions for high levels of psychotropic medication.

1.5.2. The Department estimates that between one thousand (1,000) and two thousand (2,000) children and youth may be eligible and likely to participate in the Wraparound Program statewide.

1.5.3. Wraparound Program Network

1.5.3.1. The Contractor shall establish a Wraparound Program network of licensed CMHCs, residential treatment centers, and private practitioners that:

1.5.3.1.1. Are trained in high-fidelity Wraparound.

1.5.3.1.2. Have demonstrated experience with:

1.5.3.1.2.1. Strength-based, family-driven practice and service models

1.5.3.1.2.2. Sustained partnerships with child-serving organizations, such as schools, child welfare, youth and family service providers, faith institutions, etc.

1.5.3.1.3. Employ or have contracts with parent(s) and caregiver(s) of children and youth with significant mental health conditions who have been trained to provide peer support, system navigation, and other types of assistance to families who have youth with serious emotional disturbance.

1.6. WRAPAROUND PROGRAM ACTIVITIES

1.6.1. The Contractor shall provide, arrange for, or otherwise take responsibility for the provision of high-fidelity Wraparound Care Coordination and parent/caregiver peer support.

1.6.2. The Contractor shall ensure the delivery of a high-fidelity Wraparound model as defined by the National Wraparound Implementation Center and measured by the most current version of the Wraparound Fidelity Index.

1.6.3. The Contractor shall ensure the provision of the four phases of the Wraparound Care Coordination process to ensure that every child/youth served has a family-driven, youth-guided team, facilitated by a dedicated care coordinator that

plans and ensures access to needed behavioral health, medical, oral, social, educational, developmental, and other services and supports. The four phases of the Wraparound Care Coordination process are:

1.6.3.1. A comprehensive home-based assessment of Medical Necessity for Wraparound Program.

1.6.3.2. Development and facilitation of a Child and Family Team.

1.6.3.3. Creation of an individualized care plan.

1.6.3.4. Monitoring and follow-up activities to ensure successful implementation of the individualized care plan.

1.6.4. The Contractor shall ensure the Wraparound Care Coordination includes, at a minimum, the following activities:

1.6.4.1. A comprehensive home-based assessment of Medical Necessity for the Wraparound Program including utilization of the following tools:

1.6.4.1.1. Child and Adolescent Needs and Strengths (CANS) assessment tool

1.6.4.1.2. Strengths, Needs, Culture, Discovery Assessment (Systems of Care Assessment)

1.6.4.2. Development and facilitation of a Child and Family Team to identify the unique needs of the child and family and to develop treatment approaches to address those needs. The Child and Family Team shall include the child/youth, family/caregiver, natural supports (friends, neighbors, interested stakeholders), Wraparound care coordinator, treatment providers, and any relevant social service or education entities.

1.6.4.3. Creation and monitoring of an individual care plan.

1.6.4.4. Creation of crisis/safety plan(s).

1.6.4.5. Care Coordination, including, at a minimum, the following responsibilities:

1.6.4.5.1. Face-to-face meetings at least bi-weekly

1.6.4.5.2. Regular telephonic, electronic, and other contact with youth and parent/caregiver, at a minimum of one (1) time per week

1.6.4.5.3. Linkage and referrals for supports and services

1.6.4.5.4. Assistance with system navigation

1.6.4.5.5. Attendance at relevant treatment provider meetings, such as IEP and hospital discharges

1.6.4.5.6. Aftercare planning

1.6.4.6. Education, advocacy and support to youth and parent(s)/caregiver(s).

1.6.4.7. Individualized and family-driven interventions and/or supports for the youth and parent/caregiver.

1.6.4.8. Member outreach.

1.6.4.9. Documentation of contacts and interventions.

1.6.5. The Contractor shall ensure the provision of parent/caregiver peer support for those parents and caregivers who require additional assistance to more effectively support their child's/youth's recovery.

1.6.5.1. Parent/caregiver peer support is a structured, one-to-one, strength-based relationship between a trained parent/caregiver with lived experience and a parent/caregiver whose child/youth is currently engaged with the Wraparound Program. The purpose of this service is for resolving or ameliorating the youth's emotional and behavioral needs by improving the capacity of the parent /caregiver to parent the youth so as to improve the youth's functioning.

1.7. WRAPAROUND PROGRAM ADMINISTRATION

1.7.1. The Contractor shall ensure the appropriate and cost effective administration of the Wraparound Program by:

1.7.1.1. Performing and/or reviewing eligibility assessments for the Wraparound Program

1.7.1.2. Recruiting trained Wraparound Program providers

1.7.1.3. Ensuring an adequate network of trained Wraparound care coordinators to meet the needs of all eligible children and youth in the Contractor's region.

1.7.1.4. Monitoring delivery of Wraparound Program activities and coordination of care for all active Members engaged in the Wraparound Program, including review of the statewide Systems of Care software program.

1.7.1.5. Ensuring Wraparound Program enrollees receive timely access to Medically Necessary services covered under the Accountable Care Collaborative, such as outpatient behavioral health therapy and intensive in-home therapy.

1.7.1.6. Facilitating data sharing across all treating providers and ensuring the completion of necessary consents and releases of information.

1.7.1.7. Continually monitoring Wraparound Program outcomes.

1.7.1.8. Reporting to the Department and Child Welfare and local Collaborative Management Programs on Wraparound Program utilization and referrals.

1.7.1.9. Collaborating with Community partners (counties, child welfare, probation officers, etc.) on addressing unique needs of children and youth.

1.7.1.10. Identifying a staff person to serve as the primary contact for the Wraparound Program within the region.

1.7.1.11. Assuring that the Wraparound Program delivers quality care that is consistent with Wraparound fidelity, this includes ensuring:

1.7.1.11.1. The ratio of Wraparound Program enrolled families to Wraparound care coordinator does not exceed 10:1, irrespective of whether the Wraparound care coordinators are employees of the Contractor or a Subcontractor.

1.7.1.11.2. Parent/caregiver peer support providers are trained, receive supervision, and do not have caseloads that exceed twenty (20) families.

1.7.1.12. Participating in community-based efforts to build the statewide System of Care.

1.7.1.13. Performing continuous quality improvement activities.

1.7.2. Wraparound Program Quarterly Report

1.7.2.1. The Contractor shall create and submit a Wraparound Program Quarterly Report to the Department every three (3) months. The Contractor shall ensure that the Report covers the following information:

1.7.2.1.1. Total number of Wraparound Program enrollees for each month in the reporting period.

1.7.2.1.2. Ratio of Wraparound Program enrollees to Wraparound Facilitators

1.7.2.1.3. Ratio of Wraparound Program enrollees to parent/caregiver peer

1.7.2.1.3.1. DELIVERABLE: Wraparound Program Quarterly Report

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

SECTION 2.0 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) GENERAL REQUIREMENTS

2.1. The Contractor shall manage the Colorado Pre-Admission Screen and Resident Review in accordance with state and federal statutes, rules and regulations for individuals who have or are suspected of having a mental illness or intellectual and/or developmental disability. State statutes include Section 27-1-201 et seq., C.R.S., as amended and Section 27-10-101 et seq., C.R.S., as amended.

2.2. The Contractors shall meet the three goals of PASRR: identify individuals with mental illness or intellectual and/or developmental disability, or both; ensure individuals are placed appropriately, whether in the community or in a nursing facility; and ensure that individuals receive the services required for their diagnosis in whatever setting they reside.

2.3. The Contractor shall use an existing information management system to manage and coordinate PASRR activities.

2.4. The Contractor shall attend all required PASRR training.

2.5. PASRR consists of these elements:

2.5.1. Pre-Admission Screen (PAS) Level I is a preliminary screen completed by staff from nursing facilities, Single Entry Point Agencies (SEPs) or hospital discharge

planners (referring agencies) to indicate the possible presence of mental illness or intellectual and/or developmental disability for an individual seeking nursing facility admission.

2.5.2. PAS Level II is an in-depth evaluation completed by a trained assessor to confirm the presence of mental illness or intellectual and/or developmental disability, determine the appropriate living situation, and identify any specialized services are needed.

2.5.3. Resident Review is conducted whenever there is a change in the Member's condition that may affect their mental illness or intellectual and/or developmental disability status.

2.6. REVIEW PAS LEVEL I ASSESSMENTS

2.6.1. The Contractor shall review PAS Level I assessments completed by referring agencies and submitted into the PASRR information management system. On average, the Department's contractor reviews approximately seventeen thousand (17,000) PAS Level 1 assessments throughout the state.

2.6.1.1. The Contractor shall determine if a PAS Level II Assessment is required or if the Member may be admitted to a nursing facility without the Level II assessment.

2.6.1.2. The Contractors shall exempt the Member from a PAS Level II Assessment if the Member meets any of the following criteria:

2.6.1.2.1. Member has a terminal illness.

2.6.1.2.2. Member is placed provisionally in the facility due to an emergency placement or a placement from out-of-state.

2.6.1.2.3. Member is receiving respite care through the Program of All-Inclusive Care for the Elderly.

2.6.1.2.4. Nursing facility is for convalescent care. If a Member remains after the convalescent period, the Contractor shall ensure that the referring agency request a Resident Review or initiate a PAS Level II Assessment.

2.6.1.3. The Contractor shall review supporting documentation, such as the Uniform Long-Term Care 100.2 form, hospital discharge requests and medical records. If necessary, the Contractor shall consult with the referring agency, the Member's family, the Member's physician and others knowledgeable of the Member's current status.

2.6.1.4. For Members moving from out-of-state, the Contractor shall obtain information regarding the current placement, the reason for relocation to Colorado, any suspected mental illness or intellectual and/or developmental disability diagnoses, any current or past treatment or services and supports the person is receiving, any psychotropic medications, and the Member's psychiatric stability.

2.6.2. The Contractor shall complete the PAS Level I review, update the system with the results, and notify the referring agency of the results within six (6) business

hours of receiving the PAS Level I Assessment. If the assessment is for a provisional emergency admission, the Contractor shall complete the review and notify the referring agency within six (6) hours, including on weekends and holidays.

2.6.3. The Contractor shall train referring agencies on how to submit a PAS Level I assessment to the information management system.

2.6.4. If a Member is unwilling to be admitted to a nursing facility or if a facility plans to place the Member in a secure unit, the Contractor shall ensure that the Member's guardian, medical power of attorney, medical proxy or other legal authority signs the Member into the nursing facility. If no legal authority is in place, the Contractor shall work with the facility to determine legal authority designation.

2.7. CONDUCT PAS LEVEL II ASSESSMENT

2.7.1. The Contractor shall ensure that a trained Level II assessor completes a PAS Level II Assessment for any Member who needs it. The trained assessor may be an employee or a Subcontractor. The Contractor shall ensure that all assessors have clinical supervision.

2.7.1.1. The Contractor or its designee shall conduct a comprehensive desk review and ensure the accuracy of all assessment documents and confirm that a functional assessment for LTSS has been completed.

2.7.1.2. The Contractor or its designee shall conduct a face-to-face visit with the Member seeking admission to a nursing facility.

2.7.1.3. The Contractor or its designee shall arrange for a Developmental Disability Determination prior to scheduling the PAS Level II Assessment for Members who may have an intellectual and/or developmental disability but with no prior history of a determination.

2.7.1.4. The Contractor or its designee shall assess community-based alternatives for Members considering admission to a nursing facility.

2.7.1.5. The Contractor or its designee shall request additional information, when needed, from the State Mental Health Authority or the State Intellectual Disability Authority.

2.7.2. The Contractor shall complete and submit the Level II Assessment within nine (9) calendar days from the date of referral.

2.7.3. The Contractor shall request through the information management system that the State Mental Health Authority or State Intellectual Disability Authority review the Level II Assessment, and obtain a determination letter from the appropriate authority regarding the recommendation for placement and the need for specialized services.

2.7.4. If the Member requires specialized services, the Contractor shall ensure that the Member has a Case Management Agency. If the Member does not have a case manager, the Contractor shall assist the Member, family or guardian with selecting a Case Management Agency to arrange for specialized services.

2.7.5. The Contractor shall communicate the results of the Level II Assessment to the referring agency and nursing facility. For Members in need of specialized services, the Contractor shall also communicate the results of the assessment to the Case Management Agency.

2.7.6. On average, the Department's current contractor performs approximately two thousand two hundred (2,200) Level II assessments annually throughout the state.

2.8. COORDINATE CARE PLANNING

2.8.1. The Contractor shall ensure that the nursing facility and, if applicable, the Case Management Agency and mental health center collaborate to create a Pre-Admission Care Plan. The Pre-Admission Care Plan includes what specialized services, if any, are to be provided by mental health or intellectual and/or developmental disability service providers, and which services are to be provided by the nursing facility.

2.8.2. The Contractor shall obtain approval for the Pre-Admission Care Plan from the State Mental Health Authority or the State Intellectual Disability Authority. The Contractor shall coordinate with the nursing facility to submit a revised plan if these authorities require it.

2.8.3. The Contractor shall ensure that the Pre-Admission Care Plan includes the plans, if required, for continuity of care.

2.9. ENSURE CONTINUITY OF CARE

2.9.1. The Contractor shall ensure continuity of care planning for Members receiving mental health or intellectual and/or developmental disability services, or for Members transferring from one RAE to another.

2.9.2. The Contractor shall notify the provider and other appropriate parties at the mental health center, Case Management Agency and intellectual disability service provider of the continuity of care plan. The Contractor shall:

2.9.2.1. Ensure that all necessary parties have been notified of the Member's transfer.

2.9.2.2. Review the continuity of care with the State Mental Health Authority or the State Intellectual Disability Authority, and communicate any revisions to the plan.

2.9.2.3. Include the final continuity of care plan in the completed Level II Assessment.

2.10. ENSURE RESIDENT REVIEW FOR STATUS CHANGE

2.10.1. The Contractor shall ensure that the nursing facility conducts a Level I update resident review for any Member residing in a nursing facility who experiences any the following changes:

2.10.1.1. Significant change in status affecting the Member's mental illness or intellectual and/or developmental disability status, including new or worsened serious symptoms

2.10.1.2. New diagnosis of mental illness or intellectual and/or developmental disability

2.10.1.3. Significant change in condition based on the Minimum Data Set (MDS) Assessment completed by nursing facilities

2.10.1.4. Expiration of a time limited approval, such as a provisional placement or convalescent care stay

2.10.2. The Contractor shall implement established protocols for accepting and responding to Level I updates from nursing facilities.

2.10.3. The Contractor shall review the Level I update to determine if a PAS Level II assessment is necessary. The Contractor shall complete the review and notify the nursing facility within three (3) Business Days of receiving the Level I update.

2.10.4. The Contractor shall train nursing facilities about the process for completing and submitting a Level I update resident review.

2.11. OVERSEE QUALITY AND COMPLIANCE

2.11.1. The Contractor shall review quality of all PASRR reviews to assure that referring agencies are complying with the PASRR program.

2.11.1.1. The Contractor shall investigate noncompliance concerns to determine whether further investigation or action is warranted. As part of the investigation, the Contractor shall:

2.11.1.1.1. Implement a process for identifying a provider's noncompliance with the PASRR program.

2.11.1.1.2. Notify the provider of the noncompliance issue.

2.11.1.1.3. Report issues of noncompliance to the Department.

2.11.1.1.4. Review findings with the State Mental Health Authority and the State Intellectual Disability Authority.

2.11.1.1.5. Work with the Department to develop a corrective action plan for any compliance issues.

2.11.1.1.6. Provide education and technical assistance to the referring agency to address compliance issue.

2.11.1.1.7. Provide updates to the Department of the status of the corrective action plan.

2.11.1.1.8. Notify the referring agency when it has met the terms and conditions of the corrective action plan.

2.11.1.2. The Contractor shall maintain records of noncompliance information and enter non-compliance issues as they are identified in the information management system.

2.11.1.3. The Contractor shall track the location and outcome of the Members who had a PAS Level II Assessment.

2.12. BROKERING OF CASE MANAGEMENT AGENCIES

2.12.1. The Contractor shall serve as a broker to connect Members applying for or receiving Medicaid Long-Term Services and Supports (LTSS) to a Case Management Agency (CMA), an organization that works with the Member to develop an individualized service plan, arrange for appropriate services, choose providers, and monitor the health, safety, and welfare of Members and the implementation of the services. In FY 2015–16, thirty seven thousand one hundred eighty five (37,185) clients were enrolled in HCBS waivers and approximately six thousand five hundred (6,500) individuals became newly enrolled in HCBS waivers annually.

2.13. PROVIDE PERSON-CENTERED COUNSELING FOR CHOOSING A CMA

2.13.1. The Contractor shall provide Members with open and informed choice among CMAs by functioning as a neutral party to connect Members with a CMA that addresses their needs and preferences.

2.13.1.1. The Contractor shall explain the choice process, including the Member's right to choose a CMA at any time, and the Contractor's role as an unbiased broker to Members.

2.13.1.2. If a Member has a preferred CMA, the Contractor shall honor that Member's choice so long as the CMA is not also providing direct services and can provide conflict-free case management.

2.13.1.3. If a Member does not have a preferred CMA, the Contractor shall review the options with the Member.

2.13.1.4. If a Member would like to meet with one or more CMAs before making a choice, the Contractor shall assist the Member or the Member's designated representative in setting up interviews.

2.13.2. The Contractor shall document all brokering activities within the Department-specified case management software. The Contractor shall include in its documentation that the Member was offered a choice of CMA, and which CMA the Member chose.

2.13.3. The Contractor shall provide disability competency training for its staff so they are able to knowledgeably and respectfully serve a range of Members with different needs.

2.13.4. The Contractor shall establish protocols for transferring case management brokering responsibilities to a new RAE when a Member moves to another region where the Member's current CMA does not provide case management.

2.13.5. The Contractor shall identify and contact Members who are receiving case management and HCBS direct services from the same agency, and help them choose a new CMA in accordance with the Department's conflict-free case management implementation plan.

2.14. REFER MEMBERS TO A CMA

2.14.1. The Contractor shall implement the Department's referral protocols with each CMA in its region. Referral protocols shall address, at a minimum:

2.14.1.1. Information the CMA requires for a referral.

2.14.1.2. Business process for transmitting the referral.

2.14.1.3. Process for transitioning Members who choose a new CMA that better meets their needs.

2.14.2. The Contractor shall provide to the Member, in writing, the contact information for the CMA to which the Member is referred, as well as the Member's right to choose a different CMA.

2.14.3. The Contractor shall follow up within two (2) Business Days of making a referral to ensure that the CMA has received the referral and is connecting with the Member.

2.14.4. The Contractor shall ensure that the agency providing case management services for a Member does not also provide HCBS direct services to that Member. Providing both case management and direct services is a conflict of interest that violates federal HCBS regulations and state statute.

2.14.5. The Contractor shall send a letter to the Member six (6) months after referring the Member to a CMA, to follow up on satisfaction with CMA service, provide an updated CMA list, and re-state the Member's right to choose and switch to a different CMA.

2.15. MAINTAIN AN ADEQUATE NETWORK OF CMAS

2.15.1. The Contractor shall ensure that there is adequate choice of CMAs within the region. Network adequacy is defined as the choice of at least two (2) CMAs in rural areas and at least three (3) CMAs in urban areas.

2.15.1.1. The Contractor shall maintain a list of available CMAs in the region. The list shall include:

2.15.1.1.1. Each CMA in the region

2.15.1.1.2. A summary of the qualifications and expertise of each CMA

2.15.1.1.3. Other services each CMA provides that may conflict with unbiased case management for a Member

2.16. ALIGN ACTIVITIES WITH STATE SYSTEMS

2.16.1. The Contractor shall align its activities with the Department's implementation of No Wrong Door, which improves communication among LTSS entry point agencies to ensure Members receive timely and consistent information, and creates common entry points, where Members connect to Home and Community Based Services regardless of age, pay source or disability.

2.16.2. The Contractor shall monitor the Department's transition to conflict-free case management and adjust its activities to support the transition during each phase of implementation.

EXHIBIT P, HB 21-1289 IMPLEMENTATION

STATE FISCAL YEAR 2024-25

Exhibit P, Health First Colorado Benefits for Colorado Children and Pregnant Persons without a Qualifying Immigration Status SOW

1. Project Requirements

1.1. Starting January 1, 2025, the Contractor shall expand Work to the following populations as covered Members, in compliance with C.R.S. 25.5-8-109(6)(a), and C.R.S. 25.5-8-109(7)(a):

1.1.1. Pregnant or postpartum individuals up to 12 months after the pregnancy ends who otherwise would not have been eligible for Medicaid due solely to the individual's immigration or citizenship status.

1.1.2. Children who are less than nineteen years of age who otherwise would not have been eligible for Medicaid due solely to the child's immigration or citizenship status.

1.2. Contractor shall align Work provided to these populations with Work provided to all other Members.

1.3. Contractor shall not discriminate against any Member based on immigration or citizenship status for the implementation of Work.

2. Funding Requirements

2.1. Contractor shall ensure that project funds are tracked distinctly from other funds and are not mixed with any federal funding.

2.2. Contractor shall submit financial reporting specific to these populations to the Department in a format and frequency determined by the Department.

3. Privacy

3.1. Contractor shall use the minimum data necessary to protect the personal health information and enrollment status in the program for Members covered and engaged by Contractor with the Work under these categories.

4. Deliverables

4.1. Contractor shall report on Members covered under these categories in an existing deliverable in a format and frequency determined by the Department.

5. Risk Corridor for Cover All Coloradans Population, effective January 1, 2025 through June 30, 2025

5.1. Due to uncertainty associated with coverage for the Cover All Coloradans (CAC) population, all applicable CAC cohorts for this time period shall be subject to a risk corridor calculation. The risk corridor will be calculated prior to the Medical Loss Ratio, and any reconciliations under the risk corridor will be incorporated as an adjustment to revenue within the Medical Loss Ratio calculation. (BH only) The CAC population will be excluded from the calculation of the Behavioral Health Incentive Program. Any risk corridor calculation for the CAC population will be completed after the completion of the PPS risk corridor.

5.2. Population Covered

5.2.1. The following population cohorts will be included in the CAC risk corridor:

Program	Cohort
BH	Prenatal/Delivery
	Postpartum
	Children
	Disabled Children
DH	Prenatal/Delivery
	Postpartum
	Children > 1
	Children 1+ / Foster Care
	Disabled Children

53. Calculation Process

5.3.1. The Department will calculate a CAC target PMPM as the medical portion of the actuarial sound PMPM for the contract period on a cohort basis.

5.3.2. CAC Adjusted Actual PMPM

5.3.2.1. The Department, or its designee, will calculate an adjusted actual PMPM for the contract period to be used in the risk corridor for the CAC population on a cohort level basis.

5.3.2.2. The numerator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, using the submitted encounter data with three months runout and submitted financial information, inclusive of Incurred but Not Reported (IBNR) information, on a cohort level, net of any adjustments from the PPS risk corridor.

5.3.2.3. A single PMPM over all categories of aid will be calculated as the PPS risk corridor reconciliation for behavioral health. This amount will be added to the numerator.

5.3.2.4. The denominator of the Adjusted Actual PMPM will be calculated by the Department, or its designee, as the incurred member months for the contract period with three months runout as represented in the Department's system of record on a cohort level.

5.3.3. The Department, or its designee, will calculate the ratio between the CAC Adjusted Actual PMPM and the CAC Target PMPM to determine any cost sharing reconciliation based on the calculation table listed below.

5.3.4. The actuarially determined CAC Target PMPM is equivalent to one hundred percent (100%) in the risk corridor structure.

5.3.5. Risk corridor calculations will be made according to the following:

Corridor #	Risk Corridor Min	Risk Corridor Max	MCE Share	State Share
A	0.00%	94.99%	0%	100%
B	95.00%	98.99%	50%	50%
C	99.00%	100.99%	100%	0%

D	101.00%	104.99%	50%	50%
E	105.00%	+	0%	100%

5.4. Recoupments or Additional Reimbursement

5.4.1. From the above table, a ratio of greater than 100% indicates a payment due from the Department to the Contractor. A ratio of less than 100% indicates a payment due from the Contractor to the Department.

5.4.2. After finalizing the risk corridor calculation, the Department will present the calculations to the Contractor and allow 7 business days for feedback.

5.4.3. The Department will issue a demand/notification letter for any amount due as recoupment from or payment to the Contractor.

5.4.4. The Contractor shall reimburse the Department, where applicable, within sixty (60) days of the Department issuing the demand letter.

5.4.5. The Department shall reimburse the Contractor, where applicable, for risk corridor calculations within sixty (60) days of the Department issuing the notification letter.

6. Physical Health Rates

6.1.

Category of Aid	SFY24-25 Rates
Disabled Child	$ 426.89
Non-Disabled Child (<1)	$ 383.21
Non-Disabled Child (2-18) & FC	$ 132.94
Prenatal	$ 562.98
Delivery	$ 6,492.68
Postpartum	$ 291.99

7. Behavioral Health Rates

7.1. To be negotiated.