CONTRACT AMENDMENT #14

SIGNATURE AND COVER PAGE

State Agency Department of Health Care Policy and Financing	**Original Contract Number** 19-107507
Contractor Rocky Mountain Health Maintenance Organization, Inc.	**Amendment Contract Number** 19-107507A14
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** April 30, 2018 **Current Contract Expiration Date** June 30, 2023

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 Rocky Mountain Health Maintenance Organization, Inc. DocuSigned by: By: 3FDBEA2E9D8F495... 4/17/2023 | 07:38 PDT Date:	**STATE OF COLORADO** **Jared S. Polis, Governor** Department of Health Care Policy and Financing Kim Bimestefer, Executive Director DocuSigned by: By: Kim Bimestefer 0B6A64797EA8493... 4/17/2023 | 09:58 PDT 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

DocuSigned by:
By: Jerrod Cotosman 76F69541272B43A...
4/17/2023 | 12:10 PDT
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 the 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 vendor specific requirements.

5. MODIFICATIONS

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

A. The Contract Initial Contract Expiration Date on the Contract's Signature and Cover Page is hereby deleted and replaced with the Current Contract Expiration Date shown on the Signature and Cover Page for this Amendment.

B. 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 on the Signature and Cover Page for this Amendment.

C. Exhibit B-8, Statement of Work, is hereby deleted in its entirety and replaced with Exhibit B-9, 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, and B-8 shall henceforth be a reference to Exhibit B-9.

D. Exhibit E-10, Payment, is hereby deleted in its entirety and replaced with Exhibit E-11, 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, and E-10 shall henceforth be a reference to Exhibit E-11.

E. Exhibit I-6, Capitated Behavioral Health Benefit Covered Services & Diagnoses, is hereby deleted in its entirety and replaced with Exhibit I-7, 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.

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

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-9, 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. The Contractor, as the Regional Accountable Entity, 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. The 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. The Contractor shall:

1.1.2.1. Assist the multi-payor collaborative and the Department in the selection of ten (10) to fifteen (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 the Contractor, their Network Providers and the Department;

1.1.2.4. Identify early areas of opportunity;

1.1.2.5. Share ideas regarding best and promising practices and the 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. The Contractor shall within the first one hundred and twenty (120) days of the Contract identify key performance metrics and targets in the following two (2) areas:

1.1.3.1. Percent of Members receiving care coordination;

1.1.3.2. Access standards.

1.1.4. The Contractor shall produce a return on program investment between 1.5-2.0 to 1 for the first year of Phase II, increasing in subsequent years of the Contract.

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

1.1.6. The Department will support the 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 the RAEs within each region to manage conflict and to collaborate with the Department to make decisions related to this work;

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

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

1.1.8. The Contractor shall utilize Prometheus data at a Statewide level to identify opportunities to improve Member health outcomes.

1.1.9. The 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. The 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 the 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 in **the base contract**, acronyms and abbreviations are defined at their first occurrence in this Exhibit B, 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 the 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. Business Hours – 8:00 a.m.-5 p.m. Mountain Time each Business Day.

2.1.9. 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.

2.1.10. 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.

2.1.11. 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.

2.1.12. Capitated Payment – A monthly payment the Department makes on behalf of each Member for the provision of non-fee-for-service behavioral health services delivered through the Capitated Behavioral Health Benefit.

2.1.13. 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.

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

2.1.15. 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.

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

2.1.17. 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.

2.1.18. 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.

2.1.19. 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.

2.1.20. 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

2.1.21. 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.

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

2.1.23. 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.

2.1.24. 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.

2.1.25. 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.

2.1.26. 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.

2.1.27. 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.

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

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

2.1.30. 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.

2.1.31. 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.

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

2.1.33. 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.

2.1.34. 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.

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

2.1.36. 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:

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

2.1.36.2. Serious impairment to bodily functions.

2.1.36.3. Serious dysfunction of any bodily organ or part.

2.1.37. 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.

2.1.38. 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.

2.1.39. 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.

2.1.40. 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).

2.1.41. 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.

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

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

2.1.44. 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.

2.1.45. Frontier County – A county in the Contractor's service area with a population density less than or equal to 6 persons per square mile.

2.1.46. 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).

2.1.47. Group of Practitioners – means two (2) 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.

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

2.1.49. 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.

2.1.50. 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.

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

2.1.52. HIPAA – The Health Insurance Portability and Accountability Act of 1996.

2.1.53. 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.

2.1.54. 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.

2.1.55. 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.

2.1.56. 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.

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

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

2.1.59. 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.

2.1.60. 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.

2.1.61. 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.

2.1.62. 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).

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

2.1.64. 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.

2.1.65. 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.

2.1.66. 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.

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

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

2.1.69. MFCU – Colorado Medicaid Fraud Control Unit

2.1.70. 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.

2.1.71. Network Provider – Any Primary Care Medical Provider or specialty behavioral health provider contracted with the Regional Accountable Entity (RAE) to deliver Accountable Care Collaborative services to Members.

2.1.72. 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.

2.1.73. Operational Start Date – July 1, 2018 or when the Department authorizes the Contractor to begin fulfilling its obligations under the Contract.

2.1.74. Other Personnel – Individuals and Subcontractors, in addition to Key Personnel, assigned to positions to complete tasks associated with the Work.

2.1.75. 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 abuse.

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

2.1.77. Ownership or Control Interest – Means an individual or entity that: has an ownership interest totaling five percent (5%) or more; has an Indirect Ownership Interest equal to five percent (5%) or more; has a combination of direct and Indirect Ownership Interests equal to five percent (5%) or more; owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five percent (5%) 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.

2.1.78. Part 2 Data – Information the Department shares with the Contractor that is covered under 42 C.F.R. Part 2.

2.1.79. 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.

2.1.80. PHI – Protected Health Information.

2.1.81. Population Management Framework – The Department-developed population stratification framework that includes three levels: complex care coordination and management for members with complex health needs or catastrophic costs; condition management for members with chronic or specific health conditions identified by the Department; and prevention and supportive services for general wellness and member engagement as identified and prioritized by the Department.

2.1.82. 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.

2.1.83. 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.

2.1.84. Prevalent Language – 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).

2.1.85. 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.

2.1.86. 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.

2.1.87. 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.

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

2.1.89. 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.

2.1.90. 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.

2.1.91. 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.

2.1.92. 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.

2.1.93. 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.

2.1.94. 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.

2.1.95. 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.

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

2.1.97. Provider Dispute – Means an 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 the Contractor resolves in a timely fashion through existing informal processes.

2.1.98. 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.

2.1.99. Reattribution – The process of attributing a Member to a new PCMP based upon new information (e.g., claims information, changes in PCMP status and location).

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

2.1.101. Regional Accountable Entity (RAE) – A single regional entity responsible for

implementing the Accountable Care Collaborative within its region.

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

2.1.103. 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.

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

2.1.105. Significant Business Transaction – Any business transaction or series of transactions that, during any one (1) fiscal year, exceed the lesser of twenty-five thousand dollars ($25,000.00) and five percent (5%) of the Contractor's total operating expenses.

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

2.1.107. Special Connections – The Special Connections program provides treatment services for pregnant women and women up to twelve (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, Office of Behavioral Health, and the Department to provide specialized women's services that are gender responsive and trauma informed.

2.1.108. 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.

2.1.109. Start-Up Period – The period starting on the Effective Date and ending on the Operational Start Date.

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

2.1.111. 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.

2.1.112. 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.

2.1.113. 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.

2.1.114. 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.

2.1.115. Urban County – A county in the Contractor's service area with a total population equal

to or greater than 100,000 people.

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

2.1.117. 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.

2.1.118. 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.

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

2.1.120. Wholly Owned Supplier – A supplier whose total ownership interest is held by the Contractor or by a person, persons, or other entity with an Ownership or Control Interest in the Contractor.

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

3. CONTRACTOR'S GENERAL REQUIREMENTS

3.1. The Department will contract with only one organization, the 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 this Contract.

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

3.1.2. Claims paid by the 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. The 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, the 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 the Contract or 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. The 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 the Contractor's responsibilities under this Contract.

3.5. The 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. The Contractor shall make such records available to the Department upon request, throughout the term of the Contract.

3.6. The 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-participating provider; physician services; plan; preauthorization; prescription drug coverage; primary care physician; PCP; participating provider; premium; provider; rehabilitation services and devices; skilled nursing care; specialist; and urgent care.

3.7. Contractor Performance Management

3.7.1. Performance Management Process

3.7.1.1. The Department may take action when the 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).

3.7.2. Financial accountability

3.7.2.1. The Department may recoup funds from the Contractor when the 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.

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

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

3.7.2.3.1. 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.

3.8. Deliverables

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

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

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

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

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

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

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

3.8.2.2.3.1. Readability

3.8.2.2.3.2. Spelling

3.8.2.2.3.3. Grammar

3.8.2.2.3.4. Completion

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

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

3.8.2.4. The Department will review the Deliverable and may direct Contractor to make changes to the Deliverable. Contractor shall make all changes within ten (10) Business Days following the Department's direction to make the change unless the Department provides a longer period in writing.

3.8.2.5. Changes the Department 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.

3.8.2.5.1. 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.

3.8.2.6. 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.

3.8.3. 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.

3.8.4. 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.

3.8.5. 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.

3.8.6. 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.

3.8.7. 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.

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

3.9. Stated Deliverables and Performance Standards

3.9.1. 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.

3.10. Communication Requirements

3.10.1. Communication with the Department

3.10.1.1. The 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 the Contractor uses a compatible program, then the Contractor shall ensure that all documents or files delivered to the Department are completely transferrable and reviewable, without error, on the Department's systems.

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

3.10.1.2.1. 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.

3.10.1.2.2. 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.

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

3.10.1.3. The Department will use a transmittal process to provide the Contractor with official direction within the scope of the Contract. The 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:

3.10.1.3.1. The date the transmittal will be effective.

3.10.1.3.2. Direction to the Contractor regarding performance under the Contract.

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

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

3.10.1.3.4.1. The Department will provide the 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 the 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 the Contractor through a transmittal.

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

3.10.1.4.1. 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.

3.10.1.5. If the Contractor receives conflicting transmittals, the 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.

3.10.1.6. In the event that the 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.

3.10.1.7. 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 the Contractor, and the Department may provide day-to-day communication to the Contractor without using a transmittal.

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

3.10.2. Communication with Providers and Other External Entities

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

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

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

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

3.10.2.2.3. 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.

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

3.10.2.3. The 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.

3.10.2.3.1. The 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 the Contractor's processes and procedures, or to address any communication related deficiencies determined by the Department.

3.11. Start-Up and Closeout Periods

3.11.1. The Contractor shall have a Start-Up and a Closeout Period.

3.11.2. Start-Up Period

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

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

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

3.11.3. Start-Up Plan

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

3.11.3.1.1. 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 the Contractor.

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

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

3.11.3.1.4. The 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:

3.11.3.1.4.1. Administrative staffing and resources.

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

3.11.3.1.4.3. Provider communications.

3.11.3.1.4.4. Grievances and Appeals.

3.11.3.1.4.5. Member communication, services and outreach.

3.11.3.1.4.6. Provider Network Management.

3.11.3.1.4.7. Program Integrity/Compliance.

3.11.3.1.4.8. Case management/Care Coordination/service planning.

3.11.3.1.4.9. Quality improvement.

3.11.3.1.4.10. Utilization review.

3.11.3.1.4.11. Financial reporting and monitoring.

3.11.3.1.4.12. Financial solvency.

3.11.3.1.4.13. Claims management.

3.11.3.1.4.14. Encounter Data and enrollment information management.

3.11.3.1.4.15. Staff hiring and training.

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

3.11.3.1.6. Test system compatibility.

3.11.3.1.7. Adherence to security protocols.

3.11.3.1.8. Established Provider Networks and agreements.

3.11.3.1.9. Member and provider materials and education.

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

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

3.11.3.1.12. Business Continuity Plan described in Section 3.11.1.

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

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

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

3.11.3.2.1. DELIVERABLE: Start-Up Plan

3.11.3.2.2. DUE: Within five (5) Business Days after the Effective Date

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

3.11.3.3.1. DELIVERABLE: Start-Up Plan Update

3.11.3.3.2. DUE: Within five (5) Business Days from the Department's request for an update

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

3.11.3.5. The 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.

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

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

3.11.3.6.2. DUE: Upon the Effective Date

3.11.3.7. The 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 the Contractor is ready to perform all Work by the Operational Start Date.

3.11.4. Closeout Period

3.11.4.1. The Closeout Period shall begin on the earlier of ninety (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.

3.11.4.2. This Closeout Period may extend past the termination of the Contract. The Department will perform a closeout review to ensure the Contractor has completed all requirements of the Closeout Period. If the 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.

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

3.11.4.3.1. 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.

3.11.4.3.2. 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.

3.11.4.3.3. 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.

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

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

3.11.4.3.5.1. DELIVERABLE: Member Notifications

3.11.4.3.5.2. DUE: Sixty (60) days prior to termination of the Contract

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

approval of that notification by the Department.

3.11.4.3.6.1. DELIVERABLE: Provider Notifications

3.11.4.3.6.2. DUE: Sixty (60) days prior to termination of the Contract

3.11.4.3.7. 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 the Contractor of this determination for that requirement.

3.11.5. Closeout Planning

3.11.5.1. Closeout Plan

3.11.5.1.1. The 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 the 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. The Contractor shall deliver the Closeout Plan to the Department for review and approval.

3.11.5.1.1.1. DELIVERABLE: Closeout Plan

3.11.5.1.1.2. DUE: January 1, 2019

3.11.5.1.2. The 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.

3.11.5.1.2.1. DELIVERABLE: Closeout Plan Update

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

3.12. Business Continuity

3.12.1. 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:

3.12.1.1. 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.

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

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

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

3.12.1.4. 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.

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

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

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

3.12.2.1. DELIVERABLE: Business Continuity Plan

3.12.2.2. DUE: May 1, 2018

3.12.3. Contractor shall review its Business Continuity Plan at least semi-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.

3.12.3.1. DELIVERABLE: Updated Business Continuity Plan

3.12.3.2. DUE: By July 31st of each year

3.12.4. 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.

3.13. Accreditation

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

3.13.1.1. Accreditation status, survey type, and level;

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

3.13.1.3. Expiration date of the accreditation.

3.14. Federal Financial Participation Related Intellectual Property Ownership

3.14.1. In addition to the intellectual property ownership rights specified in the Contract, the

following subsections enumerate the intellectual property ownership requirements the 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 the 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.

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

3.14.1.2. If the 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, the 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.

3.14.1.2.1. The terms of this Contract will encompass sole payment for any and all Work Product and intellectual property produced by the Contractor for the State. The 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.

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

3.14.1.4. The 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 the 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.

3.14.1.4.1. 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.

3.14.1.4.2. 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.

3.14.1.4.3. The 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.

3.14.1.4.4. The Contractor shall execute the assignment referenced in Section 3.12.1.4 immediately upon the creation of the Work Product pursuant to the terms of this Contract.

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

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

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

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

3.14.1.6. 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 the Contractor or any Subcontractor.

3.14.1.7. The 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.

3.14.1.8. 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:

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

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

3.14.1.8.3. All necessary data files.

3.14.1.8.4. User and operation manuals and other documentation.

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

3.14.1.8.6. Training materials developed for State staff, agents or designated representatives in the operation and maintenance of this software.

3.15. Performance Reviews

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

3.15.2. The Department may work with the 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.

3.15.3. The 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. The Contractor shall provide this information regardless of whether the Department decides to work with the Contractor on any aspect of the performance review or evaluation.

3.15.4. 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.

3.15.5. 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.

3.16. Renewal Options and Extensions

3.16.1. 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.

3.16.2. The Parties may amend the Contract to extend beyond seven (7) 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.

3.16.2.1. In the event that the Contract is extended beyond seven (7) 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.

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

3.17. State System Access

3.17.1. 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.

3.18. Protection of System Data

3.18.1. 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.

3.18.2. 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:

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

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

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

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

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

3.18.3.2. 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.

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

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

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

3.18.4. Colorado Information Security Policy (CISP) Compliance

3.18.4.1. 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.

3.18.4.2. For the purposes of reviewing and assessing compliance with the CISPs, the Contractor shall consider itself to be both the Information Technology Service

Provider (ITSP) and Business Owner.

3.18.4.3. 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.

3.18.4.4. 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.

3.18.4.4.1. DELIVERABLE: Annual CISP Attestation

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

3.18.4.5. 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.

3.18.5. Health and Human Services HIPAA Security Rule Risk Assessments

3.18.5.1. 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.

3.18.5.2. 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.

3.18.5.2.1. DELIVERABLE: Annual HHS Attestation

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

3.18.5.3. 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.

3.18.6. 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.

3.18.7. 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 the 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.

3.18.7.1. 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.

3.18.7.1.1. DELIVERABLE: Background Check Attestation

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

3.18.7.2. 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.

3.19. Data Handling

3.19.1. 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.

3.19.2. 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.

4. CONTRACTOR REGION AND PERSONNEL

4.1. Region

4.1.1. The Contractor shall be the RAE for Region #1 and shall be the PCCM Entity and the PIHP for Members enrolled with the Contractor.

4.1.1.1. Region 1 includes Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit Counties.

4.2. Personnel

4.2.1. The 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, the 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 the Contractor's Region, unless otherwise approved by the Department in writing.

4.2.2. The 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 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 list of names and contract information for the key personnel and other relevant management/supervisory staff assigned to the Contract.

4.2.3.1.1. DELIVERABLE: Management/supervisory staff contact information

4.2.3.1.2. DUE: Within five (5) 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 management/supervisory staff contact information

4.2.3.2.2. DUE: Within five (5) 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.

4.2.5. The Contractor shall provide the Department with an Organizational Chart listing all positions within the 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 (5) Business days after the Effective Date.

4.2.6. The 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 (5) 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 the 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 (5) Business Days of the Contractor's submission of the required information.

4.2.7.1. DELIVERABLE: Key Personnel Approval Form

4.2.7.2. DUE: Within ten (10) Business Days following the 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. The 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. The 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. The 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. The Contractor's Key Personnel and Other Personnel shall be available for all regularly scheduled meetings between the Contractor and the Department, unless the Department has granted prior, written approval.

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

4.2.10.4. At the Department's direction, the 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. The Contractor shall respond to all telephone calls, voicemails and emails from the Department within one (1) Business Day of receipt by the Contractor.

4.2.11. Key Personnel

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

4.2.11.1.1. Program Officer – One (1) 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 the Contractor's primary point of contact for the Contract and for Contract performance. The Program Officer shall work out of an office within the Contractor's Region, unless otherwise approved by the Department in writing or the Contractor chooses to have a Regional Contract Manager.

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 the 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. Chief Financial Officer (CFO) – One (1) full-time employee. The CFO shall be a senior management position.

4.2.11.1.2.1. The CFO shall:

4.2.11.1.2.1.1. 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.

4.2.11.1.2.1.2. 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.

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

4.2.11.1.2.2. The CFO shall have the following qualifications:

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

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

4.2.11.1.3. Chief Clinical Officer (CCO) – One (1) full-time employee. The CCO shall be a senior management position.

4.2.11.1.3.1. The CCO shall:

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

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

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

4.2.11.1.3.2. The CCO shall have the following qualifications:

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

4.2.11.1.3.2.2. Have a minimum of five (5) years' experience working at a management level with Medicaid programs spanning both physical and behavioral health.

4.2.11.1.3.2.3. 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.

4.2.11.1.4. Quality Improvement Director – One (1) full-time employee. The Quality Improvement Director shall be a management level position.

4.2.11.1.4.1. The Quality Improvement Director shall:

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

4.2.11.1.4.1.2. Direct and coordinate all quality improvement activities.

4.2.11.1.4.1.3. Ensure alignment with federal and state guidelines.

4.2.11.1.4.1.4. Set internal performance goals and objectives.

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

4.2.11.1.4.2.1. Minimum of a bachelor's degree in nursing, public health or strongly related field. Master's level preferred.

4.2.11.1.4.2.2. Minimum of five (5) years of professional experience in healthcare quality improvement.

4.2.11.1.4.2.3. Knowledge and Experience in the following areas:

4.2.11.1.4.2.3.1. Accreditation standards, including National Committee on Quality

Accreditation (NCQA).

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

4.2.11.1.4.2.3.3. Compliance and regulation enforcement.

4.2.11.1.5. Health Information Technology (Health IT) and Data Director – One (1) full-time employee.

4.2.11.1.5.1. The Health IT and Data Director shall:

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

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

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

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

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

4.2.11.1.5.1.5.1. Client enrollment spans

4.2.11.1.5.1.5.2. Capitation payments

4.2.11.1.5.1.5.3. Encounter Data

4.2.11.1.5.1.5.4. Health needs survey information

4.2.11.1.5.1.5.5. Admission, discharge, and transfer data

4.2.11.1.5.1.5.6. BIDM System data

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

4.2.11.1.5.2.1. Experience directing a health information technology program.

4.2.11.1.5.2.2. Experience supporting health care practices.

4.2.11.1.5.2.3. Expertise in health data analytics.

4.2.11.1.6. Utilization Management Director – One (1) full-time employee.

4.2.11.1.6.1. The Utilization Management Director shall:

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

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

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

4.2.11.1.6.2. The Utilization Management Director shall have the following

qualifications:

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

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

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

4.2.11.1.7. Regional Contract Manager (Optional) – One (1) full-time employee.

4.2.11.1.7.1. If the RAE 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 the 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, the Contractor shall ensure that at least one (1) of the Key Personnel has had the majority of their work experience working for behavioral health organizations, including at least five (5) 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. The Contractor may subcontract to complete a portion or portions of the Work required by the Contract.

4.2.13.2. The Contractor shall not subcontract more than forty percent (40%) of the total value of this Contract; this does not apply to the division of responsibilities between joint owners of the Contractor.

4.2.13.3. The 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 such subcontract, and the 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. The 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: July 1, 2018.

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

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

4.2.13.7. The 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 sixty (60) calendar days prior to termination for all general terminations and within two (2) Business Days of the decision to terminate for quality or performance issue terminations.

5. REGIONAL ACCOUNTABLE ENTITY

5.1. The 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. The Contractor shall be licensed by the Colorado Division of Insurance as either a:

5.2.1. Health Maintenance Organization (HMO) or

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

5.3. The Contractor shall administer the program in compliance with the requirements for both

a Primary Care Case Management Entity (PCCM Entity) and a Prepaid Inpatient Health Plan (PIHP) set forth in 42 C.F.R. § 438.2.

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

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

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

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

5.6. The Contractor shall create a written RAE Governance Plan that:

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

5.6.1.1. The 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.

5.6.1.2. The Contractor shall ensure that conflicts of interest include, but are not limited to, agents, Managing Employees, persons with an ownership or controlling interest in the 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.

5.6.2. Is posted publicly on the Contractor's website.

5.7. The Contractor shall submit the RAE Governance Plan to the Department.

5.7.1. DELIVERABLE: RAE Governance Plan

5.7.2. DUE: June 1, 2018

5.7.3. The Contractor shall submit an updated written RAE Governance Plan to the Department and post it when a change is made to the report.

5.8. The Contractor shall update the RAE Governance Plan and shall submit the Updated RAE Governance Plan to the Department any time a change in governance is discovered by the Contractor.

5.8.1. DELIVERABLE: Updated RAE Governance Plan

5.8.2. DUE: Within thirty (30) days after the new change in governance is discovered

6. MEMBER ENROLLMENT AND ATTRIBUTION

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

6.1.1. All full benefit Medicaid Clients will be mandatorily enrolled into the Accountable Care Collaborative Program, with the exception of individuals that choose the Program of All- Inclusive Care for the Elderly (PACE).

6.1.2. The following individuals are not full benefit Medicaid Clients and are therefore not eligible for enrollment in the Program:

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

6.1.2.2. Qualified Working Disabled Individuals (QWDI)

6.1.2.3. Qualified Individuals 1 (QI 1)

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

6.1.2.5. Undocumented immigrants

6.1.2.6. All individuals while determined presumptively eligible for Medicaid

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

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

6.2.2.1. The 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 the Contractor or the Department is responsible for reimbursement of the services provided, and whether the Contractor has authorized a referral or made special arrangements with a provider, when appropriate.

6.3. The Department will enroll Members into the Accountable Care Collaborative on the same day that a Member's Medicaid eligibility notification is received in the Colorado interChange from the Colorado Benefit Management System (CBMS). In alignment with the Member Enrollment Policy, the Department will allow retroactive enrollment for up to 90 days from when a Member received IMD services within that time period. The Department will assign Members to the Contractor based on the location of the PCMP Practice Site to which the Member is attributed (e.g., if a Member lives in Region 3, but is attributed to a PCMP Practice Site in Region 5, the Member will be assigned to the Contractor in Region 5). The PCMP attribution effective date will be the same as the RAE assignment date.

6.4. The Department will automatically re-enroll Members 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 (2) months or less.

6.5. The Contractor shall not discriminate against individuals eligible to enroll in the Accountable Care Collaborative 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. The 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. The Contractor shall accept all eligible Members that the Department assigns to the Contractor in the order in which they are assigned without restriction. The Department will assign Members to a RAE based on the Department attribution and assignment policies and procedures.

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

6.7.1. The selection of a different PCMP may result in assignment to a different RAE. Assignment into a different RAE will be effective on the first day of the month following the month when the selection was made.

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

6.8. The Contractor shall receive and process an attribution and assignment list from the Department that contains the attribution and assignment information for all Members in the Contractor's region and any additions, deletions or changes to the existing PCMP selection records.

6.8.1. The Contractor shall no less than quarterly compare this attribution and assignment list with Member claims activity to ensure accurate Member attribution and assignment. The Contractor shall follow up with Members who are seeking care from primary care providers other than the attributed PCMP to identify any barriers to accessing the PCMP and, if appropriate, to assist the Member in changing the attributed PCMP.

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

6.9. The Contractor shall work with the Department, PCMPs 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.

6.10. RAE Reassignment Process

6.10.1. The Contractor shall understand that any Member may request reassignment from the RAE serving the Member's PCMP to the RAE serving the Member's county of residence when requested by both the Member and their care coordinator/case manager

by submitting a RAE Reassignment Request Form, Exhibit F.

6.10.2. The Contractor shall support any Member that is requesting RAE reassignment. The Contractor shall share the RAE Reassignment Request form with the alternate RAE.

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

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

6.10.3.2. The Member is receiving an array of mental health and community support services from a CMHC.

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

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

6.10.4. The Contractor shall comply with and process the Department's determination regarding RAE reassignment.

6.10.5. The Contractor shall understand that if approved, assignment to the new RAE will be effective on the first day of the month following the month in which the Department approves the request for reassignment. If a request for reassignment comes too late within a month to process the request in the Colorado interChange, the reassignment will occur the first day of the second month following the month in which the Department approves the request for reassignment.

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

7. MEMBER ENGAGEMENT

7.1. Person-and Family Centered Approach

7.1.1. The Contractor shall actively engage 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 preventive and healthy behaviors as outlined in initiatives such as Colorado's 10 Winnable Battles and Colorado's State of Health.

7.1.2. The 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. The 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. The 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. The 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 and Spanish, or any other prevalent language, as directed by the Department or as required by 42 CFR 438.10.

7.2.3. The Contractor shall develop and/or 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. The 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 the Contractor of the language proficiency of Members during the Member's orientation or while being served by Network Providers.

7.2.5. The 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. The Contractor shall provide language assistance services as described in 42 C.F.R. § 438.10, for all Contractor interactions with Members and for all covered services. Language assistance services include bilingual staff and interpreter services, at no cost to any Member. Language assistance shall be provided at all points of contact, in a timely manner and during all hours of operation. The Contractor shall

implement appropriate technologies for language assistance services in accordance with evolving best practices in communication.

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

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

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

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

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.

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

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

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

7.2.7.3.1. The Contractor shall include taglines in the prevalent non-English languages in the State, and in large print, explaining the availability of written translation or

oral interpretation to understand the information provided.

7.2.7.4. The 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. The Contractor shall write all materials in easy to understand language and shall comply with all applicable requirements of 42 C.F.R. § 438.10.

7.2.7.5.1. The Contractor shall write all published information provided to Members, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department.

7.2.7.5.2. The Contractor shall publish all written materials provided to Members using a font size no smaller than twelve (12) point.

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

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

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

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

7.3. Member Communication

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

7.3.2. The Contractor shall ensure that the Contractor's Member communications adhere to Colorado Medicaid's brand standards.

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

7.3.3.1. 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.

7.3.3.1.1. During Business Hours, the Contractor shall ensure that no more than five percent (5%) 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 one-hundred and eighty (180) seconds or longer.

7.3.3.1.2. The Contractor shall ensure that the average length of time callers are waiting in the call queue before the call is answered shall be two (2) minutes or less during each calendar month.

7.3.3.1.3. The Contractor shall have no more than five (5) calls during each business week that have a maximum delay of ten (10) minutes or longer, and no calls shall have a maximum delay over twenty (20) minutes.

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

7.3.3.2.1. DELIVERABLE: Call Line Statistics Report

7.3.3.2.2. DUE: Monthly, within Fifteen (15) calendar days of the last day of the month for which the report covers.

7.3.4. The Contractor shall use Member notices developed by the Department.

7.3.5. The Contractor shall assist any Member who contacts the Contractor, including Members not in the Contractor's region who need assistance with contacting his/her PCMP and/or RAE. The Department will provide data to the Contractor on all Members for this purpose.

7.3.6. General Member Information Requirements

7.3.6.1. The Contractor shall develop electronic and written materials for distribution to newly enrolled and existing Members, with input 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 the RAE's managed care functions as a PCCM Entity and PIHP.

7.3.6.1.6. Which populations are subject to mandatory enrollment into the Accountable Care Collaborative.

7.3.6.1.7. The service area covered by the Contractor.

7.3.6.1.8. Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit.

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

7.3.6.1.10. A directory of Network Providers.

7.3.6.1.10.1. DELIVERABLE: Network Directory

7.3.6.1.10.2. DUE: Five (5) days prior to the Operational Start Date.

7.3.6.1.11. The requirement for the Contractor to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards.

7.3.6.1.12. The Contractor's responsibilities for coordination of Member care.

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

7.3.6.1.14. The 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.

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

7.3.7. Member Rights

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

7.3.7.2. The 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, including 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. Freely exercise his or her rights with the Contractor or its providers treating the Member adversely.

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

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

7.3.8. Member Handbook

7.3.8.1. The Contractor shall collaborate with the Department to create a Member Handbook for distribution to newly enrolled and existing Members that meets the requirements of 42 C.F.R. § 438.10. The Member Handbook shall 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 Program.

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 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. The Contractor shall ensure that this information includes at least the following:

7.3.8.1.6.1. An explanation that an emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

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

7.3.8.1.6.3. An explanation that Post-Stabilization Care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition when the Contractor does not respond to a request for pre-approval within one (1) hour, the Contractor cannot be contacted, or the Contractor's representative and the treating

physician cannot reach an agreement concerning the Member's care and a Managed Care Entity physician is not available for consultation.

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 transportation. How to locate information and updates to the Colorado Prescription Drug List (PDL) program.

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

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

7.3.8.1.14. A section with information specific to the Contractor's Region.

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

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

7.3.8.1.15.2. DUE: Five (5) Business days after the Effective Date.

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

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

7.3.8.2.2. DUE: Thirty (30) days prior to any contact changes taking effect.

7.3.9. Contractor Website

7.3.9.1. The Contractor shall develop and maintain a customized and comprehensive website that follows modern principles of optimizing user experience on mobile and personal computer platforms and is navigable by individuals who have low

literacy, disabilities, or require language assistance. The Contractor shall ensure that the website provides online access to general customer service information that includes, but is not limited to:

7.3.9.1.1. Contractor's contact information.

7.3.9.1.2. Member rights and handbooks.

7.3.9.1.3. Grievance and Appeal procedures and rights.

7.3.9.1.4. General functions of the Contractor.

7.3.9.1.5. Trainings.

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

7.3.9.1.6.1. Names, as well as any group affiliations.

7.3.9.1.6.2. Street addresses.

7.3.9.1.6.3. Telephone numbers.

7.3.9.1.6.4. Website URLs, as appropriate.

7.3.9.1.6.5. Specialties, as appropriate.

7.3.9.1.6.6. Whether network providers will accept new Members.

7.3.9.1.6.7. 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.

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

7.3.9.1.7. The Contractor shall ensure that the electronic provider directory is updated no later than thirty (30) calendar days after the Contractor receives updated provider information.

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

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

7.3.9.1.10. Access to care standards.

7.3.9.1.11. Health First Colorado Nurse Advice Line.

7.3.9.1.12. Colorado Crisis Services information.

7.3.9.2. The Contractor shall provide a link to the Department's website on the 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.

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

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

7.3.9.5. The 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, the 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: Fifteen (15) days from the notice of termination.

7.3.11. Information on Grievance and Appeals Process

7.3.11.1. The 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 description shall include at least 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 the Contractor to cover a service.

7.3.11.2. Advance Directives

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

7.3.11.3.3. Instructions 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, the Contractor shall reflect these changes to its advance directives information no later than ninety (90) days after the effective date of the change.

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

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

7.3.12. Other information

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

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

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

7.3.13.1.3. DUE: At least thirty (30) Business Days prior to the Contractor printing or disseminating any large-scale Member communication initiatives

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

7.3.13.2. The Department may review any Member materials used by the Contractor and request changes or redrafting of Member materials as the Department determines necessary to ensure that the language is easy to understand and that the document aligns with the Department standards. The 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. The 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, the 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 placed 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 the Contractor provides the information upon request within five (5) Business Days.

7.3.15. The 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. The Contractor shall remind these Members to update their contact information with the Department. The 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. The Contractor shall conduct outreach to these Members to assist them in responding to Department renewal requests for additional information and submitting necessary renewal forms. The Contractor shall use multiple modalities when conducting such outreach, including telephone, email, and text.

7.3.15.3. The 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. The 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, the Contractor may engage in Marketing Activities at its discretion. The Contractor shall not distribute any marketing materials without the Department's approval.

7.4.3. The 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 the Contractor proposes to use for Marketing Activities before distributing the materials. Based on this review, the Department may require changes to any materials before the Contractor may distribute those materials, or may disallow the use of anyspecific materials in its sole discretion.

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

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

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

7.4.7. The Contractor and any Subcontractors shall not, directly or indirectly, engage in door-to- door, telephone or other cold call marketing activities.

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

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

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

7.4.11. The 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. The 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. The 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. The 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 the Member's PCMP and/or RAE.

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. Contractor will work with Department to smoothly implement any new tools and/or 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. The Contractor shall onboard enrolled Members to Medicaid and the Accountable Care Collaborative.

7.6.2. The 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. The 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. The 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, the 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. The 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 and scheduling assistance.

7.6.4. The Contractor shall be accountable for providing information on EPSDT at least once

to households with multiple EPSDT-Eligible Members residing in the household. The Contractor will not be held accountable for providing EPSDT information to each individual EPSDT-Eligible Member residing in the household.

7.6.4.1. The 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. The Contractor's communications about EPSDT shall be delivered using easy-to-understand, non-technical language.

7.6.6. The 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. The 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. The Contractor shall monitor EPSDT-eligible Members' receipt of screenings and examinations in accordance with American Association of Pediatrics' Bright Futures Guidelines.

7.6.8. The 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 days 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. The 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

Education Act (IDEA); the Special Supplemental Food Program for Women, Infants and Children (WIC); school health programs of state and local education agencies (including the Education for all Handicapped Children Act of l975); and social services programs under Title XX.

7.6.10. The 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".

7.6.10.1. The 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.

7.6.11. The 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 the Contractor's communication methods for outreach and individual member reporting of completed outreach activities and attempted outreach activities.

7.6.11.1. DELIVERABLE: EPSDT Outreach Report

7.6.11.2. DUE: Quarterly, forty-five (45) days after the end of the reporting period

7.6.12. The 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.

7.6.12.1. DELIVERABLE: EPSDT Outreach Plan

7.6.12.2. DUE: Annually, on July 31

7.7. Promotion of Member Health and Wellness

7.7.1. The 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.

7.7.1.1. The Contractor's Member programs and materials shall align with the Population Management Framework and shall be part of the Contractor's Population Management Strategic Plan.

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

7.7.4. The Contractor shall collaborate with the Department on joint initiatives, as appropriate.

7.8. Prevention, Wellness, and Member Engagement Report

7.8.1. The Contractor shall submit a bi-annual report to the Department describing how the 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.

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

7.8.1.2. DUE: Every six (6) months, by November 21 and May 21

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, the Contractor shall have a Grievance and Appeal system to handle Grievances about any matter related to this Contract other than an adverse benefit determination and Appeals of an adverse benefit determination for the Capitated Behavioral Health Benefit, as well as processes to collect and track information about them.

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

8.2. The Contractor shall understand the Department's procedures for handling Appeals of physical health adverse benefit determinations and shall assist Members in following the Department's procedures.

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

8.4. The 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):

8.4.1. The Member's right to file an Appeal, including:

8.4.1.1. The requirements and timeframes for filing.

8.4.1.2. The availability of assistance with filing.

8.4.1.3. The toll-free number to file orally.

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

8.4.3. 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.

8.4.4. The Member's right to file Grievances related to the Contractor or services provided through the Contractor.

8.4.5. Any rights the Provider has to Appeal or otherwise challenge the failure of the Contractor to cover a service.

8.4.6. Any timeliness considerations in filing a Grievance, filing for an Appeal, filing for a State Fair Hearing, or seeking a Continuation of Benefits.

8.5. Grievances

8.5.1. The Contractor shall 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.

8.5.2. The 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.

8.5.3. The Contractor shall allow a Member to file a Grievance either orally or in writing at any time and shall acknowledge receiving the Grievance.

8.5.4. The Contractor shall ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were 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:

8.5.4.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

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

8.5.4.3. The Grievance or Appeal involves clinical issues.

8.5.5. The Contractor shall make a decision regarding the Grievance and provide notice to the Member of its decision within fifteen (15) Business Days of when the Member files the Grievance.

8.5.6. The Contractor may extend the timeframe for processing a Grievance by up to fourteen (14) calendar days if a Member requests; or the 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.

8.5.7. If the Contractor extends the timeline for a Grievance not at the request of a Member, the Contractor shall:

8.5.7.1. Make reasonable efforts to give the Member prompt oral notice of the delay;

8.5.7.2. Give the Member written notice, within two (2) 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.

8.5.8. The 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.

8.5.9. 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.

8.5.10. The Contractor shall document problems a Network Provider submits to the Contractor, and the solutions the 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 the Contractor to find a different solution or follow a specific course of action.

8.5.11. 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, the Contractor shall address all issues as soon as possible after the Department has informed the Contractor of the concerns. The Contractor shall keep the Department informed about progress on resolving concerns in real time, and shall advise the Department of final resolution.

8.6. Notice of Adverse Benefit Determination

8.6.1. When a Contractor denies coverage of or payment for a Covered Behavioral Health service, the Contractor shall send to the Member a notice of adverse benefit determination that meets the following requirements:

8.6.1.1. Is in writing.

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

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

8.6.1.4. Is in an easily understood language and format.

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

8.6.1.6. Explains the reasons for the adverse benefit determination.

8.6.1.7. 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.

8.6.1.8. 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.

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

8.6.1.10. Describes how a Member can Appeal or file a Grievance.

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

8.6.1.12. 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.

8.6.1.13. 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.

8.6.1.14. 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.

8.6.2. The Contractor shall ensure that decision makers take into account all comments, documents, records, and other information submitted by the Member or their

representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

8.6.3. The Contractor shall give notice according to the following schedule:

8.6.3.1. At least ten (10) days before the date of action, if the adverse benefit determination is a termination, suspension or reduction of previously authorized Medicaid-covered services.

8.6.3.2. As least five (5) days prior to the date of adverse benefit determination if the Contractor has verified information indicating probable beneficiary fraud.

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

8.6.4.1. The Member has died.

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

8.6.4.3. 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.

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

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

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

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

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

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

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

8.6.6. As expeditiously as the Member's health condition requires, but no longer than ten (10) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

8.6.6.1. The Contractor may extend the ten (10) calendar day service authorization notice timeframe of up to fourteen (14) additional days 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.

8.6.6.2. If the Contractor extends the ten (10) 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.

8.6.7. 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.

8.6.8. For cases in which a Provider, or the 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, the Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

8.6.8.1. The Contractor may extend the seventy-two (72) hours expedited service authorization decision time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest.

8.7. Handling Appeals for the Capitated Behavioral Health Benefit

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

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

8.7.3. The 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.

8.7.4. 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:

8.7.4.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

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

8.7.4.3. The grievance or appeal involves clinical issues.

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

8.7.5.1. Within sixty (60) calendar days from the date of the Contractor's notice of adverse benefit determination.

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

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

8.7.8. The 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.

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

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

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

8.7.12. The Contractor shall take no punitive action against a provider who either requests an expedited resolution or supports a Member's appeal, in accordance with 42 C.F.R. § 438.410.

8.7.13. Continuation of Benefits and Services During an Appeal

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

8.7.13.1.1. The Appeal is filed on or before the later of:

8.7.13.1.1.1. Ten (10) days after the Contractor mailed the notice of adverse benefit determination.

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

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

8.7.13.1.3. The services were ordered by an authorized Provider.

8.7.13.1.4. The authorization period has not expired.

8.7.13.1.5. The Member requests an extension of benefits.

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

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

8.7.13.2.2. The Member does not request a State Fair Hearing with continuation of benefits within ten (10) days after the date the Contractor mails an adverse Appeal decision.

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

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

8.7.13.3. The 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 the Contractor's adverse benefit determination.

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

8.7.13.5. The 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 the Contractor or State Fair Hearing Officer reverses a decision to deny authorization of the services.

8.7.13.6. The 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.

8.7.14. Resolution and Notification of Appeals

8.7.14.1. The 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:

8.7.14.1.1. For standard resolution of an Appeal and notice to the affected parties, ten (10) working days from the day the MCO or PIHP receives the Appeal.

8.7.14.2. The Contractor may extend the timeframe for processing an Appeal by up to fourteen (14) calendar days if the Member requests; or the 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.

8.7.14.2.1. The Contractor shall provide the Member with written notice within two (2) 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. The Contractor shall establish and maintain an expedited review process for Appeals when the 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.

8.7.14.2.2. If the Contractor denies a request for expedited resolution of an Appeal, the 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 (2) calendar days after receiving the request for expedited resolution.

8.7.14.2.3. The 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 seventy-two (72) hours after the Contractor receives the expedited Appeal request.

8.7.14.2.4. The Contractor may extend the timeframe for processing an expedited Appeal by up to fourteen (14) calendar days if the Member requests the extension; or the Contractor shows that there is need for additional information and that the delay is in the Member's best interest.

8.7.14.2.5. The Contractor shall provide the Member with written notice within two (2) 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.

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

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

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

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

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

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

8.7.14.4.4. Notice that the Member may be liable for the cost of any continued benefits if the Contractor's adverse benefit determination is upheld in the hearing.

8.7.15. State Fair Hearing

8.7.15.1. The Contractor shall allow a Member to request a State Fair Hearing after the Member has exhausted the Contractor's Appeal process.

8.7.15.1.1. The Member has one hundred and twenty (120) calendar days from the date of a notice of an adverse Appeal resolution to request a State Fair Hearing.

8.7.15.2. If the 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.

8.7.15.3. The 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.

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

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

8.7.16. Expedited State Fair Hearing

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

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

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

8.8. Ombudsman for Medicaid Managed Care

8.8.1. The 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.

8.8.1.1. The 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 the Contractor has previously obtained written and explicit instructions from the Member not to share information with the Ombudsman.

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

8.9. Grievance and Appeals Report

8.9.1. The Contractor shall submit a quarterly Grievance and Appeals Report that includes the following information about Member Grievances and Appeals:

8.9.1.1. A general description of the reason for the Grievance or Appeal.

8.9.1.2. The date received.

8.9.1.3. The date of each review or, if applicable review meeting.

8.9.1.4. Resolution at each level of the Appeal or Grievance, if applicable.

8.9.1.5. Date of resolution at each level, if applicable.

8.9.1.6. Name of the covered Member for whom the Appeal or Grievance was filed.

8.9.1.6.1. DELIVERABLE: Grievance and Appeals Report

8.9.1.6.2. DUE: Forty-five (45) days after the end of the reporting quarter.

9. NETWORK DEVELOPMENT AND ACCESS STANDARDS

9.1. Establishing a Network

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

9.1.2. The 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. The Contractor may create networks based on quality indicators, credentials, and price.

9.1.3. The Contractor shall ensure that its contracted networks are capable of serving all Members, including contracting with Providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities. The Contractor's networks shall include, but not be limited to, the following:

9.1.3.1. Public and Private providers, including independent practitioners.

9.1.3.2. Federally Qualified Health Centers (FQHC).

9.1.3.3. Rural Health Clinics (RHC).

9.1.3.4. Community Mental Health Centers (CMHC).

9.1.3.5. Substance Use Disorder Clinics

9.1.3.6. School Based Health Centers (SBHC).

9.1.3.7. Indian Health Care Providers.

9.1.3.8. Essential Community Providers (ECP).

9.1.3.9. Providers capable of billing both Medicare and Medicaid.

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

9.1.4.1. The anticipated number of Members.

9.1.4.2. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented.

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

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

9.1.4.5. 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.

9.1.5. The 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, the disability community and other culturally diverse communities who may be served.

9.1.5.1. The Contractor may use mechanisms such as telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds.

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

9.1.6.1. The 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.

9.1.6.2. The 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.

9.1.6.3. The Contractor shall comply with any additional provider selection requirements established by the Department.

9.1.6.3.1. The 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 during the contracting and credentialing process.

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

9.1.6.5. The 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 the Contractor.

9.1.6.5.1. The contracting and credentialing measurement period ends on the actual date of a signed and fully executed contract or when the Contractor sends a formal document denying the provider admission to the 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.

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

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

9.1.6.5.3. The Contractor shall respond to all Provider inquiries related to their credentialing and contracting within two business days.

9.1.6.6. The 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.

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

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

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

9.1.9. The Contractor shall not be required to contract with more provider than necessary to meet the needs of its Members.

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

9.1.11. The 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.

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

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

9.1.14. The Contractor shall offer contracts to all willing and qualified FQHCs, CMHCs, RHCs, and Indian Health Care Providers located in the Contract Region.

9.1.15. The 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.

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

9.2. PCMP Network

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

9.2.1.1. Enrolled as a Colorado Medicaid provider.

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

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

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

9.2.1.4.1. Community mental health centers and HIV/infectious disease practitioners may qualify as PCMPs with the Contractor's approval if all other PCMP criteria are met.

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

9.2.1.5.1. Physician (Code 05).

9.2.1.5.2. Osteopath (Code 26).

9.2.1.5.3. Federally Qualified Health Center (Code 32).

9.2.1.5.4. Rural Health Clinic (Code 45).

9.2.1.5.5. School Health Clinic (Code 51).

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

9.2.1.5.7. Clinic-Practitioner Group (Code 16).

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

9.2.1.6. Provides Care Coordination.

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

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

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

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

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

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

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

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

9.2.3. The Contractor shall contract with all willing and qualified primary care Practice Sites located within the Contractor's region that meet the criteria for being a PCMP.

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

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

9.2.4.1. Provider Type

9.2.4.2. Provider Location ID

9.2.4.3. NPI

9.2.4.4. Tax ID/EIN

9.2.4.5. Practice Legal Name

9.2.4.6. Practice DBA (if applicable)

9.2.4.7. Address

9.2.4.8. City

9.2.4.9. Zip Code

9.2.4.10. Email Contact

9.2.4.11. Phone Number

9.2.4.12. FQHC/RHC/CMHC Designation

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

9.2.4.14. Enrollment Limit

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

9.2.5.1. Provider name;

9.2.5.2. Provider ID;

9.2.5.3. Address;

9.2.5.4. City;

9.2.5.5. State;

9.2.5.6. Zip code;

9.2.5.7. Telephone number;

9.2.5.8. Provider type;

9.2.5.9. Provider's spoken languages;

9.2.5.10. Accessibility information;

9.2.5.11. Gender restriction information;

9.2.5.12. Age limit information;

9.2.5.13. Panel status (open/closed).

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

9.2.7. If a female Member's designated primary care physician is not a women's health specialist, the 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.

9.3. Specialty Behavioral Health Provider Network

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

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

9.3.3. The Contractor shall enter into contracts with any willing and qualified Community Mental Health Center in the state to enable Member choice and promote continuity of care.

9.3.3.1. When developed by the Department and the Behavioral Health Authority, the Contractor shall use the Universal Contracting provisions as established in CRS 25.5-5-402 on a timeline agreed upon by the Contractor and the Department. Per CRS 25.5-5-402 inclusion of the Universal Contracting provisions does not preclude the Contractor to have other terms to drive value and accountability.

9.3.3.2. The Department will engage the Contractor in the stakeholder process for developing the Universal Contracting provisions.

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

9.3.5. Behavioral Health Provider Credentialing and Re-credentialing

9.3.5.1. The 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 the Contractor's timeframes for the credentialing and re-credentialing processes.

9.3.5.1.1. The Contractor shall submit the Provider Credentialing Policies and Procedures to the Department.

9.3.5.1.1.1. DELIVERABLE: Provider Credentialing Policies and Procedures.

9.3.5.1.1.2. DUE: May 1, 2018.

9.3.5.2. The Contractor shall ensure that all Network Behavioral Health Providers are credentialed.

9.3.5.2.1. The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all contracts.

9.3.5.2.1.1. The 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.

9.3.5.2.1.2. The 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.

9.3.5.2.1.3. The 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.

9.3.5.2.2. The 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.

9.3.5.3. The Contractor shall credential all contracted Providers and ensure that re-credentialing of all individual behavioral health practitioners occurs at least every three (3) years.

9.3.6. The 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. The Contractor shall not enroll IHS/Tribal 638 providers in its Specialty Behavioral Health Provider Network. The 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. The Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care to:

9.4.1.1. Serve all primary care and care coordination needs;

9.4.1.2. Serve all behavioral health needs; and

9.4.1.3. Allow for adequate Member freedom of choice amongst Providers.

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

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

9.4.4. The 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.

9.4.4.1. The 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.

9.4.5. The 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. The Contractor shall ensure that the directory is updated at least monthly and shall be made available to the Department.

9.4.6. The Contractor shall ensure that its network provides for twenty-four (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).

9.4.7. The Contractor shall ensure that its PCMP network complies with the time and distance

standards in the following table:

A. PCPM 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

9.4.8. The Contractor shall ensure that its PCMP network has a sufficient number of PCMPs so that each Member has their choice of at least two (2) PCMPs 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. In the event that there are less than two (2) practitioners that meet the PCMP standards within the defined area for a specific Member, then the Contractor shall not be bound by the requirements of the prior paragraph for that Member.

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

9.4.9. The Contractor shall ensure that its behavioral health network meets the time and distance standards described in the table below for each practitioner type listed.

B. 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

9.4.10. The 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 (2) 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.

9.4.10.1. 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 the Contractor shall not be bound by the time and distance requirements of the prior table for that Member.

9.4.10.2. The Contractor shall use GeoAccess or a comparable service to measure the distance between the Members and the behavioral health providers in the Contractor's Region.

9.4.11. The Contractor shall ensure that its Provider Network meets the following practitioner to Client ratios and distance standards:

9.4.11.1. Adult primary care providers: One (1) practitioner per eighteen hundred (1,800) adult Members.

9.4.11.2. Mid-level adult primary care providers: One (1) practitioner per twelve hundred (1,200) adult Members.

9.4.11.3. Pediatric primary care providers: One (1) PCMP Provider per eighteen hundred (1,800) child Members.

9.4.11.4. Adult mental health providers: One (1) practitioner per eighteen hundred (1,800) adult Members.

9.4.11.5. Pediatric mental health providers: One (1) practitioner per eighteen hundred (1,800) child Members.

9.4.11.6. Substance use disorder providers: One (1) practitioner per eighteen hundred (1,800) Members.

9.4.12. The Contractor shall maintain sufficient Indian or Tribal Providers in the PCMP Network to ensure timely access to services available under the Contract for Indian or Tribal Members who are eligible to receive services from such Providers, in accordance

with the American Recovery and Reinvestment Act of 2009.

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

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

9.4.13.1. Urgent Care – within twenty-four (24) hours after the initial identification of need.

9.4.13.2. Outpatient Follow-up Appointments – within seven (7) days after discharge from a hospitalization.

9.4.13.3. Non-urgent, Symptomatic Care Visit – within seven (7) days after the request.

9.4.13.4. Well Care Visit – within one (1) 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.

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

9.4.13.5.1. Emergency Behavioral Health Care – by phone within fifteen (15) minutes after the initial contact, including TTY accessibility; in person within one (1) hour of contact in Urban and suburban areas, in person within two (2) hours after contact in Rural and Frontier areas.

9.4.13.5.2. Non-urgent, Symptomatic Behavioral Health Services – within seven (7) days after a Member's request.

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

9.4.13.5.3. The Contractor shall not place Members on waiting lists for initial routine service requests.

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

9.4.14.1. Utilizing out-of-network Providers.

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

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

9.4.16. The 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.

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

9.4.18. Network Changes and Deficiencies

9.4.18.1. The 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:

9.4.18.1.1. Information describing how the change will affect service delivery.

9.4.18.1.2. Availability, or capacity of covered services.

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

9.4.18.1.4. A plan to correct any network deficiency.

9.4.18.2. DELIVERABLE: Network Changes and Deficiencies

9.4.18.3. DUE: Within five (5) days after the Contractor's knowledge of the change or deficiency.

9.5. Network Adequacy Plan and Report

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

9.5.1.1. How the 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.

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

9.5.1.3. Number of Network Providers by provider typeand areas of expertise particularly:

9.5.1.3.1. Adult primary care providers.

9.5.1.3.2. Pediatric primary care providers.

9.5.1.3.3. Adult mental health providers.

9.5.1.3.4. Pediatric mental health providers.

9.5.1.3.5. Substance use disorder providers.

9.5.1.3.6. Psychiatrists.

9.5.1.3.7. Child psychiatrists.

9.5.1.3.8. Psychiatric prescribers.

9.5.1.3.9. Family planning providers.

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

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

9.5.1.6. Cultural and language expertise of providers.

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

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

9.5.1.9. Case load for behavioral health providers.

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

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

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

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

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

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

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

9.5.2.5. Performance meeting timeliness standards.

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

9.5.2.7. New providers contracted during the quarter.

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

9.5.2.9. Additional information, as requested by the Department.

9.5.3. The Contractor shall submit the Network Adequacy Report to the Department.

9.5.3.1. DELIVERABLE: Network Adequacy Report

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

9.5.4. 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. The 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 the Contractor's geographic region.

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

10.1.2. The Contractor shall collaborate with other RAEs in order to leverage the other RAEs' Health Neighborhoods and Communities to help serve any of the Contractor's enrolled Members who reside within the geographic region of another RAE.

10.1.3. The 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. The Contractor shall notify the Department upon becoming aware of new construction of an emergency department, new hospital or hospital expansion.

10.1.4.1. DELIVERABLE: Notice of New Construction

10.1.4.2. DUE: Within five (5) Business Days of becoming aware of new construction of an emergency department, new hospital or hospital expansion.

10.2. Health Neighborhood

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

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

10.2.3. The 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. The 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. The 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. The 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. The 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. The 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. The 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. The Contractor shall establish arrangements with the Colorado Crisis Services vendors for the coordination of follow-up care for Medicaid Members.

10.2.7. The Contractor shall coordinate care with Colorado's Managed Service Organizations to ensure Member access to appropriate substance use disorder treatments.

10.2.8. The 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. The Contractor shall educate hospital discharge planners on processes that support LTSS Members and non-institutional discharge options.

10.2.9. The 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. The Contractor shall coordinate with hospitals directly or use a Health Information Exchange to access hospital admit/discharge/transfer Data.

10.2.10. The 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. The 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. The Contractor shall help hospitals determine priorities and select projects, interventions and performance goals for the Hospital Transformation Program.

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

10.2.13. The 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. 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. The 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. The Contractor shall collaborate with local public health agencies to:

10.2.15.1. Design opportunities for integration of local public health activities into the Accountable Care Collaborative.

10.2.15.2. Identify 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. Explore appropriate funding approaches to support collaborative activities.

10.3. Community and the Social Determinants of Health

10.3.1. The 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, the 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. The Contractor shall know, understand and implement initiatives to build local communities 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. The 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. The 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. The 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. The Contractor shall not duplicate Community efforts to create a directory. Instead, the 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. The 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. The 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. The Contractor shall share information with Community organizations in the region about identified Community social service gaps and needs.

10.3.9. The Contractor shall engage with hospitals and local public health agencies regarding their community health needs assessments to develop and implement collaborative strategies to reduce health inequities and disparities in the Community.

10.3.10. The 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. The 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. The 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

10.3.11.3. The 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 the Contractor's processes and procedures, or to address any health equity related deficiencies determined by the Department.

10.3.11.4. The Contractor shall review and update the Health Equity Plan at least annually and submit to the Department for review.

10.3.11.4.1. DELIVERABLE: Health Equity Plan

10.3.11.4.2. DUE: July 31, 2023, and annually by July 31

10.4. Statewide Health Infrastructure

10.4.1. The 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 Colorado Office of Behavioral Health 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. The Contractor shall promote the Colorado Crisis System to Members and Providers for confidential, immediate support for mental health, substance use, or emotional help.

10.4.1.2.2. Starting in July 2022, the Contractor shall contribute administrative funding from the Capitated Payment to the Crisis Line component of the Colorado Crisis

System. The Contractor shall annually contribute one dollar from the Capitated Payment for each Member projected for enrollment with the Contractor. The number of Members projected will be agreed upon during the rates setting process at the beginning of each performance year by July 31. The Contractor may count these costs toward medical spend as activities that improve health care quality in their annual MLR calculations.

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. The 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: The Contractor shall establish a relationship and communication channels with the Department's utilization management (UM) vendor to leverage Member programs and services, such the Nurse Advice Line and the Client Overutilization Program (COUP).

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

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

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

10.4.1.7.4. The Contractor shall work with the UM vendor regarding Members identified for the Department's COUP program as described in Section 16.6.2.

10.5. Health Neighborhood and Community Report

10.5.1. The Contractor shall submit a bi-annual report to the Department describing the 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. The Contractor shall submit the Health Neighborhood and Community Report to the

Department in a format agreed upon by the Department and the Contractor.

10.5.2.1. DELIVERABLE: Health Neighborhood and Community Report

10.5.2.2. DUE: Every 6 months, by August 15 and February 14.

10.6. COVID-19

10.6.1. The 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. The 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. The 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. The 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. The Contractor shall manage the health of all its Members.

11.1.1. The Contractor shall use a health promotion/population management approach that aligns with 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. The Contractor shall use the Population Management Framework to guide work in the areas of Care Coordination, condition management, Member engagement, Health Neighborhood and Community development, practice support and financial support.

11.1.2. The 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. The 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 postnatal care to reduce premature births and infant mortality.

11.1.4. The Contractor shall focus in these areas and the Department will continue to direct information and insights to guide Contractor focus. The 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. The Contractor shall ensure that Care Coordination is one of the interventions available to Members.

11.1.5. The Contractor shall monitor and participate in the Department's effort to make the Diabetes Prevention Program a Medicaid benefit. Once a covered benefit the Contractor shall coordinate the delivery of the Diabetes Prevention Program consistently during the term of this Contract. The Contractor shall identify those who meet program criteria and outreach to those participants.

11.1.6. The Contractor shall outreach to women in the perinatal period to improve education and outcomes around maternity support and benefits and advantages. The 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. The 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.

11.2. Population Management

11.2.1. The Contractor shall design and implement population management activities in alignment with the Population Management Framework and the Department's risk stratification methodology. The Department's risk stratification methodology captures both the physical and behavioral health needs of Members.

11.2.1.1. The Contractor shall place a particular focus on Members identified as Complex Members for outreach and interventions, including care coordination.

11.2.1.2. The Contractor may substitute their own population management approach for serving Complex Members with Department approval.

11.2.1.2.1. The 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.

11.2.1.3. The Contractor shall collaborate with the Department to evolve the Population Management Framework and risk stratification methodology as appropriate.

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

11.2.2.1. Member engagement and outreach,

11.2.2.2. Wellness promotion,

11.2.2.3. Utilization of evidence-based and promising practices,

11.2.2.4. Programs for managing Department identified health conditions, and

11.2.2.5. Care Coordination for Members utilizing Medicaid services.

11.2.2.6. Addressing identified health disparities among enrolled Members.

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

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

11.2.4. The 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.

11.2.4.1. The contractor shall utilize existing programs among its network providers to manage and support members with specific health conditions.

11.2.4.2. The contractor shall develop programs to manage and support members with specific health conditions identified by the department for which the contractor's network providers do not have existing programs.

11.2.4.3. The Contractor shall incorporate evidence-based practices, and promising local initiatives that address the social determinants of health.

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

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

11.2.5.2. The 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 implementing the Population Management Strategic Plan.

11.2.6. The Contractor shall submit the Population Management Strategic Plan to the Department for review and integrate feedback as appropriate.

11.2.6.1. DELIVERABLE: Population Management Strategic Plan

11.2.6.2. DUE: Annually, July 1

11.3. Care Coordination

11.3.1. The Contractor shall ensure Care Coordination is available to Members in alignment with the Contractor's Population Management Strategic Plan and the Department's Population Management Framework. The Contractor shall use its own resources and Department insights to ensure active Care Coordination for Complex Members.

11.3.2. The Contractor shall have a specific process to ensure that infused specialty drugs are managed away from outpatient hospitals into home infusion, where appropriate.

11.3.3. The Contractor's Care Coordination activities 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 appropriate interventions.

11.3.4. The 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. The 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.

11.3.6. The Contractor shall not duplicate Care Coordination provided through LTSS and HCBS waivers and other programs designed for special populations; rather, the 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. The 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. The 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. The 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.

11.3.7.10.5. Aligns with the Contractor's Population Management Strategic Plan.

11.3.7.10.6. Protects Member privacy.

11.3.8. The Contractor shall ensure that care coordinators in the Contractor's network reach out and connect with other service providers and communicate information appropriately, consistently and without delay.

11.3.9. The 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. The 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, and Members transitioning out of institutional settings. To meet the needs of these Members, the Contractor shall:

11.3.10.1. Designate staff persons to serve as the 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. The 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. The 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. The Contractor shall process the list to identify individuals who are assigned to the Contractor or will be released to the Contractor's region and are likely to be assigned to the Contractor.

11.3.10.4.2.2. The Contractor shall provide timely outreach and transitional support to

individuals assigned to or who are likely to be assigned to the Contractor to support their successful transition to the community.

11.3.10.4.2.3. The Contractor shall coordinate transitional support between CDOC and other RAEs for individuals who were likely to but ultimately were not assigned to the Contractor.

11.3.10.4.2.4. The 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.

11.3.11. For Members with intellectual and developmental disabilities who require services for conditions other than a mental health or substance use disorder, the 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, the Contractor shall coordinate care with the state's Managed Service Organizations.

11.3.13. The 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. The Contractor shall assist care coordinators within the Contractor's network with bridging multiple delivery systems and state agencies.

11.3.15. The Contractor shall require additional support and guidance when the systems and providers engaged with a Member's complex care require leadership and direction.

11.3.16. The 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.

11.3.17. The 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, and the CMA case manager data feeds, are actively used in providing care coordination for Members.

11.3.18. Care Coordination and Complex Care Management Report The Contractor shall submit a Care Coordination and Complex Care Management Report to the Department in a format agreed to by the Department and the Contractor. The report shall include extended care coordination activities for Complex Members performed by the Contractor, Network Providers and Partners, and Subcontractors.

11.3.18.1. DELIVERABLE: Care Coordination and Complex Care Management Report

11.3.18.2. DUE: Every six (6) months, by August 15th and February 14th

11.4. Condition Management Report

11.4.1. The 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.

11.4.2. The Contractor shall submit a Condition Management Report in a format agreed upon

by the Department and the Contractor.

11.4.2.1. DELIVERABLE: Condition Management Report

11.4.2.2. DUE: Every six months, by November 21 and May 21

12. PROVIDER SUPPORT AND PRACTICE TRANSFORMATION

12.1. The 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. The 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, promotoras, 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.

12.2.1. The Contractor shall use the Population Management Framework to inform the Contractor's strategy to provide Practice Support to Network Providers.

12.3. The 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. The Contractor shall ensure that the Contractor's Provider communications adhere to Colorado Medicaid's brand standards.

12.5. The Contractor shall support the delivery of evidence-based medicine by Network Providers.

12.6. The Contractor shall include a written Practice Support Strategy as part of the Annual Network Management Strategic Plan that includes, but is not limited to, the following information:

12.6.1. The types of information and administrative support, provider trainings, and data and technology support the Contractor will offer and make available to Network Providers.

12.6.2. 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 the Contractor's efforts to implement their Population Management Strategy.

12.6.3. The Contractor shall submit the Annual Network Management Strategic Plan to the Department.

12.6.3.1. DELIVERABLE: Annual Network Management Strategic Plan

12.6.3.2. DUE: Annually, by August 1

12.7. The Contractor shall submit a Practice Support, Transformation and Communication Report to the Department.

12.7.1. DELIVERABLE: Practice Support, Transformation and Communication Report

12.7.2. DUE: Annually, by June 5th

12.8. General Information and Administrative Support

12.8.1. The Contractor shall ensure adequate informational support for Network Providers, while being mindful of not duplicating existing materials.

12.8.2. The Contractor shall maintain, staff, and publish the number for a toll-free telephone line that Providers may call regarding general information, administrative support, and complaints.

12.8.2.1. The Contractor shall respond to all Provider inquiries within two business days.

12.8.2.2. The Contractor shall submit monthly response time data from its Provider telephone line in the Call Line Statistics Report.

12.8.3. The 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:

12.8.3.1. General information about Medicaid, the Accountable Care Collaborative Program, and the Contractor's role and purpose.

12.8.3.2. The Department's process for handling appeals of physical health adverse benefit determinations and the Contractor's process for handling appeals of behavioral health adverse benefit determinations.

12.8.3.3. Available Member resources, including the Member provider directory.

12.8.3.4. Clinical resources, such as screening tools, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled.

12.8.3.5. Community-based resources, such as childcare, food assistance, services supporting elders, housing assistance, utility assistance and other non-medical supports.

12.8.4. The Contractor shall make Network Providers aware of the following Colorado Medicaid program information:

12.8.4.1. Medicaid eligibility

12.8.4.2. Medicaid covered benefits

12.8.4.3. State Plan services

12.8.4.4. EPSDT

12.8.4.5. HCBS waiver services

12.8.4.6. Capitated Behavioral Health Benefit

12.8.4.7. Claims and billing procedures

12.8.4.8. Prescriber tool opioid risk mitigation module and affordability module

12.8.4.9. Out-of-state medical care as described in 10 CCR 2505-10 8.013.

12.8.4.10. Out-of-state NEMT as described in 10 CCR 2505-10 8.014.7.

12.8.5. The Contractor shall inform Network Providers of key Department contractors, their

roles and responsibilities, including:

12.8.5.1. Business Intelligence Data Management

12.8.5.2. Colorado Medicaid's fiscal agent

12.8.5.3. Enrollment broker

12.8.5.4. Pharmacy Benefit Management System

12.8.5.5. Utilization Management

12.8.5.6. Oral Health contractor

12.8.5.7. Non-Emergent Medical Transportation administrators

12.8.5.8. Case Management Agencies

12.8.5.9. Community Center Boards

12.8.5.10. Single Entry Points

12.8.5.11. Nurse Advice Line

12.8.5.12. Crisis Services System

12.8.6. The Contractor shall act as a liaison between the Department and its other contractors, partners and providers.

12.8.7. The Contractor shall outreach to and educate specialists and other Medicaid providers regarding the Accountable Care Collaborative Program, its structure, the role of the Contractor and the supports it will offer to providers in its network.

12.8.8. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including, but not limited to all of the following:

12.8.8.1. Medicaid provider enrollment

12.8.8.2. Member eligibility and coverage policies

12.8.8.3. Service authorization and referral

12.8.8.4. Member and PCMP assignment and attribution

12.8.8.5. PCMP designation

12.8.8.6. Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits

12.8.8.7. Prescriber tool opioid risk mitigation module and affordability module

12.8.9. The Contractor shall establish a timely process for responding to and resolving barriers and problems reported by behavioral health providers related to the Contractor's payment and benefits systems, including but not limited to the following:

12.8.9.1. Billing and claims payment

12.8.9.2. Provider credentialing

12.8.9.3. Provider contracting

12.8.9.4. Service authorization.

12.8.10. The Contractor shall assist any Program provider who contacts the Contractor, including providers not in the Contractor's region who need assistance determining which Members are attributed to their practice.

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

12.8.11. The 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.

12.8.11.1. The Contractor shall promote fidelity to evidence-based practices in order to assure effectiveness of the services provided.

12.9. Provider Training

12.9.1. The Contractor shall, at a minimum, develop trainings and host forums for ongoing training regarding the Program and the services the Contractor offers.

12.9.2. The Contractor shall promote participation of Network Providers in state, local, and Contractor specific training programs.

12.9.3. The Contractor shall ensure that trainings and updates on the following topics are made available to the Contractor's Network Providers every six (6) months:

12.9.3.1. Colorado Medicaid eligibility and application processes.

12.9.3.2. Medicaid benefits.

12.9.3.3. Access to Care standards.

12.9.3.4. EPSDT.

12.9.3.5. The Contractor's Population Management Strategic Plan.

12.9.3.6. American Society of Addiction Medicine (ASAM) criteria.

12.9.3.7. Use and proper submission of COMPASS data or the current Colorado Office of Behavioral Health's data collection tool for mental health and substance use disorders.

12.9.3.8. Cultural responsiveness.

12.9.3.9. Member rights, Grievances, and Appeals.

12.9.3.10. Quality improvement initiatives, including those to address population health.

12.9.3.11. Principles of recovery and psychiatric rehabilitation.

12.9.3.12. Trauma-informed care.

12.9.3.13. Other trainings identified in consultation with the Department.

12.9.4. The Contractor shall ensure that trainings on the topics listed above are made available for Network Providers at least every six (6) months.

12.9.5. The Contractor shall maintain a record of training activities it offers and submit to the Department upon request.

12.10. Interoperability Rule

12.10.1. The Contractor shall implement and maintain a secure, standards-based application program interface (API) aligning with the Department's implementation timeline. The API shall:

12.10.1.1. Be available through a public-facing digital endpoint on the Contractor's website.

12.10.1.2. Include complete and accurate provider directory information.

12.10.1.2.1. The provider directory must meet the same technical standards as the patient access API, excluding the security protocols related to user authentication and authorization.

12.10.1.2.2. The provider directory information shall be updated no later than thirty (30) calendar days after the Department or the Contractor receives the provider directory information or updates to provider directory information.

12.10.1.3. Comply with the requirements of 42 CFR § 438.242, 45 CFR § 170.215, as well as the provider directory information specified in § 438.10.

12.10.1.4. Provide current members, or their personal representatives, with access to claims and encounter data within one (1) business day of receipt, including:

12.10.1.4.1. Adjudicated claims, including data for payment decisions that may be appealed, were appealed, or in the process of appeal.

12.10.1.4.2. Provider remittances and beneficiary cost-sharing pertaining to adjudicated claims.

12.10.1.4.3. Services and Items Provided in Treatment

12.10.1.5. Clinical information within one (1) business day of receipt, if collected and maintained by the Contractor, including:

12.10.1.5.1. Diagnoses and Related Codes

12.10.1.5.2. Medical Records and Reports

12.10.1.5.3. Statements of Medical Necessity

12.10.1.5.4. Laboratory Test Results

12.10.1.6. Information about covered outpatient drugs within one (1) business day after the effective date of any update, including:

12.10.1.6.1. Formulary of prescription drugs and costs to the member

12.10.1.6.2. Preferred drug list information

12.10.2. The 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.

12.10.3. The Contractor shall incorporate the USCDI data classes and elements received from other plans about the member.

12.10.4. The Contractor shall, upon request by a member:

12.10.4.1. 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 5 years.

12.10.4.2. 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 5 years after disenrollment.

12.11. Data Systems and Technology Support

12.11.1. The Contractor shall have expertise to support providers in implementing and utilizing health information technology (Health IT) systems and data. The Contractor shall keep up to date with changes in Health IT in order to best support providers.

12.11.2. The 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.

12.11.3. The Contractor shall make available technical assistance and training for Network Providers on how to use the following state-supported HIT systems:

12.11.3.1. Contractor's Care Coordination Tool

12.11.3.2. The BIDM System

12.11.3.3. Colorado interChange (MMIS)

12.11.3.4. Office of Behavioral Health's COMPASS data collection tool

12.11.3.5. PEAK website and PEAKHealth mobile app

12.11.3.6. Regional health information exchange

12.11.3.7. Electronic consultation and referral tools

12.11.4. The Contractor shall offer the following supports to Network Providers on managing and utilizing data:

12.11.4.1. Provide practice-level data/reports

12.11.4.2. Assist providers with data analysis and reporting

12.11.4.3. Train practices on how to utilize data to:

12.11.4.3.1. Improve care for Complex Members

12.11.4.3.2. Improve care for Members with Department identified health conditions

12.11.4.3.3. Implement wellness and prevention strategies

12.11.4.3.4. Understand how their practice is performing on Key Performance Indicators and other health outcome measures

12.11.4.3.5. Identify Members who require additional services

12.11.4.4. The Contractor shall possess the expertise and establish the infrastructure to support outbound raw claims data extracts to the PCMPs, both behavioral health claims

from the Contractor's internal system and physical health claims data from the Department.

12.11.4.4.1. The Contractor shall establish a process for PCMPs to request raw claims data extracts from the Contractor.

12.11.4.5. The 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.

12.11.4.5.1. The 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.

12.11.4.5.2. The Contractor shall identify and address gaps in information sharing or data quality.

12.12. Practice Transformation

12.12.1. The 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 promotoras, peers, and patient navigators; and implementing health programming to advance the Contractor's Population Management Strategic Plan.

12.12.2. The 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.

12.12.3. The Contractor shall offer expertise and resources necessary for practice transformation ranging from assistance with efficiency and performance enhancements to comprehensive practice redesign.

12.12.4. The 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.

12.12.5. The 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, the Contractor shall develop a practice transformation plan to:

12.12.5.1. Connect Network Providers to practice transformation resources that are readily available in the region.

12.12.5.2. Educate Network Providers about the methods, principles, best practices, and benefits of practice transformation.

12.12.5.3. Provide technical assistance, tools and resources as appropriate.

12.12.6. The 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.

12.12.7. Based on the needs of the region and the existing practice transformation resources available, the Contractor shall offer trainings, learning collaboratives, and/or other resources to support practices in achieving advanced Medical Home standards.

12.12.8. The Contractor shall work with their PCMP Network to increase the adoption and utilization rates of the Colorado Medicaid Real-Time Benefit Inquiry Module of the Department's prescriber tool. The Contractor shall follow their Department-approved prescriber tool implementation plan to reach the highest adoption and utilization rates possible. The Contractor shall keep track of which contracted PCMPs do not have specific prescriber tool functionality within their EHRs and periodically share this list with the Department.

12.13. Financial Support

12.13.1. The Contractor shall make administrative/performance payments directly to PCMP Network Providers to support the provision of Medical Home level of care and to incentivize improved outcomes.

12.13.2. The Contractor shall distribute administrative funding based on the Population Management Framework and Member acuity to ensure increased financial resources are made available for coordinating care for Complex Members.

12.13.2.1. The Contactor shall include this administrative funding distribution strategy in the RAE Administrative Payment Report.

12.13.3. The Contractor shall detail individual PCMP administrative/performance payment arrangements in their written contract with the Network Provider.

12.13.4. Administrative Payments

12.13.4.1. The Contractor shall distribute, in aggregate, at least thirty-three percent (33%) of the Contractor's administrative PMPM payments received from the Department to their PCMP network.

12.13.4.1.1. The Contractor shall offer PCMPs the option of receiving, at a minimum, a standard two dollars ($2.00) PMPM for Members utilizing Medicaid services. The Contractor may work with providers to design different value-based payment arrangements in place of the two dollars ($2.00) PMPM.

12.13.4.1.2. The Contractor shall work with Network Providers to develop a strategy to evolve administrative payments that are tied to value and outcomes, specifically for Complex Members, and align with other Department alternative payment methodologies.

12.13.4.2. The Contractor shall provide Stakeholders with opportunities to participate in and provide input toward the development of the Contractor's value-based payment strategies with Network Providers.

12.13.4.2.1. The Contractor shall have final decision-making authority in creating the strategy while ensuring a collaborative and transparent process. The Contractor shall give Stakeholders advance notice of all forums and shall give them an opportunity to participate in and provide input toward the development of the incentive/administrative payment strategy.

12.13.5. Pay for Performance

12.13.5.1. The Contractor shall share incentive payments earned for performance with PCMP Network Providers and other Health Neighborhood participants in a manner that is aligned with meeting the objectives of the Accountable Care Collaborative structure and program as the Contractor deems appropriate. The Contractor has the flexibility to design innovative approaches to distribute funds in a way that maximizes performance at the Provider level and that addresses cost trend and clinical quality outcome metrics.

12.13.5.1.1. The Contractor in its discretion shall negotiate payment arrangements and amounts with its Network Providers and Health Neighborhood participants.

12.13.6. RAE Administrative Payment Report

12.13.6.1. The Contractor shall provide the Department with a detailed reporting of the payment arrangements made with Network Providers and Health Neighborhood providers that aligns with guidance provided by the Department, including higher administrative payments for providers serving Complex Members and with consideration of current market rates. This information shall be included in the Annual Network Management Strategic Plan, as well as reported as administrative payments made in the Quarterly Financial Report.

12.13.6.2. The Contractor shall submit a RAE Administrative Payment Report to the Department any time the Contractor makes changes to its payment arrangements with Network Providers and Health Neighborhood providers outlined in the Annual Network Management Strategic Plan.

12.13.6.2.1. DELIVERABLE: Updated RAE Administrative Payment Report

12.13.6.2.2. DUE: Within thirty (30) days after the new changes to payment arrangements.

13. PRIMARY CARE ALTERNATIVE PAYMENT MODEL (APM)

13.1. The Contractor shall assist the Department with implementing the APM and support PCMPs in transitioning toward a value-based FFS system.

13.1.1. The Contractor shall participate in Department-led APM stakeholder meetings.

13.1.2. The Contractor shall assist the Department in APM-related PCMP communications and outreach.

13.2. The Contractor shall assist PCMPs in the selection of appropriate structural and performance APM measures, and the Contractor shall assist PCMPs in completing all required documentation for the Department by December of each year. Selection of measures should account for the following:

13.2.1. A PCMP's client panel and/or community

13.2.2. Alignment with other initiatives the PCMP may be participating in

13.3. The Contractor shall track which measures are selected by each participating PCMP, based on the spreadsheet provided by the Department.

13.4. As part of the Contractor's provider support and practice transformation responsibilities, the Contractor shall provide ongoing education and support to PCMPs to ensure successful participation in APM.

13.5. The Contractor shall designate a single point of contact that PCMPs can utilize for questions and support regarding the APM. The Contractor shall adequately communicate this contact information to PCMPs.

13.6. For PCMPs that have selected any structural APM measures, the Contractor shall conduct site visits to confirm PCMPs are on track to meet structural measures for the current performance year.

13.6.1. The Contractor shall communicate to PCMPs regarding which of their chosen structural measure(s) have been met.

13.6.2. The Contractor shall provide support to any PCMPs not on track to meet their chosen structural measures.

13.7. For PCMPs that have selected any structural APM measures, the Contractor shall complete all site visits by December 31 of each year (starting in 2019 and annually thereafter), to collect documentation indicating whether PCMPs met their chosen structural APM measure(s) for the previous performance year. The Contractor shall retain this documentation in accordance with documentation retention requirements in 9.A. The Contractor shall determine PCMP compliance in accordance with the APM documentation requirements detailed on the Department's website at https://www.colorado.gov/pacific/hcpf/primary-care-payment-reform-3.

13.8. The Contractor shall collect and retain copies of a PCMP's recognition, certification, or accreditation as a Patient Center Medical Home (PCMH) granted by one of the following entities:

13.8.1. National Committee for Quality Assurance (NCQA)

13.8.2. The Joint Commission

13.8.3. Utilization Review Accreditation Commission (URAC)

13.9. The Contractor shall make all documentation related to the APM available to the Department upon request.

13.10. The Contractor shall communicate the following information to the Department for each PCMP participating in the APM, by completing the spreadsheet provided by the Department:

13.10.1. SIM/CPC+ participation and good standing within SIM/CPC+

13.10.2. PCMH recognition/certification/accreditation

13.10.3. Attestation of whether a PCMP meets each of their chosen APM structural measures, if any were chosen.

13.10.4. The Contractor shall communicate this information starting December 31, 2019, and annually thereafter.

13.11. The Contractor shall encourage and incentivize contracted PCMPs to enroll and participate in the alternative payment model 2 (APM2) through methods such as offering a higher PMPM rate.

13.11.1. The Contractor shall offer technical assistance to PCMPs to explain the benefits of participating in APM2 and help with onboarding into the program.

14. CAPITATED BEHAVIORAL HEALTH BENEFIT

14.1. The Contractor shall administer and deliver the Capitated Behavioral Health Benefit and increase access to Behavioral Health services for all Medicaid Members, which means that the 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 the Contractor's physical health responsibilities.

14.2. As the administrator of a capitated benefit, the 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. The 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. The 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. The benefits of recovery and resilience principles extend across ages and settings and can be particularly helpful for low- income children.

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. The Contractor shall develop policies and procedures, as needed, on how the 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.'

14.4.6. Evidence-based: Treatment is provided in accordance with the best available research and clinical expertise.

14.4.7. 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.

14.4.8. The Contractor shall furnish information about the services that the 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.

14.4.9. The 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 the Contractor objects to the service on moral or religious grounds.

14.4.10. If the 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.

14.4.11. The 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. The 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 the 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. The 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. The 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 Uniform Service Coding Standards (USCS) Manual (the USCS 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. The Contractor shall provide or arrange for the provision of all medically necessary behavioral health services for Primary and Principal 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.

14.5.3.1. For Members also enrolled in a limited managed care capitation initiative, the 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, the Contractor shall arrange for appropriate services regardless of diagnosis or the Medicaid party responsible for reimbursing the services.

14.5.4. The 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. The 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 (6) 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. The 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.

14.5.6.1.15. *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. The 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. The 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*: The Contractor shall be financially responsible for all professional services provided in a hospital, when the procedure(s) is listed in the Uniform Service Coding Standards (USCS) 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.

14.5.6.2. Emergency and Post-Stabilization Care Services

14.5.6.2.1. The 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. The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor.

14.5.6.2.3. The 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. The 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. The Contractor shall be responsible for practitioner emergency room claims billed on a CMS-1500, when the procedure(s) is listed in the Uniform Service Coding Standards (USCS) Manual, and the Primary Diagnosis is a covered behavioral health diagnosis when a diagnosis is required.

14.5.6.2.6. The 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 the Contractor instructs the Member to seek Emergency Services.

14.5.6.2.7. The 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. The Contractor shall not refuse to cover Emergency Services based on the emergency room provider, hospital, or Fiscal Agent not notifying the Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

14.5.6.2.9. The 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. The Contractor acknowledges that the attending emergency physician, or the provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge; that determination is binding on the Contractor for coverage and payment.

14.5.6.2.11. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's provider network that are pre-approved by the Contractor.

14.5.6.2.12. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's network that are not pre-approved by the 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. The Contractor does not respond to a request for pre-approval within one (1) hour.

14.5.6.2.12.2. The Contractor cannot be contacted.

14.5.6.2.12.3. The 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, the 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. The Contractor shall limit charges to Members for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Member if he or she had obtained the services through the Contractor.

14.5.6.2.14. The 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. The 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 the Contractor from conducting a retrospective review consistent with these rules regarding emergency and Post-Stabilization Care Services.

14.5.6.2.16. The 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. The 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. The 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 twenty (20) and under in which the Member remains twenty-four (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 twenty-four (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 twenty-four (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. The 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. The 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. The 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. The 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, the 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 seventy-two (72) hours.

14.5.6.3.4. The 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 fifteen (15) days during the period of the monthly capitation payment. When members are in an IMD for more than fifteen (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. The 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. The 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 the 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. The 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. The Contractor shall work with the Colorado Mental Health Institutes to execute communication and transition plans for Members.

14.5.6.3.5.4. The 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 the Contractor's geographic service area. The 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 the Contractor's Members are discharged from a Colorado Mental Health Institute, the Contractor shall be responsible for arranging and coordinating medically necessary on-going treatment.

14.5.6.3.5.6. The Contractor who was responsible for that Member upon admission to the Colorado Mental Health Institute shall remain the 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. The 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. The Contractor's responsibility for all residential SUD services is based on the presence of a Principal or Primary SUD Diagnosis and demonstration of medical necessity based on the ASAM Criteria for the level of care provided.

14.5.6.4.3. The Contractor shall be financially responsible for the hospital stay when the Member's 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. The Contractor shall not be financially responsible for ASAM level 4 services.

14.5.6.4.4. The 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. The 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 Uniform Service Coding Standards (USCS) 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 twenty-four (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. *Residential* – Any type of twenty-four (24) hour psychiatric care, excluding room and board, provided in a non-hospital, non-nursing home setting, where the 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.

14.5.7.1.5.1. The Contractor shall not be financially responsible for covering 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).

14.5.7.1.6. *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 twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (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. The 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. The Contractor shall regularly evaluate the effectiveness of the 1915(b)(3) Waiver services over the life of the contract. The 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. The 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. The 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. The 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. The 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. The 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. The 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. The 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. The 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, the Contractor may 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. The 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. The 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. The Contractor shall record and document its notification of Members and families.

14.6.8. The Contractor shall establish clear and specific criteria for discharging Members from treatment.

14.6.8.1. The Contractor shall include this criteria in Member materials and information.

14.6.8.2. The 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. The 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. The 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 the 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 the Contractor

provided the services directly

14.6.11. If the Contractor is unable to provide covered behavioral health services to a particular Member within its network, the 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. The 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. The 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, the Contractor shall ensure they have procedures for the following:

14.7.1.1. Intake and Assessment: The 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: The Contractor shall have a service planning system that uses the information gathered in the Member's intake and assessment to build a service plan (the service plan may also be known as a treatment plan or a Member care plan).

14.7.1.3. Transitions of Care: The 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.

14.7.1.4. Continued Services to Members: The 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. The Contractor's Provider Network shall comply with the Colorado Office of Behavioral Health's data collection policies and procedures.

14.7.2.1. At the Department's request, the Contractor shall collect from their Provider Network the required Drug/Alcohol Coordinated Data System (DACODS) for Members with a substance use disorder diagnosis.

14.7.3. The 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. The Contractor shall ensure access to and appropriate utilization of covered behavioral health services.

14.8.2. The 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.

14.8.2.2.1. 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.

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.

14.8.2.9. Description of the Contractor's plan to 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.

14.8.2.10. DELIVERABLE: Utilization Management Program and Procedures

14.8.2.11. DUE: Thirty (30) days after any significant change is made.

14.8.3. The Contractor shall only utilize ASAM criteria to determine medical necessity for residential and inpatient substance use disorder treatment services.

14.8.3.1. The Contractor shall prior authorize residential and inpatient SUD services except as stated herein.

14.8.3.2. The 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, 3.3, 3.5	14 days minimum
3.7	7 days minimum
3.2WM	5 days minimum before concurrent auth
3.7WM	4 days minimum before concurrent auth

14.8.3.3. The Contractor shall authorize a minimum of thirty (30) days of care for services under the Special Connections Program.

14.8.3.4. The Contractor shall not require prior authorization for admission to a 3.2WM or 3.7WM service. Medical necessity is required and Contractor may review the case at any time to determine if medical necessity is met, but a member may not be denied admission because authorization is being reviewed. If it is determined that WM was not medically necessary at the time of admission, the Contractor may deny payment back to the date of admission. The Contractor shall perform a continued stay authorization review for all stays longer than five (5) days for a 3.2WM and longer than four (4) days for 3.7WM.

14.8.4. The 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.

14.8.5. The Contractor shall refer the case 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 the Contractor is not able to approve residential levels of care in a Qualified Residential Treatment Program (QRTP) with available clinical information for youth seeking this level of care.

14.8.5.1. The Contractor shall only use an Independent Assessment for initial authorization purposes. The Contractor shall not use an Independent Assessment for continuing authorizations.

14.8.6. The Contractor shall implement the Contractor's documented Utilization Management Program and Procedures.

14.8.7. The Contractor's utilization management process shall in no way impede timely access to services.

14.8.7.1. The Contractor shall not require prior authorization for the non-pharmaceutical components of MAT.

14.8.7.2. The Contractor shall respond to authorizations for inpatient and residential SUD services not associated with the Special Connections program within seventy-two (72) hours following the initial request.

14.8.7.3. The Contractor shall respond to authorizations for the Special Connections program

within twenty-four (24) hours following the initial request.

14.8.8. The Contractor shall have mechanisms for providers and Members on how they can obtain the utilization management decision-making criteria upon request.

14.8.9. The 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.

14.8.10. If the Contractor determines that the Member does not meet standards of Medical Necessity for behavioral health services, the Contractor shall inform the Member about alternative services and/or level of care that are recommended instead of the requested services and how other appropriate services may be obtained, pursuant to federal Medicaid managed care rules. The 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.

14.8.11. The Contractor shall disseminate practice guidelines to Members and potential Members upon request.

14.8.11.1. The Contractor shall adopt practice guidelines that consider the needs of Members.

14.8.11.2. The Contractor shall adopt practice guidelines in consultation with Network Providers.

14.8.11.3. The Contractor shall review and update practice guidelines periodically as appropriate.

14.8.12. The 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. The 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 the 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), the 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.

14.9.2. If multiple behavioral health services are provided by an FQHC or RHC within one (1)

visit, the Contractor shall require a claims submission from the FQHC or RHC with multiple lines of services and the same claim number. The Contractor shall pay the FQHC or RHC at least the encounter rate.

14.9.3. The Contractor shall submit the Encounter Data for FQHC and RHC visits to the Department per the specifications provided in Section 15.2.2.3.

14.9.4. The Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs and is required to complete the documentation located at https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms upon the Department's request.

14.9.5. The Contractor shall ensure the utilization and paid amounts for FQHC encounters in flat files matches those sent to the Department for the Managed Care Accuracy Audit Review (MCAAR).

14.10. Institutions for Mental Diseases (IMDs)

14.10.1. To provide the full continuum of medically necessary services covered under the Capitated Behavioral Health Benefit, the Contractor shall establish agreements with a statewide network of Inpatient Psychiatric Hospitals that includes Public IMDs and Private IMDs and negotiate in good faith.

14.10.2. The Contractor shall offer value-based payment agreements with a statewide network of Private IMDs and negotiate in good faith.

14.10.2.1. The Contractor's value-based payment agreement with an individual Private IMD shall:

14.10.2.1.1. Incentivize quality care and outcomes that may include follow-up after discharge, average length of stay, readmission rates, and stabilization of symptoms.

14.10.2.1.2. Adhere to the principle of serving members in the least restrictive environment.

14.10.2.1.3. Require proactive, collaborative management of members.

14.10.2.1.4. Support the timely transition of members to outpatient, community-based care.

14.10.2.1.5. Be a signed contract or legal agreement.

14.10.2.2. The 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.

14.11. Physician Incentive Plans

14.11.1. The 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.

14.11.1.1. 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.

14.11.2. The 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.

14.11.3. If the Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the Contractor shall ensure that the physician or physician group has adequate stop-loss protection.

14.11.3.1. DELIVERABLE: Physician Incentive Plan

14.11.3.2. DUE: On the Effective Date or upon implementation of a Physician Incentive Plan

14.12. Third Party Payer Liability

14.12.1. The 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.

14.12.1.1. Potential liable third parties shall include any of the sources identified in 42 C.F.R. §433.138 relating to identifying liable third parties. The Contractor shall coordinate with the Department to provide information to the Department regarding commercial third party resources.

14.12.1.2. In the case of commercial health coverage, the 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 the Contractor. If the third party payer is Medicare, the 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, the Contractor shall submit to the Department's Fiscal Agent the following information:

14.12.1.2.1. Member's Medicaid identification number

14.12.1.2.2. Member's full name.

14.12.1.2.3. Identification of the health carrier or health plan

14.12.1.2.4. Member's health plan identification and group numbers

14.12.1.2.5. Policy holder's full name

14.12.1.2.5.1. DELIVERABLE: Third Party Resource Identification

14.12.1.2.5.2. DUE: Within five (5) Business Days electronically to the Fiscal Agent's provider portal from the time when the third party resource is identified by Contractor.

14.12.2. The 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.

14.12.3. The Contractor shall also inform its Members that failure to follow the Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that the Contractor would have been liable to pay. If the Contractor substantively fails to communicate the protocols to its Members, the Member is not liable to the Contractor or the Network Provider for payment or cost of the care or services.

14.12.4. The Contractor shall not restrict access to covered services due to the existence of possible or actual third party liability.

14.12.5. The 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.

14.12.6. In the case of accident or casualty coverage, the Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by the Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor.

14.12.7. In addition to compensation paid to the Contractor under the terms of this Contract, the Contractor may retain as income all amounts recovered from third party resources, up to the Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by the Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract and state and federal laws.

14.12.8. With the exception of Section 14.12.9. and except as otherwise specified in contracts between the Contractor and Network Providers, the 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:

14.12.8.1. The sum of reported third party coinsurance and/or deductible or

14.12.8.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

14.12.9. The Contractor shall pay, except as otherwise specified in contracts between the 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.

14.12.10. The 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.

14.13. Medical Loss Ratio (MLR)

14.13.1. The 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).

14.13.2. The first annual measurement period will begin upon the start of the Operational Period of the Contract and end on June 30, 2019.

14.13.3. 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.

14.13.4. The Contractor shall submit an MLR report to the Department, for each MLR reporting year, that includes:

14.13.4.1. Total incurred claims.

14.13.4.2. Expenditures on quality improvement activities.

14.13.4.3. Expenditures related to activities compliant with program integrity requirements.

14.13.4.4. Non-claims costs.

14.13.4.5. Premium revenue.

14.13.4.6. Taxes.

14.13.4.7. Licensing fees

14.13.4.8. Regulatory fees.

14.13.4.9. Methodology(ies) for allocation of expenditures. 14.13.4.10. Any credibility adjustment applied.

14.13.4.10. The calculated MLR.

14.13.4.11. Any remittance owed to the state, if applicable.

14.13.4.12. A comparison of the information reported with the audited financial report.

14.13.4.13. A description of the aggregation method used to calculate total incurred claims.

14.13.4.14. The number of member months.

14.13.5. All data provided by the Contractor for the purpose of MLR calculation shall use actual costs.

14.13.5.1. The Contractor shall allow for four (4) months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five (5) months.

14.13.5.2. The 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. The Contractor shall submit encounter claims in compliance with requirements in Section 15.2.2.3.

14.13.5.2.1. DELIVERABLE: MLR calculation template and supporting data and documentation

14.13.5.2.2. DUE: Annually, by January 15th of each year.

14.13.5.3. The Contractor's Medical Spend will be calculated using audited supplemental data provided in the 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.

14.13.5.4. MLR Target: The Contractor shall have an MLR of at least eighty-five percent (85%). The Contractor will calculate a cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department.

14.13.5.5. 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)).

14.13.5.5.1. The 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.

14.13.5.5.2. The Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

14.13.5.5.3. The 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.

14.13.5.5.4. The 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.

14.13.5.5.5. The numerator is the sum of the Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's fraud reduction activities.

14.13.5.6. The 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%.

14.13.5.6.1. The Contractor will aggregate data for all Medicaid eligibility groups covered under this Contract.

14.13.5.7. If the Contractor's MLR does not meet or exceed the MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:

14.13.5.7.1. Reimbursement amount shall equal difference between the adjusted earned revenue and the net qualified medical expenses divided by the MLR Target as specified in federal regulations 42 CFR 438.8(f)(2)(vi).

14.13.5.7.2. The Contractor shall reimburse the Department within thirty (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 the 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.

14.13.5.7.2.1. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with the Contractor any adjustments that must be made to the Contractor's calculated MLR.

14.13.6. Subcontracted Claims Adjudication Activities

14.13.6.1. The Contractor shall require any subcontractors providing claim adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

14.13.7. 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, the Contractor shall:

14.13.7.1. Re-calculate the MLR for all MLR reporting years affected by the change; and

14.13.7.2. Submit a new MLR report meeting the applicable requirements.

14.13.8. DELIVERABLE: MLR Calculation Template

14.13.9. DUE: Annually, on January 15

14.14. Medicaid Payment in Full

14.14.1. Except as allowed in the Contract, the 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.

14.14.2. Except as allowed in the Contract, the 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 the Contractor, for covered services provided pursuant to this Contract.

14.14.3. This section shall not be construed to limit the ability of any of the Contractor's Subcontractors or Network Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against the Contractor for any service provided pursuant to this Contract or any other agreement entered into between that Subcontractor or Network Provider and the Contractor.

14.14.4. 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 the Contractor's

Members.

14.14.5. For fees or premiums charged by the Contractor to Members, the 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.

14.14.6. 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 the Contractor with CMS within two (2) years after the calendar quarter in which the Department made the expenditure. The 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 the Contractor's claims or capitation payments within two (2) 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 the Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from the Contractor all claims and capitations paid to the Contractor for any period of time disallowed by CMS.

14.14.7. The 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.

14.14.7.1. 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.

14.14.8. The Contractor shall ensure that the date of receipt is the date that the 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.

14.14.8.1. DELIVERABLE: Timely Clean Claims Payment Report

14.14.8.2. Quarterly, within forty-five (45) days following the end of the quarter for which the report covers

14.14.9. Institutions for Mental Disease (IMD) Identification Report

14.14.9.1. The 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).

14.14.9.2. The 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).

14.14.9.3. For each Member identified in accordance with Section 14.13.7.1., the report shall include:

14.14.9.3.1. Member's Medicaid ID

14.14.9.3.2. Date of Admission

14.14.9.3.3. Date of Discharge

14.14.9.3.4. Billing Provider Name

14.14.9.3.5. Billing Provider ID

14.14.9.4. DELIVERABLE: Institutions for Mental Disease (IMD) Identification Report

14.14.9.5. DUE DATE: Within ten (10) Business Days following the reporting month.

14.15. Parity

14.15.1. The Contractor shall maintain compliance with all relevant State and Federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA).

14.15.1.1. To meet the requirements of 42 CFR 440.395, the 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.

14.15.2. The 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 the 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.

14.15.2.1. The Contractor's pre-authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits as described in 42 CFR 440.395(b)(4).

14.15.3. The 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:

14.15.4. The Contractor shall provide all documentation necessary for determination of the Contractor's compliance with Federal parity requirements. The Contractor shall provide this documentation upon request for the Department's annual report as required by C.R.S. 25.5-5-421.

14.15.4.1. DELIVERABLE: Parity Report Documentation

14.15.4.2. 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. The 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. The Contractor shall understand the key cost drivers within its region and identify where there is unexplained and unwarranted variation in costs in order to develop and implement interventions.

15.1.1.1.1. The 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. The 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. The 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. The 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. The Contractor shall maintain an interface that enables the 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, the 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)

15.1.1.3.2.1. The 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. The 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. The 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. The 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. The Contractor shall share with the Network Providers, the BIDM System and with the Department any specific findings or important trends discovered through the Contractor's analysis of the available data and information.

15.1.1.3.2.6. The 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 the Contractor's Members.

15.1.1.3.2.7. The Contractor shall support and encourage Network Provider use of the BIDM System's Data Analytic Portal.

15.1.1.3.2.8. The Department will provide the Contractor with Part 2 Data for Members enrolled with the 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. The Contractor shall only use the Part 2 Data for three (3) specific purposes:

15.1.1.3.2.8.1.1. To assess calculation and payment for performance measures.

15.1.1.3.2.8.1.2. To use Prometheus to achieve the Potentially Avoidable Cost Key Performance Indicator targets.

15.1.1.3.2.8.1.3. To provide care coordination and/or case management services in support of payment or health care operations.

15.1.1.3.2.8.2. The 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.

15.1.1.3.2.8.3. The Contractor is fully bound by the provisions of 42 C.F.R. Part 2 upon receipt of the Part 2 Data,:

15.1.1.3.2.8.3.1. Consistent with 42 CFR § 2.32(a)(1), this Part 2 Data will be disclosed to Contractor from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit Contractor from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT

sufficient for this purpose (see 42 CFR § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.Implement appropriate safeguards, including written policies and procedures, to prevent unauthorized uses and disclosures of this data. These policies and procedures shall be documented and reported in the Contractor's Data Governance Policy.

15.1.1.3.2.8.3.2. Immediately report any unauthorized uses, disclosures, or breaches of Part 2 Data to the Department.

15.1.1.3.2.8.3.3. Only redisclose Part 2 Data to a third party if the third party is a contract agent of the Contractor, helping to perform its duties under the Contract, and the contract agent only discloses the information back to the Contractor or to the Department.

15.1.1.3.3. The Contractor shall receive direct admission, discharge, and transfer (ADT) data feeds from one of Colorado's regional health information exchanges.

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. The 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. The 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. The Contractor shall create a data governance policy that describes the circumstances when the Contractor will allow other entities, including providers and Community organizations, full access to Member level data, including how behavioral health data will be shared.

15.1.1.7.1. The Contractor shall update the data governance policy annually, and provide to the Department upon request.

15.2. RAE Maintained Systems

15.2.1. Care Coordination Tool

15.2.1.1. The Contractor shall possess and maintain an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. The Contractor shall make it available for use by providers and care coordinators not currently using another tool.

15.2.1.2. The 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. The 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. The 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. The 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, the Contractor shall require them to collect and report on the same data.

15.2.1.6. The 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

15.2.2.1. The Contractor shall maintain a claims processing system to reimburse providers for covered services under the Capitated Behavioral Health Benefit, and produce encounter claims.

15.2.2.2. The Contractor shall ensure that its claims processing has the capability to process claims using the billing procedure codes specified in the Uniform Service Coding Standards (USCS) Manual. The USCS Manual can be found on the Department's website.

15.2.2.3. Behavioral Health Encounter Data Reporting through the MMIS

15.2.2.3.1. The Contractor shall submit all Encounter Data on all State Plan and 1915(b)(3) Waiver services included within the Capitated Behavioral Health Benefit electronically, following the Colorado Medical Assistance Program policy rules

found in Volume VIII, the Medical Assistance Manual of the Colorado Department of Health Care Policy and Financing (Program Rules and Regulations) or in the Colorado Code of Regulations (10 CCR 2505-10). The Contractor shall ensure that the quality and timeliness of its Encounter Data meets the state's standards.

15.2.2.3.2. The 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. The Contractor shall submit any 837 format encounter claims, reflecting paid, adjusted or denied by the Contractor, via a regular monthly batch process. The Contractor shall submit all encounter claims in accordance with the following:

15.2.2.3.2.1. Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

15.2.2.3.2.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

15.2.2.3.2.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

15.2.2.3.3. The Contractor shall submit ninety-five percent (95%0 of all Encounter Data within thirty (30) days, and one hundred percent (100%) within one hundred and twenty (120) days after the end of the month in which the claim was adjudicated. The Contractor shall submit Encounter Data into the MMIS each month.

15.2.2.3.4. The Contractor shall make an adjustment to encounter claims when the 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, the Contractor shall adjust or void the encounter claim within fourteen (14) calendar days of notification by the Department.

15.2.2.3.5. The Contractor shall submit ninety-five percent (95%) of accurate Encounter Data no later than thirty (30) days, and one hundred percent (100%) no later than one hundred and twenty (120) days following the month in which the Contractor adjudicated a provider claim.

15.2.2.3.6. The 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.

15.2.2.3.6.1. The 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. The 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.

15.2.2.3.6.1.1. DELIVERABLE: Certified Encounter Data submission

15.2.2.3.6.1.2. DUE: Monthly, on the last Business Day of the month

15.2.2.3.7. The 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.

15.2.2.3.8. The Contractor shall comply with changes in Department data format requirements as necessary. The Department reserves the right to change format requirements following consultation with the Contractor, and retains the right to make the final decision regarding format submission requirements.

15.2.2.3.9. The Contractor shall use enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. The Contractor shall ensure that the data transmissions and enrollment reports shall include:

15.2.2.3.9.1. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction.

15.2.2.3.9.2. HIPAA X12N 834 Health Care Enrollment and Maintenance standard transaction.

15.2.2.3.9.3. HIPAA X12N 834 Daily Roster.

15.2.2.3.9.4. HIPAA X12N 834 Monthly Roster: Generated on the first Business Day of the month.

15.2.2.3.9.5. Colorado interChange Encounter Reconciliation Report.

15.2.3. Flat File Submission

15.2.3.1. Quarterly, the Contractor shall electronically submit a flat file table that contains all encounters for that State Fiscal Year, with one record per encounter, which the Contractor shall certify as accurate, complete, and truthful based on the Contractor's best knowledge, information, and belief. This certification shall be signed by either the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for and who reports directly to the Chief Executive Officer or Chief Financial Officer.

15.2.3.1.1. The Department shall provide the Contractor with the specifications for the flat file submission.

15.2.3.1.2. The Department shall conduct a quality review of the submission to determine if flat file meets the required specifications.

15.2.3.2. DELIVERABLE: Certified Quarterly Flat File

15.2.3.3. DUE: Quarterly, on the 21st day of the month following the close of a State Fiscal Quarter.

15.2.3.4. The Contractor shall submit a flat file that contains 95% of paid claim lines within 30 days of the claim paid quarter.

15.2.3.5. The Contractor shall submit a flat file that contains 100% of paid claim lines within 60 days of the claim paid quarter.

15.2.3.6. The Contractor shall be responsible for the accuracy of flat file submissions.

15.2.3.7. Flat file accuracy is determined quarterly for completeness of data fields, and annually for completeness of inclusion of all claims.

15.2.4. Annual Submission

15.2.4.1. The 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 the 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.

15.2.4.1.1. The Department will provide the Contractor with the specifications for the annual flat file submission.

15.2.4.1.2. The Department will conduct a quality review of the annual submission to determine if the flat file meets the required specifications.

15.2.4.1.3. DELIVERABLE: Certified Annual Flat File

15.2.4.1.4. DUE: Annually, by November 15th.

16. OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

16.1. Continuous Quality Improvement

16.1.1. The 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. The 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 the 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. The Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for both the PCCM Entity and PIHP.

16.2. Quality Improvement Program

16.2.1. The 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. The Contractor's Quality Improvement Program 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.

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. The Contractor shall develop and submit a Quality Improvement Plan to the Department and/or its designee outlining how the Contractor plans to implement its Quality Improvement Program. The 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: July 1, 2018

16.2.4. Upon Department approval, the Contractor shall implement the Quality Improvement Plan.

16.2.5. The 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. The 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. The Contractor shall include the following in the report:

16.2.6.1. A description of the techniques the 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. The 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. The Contractor shall publicly post its Annual Quality Report.

16.3. Performance Improvement Projects

16.3.1. The 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. The Contractor shall complete Performance Improvement Projects on a multiyear cycle, including annual reporting, to facilitate the integration of project findings and information into the overall quality assessment and improvement program, and to produce new information on quality of care each year.

16.3.3. The Contractor shall have a minimum of two (2) Behavioral Health Performance Improvement Projects chosen in collaboration with the Department: one (1) clinical project that may include physical health integration into behavioral health and one (1) non-clinical project.

16.3.3.1. The 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. The Contractor shall have the capacity to conduct up to two (2) additional Performance Improvement Projects upon request from CMS after Year 1 of the Contract.

16.3.5. The 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. The 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. The 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. The 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. The 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. The 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. The Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

16.4.4. The 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. The Contractor shall support Network Providers and care coordinators to collect and report information required to calculate the performance measures.

16.4.6. The Contractor shall track their performance on identified measures monthly through the BIDM System and other data resources as appropriate.

16.4.7. The 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. The Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

16.4.9. Accountable Care Collaborative Pay for Performance

16.4.9.1. The Contractor shall participate in three (3) components of pay for performance.

16.4.9.1.1. Key Performance Indicators:

16.4.9.1.1.1. The Contractor shall be capable of working to improve performance for up to nine Key Performance Indicators (KPIs) in order to earn performance payments. KPIs will be established at the Department's discretion to align with new statewide initiatives and through consultation with the Department, RAEs, and stakeholders.

16.4.9.1.1.1.1. 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.

16.4.9.1.1.1.2. The KPIs are:

16.4.9.1.1.1.3. Emergency Department (ED) Visits – A ratio of the number of Emergency Room Visits per-set-member-count per-performance-period

16.4.9.1.1.1.4. 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

16.4.9.1.1.1.5. Child and Adolescent Well Visits – Percent of child and adolescent Members who received the appropriate minimum number of well visits within the evaluation period

16.4.9.1.1.1.6. Prenatal Care – Percent of women who gave birth who received a prenatal visit during pregnancy

16.4.9.1.1.1.7. Dental Visit – Percent of Members who received professional dental services

16.4.9.1.1.1.8. 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 the Contractor.

16.4.9.1.2. Performance Pool

16.4.9.1.2.1. The Contractor may be eligible to earn additional performance payments from the Performance Pool that will be created from a portion of the withheld administrative payment and any monies not distributed to the RAEs for KPI performance. The performance pool may be used to reinforce and align evolving program goals and to focus Contractor attention on priority program outcomes including incentivizing efforts to address COVID-19.

16.4.9.1.2.2. The Contractor may be eligible to receive payments from the performance pool to:

16.4.9.1.2.2.1. Incentivize provider participation in a new state or federal initiative that aligns with the Accountable Care Collaborative and other initiatives to be determined by the Department.

16.4.9.1.2.3. The Department will design and update the performance pool strategy, payment methodology, and distribution plan in consultation with the RAEs.

16.4.9.1.2.4. Detailed performance pool 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 the Contractor.

16.4.9.1.3. Behavioral Health Incentive Program

16.4.9.1.3.1. Subject to available funding, the Contractor may be eligible to participate in a Behavioral Health Incentive Program as described in (Exhibit E).

16.4.9.1.3.2. 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 the Contractor.

16.4.10. Additional Performance Measurement

16.4.10.1. Public Reporting

16.4.10.1.1. The 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:

16.4.10.1.1.1. Key Performance Indicators

16.4.10.1.1.2. Performance pool measures

16.4.10.1.1.3. Behavioral Health Incentive Program measures

16.4.10.1.1.4. Clinical and Utilization Measures as relevant, including CMS Core Measures and HEDIS measures that align with CPC+ and other state and federal initiative.

16.4.10.1.1.5. Member experience of care as described in Section 16.5.

16.4.10.1.1.6. Operational and financial data including member enrollment and summary financial information.

16.4.10.1.1.7. The Contractor will not be eligible to earn payments for performance on the Public Reporting measures unless, the Department, at its discretion, allows the Contractor to earn performance payments on one or more of the Public Reporting measures.

16.4.10.1.1.8. The Contractor may, at its discretion, use any of the Public Reporting measures to establish a pay for performance program for the Contractor's Network Providers.

16.4.10.2. Health Equity and Performance Improvement

16.4.10.2.1. The 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.

16.4.10.2.2. The 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.

16.4.10.2.3. Over the performance period for any or all performance measures, the 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. The Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor and Network Providers.

16.5.2. The 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.

16.5.3. The Contractor shall assist the Department or it's designated vendor with the annual administration of the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for both adults and children.

16.5.3.1. The Contractor shall work with the Department to customize the CAHPS survey and to develop a sampling methodology.

16.5.3.2. The contractor shall develop strategies with the Department to increase Member participation in the Health plan CAHPS survey.

16.5.4. The Contractor shall support the Office of Behavioral Health (OBH) in administering the ECHO Survey for Behavioral Health developed by the Office of Behavioral Health among Members accessing behavioral health services at CMHCs and other contracted Behavioral Health Providers.

16.5.4.1. The Contractor shall work with CMHCs and other contracted Behavioral Health Providers in the Contractor's region to assist with sample frame creation and to update Member contact information.

16.5.4.2. The Contractor shall follow National Committee for Quality Assurance protocols and specifications.

16.5.4.3. The contractor shall develop strategies with OBH to increase Member participation in the ECHO Survey for Behavioral Health.

16.5.5. The Contractor shall inform the Department if they conduct any additional surveys of Members and share findings through the Operational Learning Collaborative.

16.5.6. The Contractor shall use the results and data from CAHPS, ECHO Survey for Behavioral Health, and all other surveys conducted by the Contractor to inform the Contractor's Quality Improvement Plan.

16.5.7. The Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

16.5.7.1. The Contractor shall monitor interventions and report on them at least one (1) time annually at the Operational Learning Collaborative.

16.5.7.2. The 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. The 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. The Contractor may incorporate mechanisms developed for the Contractor's Utilization Management program.

16.6.2. Client Over-Utilization Program (COUP)

16.6.2.1. The Contractor shall partner with the Department in administering the COUP for Members who meet the criteria for inappropriate over-utilization of health care services.

16.6.2.2. Quarterly, the Department will give the Contractor a list of all the Members who have met the Department's overutilization criteria and were notified in writing of their overutilization.

16.6.2.2.1. When appropriate, the Contractor may identify other Members for inclusion in COUP.

16.6.2.3. The Contractor shall outreach and intervene with Members identified as meeting overutilization criteria in order to link the Members to appropriate and available services. The Contractor shall actively connect and educate those Members on the following:

16.6.2.3.1. Their alignment to a PCMP, that PCMP address and the purpose of that alignment.

16.6.2.3.2. Their ability and process to change the PCMP if it is not convenient to them or their family.

16.6.2.3.3. The importance of using the PCMP and not the Emergency Room for non-emergent care.

16.6.2.4. The availability of Nurse Advice Line on a 24-hour basis and the process and telephone number to access Nurse Advice Line services.

16.6.2.5. The Contractor shall monitor Members' utilization of services and pharmaceuticals, and coordinate ongoing care.

16.6.2.6. For Members who remain on the overutilization list after a period of intervention, the Contractor shall perform a clinical review to determine the appropriateness of restricting the Member to either one medical provider and/or one pharmacy (lock in).

16.6.2.6.1. The Contractor shall appear as an expert witness in a State Fair Hearing for a Member who has appealed lock-in status.

16.6.2.7. The Contractor shall recruit providers to serve as lock-in providers.

16.6.2.7.1. The Contractor shall educate providers on what it means to be a lock-in provider, as well as provide informational materials.

16.6.2.7.2. The Contractor shall provide technical assistance to providers who will serve as primary lock-in providers.

16.6.2.7.3. The Contractor shall submit a quarterly COUP referral list to the Department for members who are determined to be appropriate for lock-in.

16.6.2.7.4. DELIVERABLE: COUP Lock-in Referral Report.

16.6.2.7.5. DUE: On the 10th calendar day of the second month of each quarter.

16.7. Quality of Care Concerns

16.7.1. The 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 the Contractor. The 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. The Contractor shall have a system for identifying and addressing all alleged QOC concerns.

16.7.2. When a QOC concern is raised, the 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 the 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 the Contractor has received a QOC.

16.7.2.7. Document the incident in a QOC summary to be sent to the Department. This file 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 and resolution letter.

16.7.2.7.7. Any referral made by the Contractor to peer review, a regulatory agency or a licensing board or agency.

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

16.7.2.7.9. Any outcome of the review as determined by the Contractor.

16.7.2.8. For QOC concerns involving Network Providers, the 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. The Contractor shall submit a letter to the Department, upon request, that includes a brief description of the QOC concern, the efforts that the Contractor took to investigate the concern and the outcome of the review as determined by the Contractor.

16.7.2.9.1. The Contractor shall include a description of whether the issue was found to be a QOC issue and what action the Contractor intends to take with the Provider(s) involved.

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

16.7.2.9.4. The Contractor shall send the complete letter within ten (10) Business Days of the Department's request. Upon request from the 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 (10) Business Days of the Department's request

16.8. External Quality Review

16.8.1. Annually, the 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. The 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 PCCM Entity

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. The 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, the 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. The 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, the 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. The Contractor shall participate in both a statewide and regional PIAC to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Members and providers in the Program. The Contractor shall ensure that both PIACs include, at a minimum, the following stakeholder representatives:

16.9.2.1.1. Members.

16.9.2.1.2. Members' families and/or caregivers.

16.9.2.1.3. PCMPs.

16.9.2.1.4. Behavioral health providers.

16.9.2.1.5. Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

16.9.2.1.6. Other individuals who can represent advocacy and Community organizations, local public health, and child welfare interests.

16.9.2.2. For the statewide PIAC, the Contractor shall:

16.9.2.2.1. Designate one (1) of the Contractor's Key Personnel to attend monthly meetings.

16.9.2.2.2. Nominate one (1) representatives from the Contractor's regional PIAC to serve as members of the statewide PIAC and ensure they consistently attend and participate in monthly meetings. The representative cannot be employed by the Contractor.

16.9.2.3. The Contractor shall create a Regional PIAC with the following responsibilities:

16.9.2.3.1. Review the Contractor's deliverables.

16.9.2.3.2. Discuss program policy changes and provide feedback.

16.9.2.3.3. Provide representatives for the statewide PIAC.

16.9.2.3.4. Review the Contractor's and Program's performance data.

16.9.2.3.5. Review Member materials and provide feedback.

16.9.2.4. The Contractor shall ensure that its Regional PIAC:

16.9.2.4.1. Be directed and chaired by one (1) of the Contractor's Key Personnel.

16.9.2.4.2. Have a formal, documented membership and governance structure that is posted on the Contractor's website for public viewing.

16.9.2.4.3. Have a formal budget for the operations of the Regional PIAC.

16.9.2.4.4. 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 the Contractor's region.

16.9.2.4.4.1. The 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.

16.9.2.4.5. Open all scheduled meetings to the public.

16.9.2.4.6. Post the minutes of each meeting on the Contractor's website within thirty (30) days of each meeting.

16.9.2.4.7. Accommodate individuals with disabilities.

16.9.3. Quality Improvement Committee

16.9.3.1. The 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. The 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. The Contractor shall participate in annual and ad hoc learning collaboratives to monitor specific program activities and share lessons learned.

16.10. RAE 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. The 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, the 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. The Contractor shall have at least thirty (30) calendar days, or a timeframe mutually agreed upon between the Department and the Contractor, to fulfill such requests.

16.11.1.2. The Contractor shall certify that data and information it submits to the Department is accurate.

16.12. RAE Health Plan Management Metrics

16.12.1. The 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. The 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. The 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. The 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. The Contractor shall comply with all applicable CMS regulations in 42 C.F.R. § 438.

17.1.3. The Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the Contract – Exhibit M, 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 the Contractor's Chief Program Officer and Compliance Officer.

17.1.5. The 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 the Contractor's commitment to comply with all applicable requirements and standards under the Contract – Exhibit M, 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 the 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, the Contractor's Key Personnel, and the Contractor's employees for the federal and state standards and requirements under the Contract.

17.1.5.4.1. The 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 the 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. The 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 the 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 the Contractor when they have received an Overpayment, to return the Overpayment to the Contractor, and to notify the Contractor in writing of the reason for the Overpayment within sixty (60) calendar days after the date on which the Overpayment was identified.

17.1.5.8.1. The Contractor shall have a process for Network Providers to report and return Overpayments to the Contractor.

17.1.5.8.2. The Contractor shall have a process for notifying the Department of an identified Overpayment within five (5) business days. The Contractor shall supply the Department the information submitted by a Network Provider related to an identified Overpayment within thirty (30) calendar days of receiving the same information.

17.1.5.9. The 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. The Contractor shall comply with the Department policies related to recoveries of Overpayments.

17.1.5.10.1. The 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. The Contractor makes an error processing the claim, but the claim is otherwise accurately submitted by the provider.

17.1.5.10.2. The Contractor shall not retroactively recover provider payments after twelve (12) months from the date a claim was paid, except when:

17.1.5.10.2.1. 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; OR

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. If the Contractor retroactively recovers a provider payment that is equal to one thousand dollars ($1000) or more, the Contractor shall work with the provider to develop a payment plan if the provider requests a payment plan.

17.1.6. The 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. The Contractor shall modify the Compliance Program as requested by the Department within ten (10) 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 (10) Business Days following the Department's request

17.2. Compliance Plan Requirements

17.2.1. The Contractor shall have a documented Compliance Plan that implements all elements of the Compliance Program.

17.2.2. The 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. The Contractor shall ensure the Compliance Plan, at minimum, includes:

17.2.3.1. A risk assessment of the 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. The 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 the 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; and

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. The Contractor shall submit its Compliance Plan to the Department for review and approval. The 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, the Contractor shall review its Compliance Plan and make any necessary revisions for the following reporting year. The 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. The Contractor shall modify the Compliance Plan as requested by the Department within ten (10) 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 (10) Business Days following the Department's request

17.3. Reports and Disclosures

17.3.1. The 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. The Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a one (1) month period.

17.3.1.1.2. The 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 the 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.

17.3.1.1.2.4.4. The Contractor shall provide the following:

17.3.1.1.2.4.4.1. Date of removal;

17.3.1.1.2.4.4.2. Reason for the termination;

17.3.1.1.2.4.4.3. Numbers of members served by the provider; and

17.3.1.1.2.4.4.4. 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. The 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 10 (ten) Business Days after the end of each month. 17.3.1.1.4.

The Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten (10) 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 (10) Business Days following the Department's request

17.3.1.2. Reports Requiring Semi-Annual Notification

17.3.1.2.1. The Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a

six (6) month period.

17.3.1.2.2. The six (6) month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

17.3.1.2.3. The Contractor shall use the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

17.3.1.2.4. The 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. The 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 forty-five (45) days of the end of the six (6) month reporting period

17.3.1.2.6. The Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten (10) 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 (10) 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. The 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. The 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 the 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 (2) 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), the 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. The Contractor shall use the Provider/Member Change in Circumstance Disclosure template.

17.3.1.3.2.3. The 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 10 (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. The 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 sixty (60) calendar days of identifying any Overpayments, per 42 C.F.R 438.608(d)(2), and any excess capitation payments, the Contractor shall report and return an Overpayment to the Department.

17.3.1.5.1.2. The 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. The 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 sixty (60) calendar days of identifying capitation or other payments.

17.4. Fraud, Waste, and Program Abuse

17.4.1. The 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. The Contractor shall temporarily suspend all review activities or actions related to any provider upon request of the Department.

17.4.3. The Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

17.4.4. The 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. The 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. The 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. The 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. The 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. The Contractor shall assist the Department, the MFCU or any other law enforcement entity as requested with any preliminary or full investigation.

17.4.8. The Contractor shall temporarily suspend all review activities or actions related to any provider which the Contractor suspects is involved in fraudulent activity. The Contractor shall continue its investigation as requested by the Department.

17.5. Provider Fraud

17.5.1. The 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, the Contractor shall use the MCO Suspected Fraud Written Notice template to notify the Department and the MFCU in writing.

17.5.3. The 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); and

17.5.3.7. Any information as required by the Department.

17.5.3.8. DELIVERABLE: Managed Care Suspected Fraud Written Notice

17.5.3.9. DUE: Within three (3) Business Days from the initial discovery to the Department and the MCFU

17.5.4. The Contractor shall provide any additional information which supplements or modifies the Managed Care Suspected Fraud Written Notice within three (3) 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 (3) Business Days following the Department's or the MFCU's request

17.6. Member Fraud

17.6.1. The 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, the 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. The 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 (3) business days from the initial discovery to the Department

17.7. Suspension of Payments Due to a Credible Allegation of Fraud

17.7.1. The 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. The Contractor shall release suspended payment amounts to the provider within one payment cycle when directed to do so by the Department.

17.7.3. The 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 the Contractor if the Contractor is under investigation for a Credible Allegation of Fraud.

17.7.5. When the Contractor has suspended payments to a provider due to a Credible Allegation of Fraud, the 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 (10th) 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. The Contractor shall enable and support the Department or its designee to conduct site reviews of the 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. The 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. The 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. The 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, the 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 the Contractor at least three (3) weeks prior to the visit. The 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. The Contractor has a minimum of thirty (30) days to submit the required materials for non-emergency reviews.

17.8.7. The 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 the 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 the Contractor within forty-five (45) days of the Site Review. The Contractor is allowed thirty (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. The Contractor shall respond to any required actions identified by the Department or its designee, if necessary, with a corrective action plan within thirty (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 the Contractor is found to be in complete compliance. The Department will notify the Contractor in writing when the corrective actions have been completed, accepted and the 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, the 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 the 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. The 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 the 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. The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. The Contractor shall not pay a Network Provider for provider-preventable conditions, as identified in the State Plan and 42 C.F.R. § 438(g). The 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. The Contractor shall create a Provider Preventable Conditions Report that includes all provider-preventable conditions. The 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. The 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 the Contractor, if the 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. The 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. The 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. The 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 (5) percent of the 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. The 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 the 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 the Contractor unless the Secretary directs otherwise.

17.9.4.4.3. May not renew or extend the existing agreement with the 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. The 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. The Contractor shall submit, full and complete information about:

17.10.1.1.1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars ($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 the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

17.10.1.2. DELIVERABLE: Disclosure of Business Transactions

17.10.1.3. DUE: Within thirty-five (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. The Contractor shall disclose to the Department information regarding ownership or control interests in the 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 thirty-five (35) calendar days of either a change of ownership or a written request by the Department.

17.10.2.2. The 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 the 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 the Contractor.

17.10.2.2.3. Tax identification number of any corporation or partnership with an ownership or control interest in the Contractor, or in any subcontractor in which the

Contractor has a five percent (5%) or more interest.

17.10.2.2.4. Whether an individual with an ownership or control interest in the Contractor is related to another person with an ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the 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 the 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 the 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. The 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. The 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 the Contractor does not use information obtained from one party in its dealings with the other.

17.10.3.3. The 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 (10) Business Days of learning of an existing appearance of a conflict of interest situation.

17.10.3.4. As required by CRS 25.5-5-402, the Contractor may be required to submit quarterly data about rates paid to providers in their network. If required to do so, the Contractor shall submit required rate information on a template provided by the Department on the last day of each State fiscal quarter.

17.10.3.4.1. DELIVERABLE: Supplemental Conflict of Interest Data

17.10.3.4.2. DUE: Quarterly, on the last day of each State fiscal quarter

17.10.4. Subcontracts and Contracts

17.10.4.1. The Contractor shall disclose to the Department copies of any existing subcontracts and contracts with providers upon request.

17.10.4.2. The Contractor shall ensure that no Member is billed by a Subcontractor or provider for any amount greater than would be owed if the 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 (5) Business Days of the Department's Request.

17.10.5. Screening of Employees and Contractors

17.10.5.1. The 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. The 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 the Contractor determines that one of its employees or Subcontractors has been excluded, then the 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 (5) 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 thirty-five (35) calendar days of the date of a written request by the Department, the Contractor shall disclose the identity of any person who:

17.10.6.1.1. Has an ownership or control interest in the Contractor, or who is a managing employee of the 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 thirty-five (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 the Contractor shall immediately notify the Department and the Office of Information Technology (OIT) of all suspected loss or compromise of sensitive data within five (5) Business

Days of the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

17.10.7.2. The 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. The 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 (5) Business Days of becoming aware of the breach

17.10.8. Maintenance of Records

17.10.8.1. The 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, the 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 (10) years.

17.10.9. Inspection and Audits

17.10.9.1. The Contractor shall allow the Department, CMS, HHS-OIG, the Comptroller General and their designees to inspect and audit any records or documents of the 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, the Contractor shall allow the Department, CMS, the HHS-OIG, the Comptroller General and their designees this authority for ten (10) 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. The 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, the 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 the Contractor or its subcontractors pertaining to the ability of the 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 the Contractor's, Subcontractor's or providers' provision of care.

17.10.9.4.5. The Contractor shall allow access to the Contractor's claims system and claims data by Department staff for program integrity activities.

17.10.9.4.6. In consultation with the Department, the 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. The Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five (5) 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, the Contractor shall participate in a robust financial reporting program.

17.11.2. The 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 the Contractor's financial information as follows:

17.11.2.1. The 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 the 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 the 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

17.11.2.1.4.2. A breakdown of how the PMPM payments were spent for each category of work

17.11.2.2. The 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 forty-five (45) days from the end of the state fiscal quarter.

17.11.3. The 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 the Contractor's Chief Financial Officer or their designee.

17.11.4. The 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 the 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 (6) months from the end of the fiscal year that the statement covers.

17.11.5. The 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 thirty (30) days after the submission of the report. The Contractor shall ensure that the Chief Program Officer and CFO are in attendance at these meetings.

17.11.6. The Contractor shall submit other financial reports and information as requested by the Department or its designee.

17.11.7. The 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, the Contractor shall produce an updated report that corrects all errors and includes all omitted data or information. The Contractor shall submit the updated report to the Department within ten (10) 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 (10) days from the Department's request for the updated report or statement.

17.12. Graduate Medical Education (GME) Hospital Report

17.12.1. The Contractor shall submit data quarterly according to the specifications provided by the Department. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. The 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. The 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. The Contractor shall not hold liable any Member for the Contractor's debts, in the event the Contractor becomes insolvent.

17.13.3. The Contractor shall not hold liable any Member for covered services provided to the Member, for which the Department does not pay the 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. The 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 the Contractor covered the services directly.

17.13.5. The 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 the Contractor's debt, in the event the Contractor becomes insolvent.

17.13.5.1. DELIVERABLE: Solvency Notification

17.13.5.2. DUE: Within two (2) Business Days of becoming aware of a possible solvency issue.

17.14. Warranties and Certifications

17.14.1. The 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. The 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 the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and one million five-hundred thousand dollars ($1,500,000.00) in aggregate per year.

17.15.1.1.2. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and three million dollars ($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 the 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. The 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, the Contractor shall notify the Department of such cancellation within two (2) Business Days of when the coverage is cancelled.

17.15.1.2. The Contractor shall notify the Department of:

17.15.1.2.1. Any action on the part of the Colorado Commissioner of Insurance identifying any noncompliance with the requirements of Section 10, 16, -401, et seq., C.R.S. as a Health Maintenance Organization.

17.15.1.2.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

17.15.1.2.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract -.

17.15.1.2.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

17.15.1.2.3.2. DUE: Within two (2) 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 the Contractor:

17.16.1.1. Fails substantially to provide medically necessary services that the 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 the Contractor, the State must provide the 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 the 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 the 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 the Contractor in other Plan, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the 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 the Contractor's Contract as described in this section, the Department shall:

17.17.2.1. Provide the 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 the 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 the Contractor that contains the effective date of the termination.

17.17.2.4.1. Upon receipt of the termination notice, the Contractor shall give Members enrolled with the 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 the Contractor of its intent to terminate under this section, the Department may give Members enrolled with the 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 the 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 the Contractor to Disenroll immediately, without cause;

17.17.4.2. Suspend all new enrollments to the Contractor's managed care capitation initiative, after the date the Secretary or the Department notifies the 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 the 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), the 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 the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the 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 the 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 the Contractor, the 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. ADDITIONAL STATEMENT OF WORK ACTIVITIES

18.1. The Contractor shall perform the Work outlined in Exhibit L, as part of the Work when requested by the Department. The Contractor shall not perform any activities included in Section 18.0 without the Department's notification and without funding being added to the Contract for these activities. Funding for these activities may be added to the Contract through the use of an Option Letter.

19. COMPENSATION AND INVOICING

19.1. Summary of Compensation to the Contractor

19.1.1. Compensation to the Contractor will consist of the following:

19.1.1.1. An administrative per-member per-month (PMPM) payment, as stated in Exhibit E, Payment, for each active Member assigned to the Contractor on the first day of the month and for Members whose enrollment starts from the 2nd through the 17th of the month, excluding any Members enrolled in the Contractor's MCO if applicable.

19.1.1.2. An actuarially certified monthly Capitated Payment, as specified in Exhibit E, Payment, for each active Member assigned to the 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 rate at the actuarially certified point estimate in accordance with 42 C.F.R. § 438.

19.1.2. Compensation to the Contractor may also consist of the following:

19.1.2.1. Key Performance Indicator incentive payments or Performance Pool payments based on the Contractor's performance.

19.1.2.2. An annual behavioral health incentive payment based on the Contractor's performance on defined behavioral health metrics.

19.2. Process for Administrative Per-Member Per-Month Payment and Capitated Payment

19.2.1. The Department will calculate the number of active Members enrolled in the Contractor's plan based on the enrollment information in the Colorado interChange.

19.2.2. The Department will remit all administrative PMPM payments and Capitated Payments through the Colorado interChange (MMIS) via electronic funds transfer to a bank account designated by the Contractor. The Department will provide the Contractor with a monthly payment report through the Colorado interChange.

19.2.2.1. The Contractor shall ensure the accuracy of direct deposit information provided to the Department and update such information as needed.

19.2.3. The Department will remit all PMPM payments and Capitated Payments to the Contractor within the month for which the payment applies.

19.2.3.1. In the event that the Contractor is not compensated for a Member in a month for which the Contractor should have been compensated, the Department will compensate the Contractor for that Member retroactively.

19.3. Special Provisions for Monthly Capitated Payment

19.3.1. The monthly Capitated Payment shall be considered payment in full for all covered services set forth in Section 14.5.

19.3.2. 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.

19.3.3. The Department will recoup partial capitation payments for short term stays in an IMD that exceed fifteen (15) days during the period of a monthly capitation payment.

19.3.4. The Contractor shall acknowledge that in State Fiscal Year 2020 the Colorado Legislature built a two percent (2%) 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 the Contractor is required to continue passing this amount on to all eligible providers in its entirety.

19.3.5. Actions Impacting Existing Rates

19.3.5.1. The 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.

19.4. Pay for Performance

19.4.1. Key Performance Indicator (KPI) Incentive Program

19.4.1.1. The Department will implement a KPI incentive program through which the Contractor may earn up to four dollars and twenty-one cents ($4.21) PMPM, effective July 1, 2022, for meeting established performance goals.

19.4.1.2. The KPI incentive payment will be set and paid as follows:

19.4.1.2.1. 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 twenty-one cents ($4.21) PMPM, effective July 1, 2022.

19.4.1.2.2. The Department will pay an incentive payment to the Contractor for each individual KPI that the Contractor meets or exceeds the established performance goal.

19.4.1.2.3. The Department shall provide to the Contractor documented calculation methodology for all measures prior to the first distribution of funds. The Department shall release the calculation methodology as a draft and shall provide a comment period of no less than two (2) weeks prior to releasing as final. The Department will determine the final measurement and pay for performance criteria.

19.4.1.2.4. The Department will remit all Payments on KPIs to the Contractor within 180 days from the last day of the quarter in which the KPI incentive payments were earned. The Department will calculate the KPI incentive payment as of the end of each quarter based off of the Contractor's performance.

19.4.1.2.4.1. The Department may consult with the RAEs to modify the KPIs, KPI performance goals, and the individual KPI PMPM payment amounts, by amendment to the Contract or the specifications document.

19.4.1.2.5. The Department will remit all incentive payments through the Colorado interChange.

19.4.2. Performance Pool

19.4.2.1. The Department will distribute the monies in the performance pool to the Contractor based on an annual strategy created in consultation with the RAEs.

19.4.2.2. The Department will provide the Contractor with the documented calculation methodology prior to the first distribution of funds. The Department will release the calculation methodology as draft and shall provide a comment period of no less than two (2) weeks prior to releasing as final.

19.4.2.3. The Department will remit all incentive payments through the Colorado interChange.

19.4.3. Behavioral Health Incentive Program Payment

19.4.3.1. The Department will implement a Behavioral Health Incentive Program enabling the Contractor to receive incentive payments for the improvement of Behavioral Health Incentive Measures as described in Exhibit E, Payment.

19.4.3.2. The Behavioral Health Incentive Program will be implemented in accordance with 42 CFR 438.6(b)(2) ensuring that the arrangement with the Contractor:

19.4.3.2.1. Does not provide for payment in excess of 105% of the approved capitation payments.

19.4.3.2.2. Is for a fixed period of time and incentive performance shall be measured during the rating period under the Contract in which the performance incentive program is applied.

19.4.3.2.3. Is not renewed automatically.

19.4.3.2.4. Is made available to both public and private contractors under the same terms of performance.

19.4.3.2.5. Is not conditioned on the Contractor entering into or adhering to intergovernmental transfer agreements.

19.4.3.2.6. Is necessary to support program initiatives as specified in the state's quality strategy.

19.4.3.3. The Department will calculate the Behavioral Health Incentive Program payment as described in Exhibit E, Payment.

19.4.3.4. The Department will provide to the 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 (2) weeks prior to releasing as final. The Department will determine the final measurement and pay for performance criteria.

19.4.3.5. 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.

19.5. Payment Calculation Disputes

19.5.1. In the event that the Contractor believes that the calculation or determination of any payment is incorrect, the Contractor shall notify the Department of its dispute within thirty (30) days 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.

19.6. Recoupments

19.6.1. The Department shall recoup monthly administrative PMPM payment, and Capitated Payment amounts or pay for performance payments paid to the Contractor in error. Error may be either human or machine error on the part of the Department, the Contractor or otherwise. Error includes, but is not limited to, lack of eligibility, computer error, change in RAE enrollment due to a Member choosing a new PCMP, or situations where the Member cannot use the Contractor's facilities.

19.6.2. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) days, the Department shall deduct the overpayments from the next payment to the Contractor.

19.6.3. The Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, the Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within ninety (90) days of termination.

19.6.4. Payments made by the Department to the Contractor due to the Contractor's omission,

fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

19.6.5. Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any monthly administrative PMPM payments and Capitated Payments.

19.7. The Contractor's obligation to refund all calculated rebates continues subsequent to the termination of the Contract.

19.8. Closeout Payments

19.8.1. Notwithstanding anything to the contrary in this Contract, all payments for the final month of this Contract shall be paid to Contractor no sooner than ten (10) 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 Jared Polis, 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 D-1

RAE: **Region # 1 – Rocky Mountain Health Plan**

System Migration
The Contractor shall meet or exceed the following obligations for a twelve (12)-month period starting two (2) weeks after the date of the system migration, effective for 1/1/23.

The Contractor's Provider phone line, as required in Ex. B section 12.8.2., shall further have the capability to receive calls and the capability to make outbound calls. The Provider phone line shall be open to receive and make calls with sufficient staff to support minimum hours of operations during Business Hours. The Provider phone line shall be capable of managing all contacts, including during fluctuations in call volumes.

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

DELIVERABLE: Provider Call Line Statistics Report
DUE: Weekly for the first 90 calendar days after the system migration start, within fifteen (15) calendar days of the last day of the weekly period for which the report covers. Monthly for the period starting 90 calendar days after the system migration start, within fifteen (15) calendar days of the last day of the month period for which the report covers.

Performance Standards
The Contractor shall report the following Performance Standards monthly during the twelve (12) months starting with the month after the system migrations occur. Compliance with Performance Standards shall be calculated and assessed on a weekly basis. If the Department institutes policy changes that affect the Performance Standards with less than 60 calendar days written notice, the Performance Standards shall be suspended no more than 15 calendar days. The Contractor shall implement all appropriate policy changes within 60 calendar days of notice from the Department. The Contractor shall work collaboratively with the Department to create a reporting template for the Performance Standards. The Department will determine the final template for the reporting of Performance Standards.

PERFORMANCE STANDARD 1: CALL CENTER ASA The Contractor shall ensure that the average length of time callers are waiting in the call queue on the Provider Call Line before the call is answered shall be three (3) minutes or less during each week.

PERFORMANCE STANDARD 2: PROVIDER RESPONSIVENESS The Contractor shall respond to 95% of all provider questions, issues, or complaints within 2 business days.

PERFORMANCE STANDARD 3: PROVIDER PAYMENT The Contractor currently pays providers through fee-for-service (FFS) contracts (where providers receive payment for each service provided) as well as value-based contracts (VBC) that include capitation and the processing of encounters where encounters are adjudicated for reporting and reconciliation, but not for direct payment. To meet Performance Standard 3 the Contractor shall:

(a) pay or adjudicate at least 95% of all clean claims for FFS contracts within 30 calendar days of the date of receipt; and pay or adjudicate 99% of all clean claims for FFS contracts within 60 calendar days of the date of receipt. Prepayment of claims for FFS contracts within 30 or 60 calendar days of claims submission shall count as "paid" and as timely payment. Contractor has and may continue to make provider pre-payments for FFS contracts; AND

(b) make all capitation payments within 48 business hours of targeted release date. Contractor shall adjudicate at least 95% of all clean encounters for VBC within 90 calendar days of the date of receipt; and adjudicate 99% of all clean encounters for VBC within 120 calendar days of the date of receipt. The 90 and 120 calendar day adjudication timelines for encounters in VBC are established since payment in the form of capitation occurs regardless of encounter process timelines.

PERFORMANCE STANDARD 4: FINANCIAL AND TRANSACTIONAL CLAIMS ACCURACY Contractor financial and transactional claims accuracy shall be 98% and 95% respectively for all clean claims adjudicated, as reported no less frequently by the Contractor on a calendar quarter basis (financial accountability shall be assessed weekly during each quarterly calculation). The sample of claims reviewed each quarter, shall include at least 25 claims (sampled randomly) that require prior authorization and/or utilization management to measure the impact of the initially non-integrated Essette clinical management system as part of the audit sample. The reporting for this Performance Standard will be based on an audit of a random sampling of claims, following auditing industry standards with processes approved by the Department, which shall not unreasonably withhold such approval.

PERFORMANCE STANDARD 5: ELIGIBILITY ACCURACY The Contractor shall load 95% of all daily compliant 834 eligibility files accurately within 24 business hours of receipt from the State or its vendors with a 98% accuracy rate.

PERFORMANCE STANDARD 6: MEMBER AND PROVIDER PORTAL FUNCTIONALITY Except for planned down time to perform scheduled maintenance or support services, including upgrades, enhancements, or changes to the applicable software or hardware, Member and Provider Portals and clinical platform (Essette) are operational, accurate, and allow users to log in and complete all designed functionality (including display of any member specific data).

<u>Financial Accountability</u>
The Contractor shall contribute funding to a holding account in the amounts provided in this section, to be distributed at a later date, as directed by the Department, per unachieved Performance Standards listed in Ex. D per week. Except as otherwise provided herein, such contributions shall apply to all unmet performance standards beginning two weeks after the migration date.

The Contractor shall deposit forty thousand dollars ($40,000.00) per week per unmet Performance Standard into the holding account for Performance Standards 1-5. Performance

Standards shall be reported monthly, but assessed for each week within the monthly reports. Each monthly report shall be due fifteen (15) calendar days after the end of the monthly reporting period.

The Contractor shall deposit twenty-five thousand dollars ($25,000.00) per week into the holding account for each week Performance Standard 6 is missed; however, financial accountability shall not be assessed on performance for the first 11 weeks after the migration.

Contractor shall create a separate holding account or bank account for the sole purpose of funding the performance guarantees. This account will be owned and maintained by the Contractor. The Contractor will submit to the Department monthly the bank statements of the cash funded, reconciled to the performance guarantee dashboard. Contractor shall deposit funds into the holding account within 30 calendar days of each month's report.

The Contractor and the Department will agree on how the funding that is contributed to the holding account shall be distributed at a later point in time. It shall not be distributed to either the Contractor or the Department. Funds shall be used to support community re-investment, improving member health, provider access or health neighborhood capacity. Funds shall not be used to enhance provider reimbursement beyond 100% of their contractual terms for timely payment.

Payments made for missing Performance Standard shall be made from the Contractor's profit margin (defined as the difference between RAE 1, Prime, and CHP total revenue and total expense) and not from operational expenses. The Contractor shall bear the responsibility of proving that reimbursements are deducted from the Contractor's profit margin during the quarterly financial review meetings with the Department. The total amount of community reinvestment account funding contributed to the holding account shall not exceed 25% of the Contractor's RAE, Prime, and CHP profit margin for calendar year 2023 as defined in the Medicaid Report Template (MRT) for SFY 23 and SFY24 as reviewed and audited by Meyers and Stauffer (or their successor) for the RAE behavioral health and Prime scopes of work, and the CHP contract. The profit from the Admin PMPM line of business under the RAE contract will be defined using the Quarterly Financial Reports. The Contractor and HCPF may mutually agree to interim estimates of profit for calendar year 2023 while MRT fillings are not yet complete.

The Contractor shall not pass on the cost of this reimbursement to Network Providers or Subcontractors that support the Work. The Contractor shall not absorb the cost of this reimbursement by reducing staff or resources dedicated to the Work.

<u>Excused Non-Compliance</u>. Except as otherwise defined above, Contractor shall not be financially accountable when non-compliance with the Performance Standards is caused by, and for the duration of the following circumstances beyond the Contractor's reasonable control, including without limitation, acts of God, acts of government other than the Colorado Department of Health Care Policy and Financing, flood, fire, earthquakes, civil unrest, acts of terror, strikes (other than those involving Contractor employees, agents, or subcontractors).

Vendor Specific Requirements			
The Contractor shall comply with the following :			
#	**Topic**	**Exhibit B SOW Citation**	**Vendor Specific Requirements**
1	Accountable Health Communities Model grant		The Contractor shall continue to invest in comprehensive, community-connected models of care, as a "Bridge Organization" convener within its Accountable Health Communities Model (AHCM). As part of AHCM, participants shall develop efficient processes for social risk factor screenings, which will happen at Primary Care Medical Providers (PCMP), Community Mental Health Clinics (CMHC) and hospital clinical sites. AHCM is prompting the Contractor and participants across the region to develop and scale new skills and tools for making referrals to community services providers, with Practice Transformation and technology supports provided by the RAE...The Region 1 Partners shall participate in the newly awarded Accountable Health Communities Model (AHCM) from CMMI to provide screening and care navigation to resources for housing, interpersonal violence, food, utilities and transportation, among other potential needs.
2	Technology		Care Coordination Tool: The Contractor, as well as all Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) within Reunion Health, shall use the Contractor's care coordination tool to provide efficient, team-based coordination of assessment, documentation, care planning and service delivery functions within the RAE. Impact Pro: The Contractor shall engage its partners in systems-level change and collaboration using robust data and analytics, and leveraging advanced analytics, including its Impact Pro platform. Using Impact Pro, the Contractor shall analyze integrated medical, behavioral and pharmacy claims as well as lab test results to identify patterns of care at the practice, hospital and regional level." Social Information Exchange: The Contractor shall utilize a social information exchange and regional data management architecture grounded in SDoH use cases to collect information on risk factors across the entire RAE Membership, identify gaps in services and prioritize community capacity building initiatives. The Contractor shall provide leadership and align organizational resources to accelerate progress on an agreed SDoH agenda. Text reminders: The Contractor shall work to reduce no-shows and social barriers by offering Members text reminders and by offering a care coordinator to individuals requiring more support. Integrated community service coordination solution: The Contractor shall integrate data from 2-1-1, Colorado's resource referral service, and other existing resources and create actionable workflows through its integrated community service coordination solution. Telehealth: The Contractor shall allow any of its primary care, behavioral health and community service partners to use the EasyCare CO platform, developed by the Contractor to support a wide variety of virtual clinic and asynchronous practice models, free of charge for virtual visits and secure chats for the populations they serve – without regard to enrollment status in RMHP, the ACC or any other payer coverage. The Contractor's EasyCare CO platform includes services provided directly by the health plan to Members, as well as those available from FQHCs, private practices and CMHCs.

			Social determinants of health screening: The Contractor's Partners shall leverage the extensive experience within its organizations, and across the community, in screening Members for physical health, behavioral health and social determinants of health needs using evidence-informed and Member-centric tools, including the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool. Lifeline: To overcome the barrier of lack of access to hardware and data plans, the Contractor shall utilize MyHealthLine, which connects Members with free smartphones and data plans through the national Lifeline benefit and provide site-based telehealth infrastructure to rural practices.
3	Transportation		As the RAE, the Contractor shall continue to incorporate transportation solutions into current ACC activities by offering additional value-added services to further address the challenges with transportation, including a Mobility Manager, transportation community grant/funding, and a Prius leasing program.
4	Integrated Pharmacist		The Contractor shall continue to utilize APM and RCCO resources to support and sustain clinical pharmacist practices directly within advanced and comprehensive care PCMP settings. Within these arrangements, the Contractor's payment agreements shall support PharmD FTE, who perform a variety of patient safety, medication consultation and cost-effectiveness analyses – directly onsite, in homes and community settings – for Members and clinician team members. The Contractor shall continue to support integrated pharmacists in three Network PCMPs: Salud Family Health Centers and Associates in Family Medicine in Fort Collins and Primary Care Partners in Grand Junction."
5	General UHC Section		The Contractor shall leverage the experience of its parent company, UnitedHealthcare, to incorporate lessons learned from work in several other states to inform its staffing plans and procedures, including support for housing services for people with comorbidities. The Contractor shall work to connect Medicaid enrollees with federally subsidized Lifeline phones to maximize the number of Medicaid enrollees who have the smart phone and data plan resources necessary to use telehealth. The Contractor shall utilize its parent company's established arrangement with Toyota that affords local plans and community partners access to low-interest financing and fleet lease arrangements. The Contractor shall leverage its parent company's robust systems and infrastructure to address social determinants of health, as well as its experience with population-based health, including: 1) Participation in the National Health Plan Collaborative and Commission to End Health Care Disparities; 2) Convening of the UnitedHealthcare Group Health Disparities Council, in which internal stakeholders develop internal solutions; 3) Optum Labs, a group within UnitedHealthcare that partners with the Mayo Clinic and the United States Department of Health and Human Services to research health disparities. The Contractor shall use its parent company's cutting-edge research on health equity to evaluate appropriate interventions for use in Region 1 in order to address the health conditions and social determinants of health specific to Western Colorado. The Contractor shall leverage the financial resources and extensive expertise of its parents company in its housing strategy. The Contractor shall leverage the expertise of its parent company and its partnership with CSH to develop our DOLA/LIHTC toolkit and to identify best practices (such as One Roof). For individuals with disabilities, the Contractor shall offer Project SEARCH employment training. The Contractor shall leverage its parent company's experience in implementing health interventions in schools, including the Project SEARCH program. Project SEARCH is defined as the following: a business-led, one-year school-to-work program that takes place entirely at the workplace. Project SEARCH helps persons with disabilities get the training and skills needed to successfully find and keep jobs in the community. The Contractor's parent company developed and implemented an email mentorship program, matching the parent company's employees with a Project SEARCH intern

			for a weekly educational and motivational email exchange. At the end of the internship, many interns are offered full-time positions at the parent company. The Contractor shall leverage its parent company's partnerships with national and international entities to improve health outcomes far beyond the clinic. Some of these partnerships include a video game maker Konami that introduced Dance Dance Revolution! Classroom Edition in three states, engaging children in activity from an early age. With the support of its parent company, the Contractor shall offer trauma-informed health education for staff and providers to take and earn free CMEs/CEUs. Additionally, the Contractor's provider directory shall have a searchable category for providers knowledgeable in trauma informed care. The Contractor shall deploy Impact Pro, an advanced analytic engine developed by its parent company, within the Contractor's operations and through external deployments in Network Provider sites. The Contractor shall utilize Impact Pro to continuously evaluate enrollment data to proactively identify health risks and intervention opportunities. The process shall include the following: 1) incorporate and integrate a variety of data from claims, pharmacy and lab data and providers; 2) use algorithms to forecast future health risk, stratify Members and provide information to help determine the intensity of care management interventions; 3) use crucial data analytic capabilities that assist in the production of targeted reports and, in turn, effective Member supports. The Contractor shall utilize its resources and experiences in the following areas to create new programs: supportive housing, transitional services, jail diversion work, network development, capitation management, community integration and social determinants of health, and school-based services are all cited as areas of expertise. The Contractor shall devote a staff member to supportive housing work and utilize its collaboration with DOLA.
6	Behavioral Health integration		The Contractor shall employ a full time Behavioral Health Integration Director.
7	Member Incentive Program		The Contractor shall present an incentive plan to the Department for approval. The Plan shall describe proposed interventions, target populations, goals and incentives. The Contractor's approach shall comply with all federal guidance and laws concerning Member incentives.
8	Provider Network		The Contractor's network shall include the following: 7.0 adult PCMP practitioners per 1,800 eligible adult members based on the enrollment estimates in the RFP, and 8.4 pediatric PCMP practitioners per 1,800 eligible pediatric members, which exceeds the Department's standard of one PCMP practitioner per 1,800 adult or child Members. The Contractor shall invite 460 Medicaid-validated mental health providers and 15 SUD providers not currently in the Contractor's statewide to provide RAE services, provided they meet contracting, credentialing and documentation requirements. The Contractor shall make all network credentialing and tiering assessments available to providers in a timely manner, no more than 90 days from the date of application. The Contractor shall document the assessments and network status decisions in an objective manner and indicate the basis of the decision, and report transparently to the members of the Director's Committee in the RAE governance structure. The Contractor shall also make the decisions available to any other interested party, including the Department, upon request.

9	Provider Training		The Contractor shall continue its work on the following projects as the RAE and expand it to the entire region: facilitating a local disability advocacy partners community town hall and provider learning collaborative like the Contractor did in Fort Collins in November 2016.; featuring an introduction to deaf culture provided by a deaf individual as the event; explaining Video Remote Interpreting and information about the Contractor care coordination resources; providing Participants with a toolkit of information that they can immediately implement within their organization to help them better serve deaf and hard of hearing populations. To support Members of the LGBTQ community, the Contractor shall assist interested practices in becoming practice allies by choosing to post small rainbows in waiting rooms, changing intake forms to use non-binary and non-heteronormative language and asking Members their preferred pronoun at appointments. The Contractor shall actively recruit LGBTQ-friendly specialists that can address the unique needs of Members seeking gender transition--such as an endocrinologist to monitor hormone treatment--and provide training to practices to know and understand the heightened risks for Members who identify as a part of the LGBTQ community, risks like suicide, mental illness, bullying or sexual violence.
10	Prevention and Wellness		The Contractor shall create MOUs with at least one recreation site in each Community to provide free or reduced price memberships (funded by the RAE) to obese Medicaid Members who have created a weight loss plan with their provider that requires enhanced physical activity. In addition, the Contractor shall refer members experiencing social isolation to recreation centers as one way to become engaged in the community and make social connections.
11	Care Coordination Manual		As part of the care coordination framework, the Contractor shall develop a Care Coordination Manual to be a living document containing all policies and procedures. The Contractor shall continually review and update the Care Coordination Manual in collaboration with all care coordination professionals to reflect the most current research into care coordination and care management, management of chronic conditions, tailoring of interventions for special Member populations, and incorporating regional resources, solutions and best practices.
12	Criminal Justice Access		The Contractor shall hold behavioral health providers accountable to ensure that Members released from jails and prisons are offered an appointment within seven days of release.
13	Data Integration		The Contractor shall integrate data from the Homeless Management Information System (HMIS), which is a class of database applications used to confidentially aggregate data on homeless populations served in the United States. The Contractor shall use this software application to record and store client-level information on the characteristics and service needs of homeless persons, coordinate care, manage their operations, and better serve their clients."

EXHIBIT E-11, Payment

ADMINISTRATIVE PER-MEMBER-PER-MONTH (PMPM) PAYMENT

Effective July 1, 2022 through the duration of this Contract, the Contractor shall be paid the following Administrative PMPM payments:

Description	PMPM Amount
All Members - ACC	$12.00
All Members – EPSDT Outreach	$0.06

MONTHLY PAYMENT FOR CAPITATED BEHAVIORAL HEALTH BENEFIT
Effective July 1, 2022 – June 30, 2023

The Contractor shall earn the following Full Risk Rates shown in the following table:

	Behavioral Health Rate
Elderly	$27.16
Disabled	$113.88
Non-Expansion Adult	$60.01
Expansion Parent	$36.00
Children	$26.62
Foster Care	$109.78
MAGI Adult	$82.27

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.

RISK CORRIDOR FOR RESIDENTIAL SUD SERVICES AND INPATIENT SUD SERVICES Effective July 1, 2022 – June 30, 2023

Due to uncertainty associated with residential SUD services and inpatient SUD services, all cohorts for this time period shall be subject to a risk corridor calculation. The risk corridor will apply to all populations only for residential SUD services and inpatient SUD services. The risk corridor will be calculated prior to the MLR, and any payments under the risk corridor will be incorporated in the MLR calculation.

1. CALCULATION PROCESS
   The Department, or its designee, will calculate adjusted service expenditures as well as member months, as determined by 820 files with sufficient runout, for the reporting period for covered services using encounter data, flat files, and financial reporting submitted by the Contractor. All financial reporting may be validated by the Department or its agents

at the Department's discretion. The basis of the risk corridor PMPM calculation equals the adjusted service expenditures divided by member months.

The residential SUD services and inpatient SUD services PMPM will be actuarially determined and is set as a portion of the actuarially certified behavioral health capitation rate. The actuarially determined residential SUD services and inpatient SUD services PMPM is equivalent to one hundred percent (100.00%) in the risk corridor structure.

Risk corridor calculations will be made according to the following:

Corridor #	Risk Corridor Min	Risk Corridor Max	RAE %	State %
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%

2. ADJUSTED SERVICE EXPENDITURES DEFINITION

The Department will determine the Contractor's adjusted service expenditures based on the Contractor's submitted service expenditures using encounter data, flat files, and financial reporting submitted by the Contractor.

The ASAM level specific rate as built into the rate model will be multiplied by the submitted units and aggregated. If submitted service expenditures exceed one hundred five percent (105%) of this calculation, the Department will set the adjusted service expenditure amount to one hundred five percent (105%). If the Contractor's submitted service expenditures does not exceed one hundred five percent (105%) of the calculation, the adjusted service expenditure amount will be set to the submitted service expenditure amount. Any expenditures for treatment under the Special Connections program, as defined within the benefit, will not be adjusted and will use the Contractor's submitted service expenditures. The Department will provide a template containing the calculation formula and ASAM level specific rates as built into the rate model to the Contractor. The Department will have final decision on the resolution of any differences in the expenditures.

Services occurring at a Community Mental Health Center shall be subject to the same repricing methodology rather than a cost report-based methodology.

3. RECOUPMENTS OR ADDITIONAL REIMBURSEMENT

The Department will calculate and determine all recoupment or additional reimbursement amounts. All calculations will be based on capitated rates, enrollment data for Members, as determined by 820 files with sufficient runout, and Contractor's adjusted service expenditures. The Contractor's adjusted service expenditures will be calculated on a PMPM basis for providing residential SUD services and inpatient SUD services at ASAM levels 3.1, 3.3, 3.5, 3.7, 3.2WM, and 3.7WM. See above for the definition of adjusted service expenditures.

After finalizing the risk corridor calculation, the Department will present and explain the calculations to the Contractor, as well as issue a demand letter for any amount due from the Contractor. The Contractor shall reimburse the Department within sixty (60) days of the Department issuing the demand letter. The Department shall reimburse the Contractor for risk corridor calculations within sixty (60) days of the Department issuing the demand letter.

RETROSPECTIVE RATE CHANGES

In relation to unique circumstances and when the Contractor and the Department agree to retrospectively change the rates, the Department will recoup overpayments. The rates for the following time periods will be adjusted according to Contract amendment or an Option Letter issued by the Department.

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PAY FOR PERFORMANCE: KEY PERFORMANCE INDICATOR INCENTIVE PROGRAM AND PERFORMANCE POOL

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 twenty-one cents ($4.21) PMPM, effective July 1, 2022. 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.

PAY FOR PERFORMANCE: BEHAVIORAL HEALTH INCENTIVE PROGRAM

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 State Fiscal Year 2023 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.

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.

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.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 G

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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, or an FQHC or RHC using revenue code 0900.

Specialty Behavioral Health Codes

00104 Anesthesia for ECT
90785
InteractiveComplexity
*
90832 Psychotherapy-30minutes
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 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 Unskilled 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 or an FQHC or RHC using revenue code 0900.	
Behavioral health codes	
90791 Diagnostic Eval w/o Medical Services 90792 Diagnostic Eval with Medical Service 90887 Interpretation/explanation of psych/medical exam/data 96116 Neurobehavioral status exam; first hr 96121 Neurobehavioral status exam; add'lhrs** 96130 Psych testing eval services; first hr 96131 Psych testing eval services; add'l hrs** 96132 Neuropsych testing eval services; firsthr 96133 Neuropsych testing eval services; add'lhrs** 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'l30min** 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 drugassessment H0002 Alcohol and/or drug screening	H0023 BH outreach/Drop in H0025 BH prevention education H0031 MH assessment by non-phys H0032 MH service plan devel bynon-phys H2000 Comprehensive multidiscipline edu H2011 Crisis intervention per 15 min S9453 Smoking cess class, non-phys, per ses S9454 Stress manage, non-phys, per ses
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 99243 Outpatient Consultation, at least 30 minutes 99244 Outpatient Consultation, at least 40 minutes 99245 Outpatient Consultation, at least 55 minutes	99252 Hospital Consultation, at least 35 minutes 99253 Hospital Consultation, at least 45 minutes 99254 Hospital Consultation, at least 45 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 99282 Emergency department visit with straightforward medical decision making 99283 Emergency department visit with low level of medical decision making	99284 Emergency department visit with moderate level of medical decision making 99285 Emergency department visit with high 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 an E&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 an E&M	

The following revenue codes (in addition to those represented in Appendix Q) 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***

2. * 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*	*Provider Type Description*
35	360	Community Mental Health Center
37	520	Licensed Psychologist
38	521	Licensed Behavioral Health Clinician
63	399	Substance Use Disorder Individual*
64	477	Outpatient Substance Use Disorder Clinics
64	871	Residential SUD ASAM level 3.1 Programs
64	872	Residential SUD ASAM level 3.3 Programs
64	873	Residential SUD ASAM level 3.5 Programs
64	874	Residential SUD ASAM level 3.7 Programs
64	875	Residential SUD ASAM level 3.2WM Programs
64	876	Residential SUD ASAM level 3.7WM Programs

*This provider type is no longer available for new enrollments

Behavioral Health ICD-10-CM Code Ranges	
Substance Use Disorder	
Start Value	*End Value*
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96

F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99
Mental Health Disorders	
Start Value	*End Value*
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F53.0	F53.1
F60.0	F64.9
F68.10	F69
F90.0	F98.4
F98.8	F99
R45.1	R45.2
R45.5	R45.82

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 sessio ns 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 (supervise d in accordance with the rules of the Colorado Board of Psychotherapists) .

Short-term Behavioral Health Service Procedure Codes

90791	Diagnost ic Evaluat io n without Medical Services
90832	Psychotherapy-30 min utes
90834	Psychotherapy-45 minutes
90837	Psychotherapy-60 minutes
90846	Family Psychotherapy (w/o patie nt)
90847	Family Psychotherapy (wi th patien t)

* 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 M-13, ADDITIONAL 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. The Contractor, as the Regional Accountable Entity shall assist the Department in reducing avoidable and unnecessary costs within the Medicaid Program without negativelyimpacting access to high-value services or positive program outcomes.

1.1.2. The 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 The Contractor shall:

1.1.2.1. Assist the multi-payor collaborative and the Department in the selection of ten (10) to fifteen (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 the 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 Prometheus and other 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. The Contractor shall within the first one hundred and twenty (120) days of the Contract identify key performance metrics and targets in the following two (2) areas:

1.1.3.1. Percent of Members receiving care coordination

1.1.3.2. Access Standards

1.1.4. The Contractor shall manage the limited managed care capitation initiative such that the capitation rates may be set at two percent (2%) or more below the fee-for-service equivalent. The savings target of two percent (2%) may be adjusted based on mutual agreement by the Department and the 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 the 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 one hundred percent (100%) of the fee-for-service equivalent, pursuant to budget neutrality requirements set forth in the Colorado statutes.

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

1.1.6. The Department will support the 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 the RAEs within each region to manage conflict and to collaborate with the Department to make decisions related to this work; and

1.1.6.4. Supporting overall RAE cost containment efforts by using available levers to require provider engagement and participation and to support RAEs in the resolution ofconflict.

1.1.6.5. Collaborating with the 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. The Contractor will receive, process, and analyze Statewide data and work collaboratively with the Department to identify trends and potentially avoidable costs.

1.1.8. The Contractor shall utilize Prometheus data at a Statewide level to identify opportunities to improve Members health outcomes.

1.1.9. The 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. The 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 the 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 in the base contract, acronyms and abbreviations are defined at their first occurrence in this Exhibit M, 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 the 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. APM-see Primary Care Alternative Payment Model

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

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

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

2.1.8. 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.

2.1.9. 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.

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

2.1.11. 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.

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

2.1.13. 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.

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

2.1.15. 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.

2.1.16. 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.

2.1.17. 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.

2.1.18. 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.

2.1.19. 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

2.1.20. 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.

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

2.1.22. 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.

2.1.23. 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.

2.1.24. 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.

2.1.25. 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.

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

2.1.27. 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.

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

2.1.29. 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.

2.1.30. 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 the Contractor as a result of Appeal and External Review Processes.

2.1.31. 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.

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

2.1.33. 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.

2.1.34. 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.

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

2.1.36. 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.

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

2.1.38. 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:

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

2.1.38.2. Serious impairment to bodily functions.

2.1.38.3. Serious dysfunction of any bodily organ or part.

2.1.39. 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.

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

2.1.41. § 438.2.

2.1.42. 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.

2.1.43. 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).

2.1.44. 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.

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

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

2.1.47. Frontier County – A county in the Contractor's service area with a population density less than or equal to 6 persons per square mile.

2.1.48. 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).

2.1.49. Group of Practitioners – means two (2) 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.

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

2.1.51. 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.

2.1.52. 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.

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

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

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

2.1.56. 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.

2.1.57. 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.

2.1.58. 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.

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

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

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

2.1.62. 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.

2.1.63. 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.

2.1.64. 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.

2.1.65. 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).

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

2.1.67. 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.

2.1.68. 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.

2.1.69. Medically Necessary – Also called Medical Necessity, shall be defined as described in 10 CCR 2505-10 § 8.076.1.8.

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

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

2.1.72. Monthly Capitation Payment – A payment the State makes on a monthly basis to a Contractor on behalf of each Member enrolled in its limited managed care capitation initiative under a contract and based on the actuarially sound capitation rate for the provision of services covered under the Contract.

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

2.1.74. Nursing Facility – A facility that primarily provides skilled nursingcare 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.

2.1.75. 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. Open Enrollment Period – the two (2) months immediately preceding the month in which a Member's birthday occurs.

2.1.76. Operational Start Date – July 1, 2018 or when the Department authorizes the Contractor to begin fulfilling its obligations under the Contract.

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

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

2.1.79. Ownership or Control Interest – Means an individual or entity that: has an ownership interest totaling five percent (5%) or more; has an indirect ownership Interest equal to five percent (5%) or more; has a combination of direct and indirect ownership interests equal to five percent (5%) or more; owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation another entity, if that interest equals at least five percent (5%) 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.

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

2.1.81. PHI - Protected Health Information.

2.1.82. 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.

2.1.83. 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.

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

2.1.85. 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.

2.1.86. 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.

2.1.87. Prevalent Language – 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).

2.1.88. 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.

2.1.89. 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.

2.1.90. 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.

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

2.1.92. 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.

2.1.93. 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.

2.1.94. 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.

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

2.1.96. 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 the Contractor resolves in a timely fashion through existing informal processes.

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

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

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

2.1.100. 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.

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

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

2.1.103. Significant Business Transaction – Any business transaction or series of transactions that, during any one (1) fiscal year, exceed the lesser of twenty-five thousand dollars ($25,000.00) and five percent (5%) of the Contractor's total operating expenses.

2.1.104. Site Review – The visit of Department staff or its designee to the site or the administrative office(s) of the 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.

2.1.105. 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.

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

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

2.1.108. 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.

2.1.109. 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.

2.1.110. Urban County – A county in the Contractor's service area with a total population equal to or greater than 100,000 people.

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

2.1.112. 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.

2.1.113. 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.

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

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

2.1.116. 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.

2.1.117. Wrap Around Benefits – Medicaid services which either exceed coverage limitations the Contractor is required by this Contract - Exhibit M to provide or, the Contractor is not obligated to provide coverage for under this Contract Exhibit M. 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. Any other term used in this Contract - Exhibit M 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, the 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 - Exhibit M.

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

3.1.2. Claims paid by the 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. The 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, the 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. The 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 the Contract – Exhibit M or 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. The 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 the Contractor's responsibilities under the work outlined in this Contract - Exhibit M.

3.5. The 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. The Contractor shall make records available to the Department upon request, throughout the term of the Contract.

3.6. The 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.

3.7. Contractor Performance Management

3.7.1. Performance Management Process

3.7.1.1. The Department may take action when the 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).

3.7.2. Financial accountability

3.7.2.1. The Department may recoup funds from the Contractor when the 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.

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

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

3.7.2.3.1. 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.

3.8. Deliverables

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

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

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

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

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

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

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

3.8.2.2.3.1. Readability

3.8.2.2.3.2. Spelling

3.8.2.2.3.3. Grammar

3.8.2.2.3.4. Completion

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

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

3.8.2.4. The Department will review the Deliverable and may direct Contractor to make changes to the Deliverable. Contractor shall make all changes within five (5) Business Days following the Department's direction to make the change unless the Department provides a longer period in writing.

3.8.2.5. 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.

3.8.2.5.1. The Department may also direct the 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.

3.8.2.6. 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.

3.8.3. 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.

3.8.4. 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.

3.8.5. 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 – Exhibit M shall be considered to be in Mountain Time, adjusted for Daylight Saving Time as appropriate, unless specifically stated otherwise.

3.8.6. 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.

3.8.7. 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- Exhibit M.

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

3.9. Stated Deliverables and Performance Standards

3.9.1. 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.

3.10. Communication Requirements

3.10.1. Communication with the Department

3.10.1.1. The 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 the Contractor uses a compatible program, then the Contractor shall ensure that all documents or files delivered to the Department are completely transferrable and reviewable, without error, on the Department's systems.

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

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

3.10.1.2.2. 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.

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

3.10.1.3. The Department will use a transmittal process to provide the Contractor with official direction within the scope of the Contract. The 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:

3.10.1.3.1. The date the transmittal will be effective.

3.10.1.3.2. Direction to the Contractor regarding performance under the Contract.

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

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

3.10.1.3.4.1. The Department will provide the 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 the 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 the Contractor through a transmittal.

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

3.10.1.4.1. 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.

3.10.1.5. If the Contractor receives conflicting transmittals, the 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.

3.10.1.6. In the event that the 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.

3.10.1.7. 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 – Exhibit M or any

compensation under the Contract. Transmittals are not intended to be the sole means of communication between the Department and the Contractor, and the Department may provide day-to-day communication to the Contractor without using a transmittal.

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

3.11. Start-Up and Closeout Periods

3.11.1. The Contractor shall have a Start-Up and a Closeout Period.

3.11.2. Start-Up Period

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

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

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

3.11.3. Start-Up Plan

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

3.11.3.1.1. 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 the Contractor.

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

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

3.11.3.1.4. The 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:

3.11.3.1.4.1. Administrative staffing and resources.

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

3.11.3.1.4.3. Provider communications.

3.11.3.1.4.4. Grievances and Appeals.

3.11.3.1.4.5. Member communication, services and outreach.

3.11.3.1.4.6. Provider Network Management.

3.11.3.1.4.7. Program Integrity/Compliance.

3.11.3.1.4.8. Case management/Care Coordination/service planning.

3.11.3.1.4.9. Quality improvement.

3.11.3.1.4.10. Utilization review.

3.11.3.1.4.11. Financial reporting and monitoring. 3.10.3.1.4.12. Financial solvency.

3.11.3.1.4.12. Claims management.

3.11.3.1.4.13. Encounter Data and enrollment information management.

3.11.3.1.5. Staff hiring and training.

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

3.11.3.1.7. Test system compatibility.

3.11.3.1.8. Adherence to security protocols.

3.11.3.1.9. Established Provider Networks and agreements.

3.11.3.1.10. Member and provider materials and education.

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

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

3.11.3.1.13. Business Continuity Plan described in Section 3.11.1.

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

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

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

3.11.3.2.1. DELIVERABLE: Start-Up Plan

3.11.3.2.2. DUE: Within five (5) Business Days after the Effective Date

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

3.11.3.3.1. DELIVERABLE: Start-Up Plan Update

3.11.3.3.2. DUE: Within five (5) Business Days from the Department's request for an update

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

3.11.3.5. The 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.

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

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

3.11.3.6.2. DUE: Upon the Effective Date

3.11.3.7. The 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 the Contractor is ready to perform all Work by the Operational Start Date.

3.11.4. Closeout Period

3.11.4.1. The Closeout Period shall begin on the earlier of ninety (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.

3.11.4.2. 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.

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

3.11.4.3.1. 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.

3.11.4.3.2. 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.

3.11.4.3.3. 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.

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

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

3.11.4.3.5.1. DELIVERABLE: Member Notifications

3.11.4.3.5.2. DUE: Sixty (60) days prior to termination of the Contract

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

3.11.4.3.6.1. DELIVERABLE: Provider Notifications

3.11.4.3.6.2. DUE: Sixty (60) days prior to termination of the Contract

3.11.4.3.7. 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 the Contractor of this determination for that requirement.

3.11.4.4. The Closeout Period may extend past the termination of the Contract. The Department will perform a closeout review to ensure that the Contractor has completed all requirements of the Closeout Period. In the event that the 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.

3.11.5. Closeout Planning

3.11.5.1. Closeout Plan

3.11.5.1.1. The 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 the 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. The Contractor shall deliver the Closeout Plan to the Department for review and approval.

3.11.5.1.1.1. DELIVERABLE: Closeout Plan

3.11.5.1.1.2. DUE: January 1, 2019

3.11.5.1.2. The 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.

3.11.5.1.2.1. DELIVERABLE: Closeout Plan Update

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

3.12. Business Continuity

3.12.1. 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:

3.12.1.1. 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.

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

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

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

3.12.1.4. 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.

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

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

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

3.12.2.1. DELIVERABLE: Business Continuity Plan

3.12.2.2. DUE: Within thirty (30) Business days after the Effective Date

3.12.3. 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.

3.12.3.1. DELIVERABLE: Updated Business Continuity Plan

3.12.3.2. DUE: July 31

3.12.4. 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.

3.13. Accreditation

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

3.13.1.1. Accreditation status, survey type, and level;

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

3.13.1.3. Expiration date of the accreditation.

3.14. Federal Financial Participation Related Intellectual Property Ownership

3.14.1. In addition to the intellectual property ownership rights specified in the Contract, the following subsections enumerate the intellectual property ownership requirements the Contractor shall meet during the term of the Contract – Exhibit M 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 the Contractor. Intellectual property ownership rights specified in the Contract – Exhibit M 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 – Exhibit M 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 – Exhibit M Funds and regardless of Contractor's performance of work.

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

3.14.1.2. If the Contractor uses Contract – Exhibit M Funds to develop necessary materials, including, but not limited to, programs, products, procedures, data and software to fulfill its obligations under the Contract – Exhibit M, the Contractor shall document all Contract – Exhibit M 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.

3.14.1.2.1. The terms of this Contract - Exhibit M will encompass sole payment for any and all Work Product and intellectual property produced by the Contractor for the State. The 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 - Exhibit M.

3.14.1.3. The Contractor shall provide the State comprehensive and exclusive access to and disclose all details of the Work Product produced using Contract – Exhibit M Funds.

3.14.1.4. The 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 the Contractor for the State, either alone or jointly, under this Contract - Exhibit M, including, but not limited to, data, software and software modifications designed, developed, created or installed using Contract – Exhibit M Funds, as allowable in the United States under 17 U.S.C.S. §201 and §204 and in any foreign jurisdictions.

3.14.1.4.1. 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.

3.14.1.4.2. 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.

3.14.1.4.3. The 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.

3.14.1.4.4. The Contractor shall execute the assignment referenced in Section 3.13.1.4 immediately upon the creation of the Work Product pursuant to the terms of this Contract - Exhibit M.

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

3.14.1.5.1. Data and software, or modifications thereof created, designed or developed using Contract – Exhibit M Funds.

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

3.14.1.5.3. All other Work Products or documents created, designed, purchased, or developed by the Contractor and funded using Contract – Exhibit M Funds.

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

3.14.1.7. The Contractor shall fully assist in and allow without dispute, both during the term of this Contract - Exhibit M 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 – Exhibit M Funds.

3.14.1.8. 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 – Exhibit M 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:

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

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

3.14.1.8.3. All necessary data files.

3.14.1.8.4. User and operation manuals and other documentation.

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

3.14.1.8.6. Training materials developed for State staff, agents or designated representatives in the operation and maintenance of this software.

3.15. Performance Reviews

3.15.1. The Department may conduct performance reviews or evaluations of the Contractor in relation to the Work performed under the Contract – Exhibit M.

3.15.2. The Department may work with the 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.

3.15.3. The 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. The Contractor shall provide this information regardless of whether the Department decides to work with the Contractor on any aspect of the performance review or evaluation.

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

3.15.5. 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.

3.16. Renewal Options and Extensions

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

3.16.2. The Parties may amend the Contract – Exhibit M to extend beyond seven (7) 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 – Exhibit M or to provide sufficient time to transition the Work.

3.16.2.1. In the event that the Contract – Exhibit M is extended beyond seven (7) years, the annual maximum compensation for the Contract – Exhibit M in any of those additional years shall not exceed the Contract – Exhibit M 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.

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

3.17. State System Access

3.17.1. 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.

3.18. Protection of System Data

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

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

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

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

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

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

3.18.2.2. 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.

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

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

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

3.18.3. Colorado Information Security Policy (CISP) Compliance

3.18.3.1. 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.

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

3.18.3.3. 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.

3.18.3.4. 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.

3.18.3.4.1.1. DELIVERABLE: Annual CISP Attestation

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

3.18.3.5. 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.

3.18.4. Health and Human Services HIPAA Security Rule Risk Assessments

3.18.4.1. 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.

3.18.4.2. 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.

3.18.4.2.1. DELIVERABLE: Annual HHS Attestation

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

3.18.4.3. 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.

3.18.5. 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.

3.18.6. 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 the 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.

3.18.6.1. 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.

3.18.6.1.1. DELIVERABLE: Background Check Attestation

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

3.19. 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. Data Handling

3.19.1. 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.

3.19.2. 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.

4. CONTRACTOR REGION AND PERSONNEL

4.1. General Requirements and Region

4.1.1. The Contractor shall provide the managed care services outlined for physical health in Contract - Exhibit M for the population enrolled in the Contractor's limited managed care capitation initiative; the behavioral health requirements from Exhibit B do not change.

4.1.2. This Contract Exhibit M operate under the state authority of C.R.S. 25.5-5-415 and is a limited managed care capitation initiative within the ACC program based on responses to the Request for Proposals 2017000265.

4.1.3. The Contractor shall provide managed care services for Members who meet the eligibility requirements necessary to be enrolled in the limited managed care capitation initiative and reside in Delta, Garfield, Gunnison, Mesa, Montrose, Ouray, Pitkin, Rio Blanco, and San Miguel counties.

4.2. Personnel

4.2.1. The 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, the 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 the Contractor's Region, unless otherwise approved by the Department in writing.

4.2.2. The 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. The Contractor shall provide qualified Key Personnel located in Colorado and Other Personnel as necessary to perform the Work throughout the term of the Contract – Exhibit M.

4.2.3.1. The Contractor shall provide the Department with a final list of individuals assigned to the Contract – Exhibit M 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 (5) Business Days following the Effective Date

4.2.3.2. The 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 (5) 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. The Contractor shall provide the Department with an Organizational Chart listing all positions within the 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 (5) Business days after the Effective Date.

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

4.2.6.1. DELIVERABLE: Updated Organizational Chart

4.2.6.2. DUE: Within five (5) Business Days from any change in Key Personnel or from the Department's request for an updated Organizational Chart.

4.2.7. The 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. The Contractor shall submit the Key Personnel Approval Form for the 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 (5) Business Days of the Contractor's submission of the required information.

4.2.7.1. DELIVERABLE: Key Personnel Approval Form

4.2.7.2. DUE: Within ten (10) Business Days following the 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. The 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. The Contractor shall ensure Key Personnel and Other Personnel assigned to the Contract – Exhibit M are available for meetings with the Department during the Department's normal business hours, as determined by the Department. The 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. The Contractor's Key Personnel and Other Personnel shall be available for all regularly scheduled meetings between the Contractor and the Department, unless the Department has granted prior, written approval.

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

4.2.10.4. At the Department's direction, the 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. The Contractor shall respond to all telephone calls, voicemails and emails from the Department within one (1) Business Day of receipt by the Contractor.

4.2.11. Key Personnel

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

4.2.11.1.1. Contract Manager – One (1) full-time employee.

4.2.11.1.1.1. The Contract Manager shall:

4.2.11.1.1.1.1. Serve as the Contractor's primary point of contact for the Contract – Exhibit M and for Contract – Exhibit M performance.

4.2.11.1.1.1.2. Oversee operational procedures, business processes, and reporting. Ensure the completion of all work in accordance with the Contract – Exhibit M's requirements. This includes, but is not limited to, ensuring the accuracy, timeliness and completeness of all work.

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

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

4.2.11.1.1.1.5. Work out of an office within the Contractor's Region.

4.2.11.1.2. Utilization Management Manager – One (1) full-time employee.

4.2.11.1.2.1. The Utilization Management Manger 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 Manager 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 three 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.

4.2.12. 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 Exhibit M.

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 - Exhibit M, Contractor shall provide all additional Other Personnel necessary to perform the Work in accordance with the requirements of this Contract – Exhibit M 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 - Exhibit M.

4.2.13. Subcontractors

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

4.2.13.2. The Contractor shall not subcontract more than forty percent (40%) of the total value of this Contract – Exhibit M; this does not apply to the division of responsibilities between joint owners of the Contractor.

4.2.13.3. The Contractor shall not enter into any subcontract in connection with its obligations under this Contract – Exhibit M without providing notice to the Department. The Department may reject any subcontract and the 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. The 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: July 1, 2018.

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

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

4.2.13.7. The 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 sixty (60) calendar days prior to termination for all general terminations and within two (2) Business Days of the decision to terminate for quality or performance issue terminations.

5. REGIONAL ACCOUNTABLE ENTITY LIMITED MANAGED CARE CAPITATION INITIATIVE

5.1. The Contractor shall perform all of the functions described in this Contract - Exhibit M 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. The Contractor shall be licensed pursuant to Section 10-16-401, et seq., C.R.S., as a Health Maintenance Organization.

5.2.1. The Contractor shall notify the Department, within two (2) business days, of any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, denying renewal, or notifying the 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 the Contractor to properly perform this Contract - Exhibit M and/or failure to notify the Department as required by this section, may be grounds for the immediate termination of this Contract - Exhibit M by the Department for default.

5.2.2. The 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. The Contractor shall notify the Department, within two (2) 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 - Exhibit M by the Department for default.

5.2.3. The contractor shall administer this limited managed care initiative in compliance with the requirements for an MCO and as one program that integrates clinical care, operations, management and data system aligned with the managed care authorities in the Contract Exhibit B.

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

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

5.2.4.2. The Age Discrimination Act of 1975;

5.2.4.3. The Rehabilitation Act of 1973;

5.2.4.4. Title IX of the Education Amendments of 1972;

5.2.4.5. The Americans with Disabilities Act; and

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

5.3. The Contractor shall have a governing body responsible for oversight of the Contractor's activities in relation to this Contract – Exhibit M.

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

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

5.5. The Contractor shall create a written RAE Governance Plan that:

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

5.5.1.1. The 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.

5.5.1.2. The Contractor shall ensure that conflicts of interest include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the 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.

5.5.2. Is posted publicly on the Contractor's website.

5.6. The Contractor shall submit the RAE Limited Managed Care Capitation Initiative Governance Plan to the Department.

5.6.1. DELIVERABLE: RAE Limited Managed Care Capitation Initiative Governance Plan

5.6.2. DUE: June 1, 2018

5.6.3. The Contractor shall submit an updated written RAE Limited Managed Care Capitation Initiative Governance Plan to the Department and post it when a change is made to the plan.

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

5.7.1. DELIVERABLE: Updated RAE Limited Managed Care Capitation Initiative Governance Plan

5.7.2. DUE: Within thirty (30) days after the new change in governance is discovered

6. MEMBER ENROLLMENT AND ATTRIBUTION

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

6.1.1. Individuals in the following Program Aid Codes are eligible for enrollment in the Contractor's limited 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. NF/Hospital 300% Institutionalized – MJ

6.1.1.3. SSI Mandatory – BJ

6.1.1.4. Former Foster Care – FF

6.1.1.5. Pickle - B1

6.1.1.6. DAC (Disabled Adult Child) – BF

6.1.1.7. QDW (Qualified Disabled Widow/er) – BM

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

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

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

6.1.1.11. MAGI Pregnant (Modified Adjusted Gross Income, pregnant clients) – HP

6.1.1.12. Legal Immigrant Prenatal - HB

6.1.1.13. Psych <21 - H1

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

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

6.1.1.16. Transitional Med - H3

6.1.1.17. 4 Month Extended - H6

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

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

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

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

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

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

6.3. The Department will enroll Members into the Contractor's limited 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. Enrollment During Hospitalization

6.3.1.1. If a Potential Member of the Contractor's limited 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.

6.3.1.1.1. The Contractor shall, within fourteen (14) calendar days of the date the Contractor discovers the Member or Potential Member's hospital admission, request in writing to the Department that the enrollment be delayed. The 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 the Contractor in writing within five (5) 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 into the limited managed care capitation initiative that was in effect at the time of their loss of Medicaid eligibility if there is a loss of Medicaid eligibility of two (2) months or less.

6.5. The Contractor shall not discriminate against individuals eligible to enroll in the limited 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. The 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. The Contractor shall accept all eligible Members that the Department assigns to the Contractor in the order in which they are assigned without restriction and according to the Department's enrollment policies and procedures.

6.6.1. The Department will enroll Members with the appropriate aid eligibility category and in the 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 the Contractor's limited managed care capitation initiative will have ninety (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 twelve (12) months and a Member may not disenroll from the Contractor's limited managed care capitation initiative except as provided in section 6.13. Disenrollment from the Limited Managed Care Capitation Initiative.

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 – Exhibit M manager for approval.

6.9. The 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. The Contractor shall receive and process an enrollment file from the Department that contains the attribution and assignment information for all Members in the Contractor's region and any additions, deletions or changes to the existing PCMP selection records.

6.11. The 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. The Contractor shall understand that there will be an enrollment cap for the limited managed care initiative. The Department will utilize the annual Medicaid Caseload Budget Request to set the 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 the Contractor's enrollment cap in November and February of each state fiscal year. The Department shall inform the Contractor, in writing, of any changes to the enrollment cap.

6.12.1.2. The Contractor's enrollment cap is set at 60,000 members for SFY 2022-2023.

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

6.13. Disenrollment from the Limited Managed Care Capitation Initiative

6.13.1. The Contractor may only request disenrollment of a Member from the Contractor's limited managed care capitation initiative for cause. The Department shall review the Contractor's requests for disenrollment and may grant or reject the 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 the Contractor.

6.13.1.4. Member moves out of the Contractor's service area.

6.13.1.5. The Contractor's limited 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 the 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. The 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, the Contractor shall send a written warning that the continuation of the behavior or misconduct will result in disenrollment from the Contractor's limited managed care capitation initiative. The 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, the 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 the Contractor as part of the Member's enrollment in the Contractor's limited 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 because of:

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 the Contractor's ability to furnish services to that Member or other Members.

6.13.3. The Department may disenroll any Member, who requests disenrollment, in its sole discretion.

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

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 the Contractor's service area.

6.13.4.1.2. The 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 the 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 the Contractor's limited managed care capitation initiative with his/her Physician and the Physician leave the 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 limited managed care capitation imitative offered by the 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.

6.13.4.1.12. 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. Without cause, under the following circumstances:

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

6.13.4.2.2. A Member may request disenrollment at least once every twelve (12) months after the first ninety (90) day period.

6.13.4.2.3. 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.

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

6.13.4.3. 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 the Contractor refers the request to the Department. 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.

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

6.13.4.5. 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.

6.13.5. The Contractor shall use reports and information from interChange to verify the Medicaid eligibility and enrollment in the Contractor's limited managed care capitation initiative for its Members. These reports may include some or all of the following:

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

6.13.5.2. 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, disenrollments will be effective the first day of the month following the month in which the request for disenrollment was made. 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.

6.14.2. 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.

6.14.3. Disenrollment Postponed Due to Inpatient Hospital Stay

6.14.3.1. If a current Member of a Contractor's limited managed care capitation initiative is an inpatient of a Hospital at 11:59 p.m. the day before his/her Disenrollment from the 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.

6.14.3.1.1. The Contractor shall, within ten (10) calendar days of the date the Contractor discovers the Member or Potential Member's hospital admission, request in writing to the Department that the disenrollment be delayed. The 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 the Contractor in writing within five (5) Business Days of Contractor's request to postpone disenrollment or upon confirmation of the hospitalization, whichever is later.

7. MEMBER ENGAGEMENT

7.1. Person-and Family Centered Approach

7.1.1. The Contractor shall actively engage 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 preventive and healthy behaviors as outlined in initiatives such as Colorado's 10 Winnable Battles and Colorado's State of Health.

7.1.2. The 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. The 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. The 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. The 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 prevalent language, as directed by the Department or as required by 42 CFR 438.10.

7.2.3. The Contractor shall develop and/or 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. The 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 the Contractor of the language proficiency of Members during the Member's orientation or while being served by Network Providers.

7.2.5. The 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. The 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 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. The Contractor shall implement appropriate technologies for language assistance services in accordance with evolving best practices in communication.

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

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

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

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

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.

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

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

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

7.2.7.3.1. The Contractor shall include taglines in the prevalent non-English 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. The 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. The Contractor shall write all materials in easy to understand language and shall comply with all applicable requirements of 42 C.F.R. § 438.10.

7.2.7.5.1. The Contractor shall write all published information provided to Members, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department.

7.2.7.5.2. The Contractor shall publish all written materials provided to Members using a font size no smaller than twelve (12) point.

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

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

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

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

7.3. Member Communication

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

7.3.2. The Contractor shall ensure that the Contractor's Member communications adhere to Colorado Medicaid's brand standards.

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

7.3.3.1. 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.

7.3.3.1.1. During Business Hours, the Contractor shall ensure that no more than five percent (5%) 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 one-hundred and eighty (180) seconds or longer.

7.3.3.1.2. The Contractor shall ensure that the average length of time callers are waiting in the call queue before the call is answered shall be two (2) minutes or less during each calendar month.

7.3.3.1.3. The Contractor shall have no more than five (5) calls during each business week that have a maximum delay of ten (10) minutes or longer, and no calls shall have a maximum delay over twenty (20) minutes.

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

7.3.3.2.1. DELIVERABLE: Call Line Statistics Report

7.3.3.2.2. DUE: Monthly, within Fifteen (15) calendar days of the last day of the month for which the report covers.

7.3.4. The Contractor shall disseminate practice guidelines to Members and potential Members upon request.

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

7.3.5.1. The 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. The Contractor shall develop electronic and written materials for distribution to newly enrolled and existing Members, with input 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 the RAE's managed care functions as a PCCM Entity, PIHP and MCO.

7.3.6.1.6. The service area covered by the Contractor.

7.3.6.1.7. Medicaid benefits, including State Plan benefits and those in the limited managed care capitation initiative.

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 (5) days prior to the Operational Start Date.

7.3.6.1.10. The Contractor's responsibilities for coordination of Member care.

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

7.3.6.1.12. The 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.

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

7.3.7. Member Rights

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

7.3.7.2. The 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, including 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. Freely exercise his or her rights with the Contractor or its providers treating the Member adversely.

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

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

7.3.8. Member Handbook

7.3.8.1. The Contractor shall collaborate with the Department to create a Member Handbook for distribution to newly enrolled and existing Members that meets the requirements of 42 C.F.R. § 438.10. The Member Handbook shall 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 Program.

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 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. The Contractor shall ensure that this information includes at least the following:

7.3.8.1.6.1. An explanation that an emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

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

7.3.8.1.6.3. An explanation that post-stabilization care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition when the Contractor does not respond to a request for pre-approval within one (1) hour, the Contractor cannot be contacted, or the Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a limited 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 transportation.

7.3.8.1.12. How to locate information and updates to the 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 the Contractor's Service Area.

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

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

7.3.8.1.16.2. DUE: Five (5) days after the Effective Date.

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

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

7.3.8.2.2. DUE: Thirty (30) days prior to any contact changes taking effect.

7.3.9. Contractor Website

7.3.9.1. The Contractor shall develop and maintain a customized and comprehensive website that follows modern principles of optimizing user experience on mobile and personal computer platforms and is navigable by individuals who have low literacy, disabilities, or require language assistance. The Contractor shall ensure that the website provides online access to general customer service information that includes, but is not limited to:

7.3.9.1.1. Contractor's contact information.

7.3.9.1.2. Member rights and handbooks.

7.3.9.1.3. Grievance and Appeal procedures and rights.

7.3.9.1.4. General functions of the Contractor.

7.3.9.1.5. Trainings.

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

7.3.9.1.6.1. Names, as well as any group affiliations.

7.3.9.1.6.2. Street addresses.

7.3.9.1.6.3. Telephone numbers.

7.3.9.1.6.4. Website URLs, as appropriate.

7.3.9.1.6.5. Specialties, as appropriate.

7.3.9.1.6.6. Whether network providers will accept new Members.

7.3.9.1.6.7. 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.

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

7.3.9.1.7. The Contractor shall ensure that the electronic provider directory is updated no later than thirty (30) calendar days after the Contractor receives updated provider information.

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

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

7.3.9.1.10. Access to care standards.

7.3.9.1.11. Health First Colorado Nurse Advice Line.

7.3.9.1.12. Colorado Crisis Services information.

7.3.9.2. The Contractor shall provide a link to the Department's website on the 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.

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

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

7.3.9.5. The 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, the 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: Fifteen (15) days from the notice of termination.

7.3.11. Information on Grievance and Appeals Process

7.3.11.1. The 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 description shall include at least 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 the Contractor to cover a service.

7.3.11.2. Advance Directives

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

7.3.11.3.3. Instructions 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, the Contractor shall reflect these changes to its advance directives information no later than ninety (90) days after the effective date of the change.

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

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

7.3.12. Other information

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

7.3.13. Member Material Review Process

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

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

7.3.13.1.2. Notification of large-scale Member communication initiative

7.3.13.1.3. DUE: At least thirty (30) Business Days prior to the Contractor printing or disseminating any large-scale Member communication initiatives

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

7.3.13.2. The Department may review any Member materials used by the Contractor and request changes or redrafting of Member materials as the Department determines

necessary to ensure that the language is easy to understand and that the document aligns with the Department standards. The 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. The 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, the 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 placed 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 the Contractor provides the information upon request within five (5) Business Days.

7.3.15. The 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. The Contractor shall remind these Members to update their contact information with the Department. The 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. The Contractor shall conduct outreach to these Members to assist them in responding to Department renewal requests for additional information and submitting necessary renewal forms. The Contractor shall use multiple modalities when conducting such outreach, including telephone, email, and text.

7.3.15.3. The 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. The 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, the Contractor may engage in Marketing Activities at its discretion. The Contractor shall not distribute any marketing materials without the Department's approval.

7.4.3. The 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 the Contractor proposes to use for Marketing Activities before distributing the materials. Based on this review, the Department may require changes to any materials before the Contractor may distribute those materials, or may disallow the use of any specific materials in its sole discretion.

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

7.4.5. The Contractor shall distribute the marketing materials to the entire Service Area as defined by Exhibit M.

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

7.4.7. The Contractor and any Subcontractors shall not, directly or indirectly, engage in door-to- door, telephone or other cold call marketing activities.

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

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

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

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

7.5.2.1. The Contractor shall have the capability to process a daily data transfer from the Department or its delegate containing responses to Member Health Needs Surveys. The 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 the Member's PCMP and/or RAE.

7.5.3. 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. Contractor will work with Department to smoothly implement any new tools and/or 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. The Contractor shall onboard enrolled Members to Medicaid and the Accountable Care Collaborative.

7.6.2. The 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. The 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. The 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, the 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. The 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 and scheduling assistance.

7.6.4. The Contractor shall be accountable for providing information on EPSDT at least once to households with multiple EPSDT-Eligible Members residing in the household. The Contractor will not be held accountable for providing EPSDT information to each individual EPSDT-Eligible Member residing in the household.

7.6.5. The 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. The Contractor's communications about EPSDT shall be delivered using easy-to-understand, non-technical language.

7.6.6. The 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. The 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. The Contractor shall monitor EPSDT-eligible Members' receipt of screenings and examinations in accordance with American Association of Pediatrics' Bright Futures Guidelines.

7.6.8. The 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 days 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

7.6.8.4. a.m. and 9 p.m. Monday through Friday and 10 a.m. through 4 p.m. Saturday or Sunday.

7.6.8.5. Attempt to reach members more than once through multiple methods

7.6.8.6. 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. The 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 Education Act (IDEA); the Special Supplemental Food Program for Women, Infants and Children (WIC); school health programs of state and local education agencies (including the Education for all Handicapped Children Act of l975); and social services programs under Title XX.

7.6.10. The 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".

7.6.10.1. The 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.

7.6.11. The 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. The Contractor shall submit a quarterly EPSDT Outreach Report to the Department, in a format to be determined by the Department. The Monthly EPSDT Outreach Report will include descriptions of the Contractor's communication methods for outreach and individual member reporting of completed outreach activities and attempted outreach activities.

7.6.11.1. DELIVERABLE: EPSDT Outreach Report

7.6.11.2. DUE: Quarterly, forty-five (45) days after the end of the reporting period

7.6.12. The 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.

7.6.12.1. DELIVERABLE: EPSDT Outreach Plan

7.6.12.2. DUE: Annually, on July 31

7.7. Promotion of Member Health and Wellness

7.7.1. The 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.

7.7.1.1. The Contractor's Member programs and materials shall align with the Population Management Framework and shall be part of the Contractor's Population Management Strategic Plan.

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

7.7.4. The Contractor shall collaborate with the Department on joint initiatives, as appropriate.

7.7.5. EPSDT Program

7.7.5.1. The Contractor shall ensure the delivery of EPSDT services for Contractor Covered Services. The Contractor shall have written policies and procedures for providing EPSDT services including lead testing and immunizations to the eligible population.

7.7.5.2. The 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.

7.7.5.3. The Contractor shall assure the provision of all required components of periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. At a minimum, such efforts shall include:

7.7.5.3.1. Education and outreach to eligible Members of the importance of EPSDT services.

7.7.5.3.2. A proactive approach to ensure eligible Members obtain EPSDT services including but not limited to 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. Systematic communication process with network providers regarding the Department's EPSDT requirements.

7.7.5.3.3. Process to measure and assure compliance with the EPSDT schedule.

7.7.5.3.4. Per 42 C.F.R 438.210 a process to assure that the medically necessary services not covered by the Contractor are referred to the correct provider with the appropriate referral information for action.

7.7.5.3.5. Comply 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.

7.7.5.3.6. Contractor must apply the Department's definition of Medical Necessity to all members ages 20 and under.

7.7.5.4. 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.

7.7.5.5. The Contractor shall complete and submit an annual EPSDT Report to the Department.

7.7.5.6. The EPSDT Report shall be provided to the Department on the Form CMS-416 and contain all information required for that form for the most recent period from October 1st through September 30th.

7.7.5.6.1. DELIVERABLE: EPSDT Report

7.7.5.6.2. 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. The Contractor shall submit a bi-annual report to the Department describing how the 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.

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

7.8.1.2. DUE: Every six (6) months, by November 21 and May 21

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, the Contractor shall have a Grievance and Appeal system to handle Grievances about any matter related to this Contract - Exhibit M other than an adverse benefit determination and Appeals of an adverse benefit determination for the limited managed care capitation initiative, as well as processes to collect and track information about them. The Contractor shall have only one level of appeal for enrollees as required by 42 C.F.R. § 438.402(b).

8.2. The Contractor shall understand the Department's procedures for handling Appeals of physical health adverse benefit determinations and shall assist Members in following the Department's procedures.

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

8.4. The 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):

8.4.1. The Member's right to file an Appeal, including:

8.4.1.1. The requirements and timeframes for filing.

8.4.1.2. The availability of assistance with filing.

8.4.1.3. The toll-free number to file orally.

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

8.4.3. 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.

8.4.4. The Member's right to file Grievances related to the Contractor or services provided through the Contractor.

8.4.5. Any rights the Provider has to Appeal or otherwise challenge the failure of the Contractor to cover a service.

8.4.6. Any timeliness considerations in filing a Grievance, filing for an Appeal, filing for a State Fair Hearing, or seeking a Continuation of Benefits.

8.5. Grievances

8.5.1. The Contractor shall establish and maintain a Grievance process through which Members may express dissatisfaction about any matter related to this Contract - Exhibit M other than an Adverse Benefit Determination.

8.5.1.1. The Contractor shall create a grievance process that provides a Member sufficient time to disenroll, no later than the first (1st) day of the second (2nd) month following the month in which the member or the Contractor files the request to disenroll, based on the timeframe specified in 42 CFR 438.56(e)(1) if the Contractor approves a disenrollment in response to a grievance.

8.5.2. The 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.

8.5.3. The Contractor shall allow a Member to file a Grievance either orally or in writing at any time and shall acknowledge receiving the Grievance. The Contractor shall ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were 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:

8.5.3.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

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

8.5.3.3. The Grievance or Appeal involves clinical issues.

8.5.4. The Contractor shall make a decision regarding the Grievance and provide notice to the Member of its decision within fifteen (15) Business Days of when the Member files the Grievance.

8.5.5. The Contractor may extend the timeframe for processing a Grievance by up to fourteen (14) calendar days if a Member requests; or the 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.

8.5.6. If the Contractor extends the timeline for a Grievance not at the request of a Member, the Contractor shall:

8.5.6.1. Make reasonable efforts to give the Member prompt oral notice of the delay;

8.5.6.2. Give the Member written notice, within two (2) 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.

8.5.7. The 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

8.5.8. 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.

8.5.9. The Contractor shall document problems a Network Provider submits to the Contractor, and the solutions the 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 the Contractor to find a different solution or follow a specific course of action.

8.5.10. 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, the Contractor shall address all issues as soon as possible after the Department has informed the Contractor of the concerns. The Contractor shall keep the Department informed about progress on resolving concerns in real time, and shall advise the Department of final resolution.

8.6. Notice of Adverse Benefit Determination

8.6.1. When a Contractor denies coverage of or payment for a covered service, the Contractor shall send to the Member a notice of adverse benefit determination that meets the following requirements:

8.6.1.1. Is in writing.

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

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

8.6.1.4. Is in an easily understood language and format.

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

8.6.1.6. Explains the reasons for the adverse benefit determination.

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

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

8.6.1.9. Describes how a Member can Appeal or file a Grievance.

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

8.6.1.11. 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.

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

8.6.2. The 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.

8.6.3. The Contractor shall give notice according to the following schedule:

8.6.3.1. At least ten (10) days before the date of action, if the adverse benefit determination is a termination, suspension or reduction of previously authorized Medicaid-covered services.

8.6.3.2. As least five (5) days prior to the date of adverse benefit determination if the Contractor has verified information indicating probable Member fraud.

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

8.6.4.1. The recipient has died.

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

8.6.4.3. 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.

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

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

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

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

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

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

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

8.6.6. As expeditiously as the Member's health condition requires, but no longer than ten (10) calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

8.6.6.1. The Contractor may extend the ten (10) calendar day service authorization notice timeframe of up to fourteen (14) additional days 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.

8.6.6.2. If the Contractor extends the ten (10) 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.

8.6.7. 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.

8.6.8. For cases in which a Provider, or the 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, the Contractor shall make an expedited service authorization decision and provide notice as expeditiously as the Members health condition requires and no later than seventy-two (72) hours after receipt of the request for service.

8.6.8.1. The Contractor may extend the seventy-two (72) hours expedited service authorization decision time period by up to fourteen (14) calendar days if the Member requests an extension, or if the Contractor justifies a need for additional information and how the extension is in the Member's interest.

8.7. Handling Appeals

8.7.1. The 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).

8.7.2. The 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.

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

8.7.4. 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:

8.7.4.1. The Grievance is regarding a denial of expedited resolutions of an Appeal.

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

8.7.4.3. The Grievance or Appeal involves clinical issues.

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

8.7.5.1. Within sixty (60) calendar days from the date of the Contractor's notice of adverse benefit determination.

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

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

8.7.8. The 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.

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

8.7.10. The 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.

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

8.7.12. The Contractor shall take not punitive action against a Provider who requests an expedited resolution.

8.7.13. Continuation of Benefits and Services During an Appeal

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

8.7.13.1.1. The Appeal is filed on or before the later of:

8.7.13.1.1.1. Ten (10) days after the Contractor mailed the notice of adverse benefit determination.

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

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

8.7.13.1.3. The services were ordered by an authorized Provider.

8.7.13.1.4. The authorization period has not expired.

8.7.13.1.5. The Member requests an extension of benefits.

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

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

8.7.13.1.8. The Member does not request a State Fair Hearing with continuation of benefits within ten (10) days after the date the Contractor mails an adverse Appeal decision.

8.7.13.1.9. A State Fair Hearing decision adverse to the Member is made. 8.7.13.2.4. The service authorization expires or the authorization limits are met.

8.7.13.2. The 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 the Contractor's adverse benefit determination.

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

8.7.13.4. The 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 the Contractor or State Fair Hearing Officer reverses a decision to deny authorization of the services.

8.7.13.5. The 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.

8.7.14. Resolution and Notification of Appeals

8.7.14.1. The 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:

8.7.14.1.1. For standard resolution of an Appeal and notice to the affected parties, ten (10) working days from the day the MCO or PIHP receives the Appeal.

8.7.14.2. The Contractor may extend the timeframe for processing an Appeal by up to fourteen (14) calendar days if the Member requests; or the 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.

8.7.14.2.1. The Contractor shall provide the Member with written notice within two (2) 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. The Contractor shall establish and maintain an expedited review process for Appeals when the 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.

8.7.14.2.2. If the Contractor denies a request for expedited resolution of an Appeal, the 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 (2) calendar days after receiving the request for expedited resolution.

8.7.14.2.3. The 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 seventy-two (72) hours after the Contractor receives the expedited Appeal request.

8.7.14.2.4. The Contractor may extend the timeframe for processing an expedited Appeal by up to fourteen (14) calendar days if the Member requests the extension; or the Contractor shows that there is need for additional information and that the delay is in the Member's best interest.

8.7.14.2.5. The Contractor shall provide the Member with written notice within two (2) 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.

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

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

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

8.7.14.4.1. The Member's right to request a State Fair Hearing. 8.7.14.4.2. How the Member can request a State Fair Hearing.

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

8.7.14.4.3. Notice that the Member may be liable for the cost of any continued benefits if the Contractor's adverse benefit determination is upheld in the hearing.

8.7.15. State Fair Hearing

8.7.15.1. The Contractor shall allow a Member to request a State Fair Hearing after the Member has exhausted the Contractor's Appeal process.

8.7.15.1.1. The Member has one hundred and twenty (120) calendar days from the date of a notice of an adverse Appeal resolution to request a State Fair Hearing.

8.7.15.2. If the 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.

8.7.15.3. The 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.

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

8.7.15.5. The Contractor shall participate in all State Fair Hearings regarding Appeals and other matters arising under this Contract - Exhibit M.

8.7.15.6. Expedited State Fair Hearing

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

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

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

8.8. Ombudsman for Medicaid Managed Care

8.8.1. The 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.

8.8.1.1. The 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 the Contractor has previously obtained written

and explicit instructions from the Member not to share information with the Ombudsman.

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

8.9. Grievance and Appeals Report

8.9.1. The Contractor shall submit a quarterly Grievance and Appeals Report that includes the following information about Member Grievances and Appeals:

8.9.1.1. A general description of the reason for the Grievance or Appeal.

8.9.1.2. The date received.

8.9.1.3. The date of each review or, if applicable review meeting.

8.9.1.4. Resolution at each level of the Appeal or Grievance, if applicable.

8.9.1.5. Date of resolution at each level, if applicable.

8.9.1.6. Name of the covered Member for whom the Appeal or Grievance was filed.

8.9.1.6.1. DELIVERABLE: Grievance and Appeal Report

8.9.1.6.2. DUE: Forty-five (45) days after the end of the reporting quarter.

9. NETWORK DEVELOPMENT AND ACCESS STANDARDS

9.1. Establishing a Network

9.1.1. The 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. The 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.

9.1.3. The Contractor may create networks based on quality indicators, credentials, and price. The 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. The Contractor's network shall include both Essential Community Providers, as designated at 10 C.C.R. 2505-10 §8.205.5.A, and other providers.

9.1.5. The 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 numbers 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. The 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, the disability community and other culturally diverse communities who may be served.

9.1.6.1. The Contractor may use mechanisms such as telemedicine to address geographic barriers to accessing clinical providers from diverse backgrounds.

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

9.1.7.1. The 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.

9.1.7.2. The 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.

9.1.7.3. The Contractor shall comply with any additional Provider selection requirements established by the Department.

9.1.7.3.1. The 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 during the contracting and credentialing process.

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

9.1.7.5. The 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 the Contractor.

9.1.7.5.1. The contracting and credentialing measurement period ends on the actual date of a signed and fully executed contract or when the Contractor sends a formal document denying the provider admission to the 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.

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

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

9.1.7.5.3. The Contractor shall respond to all Provider inquiries related to their credentialing and contracting within two business days.

9.1.7.6. The 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.

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

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

9.1.9. The Contractor shall ensure that its network provides the Contractor's Members with a reasonable choice of Providers.

9.1.10. The Contractor shall not be required to contract with more providers than necessary to meet the needs of its Members.

9.1.11. The Contractor shall allow each Member to choose a PCMP to the extent possible and appropriate.

9.1.12. The 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.

9.1.13. The 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.

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

9.1.15. The Contractor shall document its relationship with and requirements for each provider participating in the Contractor's network in a written contract.

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

9.1.17. The 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.

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

9.1.19. The 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.

9.1.20. The Contractor shall permit Indian Members to access out-of-state Indian Health Care Providers, in accordance with 42 CFR 438.14(b)(5), in a state where timely access to covered services cannot by ensured due to few or no Indian Health Care Providers.

9.2. Provider Credentialing and Re-credentialing

9.2.1. The Contractor shall have documented procedures for credentialing and re-credentialing Network Providers that is publicly available to providers upon request. The documented procedures shall include the Contractor's timeframes for the credentialing and re- credentialing processes.

9.2.2. The Contractor shall submit the Provider Credentialing Policies and Procedures to the Department.

9.2.2.1. DELIVERABLE: Provider Credentialing Policies and Procedures.

9.2.2.2. DUE: May 1, 2018.

9.2.3. The Contractor shall ensure that all Network Providers are credentialed.

9.2.4. The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all contracts.

9.2.5. The 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. The Contractor shall credential all contracted Providers and ensure that re-credentialing of all individual practitioners occurs at least every three (3) years.

9.2.7. The 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. PCMP Network

9.2.8.1. The Contractor shall ensure that all primary care providers in its network are contracted PCMPs that 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 as PCMPs with the Contractor's approval if all other PCMP 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 the Contractor to share data with the Department.

9.2.8.2. The Contractor may enter into a written agreement with a primary care Provider to fulfill some of the specific criteria listed above on behalf of a Provider, such as the Contractor provides 24/7 phone coverage for a practice or provides Care Coordination for a practice. The Contractor shall partner with these PCMPs to

identify practice goals and support the PCMPs in working toward achieving these goals.

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

9.2.8.3.1. The 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, the 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. The 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 the Contractor's limited managed care capitation initiative.

9.2.8.3.4. The 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 the Contractor's network as a primary care provider and has the capacity to provide the services.

9.2.8.3.5. The 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 - Exhibit M through an I/T/U provider or through referral from premiums and copays.

9.3. Access to Care Standards

9.3.1. The Contractor shall ensure that its network is sufficient to meet the requirements for every Member's access to care to:

9.3.1.1. Serve all primary care and care coordination needs;

9.3.1.2. Serve all specialty and ancillary care needs; and allow for adequate Member freedom of choice amongst Providers.

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

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

9.3.4. The 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.

9.3.5. The 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.

9.3.6. The 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. The Contractor shall ensure that the directory is updated at least monthly and shall be made available to the Department.

9.3.7. The Contractor shall ensure that its network provides for twenty-four (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).

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

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

9.3.8.1.1. The Contractor shall ensure that its PCMP network has a sufficient number of PCMPs so that each Member has their choice of at least two (2) PCMPs 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.

9.3.8.1.2. In the event that there are less than two (2) practitioners that meet the PCMP standards within the defined area for a specific Member, then the Contractor shall not be bound by the requirements of the prior paragraph for that Member.

9.3.8.1.3. The Contractor shall use GeoAccess or a comparable service to measure the distance between the Members and the Providers in the Contractor's Service Area.

9.3.8.2. The Contractor shall ensure that its networks meets the following Practitioner to Member ratios:

9.3.8.2.1. Adult Primary Care Medical Providers: One (1) practitioner per 1:1,800 adult Members.

9.3.8.2.2. Mid-level adult primary care providers: One (1) practitioner per twelve hundred (1,200) adult members.

9.3.8.2.3. Pediatric primary care: One (1) practitioner per 1:1,800 adult Members.

9.3.8.2.4. Physician specialist, includes Physicians designated to practice Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary Medicine, General Surgery, Ophthalmology and Urology: One (1) Physician specialist per eighteen hundred (1,800) Members.

9.3.8.2.4.1. 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.

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

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

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

9.3.9.1. The Contractor shall ensure its network is sufficient so that services are provided to Members on a timely basis, as follows:

9.3.9.1.1. Urgent Care – within twenty-four (24) hours after the initial identification of need.

9.3.9.1.2. Outpatient Follow-up Appointments – within seven (7) days after discharge from a hospitalization.

9.3.9.1.3. Non-urgent, symptomatic care visit – within seven (7) days after the request.

9.3.9.1.4. Well Care Visit – within one (1) 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.

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

9.3.10. The Contractor shall not place Members on waiting lists for initial routine service requests. The Contractor shall take actions necessary to ensure that all Covered Services under this Exhibit M are provided to Members with reasonable promptness, including but not limited to the following:

9.3.10.1. Utilizing out-of-network Providers.

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

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

9.3.12. The 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.

9.3.13. The Contractor shall provide for a Member to receive a second opinion from a qualified health care professional within the network, or arrange for the Member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the Member.

9.3.14. Network Changes and Deficiencies

9.3.14.1. The 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:

9.3.14.1.1. Information describing how the change will affect service delivery.

9.3.14.1.2. Availability, or capacity of covered services.

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

9.3.14.1.4. A plan to correct any network deficiency.

9.3.14.1.4.1. DELIVERABLE: Network Changes and Deficiencies.

9.3.14.1.4.2. DUE: Within five (5) days after the Contractor's knowledge of the change or deficiency.

9.4. Network Adequacy Plan and Report

9.4.1. The Contractor shall create a Network Adequacy Plan as part of the Annual Network Management Strategic Plan that contains, at a minimum, the following information for its provider networks.

9.4.1.1. How the 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 - Exhibit M for all Members, including those with limited English proficiency and Members with physical or mental disabilities.

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

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

9.4.1.3.1. Adult primary care providers.

9.4.1.3.2. Pediatric primary care providers.

9.4.1.3.3. OB/GYN.

9.4.1.3.4. Family planning providers.

9.4.1.3.5. Gerontologists.

9.4.1.3.6. Internal Medicine providers.

9.4.1.3.7. Physician Specialists.

9.4.1.3.7.1. The Contractors and the Department shall determine specific specialty groups that require further reporting on an ongoing basis.

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

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

9.4.1.6. Cultural and language expertise of providers.

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

9.4.1.8. 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 the Contractor's provider network.

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

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

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

9.4.2.2. Number and percent of specialty providers accepting Medicaid Members.

9.4.2.2.1. The Department, in collaboration with the Contractor, will determine specific specialty groups that require further reporting on an ongoing basis.

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

9.4.2.4. Performance meeting timeliness standards.

9.4.2.5. New providers contracted during the quarter.

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

9.4.2.7. Additional information, as requested by the Department.

9.4.3. The Contractor shall submit the Network Adequacy Report to the Department.

9.4.3.1. DELIVERABLE: Network Adequacy Report

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

9.4.4. 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. The 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 the Contractor's geographic Service Area.

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

10.1.2. The Contractor shall collaborate with other RAEs in order to leverage the other RAEs' Health Neighborhoods and Communities to help serve any of the Contractor's enrolled Members who reside within the geographic region of another RAE.

10.1.3. The 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. The Contractor shall notify the Department upon becoming aware of new construction of an emergency department, new hospital or hospital expansion.

10.1.4.1. DELIVERABLE: Notice of New Construction

10.1.4.2. DUE: Within five (5) Business Days of becoming aware of new construction of an emergency department, new hospital or hospital expansion.

10.2. Health Neighborhood

10.2.1. The 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. The 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.

10.2.2.1. The Contractor shall use the Population Management Framework and the Contractor's Population Management Strategic Plan to inform the Contractor's

efforts to manage and coordinate care among diverse networks of health providers and supportive organizations.

10.2.3. The 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. The 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. The 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. The 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. The Contractor shall promote and ensure the systematic utilization of the Colorado Medical Society's Primary Care-Specialty Care Compact among Providers in the region's Health Neighborhood.

10.2.5.1.1. The compact is designed to enable flexibility in establishing agreements between any Medicaid provider to foster proactive communication, collaborative care management and planning across diverse care settings.

10.2.5.2. The 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.

10.2.5.2.1. The 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. The 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. The Contractor shall establish arrangements with the Colorado Crisis Services vendors for the coordination of follow-up care for Medicaid Members.

10.2.7. The Contractor shall coordinate care with Colorado's Managed Service Organizations to ensure Member access to substance use disorder treatments that are not a covered Medicaid benefit, such as inpatient substance use treatment.

10.2.8. The 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. The Contractor shall educate hospital discharge planners on processes that support LTSS Members and non-institutional discharge options.

10.2.9. The 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. The Contractor shall coordinate with hospitals directly or use a Health Information Exchange to access hospital admit/discharge/transfer Data.

10.2.9.1. The Contractor shall follow-up with discharged Members to:

10.2.9.1.1. Ensure the Member understood discharge instructions;

10.2.9.2. Schedule a follow-up physician or PCMP visit in accordance with the discharge plan; and

10.2.9.3. Ensure the Member filled related prescriptions in accordance with the discharge plan.

10.2.10. The 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. The 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. The Contractor shall help hospitals determine priorities and select projects, interventions and performance goals for the Hospital Transformation Program.

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

10.2.13. The 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. 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. The 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. The Contractor shall collaborate with local public health agencies to:

10.2.15.1. Design opportunities for integration of local public health activities into the Accountable Care Collaborative.

10.2.15.2. Identify 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. Explore appropriate funding approaches to support collaborative activities.

10.3. Community and the Social Determinants of Health

10.3.1. The 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, the 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. The Contractor shall know, understand and implement initiatives to build local communities 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. The 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. The 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. The 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. The Contractor shall not duplicate Community efforts to create a directory. Instead, the 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. The 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. The 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. The Contractor shall share information with Community organizations in the region about identified Community social service gaps and needs.

10.3.9. The Contractor shall engage with hospitals and local public health agencies regarding their community health needs assessments to develop and implement collaborative strategies to reduce health inequities and disparities in the Community.

10.3.10. The 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. The 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. The 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

10.3.11.3. The 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 the Contractor's processes and procedures, or to address any health equity related deficiencies determined by the Department.

10.3.11.4. The Contractor shall review and update the Health Equity Plan at least annually and submit to the Department for review.

10.3.11.4.1. DELIVERABLE: Health Equity Plan

10.3.11.4.2. DUE: July 31, 2023, and annually by July 31

10.4. Statewide Health Infrastructure

10.4.1. The 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 Colorado Office of Behavioral Health 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. The 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. The 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.

10.5. Health Neighborhood and Community Report

10.5.1. The Contractor shall submit a report to the Department describing the 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. The Contractor shall submit the Health Neighborhood and Community Report to the Department in a format agreed upon by the Department and the Contractor.

10.5.2.1. DELIVERABLE: Health Neighborhood and Community Report

10.5.2.2. DUE: Every 6 months, by August 15 and February 14.

10.6. Social Needs Screenings

10.6.1. The Contractor shall report on social needs screenings in order to advance the Department's Population Management Framework within the Contractor's Statement of Work.

10.6.2. The Contractor shall submit a Social Needs Screening report in a format agreed upon by the Department and the Contractor.

10.6.2.1. DELIVERABLE: Social Needs Screening Report.

10.6.2.2. DUE: August 15th and February 14th.

10.7. COVID-19

10.7.1. The 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.

10.7.2. The 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.

10.7.3. The 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.

10.7.4. The 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. The Contractor shall manage the health of all its Members.

11.1.1. The Contractor shall use a health promotion/population management approach that aligns with 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. The Contractor shall use the Population Management Framework to guide work in the areas of Care Coordination, condition management, Member engagement, Health Neighborhood and Community development, practice support and financial support.

11.1.2. The 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. The 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.

11.1.4. The Contractor shall focus in these areas and the Department will continue to direct information and insights to guide Contractor focus. The 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. The Contractor shall ensure that Care Coordination is one of the interventions available to Members.

11.1.5. The Contractor shall monitor and participate in the Department's effort to make the Diabetes Prevention Program a Medicaid benefit. Once a covered benefit the Contractor shall coordinate the delivery of the Diabetes Prevention Program consistently during the term of this Contract – Exhibit M. The Contractor shall identify those who meet program criteria and outreach to those participants.

11.1.6. The Contractor shall outreach to women in the perinatal period to improve education and outcomes around maternity support and prenatal care benefits and advantages. The 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. The 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.

11.2. Population Management

11.2.1. The Contractor shall design and implement population management activities in alignment with the Population Management Framework and the Department's risk stratification methodology. The Department's risk stratification methodology captures both the physical and behavioral health needs of Members

11.2.1.1. The Contractor shall place a particular focus on Members identified as Complex Members for outreach and interventions, including care coordination.

11.2.1.2. The Contractor may substitute their own population management approach for serving Complex Members with Department approval.

11.2.1.2.1. The 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.

11.2.1.3. The Contractor shall collaborate with the Department to evolve the Population Management Framework and risk stratification methodology as appropriate.

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

11.2.2.1. Member engagement and outreach,

11.2.2.2. Wellness promotion,

11.2.2.3. Utilization of evidence-based and promising practices,

11.2.2.4. Programs for managing Department identified health conditions, and

11.2.2.5. Care Coordination for Members utilizing Medicaid services.

11.2.2.6. Addressing identified health disparities among enrolled Members.

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

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

11.2.4. The 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.

11.2.4.1. The contractor shall utilize existing programs among its network providers to manage and support members with specific health conditions.

11.2.4.2. The contractor shall develop programs to manage and support members with specific health conditions identified by the department for which the contractor's network providers do not have existing programs.

11.2.4.3. The Contractor shall incorporate evidence-based practices, and promising local initiatives that address the social determinants of health.

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

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

11.2.5.2. The 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 implementing the Population Management Strategic Plan.

11.2.6. The Contractor shall submit the Population Management Strategic Plan to the Department for review and integrate feedback as appropriate.

11.2.6.1. DELIVERABLE: Population Management Strategic Plan

11.2.6.2. DUE: Annually, July 1

11.3. Care Coordination

11.3.1. The Contractor shall ensure Care Coordination is available to Members in alignment with the Contractor's Population Management Strategic Plan and the Department's Population Management Framework. The Contractor shall use its own resources and Department insights to ensure active Care Coordination for Complex Members.

11.3.2. The Contractor shall have a specific process to ensure that infused specialty drugs are managed away from outpatient hospitals into home infusion, where appropriate.

11.3.3. The Contractor's Care Coordination activities 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 appropriate interventions.

11.3.4. The 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. The 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 the 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 - Exhibit M.

11.3.6. The Contractor shall not duplicate Care Coordination provided through LTSS and HCBS waivers and other programs designed for special populations; rather, the 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. The 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. The Contractor shall ensure Care Coordination is document in the form of a care plan for Members who require more intense or extended assistance including Complex Members.

11.3.7.11. The Contractor shall ensure Care Coordination care plans are regularly and sufficiently monitored and include the following:

11.3.7.11.1. A lead care coordinator

11.3.7.11.2. Goals and outcomes

11.3.7.11.3. Be member and/or caregiver driven

11.3.7.12. Aligns with the Contractor's Population Management Strategic Plan.

11.3.7.13. Protects Member privacy.

11.3.8. The Contractor shall ensure that care coordinators in the Contractor's network reach out and connect with other service providers and communicate information appropriately, consistently and without delay.

11.3.9. The 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. The 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, and Members transitioning out of institutional settings. To meet the needs of these Members, the Contractor shall:

11.3.10.1. Designate staff persons to serve as the 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. The 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. The 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. The Contractor shall process the list to identify individuals who are assigned to the Contractor or will be released to the Contractor's region and are likely to be assigned to the Contractor.

11.3.10.4.2.2. The Contractor shall provide timely outreach and transitional support to individuals assigned to or who are likely to be assigned to the Contractor to support their successful transition to the community.

11.3.10.4.2.3. The Contractor shall coordinate transitional support between CDOC and other RAEs for individuals who were likely to but ultimately were not assigned to the Contractor.

11.3.10.4.2.4. The Contractor shall safely destroy the Department of Corrections list following processing to ensure privacy protections.

11.3.10.4.3. 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.

11.3.11. For Members with intellectual and developmental disabilities who require services for conditions other than a mental health or substance use disorder, the 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, the Contractor shall coordinate care with the state's Managed Service Organizations.

11.3.13. The 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. The Contractor shall assist care coordinators within the Contractor's network with bridging multiple delivery systems and state agencies.

11.3.15. The Contractor shall require additional support and guidance when the systems and providers engaged with a Member's complex care require leadership and direction.

11.3.16. The 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.

11.3.17. The 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, and the CMA case manager data feeds, are actively used in providing care coordination for Members.

11.4. Care Coordination and Complex Care Management Report

11.4.1. The Contractor shall submit a Care Coordination and Complex Care Management Report to the Department in a format agreed to by the Department and the Contractor. The report shall include extended care coordination activities for Complex Members performed by the Contractor, Network Providers and Partners, and Subcontractors.

11.4.1.1. DELIVERABLE: Care Coordination and Complex Care Management Report

11.4.1.2. DUE: Every six (6) months, by August 15th and February 14th

11.5. Condition Management Report

11.5.1. The 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.

11.5.2. The Contractor shall submit a Condition Management Report in a format agreed upon by the Department and the Contractor.

11.5.2.1. DELIVERABLE: Condition Management Report

11.5.2.2. DUE: Every six months, by November 21 and May 21

12. PROVIDER SUPPORT AND PRACTICE TRANSFORMATION

12.1. The 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. The 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.

12.2.1. The Contractor shall use the Population Management Framework to inform the Contractor's strategy to provide Practice Support to Network Providers.

12.3. The 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. The Contractor shall ensure that the Contractor's Provider communications adhere to Colorado Medicaid's brand standards.

12.5. The Contractor shall support the delivery of evidence-based medicine by Network Providers.

12.6. The Contractor shall include a written Practice Support Strategy as part of the Annual Network Management Strategic Plan that includes, but is not limited to, the following information:

12.6.1. The types of information and administrative support, provider trainings, and data and technology support the Contractor will offer and make available to Network Providers.

12.6.2. 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 the Contractor's efforts to implement their Population Management Strategy.

12.6.3. The Contractor shall submit the Annual Network Management Strategic Plan to the Department

12.6.3.1. DELIVERABLE: Annual Network Management Strategic Plan

12.6.3.2. DUE: Annually, August 1

12.7. The Contractor shall submit a Practice Support, Transformation and Communication Report to the Department.

12.7.1. DELIVERABLE: Practice Support, Transformation and Communication Report

12.7.2. DUE: Annually, on June 5

12.8. General Information and Administrative Support

12.8.1. The Contractor shall ensure adequate informational support for Network Providers, while being mindful of not duplicating existing materials.

12.8.2. The Contractor shall maintain, staff, and publish the number for a toll-free telephone line that Providers may call regarding general information, administrative support, and complaints.

12.8.2.1. The Contractor shall respond to all Provider inquiries within two business days.

12.8.2.2. The Contractor shall submit monthly response time data from its Provider telephone line in the Call Line Statistics Report.

12.8.3. The 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:

12.8.3.1. General information about Medicaid, the Accountable Care Collaborative Program, and the Contractor's role and purpose.

12.8.3.2. The Contractor's process for handling appeals of physical health adverse benefit determinations.

12.8.3.3. Available Member resources, including the Member provider directory.

12.8.3.4. Clinical resources, such as screening tools, clinical guidelines, practice improvement activities, templates, trainings and any other resources the Contractor has compiled.

12.8.3.4.1. Community-based resources, such as child care, food assistance, services supporting elders, housing assistance, utility assistance and other non-medical supports.

12.8.4. The Contractor shall make Network Providers aware of the following Colorado Medicaid program information:

12.8.4.1. Medicaid eligibility

12.8.4.2. Medicaid covered benefits

12.8.4.3. State Plan services

12.8.4.4. EPSDT

12.8.4.5. HCBS waiver services

12.8.4.6. Capitated Behavioral Health Benefit

12.8.4.7. Claims and billing procedures

12.8.4.8. Prescriber tool opioid risk mitigation module and affordability module

12.8.4.9. Prior authorization referral requirements.

12.8.4.10. Out-of-state medical care as described in 10 CCR 2505-10 8.013.

12.8.4.11. Out-of-state NEMT as described in 10 CCR 2505-10 8.014.7.

12.8.5. The Contractor shall act as a liaison between the Department and its other contractors, partners and providers.

12.8.6. The Contractor shall outreach to and educate specialists and other Medicaid providers regarding the Accountable Care Collaborative Program, its structure, the role of the Contractor and the supports it will offer to providers in its network.

12.8.7. The Contractor shall assist providers in resolving barriers and problems related to the Colorado Medicaid systems, including:

12.8.7.1. Medicaid provider enrollment

12.8.7.2. Member eligibility and coverage policies

12.8.7.3. EPSDT

12.8.7.4. Prescriber tool opioid risk mitigation module and affordability module

12.8.8. The 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..

12.8.8.1. The Contractor shall promote fidelity to evidence-based practices in order to assure effectiveness of the services provided.

12.9. Provider Training

12.9.1. The Contractor shall, at a minimum, develop trainings and host forums for ongoing training regarding the Program and the services the Contractor offers.

12.9.2. The Contractor shall promote participation of Network Providers in state, local, and Contractor specific training programs.

12.9.2.1. The Contractor shall ensure that trainings and updates on the following topics are made available to the Contractor's Network Providers every six (6) months:

12.9.2.2. Colorado Medicaid eligibility and application processes.

12.9.2.3. Medicaid benefits.

12.9.2.4. Access to Care standards.

12.9.2.5. EPSDT.

12.9.2.6. The Contractor's Population Management Plan Strategy.

12.9.2.7. Cultural responsiveness.

12.9.2.8. Member rights, Grievances, and Appeals.

12.9.2.9. Quality improvement initiatives, including those to address population health.

12.9.2.10. Trauma-informed care.

12.9.2.11. Other trainings identified in consultation with the Department.

12.9.3. The Contractor shall maintain a record of training activities it offers and submit to the Department upon request.

12.10. Interoperability Rule

12.10.1. The Contractor shall implement and maintain a secure, standards-based application program interface (API) aligning with the Department's implementation timeline. The API shall:

12.10.1.1. Be available through a public-facing digital endpoint on the Contractor's website.

12.10.1.2. Include complete and accurate provider directory information.

12.10.1.2.1. The provider directory must meet the same technical standards as the patient access API, excluding the security protocols related to user authentication and authorization.

12.10.1.2.2. The provider directory information shall be updated no later than thirty (30) calendar days after the Department or the Contractor receives the provider directory information or updates to provider directory information.

12.10.1.2.3. Comply with the requirements of 42 CFR § 438.242, 45 CFR § 170.215, as well as the provider directory information specified in § 438.10.

12.10.1.2.4. Provide current members, or their personal representatives, with access to claims and Encounter Data within one (1) business day of receipt, including:

12.10.1.2.4.1. Adjudicated claims, including data for payment decisions that may be appealed, were appealed, or in the process of appeal.

12.10.1.2.4.2. Provider remittances and beneficiary cost-sharing pertaining to adjudicated claims.

12.10.1.2.4.3. Services and Items Provided in Treatment

12.10.1.2.5. Clinical information within one (1) business day of receipt, if collected and maintained by the Contractor, including:

12.10.1.2.5.1. Diagnoses and Related Codes

12.10.1.2.5.2. Medical Records and Reports

12.10.1.2.5.3. Statements of Medical Necessity

12.10.1.2.5.4. Laboratory Test Results

12.10.1.2.6. Information about covered outpatient drugs within one (1) business day after the effective date of any update, including:

12.10.1.2.6.1. Formulary of prescription drugs and costs to the member

12.10.1.2.6.2. Preferred drug list information

12.10.2. The 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.

12.10.3. The Contractor shall incorporate the USCDI data classes and elements received from other plans about the member.

12.10.4. The Contractor shall, upon request by a member:

12.10.4.1. 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 5 years.

12.10.4.2. 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 5 years after disenrollment.

12.11. Data Systems and Technology Support

12.11.1. The Contractor shall have expertise to support providers in implementing and utilizing health information technology (Health IT) systems and data. The Contractor shall keep up to date with changes in Health IT in order to best support providers.

12.11.2. The 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.

12.11.3. The Contractor shall make available technical assistance and training for Network Providers on how to use the following state-supported HIT systems:

12.11.3.1. Contractor's Care Coordination Tool

12.11.3.2. The BIDM System

12.11.3.3. Colorado interChange (MMIS)

12.11.3.4. Office of Behavioral Health's COMPASS data collection tool

12.11.3.5. PEAK website and PEAKHealth mobile app

12.11.3.6. Regional health information exchange

12.11.3.7. Electronic consultation and referral tools

12.11.4. The Contractor shall offer the following supports to Network Providers on managing and utilizing data:

12.11.4.1. Provide practice-level data/reports

12.11.4.2. Assist providers with data analysis and reporting

12.11.4.3. Train practices on how to utilize data to:

12.11.4.3.1. Improve care for Complex Members

12.11.4.3.2. Improve care for Member with Department identified health conditions

12.11.4.3.3. 12.10.4.3.3. Implement wellness and prevention strategies. Understand how their practice is performing on Key Performance Indicators and other health outcome measures

12.11.4.3.4. Identify Members who require additional services

12.11.4.4. The Contractor shall possess the expertise and establish the infrastructure to support outbound raw claims data extracts to the PCMPs, both behavioral health claims from the Contractor's internal system and physical health claims data from the Department.

12.11.4.4.1. The Contractor shall establish a process for PCMPs to request raw claims data extracts from the Contractor.

12.11.4.5. The 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.

12.11.4.5.1. The 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.

12.11.4.5.2. The Contractor shall identify and address gaps in information sharing or data quality.

12.12. Practice Transformation

12.12.1. The 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 promoters, peers, and patient navigators; and implementing health programming to advance the Contractor's Population Management Strategic Plan

12.12.2. The 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.

12.12.3. The Contractor shall offer expertise and resources necessary for practice transformation ranging from assistance with efficiency and performance enhancements to comprehensive practice redesign.

12.12.4. The 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.

12.12.5. The 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, the Contractor shall develop a practice transformation plan to:

12.12.5.1. Connect Network Providers to practice transformation resources that are readily available in the Service Area.

12.12.5.2. Educate Network Providers about the methods, principles, best practices, and benefits of practice transformation.

12.12.5.3. Provide technical assistance, tools and resources as appropriate.

12.12.6. The 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.

12.12.7. Based on the needs of the region and the existing practice transformation resources available, the Contractor shall offer trainings, learning collaboratives, and/or other resources to support practices in achieving advanced Medical Home standards.

12.12.8. The Contractor shall work with their PCMP Network to increase the adoption and utilization rates of the Colorado Medicaid Real-Time Benefit Inquiry Module of the Department's prescriber tool. The Contractor shall follow their Department-approved prescriber tool implementation plan to reach the highest adoption and utilization rates possible. The Contractor shall keep track of which contracted PCMPs do not have specific prescriber tool functionality within their EHRs and periodically share this list with the Department.

12.13. Financial Support

12.13.1. The Contractor shall develop provider value-based payments aligned with the Department's priorities. The Contractor shall support and align with the Department's alternative payment model, including higher administrative payments for providers serving Complex Members and with consideration of current market rates.

12.13.2. The Contractor shall distribute administrative funding based on the Population Management Framework and Member acuity to ensure increased financial resources are made available for coordinating care for Complex Members.

12.13.2.1. The Contactor shall include this administrative funding distribution strategy in the Annual Network Management Strategic Plan.

13. ALTERNATIVE PAYMENT MODEL

13.1. The Contractor shall assist the Department with implementing the Alternative Payment Model and support network providers impacted by this payment model.

14. CAPITATED PHYSICAL HEALTH BENEFIT

14.1. Covered Services

14.1.1. Health Coverage

14.1.1.1. The Contractor shall provide or shall arrange to have provided all Covered Services specified in Exhibit M-6. The Contractor shall provide Care Coordination, Utilization Management and Medical Management for Members to promote the appropriate and cost-effective utilization of Covered Services. The Contractor shall ensure that the services provided are sufficient in amount, duration and scope to reasonably beexpected to achieve the purpose for which the services are furnished.

14.1.1.1.1. The Contractor may cover services or settings that are in lieu of State Plan services if the following criteria are met:

14.1.1.1.1.1. The Department deems the alternative service or setting as a medically necessary appropriate substitute for the covered service or setting;

14.1.1.1.1.2. The Department deems the alternative service or setting as a cost-effective substitute for the covered service or setting;

14.1.1.1.1.3. The Contractor does not require the Member to use the alternative service or setting;

14.1.1.1.1.4. Alternative services and settings are outlined in Exhibit M-6; and

14.1.1.1.1.5. The alternative services and settings are offered to Members during the enrollment process.

14.1.1.2. The 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.

14.1.1.3. The 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.

14.1.1.4. The Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service if the Contractor objects to the service on moral or religious grounds.

14.1.1.5. Any cost sharing imposed on Members is in accordance with Medicaid FFS requirements at 42 CFR 447.50 through 42 CFR 447.82

14.1.2. Covered Services Through Network Providers

14.1.2.1. Covered Services shall be made available in the Service Area only through Network Providers or non-Network Providers authorized by the Contractor. A Network Provider is any Physician, Hospital, or other healthcare professional or facility that has entered into a professional service agreement with the Contractor to provide clinical services to the Contractor's Members.

14.1.2.2. Except for Emergency Services, Post Stabilization Services, and Urgently Needed Services, the 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:

14.1.2.2.1. Special arrangements or Referrals are made by a Network Provider or the Contractor, as specified in the Member handbook.

14.2. Coverage of Specific Services and Responsibilities

14.2.1. Emergency Services

14.2.1.1. Emergency services that are:

14.2.1.1.1. Furnished by a provider that is qualified to administer these services according to 42 CFR 438.

14.2.1.1.2. Needed to evaluate or stabilize an Emergency Medical Condition.

14.2.1.2. The 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). The Contractor:

14.2.1.2.1. Shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor.

14.2.1.2.1.1. 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.

14.2.1.2.1.2. Shall not deny payment for treatment obtained under either of the following circumstances:

14.2.1.2.1.2.1. 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.

14.2.1.2.1.2.2. A representative of the Contractor instructs the Member to seek Emergency Services.

14.2.1.2.1.3. Shall not refuse to cover Emergency Services based on the emergency room Provider, Hospital or fiscal agent not notifying the Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

14.2.1.2.1.4. 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.

14.2.1.2.1.5. 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 the Contractor for coverage and payment.

14.2.1.2.1.6. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's Provider Network that are pre-approved by the Contractor.

14.2.1.2.1.7. The Contractor shall be financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's network that are not pre- approved by the Contractor, but that are administered to maintain, improve or resolve the Member's stabilized condition if any of the following are true:

14.2.1.2.1.7.1. The Contractor does not respond to a request for pre-approval within one (1) hour of receiving the request.

14.2.1.2.1.7.2. The Contractor cannot be contacted.

14.2.1.2.1.7.3. The 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, the 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.

14.2.1.2.1.7.4. The Contractor shall limit charges to Members for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Member if he or she had obtained the services through the Contractor.

14.2.1.2.1.8. The Contractor's financial responsibility for Post-Stabilization Care Services when not pre-approved ends when:

14.2.1.2.1.8.1. A plan Provider with privileges at the treating Hospital assumes responsibility for the Member's care.

14.2.1.2.1.8.2. A plan Provider assumes responsibility for the Member's care through transfer.

14.2.1.2.1.8.3. The Contractor and the treating Provider reach an agreement concerning the Member's care.

14.2.1.2.1.8.4. The Member is discharged.

14.2.1.2.2. The Contractor shall ensure that Members within the Service Area shall have access to Emergency Services on a twenty-four (24) hour per day, seven (7) day per week basis.

14.2.1.3. Emergency Ambulance Transportation

14.2.1.3.1. The Contractor shall make reasonable efforts to ensure that Members within the Service Area shall have access to emergency ambulance transportation on a twenty- four (24) hour per day, seven (7) day per week basis. This includes providing access for Members with medical, physical, psychiatric or behavioral emergencies.

14.2.1.4. Verification of Medical Necessity for Emergency Services

14.2.1.4.1. The Contractor may require that all claims for Emergency Services be accompanied by sufficient documentation to verify nature of the services. The Contractor shall not deny benefits for conditions which a reasonable person outside of the medical community would perceive as Emergency Medical Conditions. The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

14.2.1.5. Poststabilization Care Services

14.2.1.5.1. The Contractor shall provide coverage for Poststabilization Care Services in compliance with 42 C.F.R. § 438.114(e) and 42 CFR §422.113(c).

14.2.1.6. Coverage of Prescription Drugs

14.2.1.6.1. Effective January 1, 2024, the Contractor shall not allow the use of spread pricing, as defined by CMS, by the Contractor's Pharmacy Benefit Management System.

14.2.1.6.2. Medicare Prescription Drug, Improvement, and Modernization Act (MMA)

14.2.1.6.2.1. The Contractor shall not provide drugs described in Medicare Part D to individuals eligible for both Medicare and Medicaid.

14.2.1.6.2.2. The 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.

14.2.1.6.2.3. The 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.

14.2.1.6.3. The 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. The Contractor's internal prior authorization criteria shall not apply to prescription drugs carved out of this Contract - Exhibit M. Such Covered Drugs must be prescribed and dispensed within the Contractor's parameters for pharmaceuticals, and as follows:

14.2.1.6.3.1. The Contractor shall establish a drug formulary, for all Medically Necessary Covered Drugs with its own prior authorization criteria, provided the Contractor includes each therapeutic drug category in the Medicaid program. The Contractor shall ensure that the formulary requires the following:

14.2.1.6.3.1.1. Information in electronic or paper form about which generic and name brand medications are covered, as well as which tier each medication is on.

14.2.1.6.3.1.2. The formulary drug list on the Contractor's website in a machine-readable file and format as specified by the Secretary.

14.2.1.6.3.2. The Contractor shall develop and maintain a prior authorization program to provide Covered Drugs for any Medically Necessary conditions unmet by the Contractor's formulary product. The Contractor shall ensure that the program includes the following criteria:

14.2.1.6.3.2.1. Provision of a telephonic or telecommunication response within 24 hours of a request for prior authorization; and

14.2.1.6.3.2.2. Prescription of at least a seventy-two (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 authorizationmay be given retroactively if the drug had to be dispensed immediately for the Member's well-being.

14.2.1.6.4. If a Member requests a brand name drug for a prescription that is included on the 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.

14.2.1.6.5. Outpatient Drug Coverage & Drug Utilization

14.2.1.6.5.1. The 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. The Contractor's DUR program shall perform the following functions:

14.2.1.6.5.1.1. Prospective drug review, including:

14.2.1.6.5.1.1.1. A prospective safety edit regarding:

14.2.1.6.5.1.1.2. Days' supply for patients not currently receiving opioid therapy for initial prescription fills;

14.2.1.6.5.1.1.3. Early refills, for subsequent prescription fills;

14.2.1.6.5.1.1.4. Therapeutically duplicative initial and subsequent opioid prescription fills;

14.2.1.6.5.1.1.5. Quantity of prescription dispensed for initial and subsequent prescription fills;

14.2.1.6.5.1.1.6. The maximum daily morphine equivalent for treatment of pain

14.2.1.6.5.1.2. Retrospective drug use review, including:

14.2.1.6.5.1.2.1. 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;

14.2.1.6.5.1.2.2. An automated claims review process that indicates fills of opioids in excess of limitations identified by the State; and

14.2.1.6.5.1.2.3. An automated claims review process that monitors when an individual is concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics.

14.2.1.6.5.1.2.4. 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;

14.2.1.6.5.1.2.5. Processes to identify potential fraud or abuse of controlled substances by beneficiaries, health care providers, and pharmacies;

14.2.1.6.5.1.2.6. Establish and operate a DUR Board, and

14.2.1.6.5.1.2.7. An educational program

14.2.1.6.5.2. The 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.

14.2.1.6.5.2.1. The Contractor shall provide the Department with a detailed report of its drug utilization review program activities on an annual basis, within forty-five (45) days after receiving a written request from the Department. The Contractor shall ensure that the report includes information as required by the Secretary of Health and Human Services, the CMS Medicaid Drug Utilization Review report, and the Department.

14.2.1.6.5.2.1.1. DELIVERABLE: DUR Program Activities Report

14.2.1.6.5.2.1.2. DUE: Within forty-five (45) days after receiving a written request from the Department.

14.2.1.6.5.3. The 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.

14.2.1.6.5.4. The 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.

14.2.1.6.5.5. The 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.

14.2.1.6.5.6. The 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.

14.2.1.6.5.7. The 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.

14.2.1.6.5.8. The Contractor shall report the following drug utilization data and information necessary for the Department to bill manufacturers for rebates no later than forty- five (45) calendar days after the end of each quarterly rebate period:

14.2.1.6.5.8.1. Total number of units of each dosage form, strength, and package size by National Drug Code of all outpatient drugs covered and dispensed by the Contractor.

14.2.2. Inpatient Hospital Services

14.2.2.1. The Contractor shall be responsible for inpatient hospital stays based on the Principal Diagnosis that requires inpatient care.

14.2.2.1.1. The 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.

14.2.2.1.2. The 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

14.2.2.1.3. The Contractor shall not be responsible for the hospital stay when the Principal Diagnosis is for substance abuse rehabilitation.

14.2.2.2. Coverage for Emergency Services

14.2.2.2.1. The 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.

14.2.2.3. The 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.

14.2.2.3.1. The Contractor's responsibility for the Covered Services of outpatient Hospital Services is based on the diagnosis and the billing procedures of the Hospital.

14.2.2.3.2. For any procedure billed in a UB-92/ANSI 837I, Health Care Claim Institutional (ANSI 837I) format, the 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:

14.2.2.3.2.1. The procedure is billed on a UB-92/ANSI 837I claim form, and

14.2.2.3.2.2. The Principal Diagnosis is a medical diagnosis.

14.2.2.3.3. For any procedure billed in a HCFA-1500/ANSI 837P, Health Care Claim Professional Format, the 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:

14.2.2.3.3.1. The procedure is billed on a HCFA-1500/ANSI 837P claim form, and 14.2.2.3.3.2.

14.2.2.3.3.2. 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.

14.2.2.4. Wrap Around (Fee For Service) Benefits

14.2.2.4.1. The Contractor shall communicate to its Network Providers and Members information about Medicaid Wrap Around Benefits, which are not Covered Services under this Contract - Exhibit M but are available to Members under Medicaid fee for service (FFS).

14.2.2.4.2. The Contractor shall instruct its Network Providers on how to refer a Member for such services. The Contractor shall advise Network Providers of Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) support services that are available through other entities. The 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.

14.2.2.4.3. The Contractor shall inform its Home Health Services Providers and Members that Home Health Services after sixty (60) consecutive days are not Covered Services but are available to Members under FFS and require prior authorization. If Home Health Services after sixty (60) consecutive days are anticipated, the Contractor shall ensure that, at least thirty (30) days prior to the sixtieth (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.

14.2.2.4.4. The Contractor shall inform its Network Providers of the services provided by the RAEs.

14.2.3. Coverage of Abortions

14.2.3.1. The Contractor shall cover abortions in the following situations, in accordance with 42 CFR 441.202 and the Consolidated Appropriations Act of 2008:

14.2.3.1.1. When the pregnancy is the result of an act of rape or incest.

14.2.3.1.2. 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.

14.3. Exclusions

14.3.1. Acupuncture

14.3.2. Air ambulance services when a Client could be safely transported by ground ambulance or by means other than ambulance.

14.3.3. Ambulatory surgical procedures not listed on the state approved list.

14.3.4. Ambulance services when a Client could be safely transported by means other than ambulance.

14.3.5. 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 - Exhibit M 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.

14.3.6. Autopsy charges

14.3.7. Biofeedback, stress management, behavioral testing and training, and counseling for sexual dysfunction.

14.3.8. Capitated Behavioral Health Benefit services as described in Contract – Exhibit I.

14.3.9. Chiropractic services unless Medicare has paid as primary and diagnostic imaging has shown the condition to be subluxation.

14.3.10. 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.

14.3.11. Counseling for the care or treatment of marital or family problems; social, occupational, religious, or other social maladjustments; behavioral disorders or chronic situational reactions.

14.3.12. Dental services:

14.3.12.1. Dental prosthesis, or any treatment on or to the teeth, gums, or jaws and other services customarily provided for by a dentist.

14.3.12.2. 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 the Contractor to relate to a dental condition.

14.3.13. Durable Medical Equipment to include wheelchair lifts for vans or automobiles, continuous glucose monitors for Members that are 21 years old and older, hot tubs, Jacuzzis, exercise bikes or equipment, treadmills, stair glides, ramps for use with vehiclesor homes, memberships in health clubs, or fees for swimming or other exercise or activities.

14.3.14. Experimental or investigational services or pharmaceuticals.

14.3.14.1. Any treatment, procedure, drug or device that has been reviewed and found by the Department to be experimental or investigational or the treatment, procedure, drug or device has been reviewed by the Contractor and found not to meet all of the eligible for coverage criteria below with respect to the particular illness or disease to be treated, or a treatment, procedure, drug or device. Eligible for coverage criteria include:

14.3.14.1.1. The treatment, procedure, drug or device must have final approval from the Food and Drug Administration (FDA), if applicable;

14.3.14.1.2. The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the treatment, procedure, drug or device on health outcomes;

14.3.14.1.3. The treatment, procedure, drug or device must improve or maintain the net health outcome;

14.3.14.1.4. The treatment, procedure, drug or device must be as beneficial as any established alternative; and

14.3.14.1.5. The improvements in health outcomes must be attainable outside the investigational settings.

14.3.14.1.6. Additionally, the treatment, procedure, drug or device must be Medically Necessary and not excluded by any other Contract - Exhibit M exclusion.

14.3.15. Government-sponsored care

14.3.15.1. Items and services provided by federal programs, such as a Veteran's Hospital.

14.3.15.2. Services provided in facilities that serve a specific population, such as prisoners.

14.3.15.3. Care for conditions that federal, state, or local laws require to be treated in a public facility.

14.3.15.4. 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.

14.3.16. 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.

14.3.17. FQHC Services: Inpatient hospital stays are not covered under FQHC Services but may bea benefit under Inpatient Hospital Care.

14.3.18. 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.

14.3.19. 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 - Exhibit M 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 - Exhibit M.

14.3.20. High colonics

14.3.21. Holistic or homeopathic care including drugs and ecological or environmental medicine.

14.3.22. Home delivery: Services associated with non-emergent home delivery, unless prior authorized by the Contractor are excluded.

14.3.23. 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 - Exhibit M.

14.3.23.1. Long Term Home as defined by 10 CCR 2505-10, Section 8.520.K.3.a is excluded.

14.3.23.2. Home Health Services provided by a person who ordinarily resides in the Client's home or is an immediate family member are not covered.

14.3.24. 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.

14.3.25. Hypnosis

14.3.26. Immunizations related to foreign travel.

14.3.27. Imaging (Radiology or X-ray) Services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

14.3.28. 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.

14.3.29. Inpatient hospital excluded services include:

14.3.29.1. Psychiatric/psychological care included and covered as part of the RAE Capitated Behavioral Health Benefit.

14.3.29.2. Discharge medications and experimental drugs.

14.3.29.3. Inpatient hospital services defined as experimental by the Medicare program.

14.3.29.4. 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.

14.3.30. 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.

14.3.31. Isometric exercise

14.3.32. Expenses for medical reports, including presentation and preparation.

14.3.33. Laboratory services performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

14.3.34. Long Term Home Health as defined at 10 CCR 2505-10, Sections 8.520 is excluded.

14.3.35. Mental Health inpatient or outpatient psychiatric or psychological care that is a benefit of the RAE Capitated Behavioral Health Benefit. Hospital inpatient or outpatient care with a Primary or Principal Diagnosis listed in Exhibit I is a benefit of the RAE Capitated Behavioral Health Benefit. All other mental health services are a benefit of the RAE if both the diagnosis and procedure codes are listed in Exhibit I.

14.3.36. 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.

14.3.37. Nurse Home Visitor Program - Home visiting program for first time mothers by Registered Nurses, with sites approved by and contracted with CDHS.

14.3.38. 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.

14.3.39. Physical examinations of the following nature are excluded:

14.3.39.1. 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.

14.3.39.2. 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.

14.3.40. 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.

14.3.41. Private Duty Nursing (PDN). Private duty nursing services are a Wrap Around Benefit.

14.3.42. Psychiatric/psychological care as follows:

14.3.42.1. Milieu therapy

14.3.42.2. Play therapy

14.3.42.3. Day care

14.3.42.4. Electroshock treatment rehabilitation

14.3.42.5. Night care

14.3.42.6. Family therapy

14.3.42.7. Biofeedback

14.3.43. Reversal of surgically performed sterilization or subsequent re-sterilization.

14.3.44. Skilled Nursing Facility Services are a Wrap Around Benefit.

14.3.45. Substance or alcohol abuse, inpatient or residential rehabilitation.

14.3.46. Surrogate Mother Services or supplies received in connection with a Client acting as or utilizing the services of a surrogate mother.

14.3.47. Transportation, non-emergent, to medical appointments.

14.3.48. Travel, whether or not recommended or prescribed by a Physician or other medical practitioner.

14.3.49. 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.

14.3.50. Wrap Around Benefits are services that are Medicaid benefits not paid by the HMO. 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:

14.3.50.1. Auditory Services for children. HMO 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.

14.3.50.2. Comprehensive dental assessment, care and treatment for children.

14.3.50.3. Adult Dental services consisting of diagnostic procedures, preventative procedures, restorative procedures, periodontal care, endodontic treatment and oral surgery.

14.3.50.4. 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.

14.3.50.5. Extraordinary Home Health Services —A benefit for Members under the age of 21 that includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child's place of residence.

14.3.50.6. HCBS Services including case management (for Model 200 children); home modification, electronic monitoring, personal care and non-medical transportation.

14.3.50.7. Hospice services, however client may continue to get care not related to the terminal illness from the HMO, but will be disenrolled if requested.

14.3.50.8. Hospital back up level of care as set forth in 10 CCR 2505-10, Section 8.470.

14.3.50.9. 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.

14.3.50.10. 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.

14.3.50.11. Non-emergency transportation to medical appointments for Covered Services only, through the client's county of residence.

14.3.50.12. Pediatric Behavioral Therapies.

14.3.50.13. 14.3.51.13. Personal care benefit for children.

14.3.50.14. Private Duty Nursing (PDN), nursing services only.

14.3.50.15. 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.

14.4. Service Limits

14.4.1. The 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.

14.4.2. The 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.

14.4.3. The 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.

14.4.4. The 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.

14.4.5. The Contractor may place appropriate limits on a service as follows:

14.4.5.1. On the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity.

14.4.5.2. For Utilization Management, provided the services furnished can reasonably be expected to achieve their purpose.

14.4.5.2.1. The Contractor may 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.

14.4.6. The 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.

14.4.7. The 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. The Contractor shall record and document its notification of Members and families.

14.4.8. The Contractor shall establish clear and specific criteria for discharging Members from treatment.

14.4.8.1. The Contractor shall include this criteria in Member materials and information.

14.4.8.2. The 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.

14.4.9. The Contractor shall not be liable for any Covered Services provided prior to the date a Member is enrolled under this Contract – Exhibit M or after the date of disenrollment.

14.4.10. The Contractor shall not hold a Member liable for Covered Services:

14.4.10.1. Provided to the Member, for which the Department does not pay the Contractor

14.4.10.2. 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

14.4.10.3. 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 the Contractor provided the services directly

14.4.11. The Contractor shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

14.4.11.1. The Contractor's network shall provide the Contractor's Members with a meaningful choice in selecting a PCMP. The Contractor shall allow, to the extent possible and appropriate, each Member to choose a PCMP.

14.4.11.2. The 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.

14.4.11.3. The Contractor shall have policies and procedures describing the mechanisms used to ensure Provider compliance with the terms of this Contract - Exhibit M.

14.4.11.4. The Contractor shall document its relationship with and requirements for each PCMP in the Contractor's network in a written contract.

14.4.11.5. The Contractor shall offer contracts to all FQHCs, RHCs, and Indian Health Care Providers located in the Contract – Exhibit M Service Area.

14.4.11.6. The 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.

14.5. Service Planning, Coordination and Care Transitions

14.5.1. Based on the Member's needs and level of care required, the Contractor shall ensure they have procedures for the following:

14.5.1.1. Intake and Assessment: The Contractor shall ensure that each Member receives an individual intake and assessment appropriate for the level of care needed.

14.5.1.2. Service Planning: The 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 in a timely manner (the service plan may also be known as a treatment plan or a Member care plan).

14.5.1.3. Transitions of Care: The 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.

14.5.1.4. Continued Services to Members: The 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

14.5.2. The 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:

14.5.2.1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

14.5.2.2. Any information the Member needs to decide among all relevant treatment options.

14.5.2.3. The risks, benefits, and consequences of treatment or non-treatment.

14.5.3. The 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.

14.6. Utilization Management

14.6.1. The Contractor shall ensure access to and appropriate utilization of covered health services.

14.6.2. The 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:

14.6.2.1. Description of its utilization management program structure and assignment of responsibility for utilization management activities to appropriate individuals.

14.6.2.2. Identification of a designated licensed medical professional responsible for program implementation, oversight, and evaluation.

14.6.2.2.1. 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.

14.6.2.3. Evidence of a behavioral health practitioner's involvement in program development and implementation.

14.6.2.4. Identification of the type of personnel responsible for each level of utilization management decision-making.

14.6.2.5. Standards for utilization management personnel to consult with the ordering provider prior to denial or limitation of requested/provided services.

14.6.2.6. Policies and procedures for the use and periodic review of written clinical decision-making criteria based on clinical evidence.

14.6.2.7. Provider dispute resolution

14.6.2.8. Description of a Provider Dispute Resolution process which follows Division of Insurance Provider Dispute Resolution requirements and timelines.

14.6.2.9. Description of how the 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.

14.6.2.10. DELIVERABLE: Utilization Management Program and Procedures

14.6.2.11. DUE: Thirty (30) days after any significant change is made.

14.6.3. The Contractor shall implement the Contractor's documented Utilization Management Program and Procedures.

14.6.4. The Contractor's utilization management process shall in no way impede timely access to services.

14.6.4.1. The Contractor shall not require prior authorization for the non-pharmaceutical components of MAT.

14.6.5. The Contractor shall have mechanisms for providers and Members on how they can obtain the utilization management decision-making criteria upon request.

14.6.6. The 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.

14.6.7. The Contractor shall disseminate practice guidelines to Members and potential Members upon request.

14.6.7.1. The Contractor shall adopt practice guidelines that consider the needs of Members.

14.6.7.2. The Contractor shall adopt practice guidelines in consultation with Network Providers.

14.6.7.3. The Contractor shall review and update practice guidelines periodically as appropriate.

14.6.8. In compliance with CRS 25.5-5-422, on or after January 1, 2020 the Contractor shall not:

14.6.8.1. Impose any prior authorization requirements on any prescription medication approved by the Food and Drug Administration (FDA) for the treatment of substance use disorders.

14.6.8.2. 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.

14.6.8.3. 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.

14.6.9. The 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, the Contractor shall make the determination in consultation with the Department, based on medical necessity and clinical evidence for use.

14.6.10. The 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.

14.6.11. The 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.

14.6.12. The Contractor shall provide education and ongoing guidance to Members and Providers about its utilization management program and protocols.

14.7. FQHC And RHC Encounter Reimbursement

14.7.1. The 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.

14.7.2. Each FQHC and RHC has an encounter rate calculated in accordance with 10 CCR 2505- 10 § 8.700.6C.

14.7.3. The Department shall notify the Contractor of changes to the FQHC and RHC rates and rules.

14.7.4. 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), the 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.

14.7.5. If multiple services are provided by an FQHC or RHC within one (1) visit, the Contractor shall require a claims submission from the FQHC or RHC with multiple lines

of services and the same claim number. The Contractor shall pay the FQHC or RHC at least the encounter rate.

14.7.6. The Contractor shall submit the Encounter Data for FQHC and RHC visits to the Department per the specifications provided in Section 15.2.2.

14.7.6.1. DELIVERABLE: FQHC and RHC Encounter Data

14.7.6.2. DUE: Within thirty (30) days before the end of each calendar year quarter

14.7.7. The Contractor shall participate in the Department's accuracy audits process for FQHCs and RHCs and is required to complete the documentation located at https://www.colorado.gov/pacific/hcpf/federally-qualified-health-center-forms upon the Department's request.

14.7.8. The Contractor shall ensure the utilization and paid amounts for FQHC encounters in flat files matches those sent to the Department for the Managed Care Accuracy Audit Review (MCAAR).

14.8. Indian Health Services Providers Reimbursement

14.8.1. The Contractor shall reimburse any Indian Health Care Provider (IHCP) enrolled in Medicaid as an FQHC but not a Network Provider at least the encounter rate.

14.8.2. The 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.

14.8.3. The 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.

14.9. Physician Incentive Plans

14.9.1. The 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.

14.9.1.1. 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.

14.9.2. The 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.

14.9.3. If the Contractor puts a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the Contractor shall ensure that the physician or physician group has adequate stop-loss protection.

14.9.3.1. DELIVERABLE: Physician Incentive Plan

14.9.3.2. DUE: Effective Date or upon implementation of a physician incentive plan

14.10. Third Party Payer Liability

14.10.1. The 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 - Exhibit M. 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.

14.10.1.1. Potential liable third parties shall include any of the sources identified in 42 C.F.R. § 433.138 relating to identifying liable third parties. The Contractor shall coordinate with the Department to provide information to the Department regarding commercial third party resources.

14.10.1.2. In the case of commercial health coverage, the 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 the Contractor. If the third party payer is Medicare, the 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, the Contractor shall submit to the Department's fiscal agent the following information:

14.10.1.2.1. Member's Medicaid identification number

14.10.1.2.2. Member's full name.

14.10.1.2.3. Identification of the health carrier or health plan

14.10.1.2.4. Member's health plan identification and group numbers

14.10.1.2.5. Policy holder's full name

14.10.1.2.5.1. DELIVERABLE: Third Party Resource Identification

14.10.1.2.5.2. DUE: Within five (5) Business Days electronically to the fiscal agent's provider portal from the time when the third party resource is identified by Contractor.

14.10.2. The 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.

14.10.3. The Contractor shall also inform its Members that failure to follow the Contractor's protocols will result in a Member being liable for the payment or cost of any care or services that the Contractor would have been liable to pay. If the Contractor substantively fails to communicate the protocols to its Members, the Member is not

liable to the Contractor or the Network Provider for payment or cost of the care or services.

14.10.4. The Contractor shall not restrict access to covered services due to the existence of possible or actual third party liability.

14.10.5. The 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.

14.10.6. In the case of accident or casualty coverage, the Contractor shall actively pursue and collect from third party resources that have been identified except when it is reasonably anticipated by the Contractor that the cost of pursuing recovery will exceed the amount that may be recovered by the Contractor.

14.10.6.1. The Contractor shall limit recoveries to the amount that Medicaid would have paid under Medicaid Fee-for-Service.

14.10.7. In addition to compensation paid to the Contractor under the terms of this Contract - Exhibit M, the Contractor may retain as income all amounts recovered from third party resources, up to the Contractor's reasonable and necessary charges for services provided in-house and the full amounts paid by the Contractor to Network Providers, as long as recoveries are obtained in compliance with the Contract – Exhibit M and state and federal laws.

14.10.8. With the exception of Section 14.10.9. and except as otherwise specified in contracts between the Contractor and Network Providers, the 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:

14.10.8.1. The sum of reported third party coinsurance and/or deductible or

14.10.8.2. The Colorado Medicaid allowed rate minus the amount paid by the third party, whichever is lower.

14.10.9. The Contractor shall pay, except as otherwise specified in contracts between the 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.

14.10.10. The 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.

14.11. Medical Loss Ratio (MLR)

14.11.1. The 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).

14.11.2. The first annual measurement period will begin upon the start of the Operational Period of the Contract and end on June 30, 2019.

14.11.3. 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.

14.11.4. The Contractor shall submit an MLR report to the Department, for each MLR reporting year, that includes:

14.11.4.1. Total incurred claims.

14.11.4.2. Expenditures on quality improvement activities.

14.11.4.3. Expenditures related to activities compliant with program integrity requirements.

14.11.4.4. Non-claims costs.

14.11.4.5. Premium revenue.

14.11.4.6. Taxes.

14.11.4.7. Licensing fees

14.11.4.8. Regulatory fees.

14.11.4.9. Methodology(ies) for allocation of expenditures.

14.11.4.10. Any credibility adjustment applied if the MLR reporting year experience is partially credible.

14.11.4.10.1. Any credibility adjustment shall be added to the reported MLR calculation before calculating any remittances.

14.11.4.10.2. The Contractor shall not add a credibility adjustment to the calculated MLR if the MLR reporting year experience is fully credible.

14.11.4.11. The calculated MLR.

14.11.4.12. Any remittance owed to the state, if applicable.

14.11.4.13. A comparison of the information reported with the audited financial report.

14.11.4.14. A description of the aggregation method used to calculate total incurred claims.

14.11.4.15. The number of member months.

14.11.5. All data provided by the Contractor for the purpose of MLR calculation shall use actual costs.

14.11.5.1. The Contractor shall allow for three (3) months claims runout before calculating the MLR. The validation of the MLR, by the Department, may take an additional five (5) months.

14.11.5.2. The 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. The Contractor shall submit encounter claims in compliance with requirements in Section 15.2.2.

14.11.5.2.1. DELIVERABLE: MLR calculation template and supporting data and documentation

14.11.5.2.2. DUE: Annually, by January 15th of each year.

14.11.5.3. The Contractor's Medical Spend will be calculated using audited supplemental data provided in the 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.

14.11.5.4. MLR Target: The Contractor shall have an MLR of at least eighty-nine percent (89%). The Contractor will calculate a cohort specific and plan-wide Medical Loss Ratio (MLR) each SFY using the template provided by the Department.

14.11.5.5. 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)).

14.11.5.5.1. The 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.

14.11.5.5.2. The Contractor shall ensure that expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

14.11.5.5.3. The 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.

14.11.5.5.4. The 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.

14.11.5.5.5. The numerator is the sum of the Contractor's incurred claims; Contractor's expenditures for activities that improve health care quality; and Contractor's fraud reduction activities.

14.7.1.1. The 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%.

14.11.5.5.6. The Contractor will aggregate data for all Medicaid eligibility groups covered under this Contract - Exhibit M.

14.11.5.6. If the Contractor's MLR does not meet or exceed the MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:

14.11.5.6.1. 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).

14.11.5.6.2. The Contractor shall reimburse the Department within thirty (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 the 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.

14.11.5.6.2.1. The Department will validate the MLR after any annual adjustments are made,

14.11.5.6.2.2. The Department will discuss with the Contractor any adjustments that must be made to the Contractor's calculated MLR.

14.11.5.6.3. Adjusted MLR Target: The MLR Target will be decreased according to the MLR Quality Measure Target Table. The lowest possible Adjusted MLR Target is four percent (4%) lower than the MLR Target, or eighty-five percent (85%). If the Contractor does not meet any MLR Quality Targets, then the Adjusted MLR Target is equal to the MLR Target, eighty-nine percent (89%).

14.11.5.6.4. An Adjusted MLR can only be earned if the Contractor meets requirements for timely and accurate data submission set by the Department. The Department shall meet with Contractor on a monthly basis to advise of specifications, timing, format and related requirements, and any changes in process in advance of each quarterly submission. The Department shall permit the Contractor at least two resubmission opportunities to correct errors within the term of the 12-month contract period prior to disqualifying the contractor for MLR measure incentives.

14.11.6. MLR Quality Targets

14.11.6.1. The Contractor shall participate in the measurement and reporting of MLR quality metrics required by the Department for the Contractor's Adjusted MLR, with the expectation that this information will be placed in the public domain.

14.11.6.2. The Department shall provide to the Contractor documented calculation methodology for all metrics.

14.11.6.2.1. The Department shall release the calculation methodology as a draft and shall provide a comment period of no less than two (2) weeks prior to releasing as final.

14.11.6.2.2. The Department shall determine the final Adjusted MLR metric criteria.

14.11.6.3. The Contractor shall provide data, as requested, to enable the Department or its designee to calculate the quality metrics.

14.11.6.4. The Contractor shall support Network Providers to collect and report information required to calculate the quality metrics.

14.11.6.5. The Contractor shall be held to the following four (4) quality metrics in relation to the Adjusted MLR Target:

14.11.6.5.1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (CMS 137vb)

14.11.6.5.2. Housing and Health Initiative

14.11.6.5.3. Diabetes HbA1c Poor Control

14.11.6.5.4. Prenatal and Postpartum Care: Prenatal Care (NQF1517); Prenatal and Postpartum Care: Postpartum Care (NQF1517)

14.11.6.6. Quality Targets Table

14.11.6.6.1. The Contractor shall be held to the following four (4) quality metrics and their respective risk allocations in relation to the Adjusted MLR Target.

MLR Quality Measure Target Table

Quality Metric	**Percentage Adjustment Made to the MLR**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Subtract one percent (-1. %)
Housing and Healthcare	Subtract one percent (-1%)
Diabetes HbA1c Poor Control <9.0%	Subtract one percent (-1. %)
Prenatal and Postpartum Care: Prenatal Care (NQF1517); Prenatal and Postpartum Care: Postpartum Care (NQF1517)	Subtract one percent (-1%)
Total Percentage Points	**Subtract four percent (-4%)**

14.11.6.7. If the Contractor's MLR does not meet or exceed the MLR Target, then the Contractor shall reimburse the Department the difference using the following formula:

14.11.6.7.1. 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).

14.11.6.7.2. The Department will validate the MLR after any annual adjustments are made. The Department will discuss with the Contractor any adjustments that must be made to the Contractor's calculated MLR.

14.11.6.7.3. The Contractor shall submit all encounters, audited financial statements and reporting, and flat files for the measurement period, before the Department can validate the MLR.

14.11.6.7.4. The 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 the Contractor's annual financial reporting.

14.11.6.7.5. The Contractor shall reimburse the Department within thirty (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 the 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.

14.11.6.8. Subcontracted Claims Adjudication Activities

14.11.6.8.1. The Contractor shall require any subcontractors providing claim adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

14.11.6.8.2. 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, the Contractor shall:

14.11.6.8.2.1. Re-calculate the MLR for all MLR reporting years affected by the change; and

14.11.6.8.2.2. Submit a new MLR report meeting the applicable requirements.

14.11.6.8.2.2.1. DELIVERABLE: MLR Calculation Template 14.11.6.8.2.2.2.

DUE: Annually on January 31

14.11.6.9. To the extent that the Contractor has access to identifiable, client-level clinical quality measure (CQM) data relevant to the MLR Quality Targets in an electronic format, the Contractor shall share this data with the Department. The Contractor will work with the Department to establish an appropriate format and method of data transfer.

14.12. Medicaid Payment in Full

14.12.1. Except as allowed in the Contract, the 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 Exhibit M.

14.12.2. Except as allowed in the Contract – Exhibit M, the 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 the Contractor, for covered services provided pursuant to this Contract - Exhibit M.

14.12.3. This section shall not be construed to limit the ability of any of the Contractor's Subcontractors or Network Providers to bill, charge, seek compensation, remuneration or reimbursement from or have any recourse against the Contractor for any service provided pursuant to this Contract - Exhibit M or any other agreement entered into between that Subcontractor or Network Provider and the Contractor.

14.12.4. This provision shall survive the termination of this Contract - Exhibit M, for authorized services rendered prior to the termination of this Contract - Exhibit M, regardless of the reason for the termination. This provision shall be construed to be for the benefit of the Contractor's Members.

14.12.5. For fees or premiums charged by the Contractor to Members, the 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.

14.12.6. 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 the Contractor with CMS within two (2) years after the calendar quarter in which the Department made the expenditure. The 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 the Contractor's claims or capitation payments within two (2) 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 the Contractor for any period of time disallowed by CMS. Furthermore, the Department shall recover from the Contractor all claims, and capitations paid to the Contractor for any period of time disallowed by CMS.

14.12.7. The 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 (i.e. those 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.

14.12.8. The Contractor shall ensure that the date of receipt is the date that the 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.

14.12.8.1. 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 includes a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

14.12.8.1.1. DELIVERABLE: Timely Clean Claims Payment Report

14.12.8.1.2. DUE: Quarterly, within forty-five (45) days following the end of the quarter for which the report covers

15. DATA, ANALYTICS AND CLAIMS PROCESSING SYSTEMS

15.1. Central Role of Data and Analytics

15.1.1. The 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. The 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. The 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. The 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. The 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. The 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. The Contractor shall maintain an interface that enables the 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, the 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. The 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. The 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. The 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. The 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. The Contractor shall share with the Network Providers, the BIDM System and with the Department any specific findings or important trends discovered through the Contractor's analysis of the available data and information.

15.1.1.3.2.6. The 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 the Contractor's Members.

15.1.1.3.2.7. The Contractor shall support and encourage Network Provider use of the BIDM System's Data Analytic Portal.

15.1.1.3.2.8. The Department will provide the Contractor with Part 2 Data for Members enrolled with the Contractor, subject to the limitations and requirements contained in this contract provision and 42 C.F.R. Part 2.

15.1.1.3.2.9. The Contractor shall only use the Part 2 Data for three (3) specific purposes:

15.1.1.3.2.10. To assess calculation and payment for performance measures.

15.1.1.3.2.11. To use Prometheus to achieve the Potentially Avoidable Cost Key Performance Indicator targets.

15.1.1.3.2.12. To provide care coordination and/or case management services in support of payment or health care operations.

15.1.1.3.2.13. The 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.

15.1.1.4. Contractor shall work with the Department to ensure that the tools employed by Contractor to meet the obligations under this Contract - Exhibit M are sufficient, including receiving, reviewing and discussing the recommendations made by the Department.

15.1.1.5. The 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. The 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 – Exhibit M shall negate or supersede the provisions of the HIPAA privacy requirements.

15.1.1.7. The Contractor shall create a data governance policy.

15.1.1.7.1. The Contractor shall ensure that the data governance policy describes in what circumstances the 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. The 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. The Contractor shall possess and maintain an electronic Care Coordination Tool to support communication and coordination among members of the Provider Network and Health Neighborhood. The Contractor shall make it available for use by providers and care coordinators not currently using another tool.

15.2.1.2. The 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. The 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. The 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. The Contractor shall collect and be able to report the information identified in Section

15.2.1.6. 15.2.1.3 for its entire network. Although Network Providers and subcontracted Care Coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.

15.2.1.7. The 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. Medical Encounter Claims

15.2.2.1. Medical encounter claims include paid services delivered by any Provider. These claims may include, but are not limited to services delivered by medical groups, practices, clinics, Physicians, mid-level practitioners, medical equipment suppliers, familyplanning clinics, independent laboratories, optometrists, podiatrists, FQHCs, freestanding rehabilitation centers, or any other Providers.

15.2.2.2. When a Member receives services from multiple Providers in the same day, Contractor shall submit separate encounter claims for each visit for each Provider.

15.2.2.3. The Contractor shall ensure that its claims processing has the capability to process claims using the billing procedure codes specified in the Uniform Service Coding Standards (USCS) Manual. The USCS Manual can be found on the Department's website.

15.2.3. Encounter Claims Data Reporting through the MMIS

15.2.3.1. The Contractor shall submit all Encounter Data on all State Plan 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). The Contractor shall ensure that the quality and timeliness of its Encounter Data meets the state's standards.

15.2.3.2. The 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.

15.2.3.3. The 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.

15.2.3.4. The 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. The Contractor shall submit any 837 format encounter claims, reflecting paid, adjusted or denied by the Contractor, via a regular monthly batch process. The Contractor shall submit all encounter claims in accordance with the following:

15.2.3.4.1. Applicable HIPAA transaction guides posted available at http://www.wpcedi.com.

15.2.3.4.2. Provider Billing Manual Guidelines available at: http://www.colorado.gov/hcpf.

15.2.3.4.3. 837 X12N Companion Guide Specifications available at http://www.colorado.gov/hcpf.

15.2.3.5. The 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:

15.2.3.5.1. Medicaid Management Information System (MMIS) reports, which verify Medicaid eligibility

15.2.3.5.2. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction

15.2.3.5.3. HIPAA compliant X12N 834 Health Care Enrollment and Maintenance standard transaction

15.2.3.6. The Contractor shall submit ninety-five percent (95%) of Encounter Data within thirty (30) days, and one hundred percent (100%) within one hundred and twenty (120) days after the end of the month in which the claim was adjudicated. . The Contractor shall submit Encounter Data into the MMIS each month.

15.2.3.7. The Contractor shall make an adjustment to encounter claims when the 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, the Contractor shall adjust or void the encounter claim within fourteen (14) calendar days of notification by the Department.

15.2.3.8. The Contractor shall submit ninety-five percent (95%) of accurate Encounter Data no later than thirty (30) days, and one hundred percent (100%) within one hundred and twenty (120) days following the month in which the Contractor adjudicated a provider claim.

15.2.3.8.1. The 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. The 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.

15.2.3.8.1.1. DELIVERABLE: Certified Encounter Data submission

15.2.3.8.1.2. DUE: Monthly, on the last Business Day of the month

15.2.3.9. The 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.

15.2.3.10. The Contractor shall comply with changes in Department data format requirements as necessary. The Department reserves the right to change format requirements following consultation with the Contractor, and retains the right to make the final decision regarding format submission requirements.

15.2.3.11. The Contractor shall use enrollment reports to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. The Contractor shall ensure that the data transmissions and enrollment reports shall include:

15.2.3.11.1. HIPAA compliant X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products transaction.

15.2.3.11.2. HIPAA X12N 834 Health Care Enrollment and Maintenance standard transaction.

15.2.3.11.3. HIPAA X12N 834 Daily Roster.

15.2.3.11.4. HIPAA X12N 834 Monthly Roster: Generated on the first Business Day of the month.

15.2.3.11.5. Colorado interChange Encounter Reconciliation Report.

15.2.4. Flat File Submission

15.2.4.1. The 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 the Contractor shall certify as accurate, complete, and truthful based on the 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.

15.2.4.2. The Department shall provide the Contractor with the specifications for the flat file submission.

15.2.4.3. The Department shall conduct a quality review of the submission to determine if flat file meets the required specifications.

15.2.4.3.1. DELIVERABLE: Certified Quarterly Flat File

15.2.4.3.2. DUE: Quarterly, fifteen (15) days after the state fiscal year quarter ends.

15.2.4.3.3. The Contractor shall submit a flat file that contains 95% of paid claim lines within 30 days of the claim paid quarter.

15.2.4.3.4. The Contractor shall submit a flat file that contains 100% of paid claim lines within 60 days of the claim paid quarter.

15.2.4.3.5. The Contractor shall be responsible for the accuracy of flat file submissions.

15.2.4.3.6. Flat file accuracy is determined quarterly for completeness of data fields, and annually for completeness of inclusion of all claims.

15.2.4.4. Annual Submission

15.2.4.4.1. The 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 the 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.

15.2.4.4.2. The Department will provide the Contractor with the specifications for the annual flat file submission.

15.2.4.4.3. The Department will conduct a quality review of the annual submission to determine if the flat file meets the required specifications.

15.2.4.4.3.1. DELIVERABLE: Certified Annual Flat File

15.2.4.4.3.2. DUE: Annually, by October 15th.

16. OUTCOMES, QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

16.1. Continuous Quality Improvement

16.1.1. The 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. The 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 the 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. The Contractor shall create a single, unified Quality Improvement Program that meets federal requirements for both the PCCM Entity and PIHP.

16.2. Quality Improvement Program

16.2.1. The 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. The Contractor's Quality Improvement Program for the limited 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. The Contractor shall develop and submit a Quality Improvement Plan to the Department and/or its designee outlining how the Contractor plans to implement its Quality Improvement Program. The Contractor shall make reasonable changes to the Quality Improvement Planat the Department's direction.

16.2.3.1. DELIVERABLE: Quality Improvement Plan

16.2.3.2. DUE: July 1, 2018

16.2.4. Upon Department approval, the Contractor shall implement the Quality Improvement Plan.

16.2.5. The 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. The 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. The Contractor shall include the following in the report:

16.2.6.1. A description of the techniques the 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. The 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. The Contractor shall publicly post its Annual Quality Report.

16.2.9. Performance Improvement Projects

16.2.10. The 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.

16.2.11. The 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.

16.2.12. The Contractor shall have a minimum of two (2) Performance Improvement Projects chosen in collaboration with the Department: one (1) clinical project that may include physical health integration into behavioral health and one (1) non-clinical project.

16.2.12.1. The 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.

16.2.13. The Contractor shall have the capacity to conduct up to two (2) additional Performance Improvement Projects upon request from CMS after Year 1 of the Contract – Exhibit M.

16.2.14. The Contractor shall ensure that Performance Improvement Projects include the following:

16.2.14.1. Measurement of performance using objective quality indicators.

16.2.14.2. Implementation of system interventions to achieve improvement in quality.

16.2.14.3. Evaluation of the effectiveness of the interventions.

16.2.14.4. Planning and initiation of activities for increasing or sustaining improvement.

16.2.15. The 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.

16.2.16. The 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:

16.2.16.1. Measurement and intervention to achieve a measurable effect on health outcomes and Member satisfaction

16.2.16.2. Mechanisms to detect both under-utilization and over-utilization of services

16.2.16.3. Mechanisms designed to assess the quality and appropriateness of care furnished to Members with special health care needs

16.2.16.4. Measurement of performance using objective valid and reliable quality indicators

16.2.16.5. Implementation of system interventions to achieve improvement in quality

16.2.16.6. Empirical evaluation of the effectiveness of the interventions

16.2.17. The Contractor shall summarize the status and results of each Performance Improvement Project in the Annual Quality Report described in 5.14.2.5.

16.3. Performance Measurement

16.3.1. As applicable to the limited managed care capitation initiative, the 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.

16.3.2. The Contractor shall be accountable for achieving annually established cost trend and clinical quality outcome metrics.

16.3.3. The 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. The 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.

16.3.4. The Contractor shall support Network Providers and care coordinators to collect and report information required to calculate the performance measures.

16.3.5. The Contractor shall track their performance on identified measures monthly through the BIDM System and other data resources as appropriate.

16.3.6. The 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.

16.3.7. The Contractor shall track and report on additional performance measures when they are developed and required by CMS, the state or the Department.

16.3.8. Alignment with the RAE Accountable Care Collaborative Pay for Performance

16.3.8.1. The Contractor shall work to improve performance for up to nine (9) 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.

16.3.8.1.1. Following the first year of the Contract – Exhibit M, 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.

16.3.8.1.2. The Contractor shall calculate and report quarterly to the Department performance on the KPIs.

16.3.8.1.2.1. DELIVERABLE: KPI Performance Reporting

16.3.8.1.2.2. DUE: Quarterly, within 150 calendar days following the reporting quarter.

16.3.8.1.3. The KPIs are:

16.3.8.1.4. Emergency Department (ED) Visits – A ratio of the number of Emergency Room Visits per-set-member-count per-performance-period

16.3.8.1.5. 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

16.3.8.1.6. Child and Adolescent Well Visits – Percent of child and adolescent Members who received the appropriate minimum number of well visits within the evaluation period

16.3.8.1.7. Prenatal Care – Percent of women who gave birth who received a prenatal visit during pregnancy

16.3.8.1.8. Dental Visit – Percent of Members who received professional dental services

16.3.8.1.9. 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 the Contractor.

16.3.9. Additional Performance Measurement

16.3.9.1. Public Reporting

16.3.9.1.1. The 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:

16.3.9.1.1.1. Clinical and Utilization Measures as relevant, including CMS Core Measures and HEDIS measures that align with CPC+, and other state and federal initiatives

16.3.9.1.1.2. Member experience of care as described in Section 16.5.

16.3.9.1.1.3. Operational and financial data including member enrollment and summary financial information

16.3.9.1.2. Healthcare Effectiveness Data and Information Set (HEDIS)

16.3.9.1.2.1. The Contractor shall calculate and submit specified HEDIS measures, and core set measures as required by the Department, as updated by CMS annually. The Contractor shall track the CMS core measure set development to ensure reporting on the current measure set. The Department will collaborate with the Contractor's quality improvement committee to designate the required measures.

16.3.9.1.2.2. The Contractor shall analyze and respond to results indicated in the HEDIS measures.

16.3.9.1.2.3. The 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.

16.3.9.1.2.4. Any failed audit that nullifies more than three (3) required HEDIS measures is considered non-compliant with this requirement.

16.3.9.1.2.4.1. During any HEDIS year in which more than three (3) required HEDIS measures are considered not compliant, the Contractor shall re-calculate and submit the previously invalid measure rates within thirty (30) days from the date of the invalid measure. The Contractor shall ensure those measure rates are audited by an NCQA certified individual entity.

16.3.9.1.3. Health Equity and Performance Improvement

16.3.9.1.3.1. The 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.

16.3.9.1.3.2. The 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.

16.3.9.1.3.3. Over the performance period for any or all performance measures, the 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.

16.4. Member Experience of Care

16.4.1. The Contractor shall monitor Member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided by the Contractor and Network Providers.

16.4.2. The 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.

16.4.2.1. The Contractor shall submit monthly average speed of answer data from its Member contact center in the Call Line Statistics Report.

19.8.1.1.

16.4.2.2. The Contractor shall administer an annual Consumer Assessment of Health Plan Survey (CAHPS) with the Department identified survey supplements for adults and to measure satisfaction with their enrollees.

16.4.2.3. The Contractor shall administer the CAHPS through a certified survey vendor in compliance with appropriate survey protocols.

16.4.2.4. The Contractor shall share the survey results with the Department immediately following NCQA annual submission.

16.4.3. The 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).

16.4.4. The Contractor shall implement and maintain a mechanism to assess quality and appropriateness of care for Persons with Special Health Care Needs.

16.4.5. The Contractor shall inform the Department if they conduct any additional surveys of Members and share findings through the Operational Learning Collaborative.

16.4.6. The Contractor shall use the results and data from CAHPS and all other surveys conducted by the Contractor to inform the Contractor's Quality Improvement Plan.

16.4.7. The Contractor shall identify, develop, and implement interventions with Network Providers to improve survey scores identified for improvement.

16.4.7.1. The Contractor shall monitor interventions and report on them at least one (1) time annually at the Operational Learning Collaborative.

16.4.7.2. The 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.

16.5. Mechanisms to Detect Overutilization and Underutilization of Services

16.5.1. The 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. The Contractor may incorporate mechanisms developed for the Contractor's Utilization Management program.

16.6. Quality of Care Concerns

16.6.1. The 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 the Contractor. The Contractor shall not consider Member complaints about care to be QOC concerns and should process these complaints as Grievances, unless the Department instructs otherwise.

16.6.1.1. The Contractor shall have a system for identifying and addressing all alleged QOC concerns.

16.6.2. When a QOC concern is raised, the Contractor shall investigate, analyze, track, trend and resolve QOC concerns by doing the following, but not limited to:

16.6.2.1. Investigate the QOC issue(s).

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

16.6.2.3. Refer QOC issues to the Contractor's peer review committee, when appropriate.

16.6.2.4. 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.

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

16.6.2.6. Notify the Department that the Contractor has received a QOC.

16.6.2.7. Document the incident in a QOC summary to be sent to the Department. This summary shall include, at a minimum:

16.6.2.7.1. The name and contact information of the originator of the QOC concern.

16.6.2.7.2. A description of the QOC concern including issues, dates and involved parties.

16.6.2.7.3. All steps taken during the QOC investigation and resolution process.

16.6.2.7.4. Corrective action(s) implemented and their effectiveness

16.6.2.7.5. Evidence of the QOC resolution.

16.6.2.7.6. A copy of the acknowledgement letter.

16.6.2.7.7. Any referral made by the Contractor to peer review, a regulatory agency or a licensing board or agency.

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

16.6.2.7.9. Any outcome of the review as determined by the Contractor.

16.6.2.8. For QOC concerns involving Network Providers, the 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.

16.6.2.9. The Contractor shall submit a letter to the Department, upon request, that includes a brief description of the QOC concern, the efforts that the Contractor took to investigate the concern and the outcome of the review as determined by the Contractor.

16.6.2.9.1. The Contractor shall include a description of whether the issue was found to be a QOC issue and what action the Contractor intends to take with the Provider(s) involved.

16.6.2.9.2. The Contractor shall not include in its letter the names of the persons conducting the investigation or participating in a peer review process.

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

16.6.2.9.4. The Contractor shall send the complete letter within ten (10) Business Days of the Department's request. Upon request from the Contractor, the Department may allow additional time to investigate and report.

16.6.2.9.5. DELIVERABLE: QOC Letter

16.6.2.9.6. DUE: Within ten (10) Business Days of the Department's request

16.7. External Quality Review

16.7.1. Annually, the Contractor shall participate in an external independent Site Review and performance measure validation in order to review compliance with Department standards and Contract – Exhibit M requirements. External quality review activities shall be conducted in accordance with federal regulations 42 C.F.R. § 438 and the CMS mandatory activity protocols.

16.7.2. The Contractor shall participate in an external quality review that includes a review of the Contractor's activities in its role as a MCO Entity.

16.7.3. The Contractor shall participate in an annual external review that may include, but is not limited to, the following:

16.7.3.1. Medical Record review. For external review activities involving Medical Record abstraction, the 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.

16.7.3.2. Performance improvement projects and studies.

16.7.3.3. Surveys.

16.7.3.4. Network adequacy during the preceding 12 months.

16.7.3.5. Calculation and audit of quality and utilization indicators.

16.7.3.6. Administrative data analyses.

16.7.3.7. Review of individual cases.

16.7.3.8. Care Coordination record review.

16.7.3.9. Provider site visits.

16.7.3.10. Encounter Data validation.

16.7.4. The 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.

16.8. Advisory Committees and Learning Collaboratives

16.8.1. To ensure the Program is effectively serving Members and providers, the 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.

16.8.2. Program Improvement Advisory Committees (PIAC)

16.8.2.1. The Contractor shall participate in both a statewide and regional PIAC to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of Members and providers in the Program. The Contractor shall ensure that the regional PIACs includes, at a minimum, the following stakeholder representatives:

16.8.2.1.1. Members.

16.8.2.1.2. Members' families and/or caregivers. 16.9.2.1.3.PCMPs.

16.8.2.1.3. Behavioral health providers.

16.8.2.1.4. Health Neighborhood provider types (specialists, hospitals, LTSS, oral health, nursing facilities).

16.8.2.1.5. Other individuals who can represent advocacy and Community organizations, local public health, and child welfare interests.

16.8.2.2. For the statewide PIAC, the Contractor shall:

16.8.2.2.1. Designate one (1) representative from the Contractor's organization who understands the scope of this Contract - Exhibit M to attend monthly meetings.

16.8.2.2.2. The Department may, at its own discretion, request greater alignment and engagement between the Contractor's regional PIAC and the statewide PIAC.

16.8.2.3. The Contractor shall create a Regional PIAC with the following responsibilities:

16.8.2.3.1. Review the Contractor's deliverables.

16.8.2.3.2. Discuss program policy changes and provide feedback.

16.8.2.3.3. Provide representatives for the statewide PIAC.

16.8.2.3.4. Review the Contractor's and Program's performance data.

16.8.2.3.5. Review Member materials and provide feedback.

16.8.2.4. The Contractor shall ensure that its Regional PIAC:

16.8.2.4.1. Be directed and chaired by one (1) of the Contractor's Key Personnel.

16.8.2.4.2. Have a formal, documented membership and governance structure that is posted on the Contractor's website for public viewing.

16.8.2.4.3. Have a formal budget for the operations of the Regional PIAC.

16.8.2.4.4. 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 the Contractor's region.

16.8.2.4.5. The 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.

16.8.2.4.6. Open all scheduled meetings to the public.

16.8.2.4.7. Post the minutes of each meeting on the Contractor's website within thirty (30) days of each meeting.

16.8.2.4.8. Accommodate individuals with disabilities.

16.8.3. Quality Improvement Committee

16.8.3.1. The 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.

16.8.4. Operational Learning Collaborative

16.8.4.1. The 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.

16.8.4.1.1. Wellness activities.

16.8.4.1.2. Provider payment models.

16.8.4.1.3. Health Promotion and Population Stratification and Management.

16.8.4.1.4. Member engagement.

16.8.4.1.5. Health Neighborhood and Community development.

16.8.4.1.6. Provider support and practice transformation.

16.8.4.1.7. Data analytics.

16.8.4.1.8. Care Coordination, including cross-agency, cross-system activities.

16.8.4.1.9. Health information initiatives and technologies.

16.8.4.1.10. Strategies used to address social determinants of health.

16.8.4.1.11. Transitions of care, including hospital discharge and LTSS Members transitioning to the community.

16.8.4.1.12. The Contractor shall participate in annual and ad hoc learning collaboratives to monitor specific program activities and share lessons learned.

16.9. RAE Quarterly Leadership Meeting

16.9.1. The Contractor shall host a quarterly meeting with Department leadership (to include the Executive Director) to review the following:

16.9.1.1. Performance reports that summarize Contractor performance, including:

16.9.1.1.1. Care Coordination;

16.9.1.1.2. Population Health Management Report;

16.9.1.1.3. Network Adequacy Report;

16.9.1.1.4. Grievances and Appeals;

16.9.1.1.5. Member Engagement;

16.9.1.1.6. Administrative Payment Arrangements;

16.9.1.1.7. Client Over-Utilization Program.

16.9.1.2. Areas of opportunity and challenge to be addressed for the Contractor to improve performance, including barriers to properly address those opportunities and challenges.

16.9.1.3. Provider areas of opportunity and where the Department can be of assistance.

16.10. Ad Hoc Quality Reports

16.10.1. The Contractor shall provide to the Department or its agents any information or data relative to the Contract – Exhibit M. In such instances, and at the direction of the Department, the 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.

16.10.2. The Contractor shall have at least thirty (30) calendar days, or a timeframe mutually agreed upon between the Department and the Contractor, to fulfill such requests.

16.10.3. The Contractor shall certify that data and information it submits to the Department is accurate.

16.11. Health Plan Management Metrics

16.11.1. The 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:

16.11.1.1. Claim payment statistics

16.11.1.2. Member grievance reporting

16.11.1.3. Provider response statistics

16.11.1.4. Provider contracting status reporting

16.11.2. The 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. The Contractor shall have a program in place for ensuring compliance with the ACC Program rules, Contract – Exhibit M requirements, state and federal regulations and confidentiality regulations, and a program to detect Fraud, Waste and Program Abuse. The 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. The Contractor shall comply with all applicable CMS regulations in 42 C.F.R. § 438.

17.1.3. The Contractor, and Subcontractors to the extent that the Subcontractor is delegated responsibility by the 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 the Contractor's Chief Program Officer and Compliance Officer.

17.1.5. The 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 the 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 – Exhibit M 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 the Contractor's compliance program and its compliance with the requirements under the Contract – Exhibit M.

17.1.5.4. A system for training and education for the Compliance Officer, the Contractor's Key Personnel, and the Contractor's employees for the federal and state standards and requirements under the Contract – Exhibit M.

17.1.5.4.1. The 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 the 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 – Exhibit M. The 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 the 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 the Contractor when they have received an Overpayment, to return the Overpayment to the Contractor, and to notify the Contractor in writing of the reason for the Overpayment within sixty (60) calendar days after the date on which the Overpayment was identified.

17.1.5.8.1. The Contractor shall have a process for Network Providers to report and return Overpayments to the Contractor.

17.1.5.9. The Contractor shall have a process for notifying the Department of an identified Overpayment within five (5) business days. The Contractor shall supply the Department the information submitted by a Network Provider related to an

identified Overpayment within thirty (30) calendar days of receiving the same information.

17.1.5.10. The Contractor, if it makes or receives annual payments under the Contract – Exhibit M 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.

17.1.5.11. The Contractor shall comply with the Department policies related to recoveries of Overpayments.

17.1.5.12. The 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.

17.1.5.13. 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.

17.1.5.14. 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.

17.1.5.15. 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.

17.1.5.16. DELIVERABLE: Compliance Program documents and information

17.1.5.17. DUE: Annually, by July 31

17.1.6. The Contractor shall modify the Compliance Program as requested by the Department within ten (10) Business Days following the receipt of the Department's requested changes.

17.1.6.1. DELIVERABLE: Compliance Program revisions and changes

17.1.6.2. DUE: Within ten (10) Business Days following the Department's request

17.2. Compliance Plan Requirements

17.2.1. The Contractor shall have a documented Compliance Plan that implements all elements of the Compliance Program.

17.2.2. The 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. The Contractor shall ensure the Compliance Plan, at minimum, includes:

17.2.3.1. A risk assessment of the 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

17.2.3.2.3. 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. The 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 the 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; and

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 (i.e.

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. The Contractor shall submit its Compliance Plan to the Department for review and approval. The 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, the Contractor shall review its Compliance Plan and make any necessary revisions for the following reporting year. The 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

17.2.5.3. The Contractor shall modify the Compliance Plan as requested by the Department within ten (10) Business Days following the receipt of the Department's requested changes.

17.2.5.3.1. DELIVERABLE: Compliance Plan revisions and changes

17.2.5.3.2. DUE: Within ten (10) Business Days following the Department's request

17.3. Reports and Disclosures

17.3.1. The 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.

17.3.2. Reports Requiring Monthly Notification

17.3.2.1. The Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a one (1) month period.

17.3.2.2. The Contractor shall report, at minimum:

17.3.2.2.1. 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;

17.3.2.2.2. 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;

17.3.2.2.3. All provider circumstance changes where a provider is no longer in the Contractor's network, but was not removed for cause, including providing information on why the provider was withdrawn;

17.3.2.2.4. Any provider terminations not based on quality or performance or for cause, including but not limited to:

17.3.2.2.4.1. A change in ownership or control of a provider;

17.3.2.2.4.2. A provider voluntarily withdrawing from the MCE's network; and

17.3.2.2.4.3. The death of a provider.

17.3.2.2.4.3.1. The Contractor shall provide the following:

17.3.2.2.4.3.2. Date of removal;

17.3.2.2.4.3.3. Reason for the termination;

17.3.2.2.4.3.4. Numbers of members served by the provider; and

17.3.2.2.4.3.5. Plan to ensure that members receive continuous services.

17.3.2.2.5. Any other information as specified by the Department.

17.3.2.2.6. The Contractor shall use the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

17.3.2.2.6.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report

17.3.2.2.6.2. DUE: Within 10 (ten) Business Days after the end of each month. 17.3.2.2.7.

The Contractor shall modify the Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten (10) Business Days following the receipt of the Department's requested changes.

17.3.2.2.7.1. DELIVERABLE: Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

17.3.2.2.7.2. DUE: Within ten (10) Business Days following the Department's request

17.3.2.3. Reports Requiring Semi-Annual Notification

17.3.2.3.1. The Contractor shall report all work, activities, and events related to program integrity compliance and Fraud, Waste and Program Abuse, occurring within a six (6) month period.

17.3.2.3.2. The six (6) month reporting periods are defined from January 1 through June 30 and July 1 through December 31.

17.3.2.3.3. The Contractor shall use the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report template.

17.3.2.3.4. The Contractor shall report, at minimum:

17.3.2.3.4.1. 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;

17.3.2.3.4.2. 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;

17.3.2.3.4.3. 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.

17.3.2.3.4.4. 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

17.3.2.3.4.5. Any other information as specified by the Department.

17.3.2.3.5. The Contractor shall not include activities related to administrative billing issues, such as reviews of financial statements or credit balances.

17.3.2.3.5.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Abuse Consolidated Activity Report

17.3.2.3.5.2. DUE: Within forty-five (45) days of the end of the six (6) month reporting period

17.3.2.3.6. The Contractor shall modify the Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report as requested by the Department within ten (10) Business Days following the receipt of the Department's requested changes.

17.3.2.3.6.1. DELIVERABLE: Semi-Annual Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report revisions and changes

17.3.2.3.6.2. DUE: Within ten (10) Business Days following the Department's request

17.3.2.4. Disclosures Requiring Prompt Notification

17.3.2.4.1. Provider Terminations

17.3.2.4.1.1. The 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

17.3.2.4.1.2. The Contractor shall provide the following:

17.3.2.4.1.2.1. Provider's name and identification number;

17.3.2.4.1.2.2. Date of removal;

17.3.2.4.1.2.3. Number of members served by the provider;

17.3.2.4.1.2.4. Reason for the termination;

17.3.2.4.1.2.5. Narrative describing how the Contractor intends to provide or services for affected members after the termination; and

17.3.2.4.1.2.6. Any information as required by the Department.

17.3.2.4.1.2.7. DELIVERABLE: Notice of Network Provider Termination for Quality of Performance or For Cause

17.3.2.4.1.2.8. DUE: Within two (2) Business Days of the decision to terminate for quality or performance issue terminations or terminations for cause

17.3.2.4.2. Changes in Member Circumstances Affecting Eligibility

17.3.2.4.2.1. In accordance with 42 C.F.R. 438.608 (a)(3), the 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:

17.3.2.4.2.1.1. Changes in the Member's residence.

17.3.2.4.2.1.2. The death of a Member.

17.3.2.4.2.2. The Contractor shall use the Provider/Member Change in Circumstance Disclosure template.

17.3.2.4.2.3. The Contractor shall provide the following:

17.3.2.4.2.3.1. The member's name;

17.3.2.4.2.3.2. Medicaid ID number;

17.3.2.4.2.3.3. Date of change;

17.3.2.4.2.3.4. Description of the change; and

17.3.2.4.2.3.5. Any information as required by the Department.

17.3.2.4.2.3.6. DELIVERABLE: Monthly Member Change in Circumstance Disclosure Report

17.3.2.4.2.3.7. DUE: Within 10 (ten) Business Days after the end of each month.

17.3.2.5. Disclosures Requiring Notification within 30 Days

17.3.2.5.1. Provider Licensure and Professional Review Actions

17.3.2.5.1.1. The 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:

17.3.2.5.1.1.1. Malpractice payments;

17.3.2.5.1.1.2. Licensure and certification actions;

17.3.2.5.1.1.3. Negative actions or findings;

17.3.2.5.1.1.4. Adverse actions;

17.3.2.5.1.1.5. Health Care-related Criminal Convictions;

17.3.2.5.1.1.6. Health Care-related Civil Judgments;

17.3.2.5.1.1.7. Exclusions from Federal or state health care programs; and

17.3.2.5.1.1.8. Other adjudicated actions of decisions.

17.3.2.5.1.1.9. DELIVERABLE: Notification of Adverse Licensure of Professional Review

17.3.2.5.1.1.10. DUE: Must be submitted to the Department and National Practitioner Data Bank within 30 days following the action being reported.

17.3.2.6. Disclosures Requiring Notification within 60 days

17.3.2.6.1. Overpayments and Excess Capitation Payments

17.3.2.6.1.1. Within sixty (60) calendar days of identifying any Overpayments, per 42 C.F.R 438.608(d)(2), and any excess capitation payments, the Contractor shall report and return an Overpayment to the Department.

17.3.2.6.1.2. The Contractor shall provide the following:

17.3.2.6.1.2.1. 17.3.1.5.1.2.1. Client information;

17.3.2.6.1.2.2. Claims information;

17.3.2.6.1.2.3. Encounter Data information;

17.3.2.6.1.2.4. Paid amounts:

17.3.2.6.1.2.5. Provider information;

17.3.2.6.1.2.6. Dates of when Overpayment was identified and recovered;

17.3.2.6.1.2.7. Recovery amounts;

17.3.2.6.1.2.8. Capitation information; and

17.3.2.6.1.2.9. Any information as required by the Department.

17.3.2.6.1.3. The Contractor shall use the Overpayment and Recovery Disclosure template.

17.3.2.6.1.3.1. DELIVERABLE: Overpayment and Recovery Notification Disclosure

17.3.2.6.1.3.2. DUE: Within sixty (60) calendar days of identifying capitation or other payments.

17.4. Fraud, Waste, and Program Abuse

17.4.1. The 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. The Contractor shall temporarily suspend all review activities or actions related to any provider upon request of the Department.

17.4.3. The Contractor shall abandon a review and stop all work on the review when requested to do so by the Department.

17.4.4. The 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. The 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 – Exhibit M.

17.4.5.3. Provider treatment and business practices.

17.4.5.4. Provider billing practices and patterns.

17.4.5.5. The 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. The 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. The 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. The Contractor shall assist the Department, the MFCU or any other law enforcement entity as requested with any preliminary or full investigation.

17.4.8. The Contractor shall temporarily suspend all review activities or actions related to any provider which the Contractor suspects is involved in fraudulent activity. The Contractor shall continue its investigation as requested by the Department.

17.5. Provider Fraud

17.5.1. The 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 – Exhibit M, including any Utilization Management or review activities.

17.5.2. Upon identification or suspicion of suspected provider Fraud, the Contractor shall use the MCO Suspected Fraud Written Notice template to notify the Department and the MFCU in writing.

17.5.3. The 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); and

17.5.3.7. Any information as required by the Department.

17.5.3.8. DELIVERABLE: Managed Care Suspected Fraud Written Notice

17.5.3.9. DUE: Within three (3) Business Days from the initial discovery to the Department and the MCFU

17.5.4. The Contractor shall provide any additional information which supplements or modifies the Managed Care Suspected Fraud Written Notice within three (3) 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 (3) Business Days following the Department's or the MFCU's request

17.6. Member Fraud

17.6.1. The 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, the 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. The 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 (3) business days from the initial discovery to the Department

17.7. Suspension of Payments Due to a Credible Allegation of Fraud

17.7.1. The 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. The Contractor shall release suspended payment amounts to the provider within one payment cycle when directed to do so by the Department.

17.7.3. The 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 the Contractor if the Contractor is under investigation for a Credible Allegation of Fraud.

17.7.5. When the Contractor has suspended payments to a provider due to a Credible Allegation of Fraud, the 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 (10th) Business Day of each month for the previous month where payments to a provider have been suspended due to a Credible Allegation ofFraud

17.8. Quality Improvement Inspection, Monitoring and Site Reviews

17.8.1. The Contractor shall enable and support the Department or its designee to conduct site reviews of the 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 – Exhibit M.

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. The 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. The 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. The 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, the 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 the Contractor at least three (3) weeks prior to the visit. The 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. The Contractor has a minimum of thirty (30) days to submit the required materials for non-emergency reviews.

17.8.7. The Contractor shall make available, to the Department and its agents for Site Review, all records and documents related to the execution of this Contract – Exhibit M, either on a scheduled basis, or immediately on an emergency basis. Delays in the availability of such documents and records may subject the 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 the Contractor within forty-five (45) days of the Site Review. The Contractor is allowed thirty (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. The Contractor shall respond to any required actions identified by the Department or its designee, if necessary, with a corrective action plan within thirty (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 the Contractor is found to be in complete compliance. The Department will notify the Contractor in writing when the corrective actions have been completed, accepted and the Contractor is considered to be in compliance with Department regulations and the Contract – Exhibit M.

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, the 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 the 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. The 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 the Contractor about the requirements under this Contract – Exhibit M.

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. The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment. The Contractor shall not pay a Network Provider for provider-preventable conditions, as identified in the State Plan and 42 C.F.R. § 438(g). The 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. The Contractor shall create a Provider Preventable Conditions Report that includes all provider-preventable conditions. The 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. The 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 – Exhibit M 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 the Contractor, if the 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. The 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. The 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. The 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 (5) percent of the 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. The 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 the 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 the Contractor unless the Secretary directs otherwise.

17.9.4.4.3. May not renew or extend the existing agreement with the 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. The 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

17.9.5.1.1.4. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;

17.9.5.1.1.5. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; or

17.9.5.1.1.6. 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. The Contractor shall submit, full and complete information about:

17.10.1.1.1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars ($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 the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

17.10.1.2. DELIVERABLE: Disclosure of Business Transactions

17.10.1.3. DUE: Within thirty-five (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. The Contractor shall disclose to the Department information regarding ownership or control interests in the 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 thirty-five (35) calendar days of either a change of ownership or a written request by the Department.

17.10.2.2. The 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 the 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 the Contractor.

17.10.2.2.3. Tax identification number of any corporation or partnership with an ownership or control interest in the Contractor, or in any subcontractor in which the Contractor has a five percent (5%) or more interest.

17.10.2.2.4. Whether an individual with an ownership or control interest in the Contractor is related to another person with an ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether an individual with an ownership or control interest in any subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the 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 the 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 the 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. The Contractor shall comply with the conflict of interest safeguards described in 42C.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. The 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 the Contractor does not use information obtained from one party in its dealings with the other.

17.10.3.3. The 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 (10) Business Days of learning of an existing appearance of a conflict of interest situation.

17.10.3.4. As required by CRS 25.5-5-402, the Contractor may be required to submit quarterly data about rates paid to providers in their network. If required to do so, the Contractor shall submit required rate information on a template provided by the Department on the last day of each State fiscal quarter.

17.10.3.4.1. DELIVERABLE: Supplemental Conflict of Interest Data

17.10.3.4.2. DUE: Quarterly, on the last day of each State fiscal quarter

17.10.4. Subcontracts and Contracts

17.10.4.1. The Contractor shall disclose to the Department copies of any existing subcontracts and contracts with providers upon request.

17.10.4.2. The Contractor shall ensure that no Member is billed by a Subcontractor or provider for any amount greater than would be owed if the 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 (5) Business Days of the Department's Request.

17.10.5. Screening of Employees and Contractors

17.10.5.1. The 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. The 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 the Contractor determines that one of its employees or Subcontractors has been excluded, then the 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 (5) 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 thirty-five (35) calendar days of the date of a written request by the Department, the Contractor shall disclose the identity of any person who:

17.10.6.1.1. Has an ownership or control interest in the Contractor, or who is a managing employee of the 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.

17.10.6.1.3. DELIVERABLE: Disclosure of Information on Persons Convicted of a Crime

17.10.6.1.4. DUE: Within thirty-five (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 the Contractor shall immediately notify the Department and the Office of Information Technology (OIT) of all suspected loss or compromise of sensitive data within five (5) Business Days of the suspected loss or compromise and shall work with the Department regarding recovery and remediation.

17.10.7.2. The 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. The 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 (5) Business Days of becoming aware of the breach

17.10.8. The Contractor shall ensure that all Subcontractors and providers comply with all record maintenance requirements of the Contract – Exhibit M.

17.10.8.1. Notwithstanding any other requirement of the Contract, the 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 (10) years.

17.10.9. Inspection and Audits

17.10.9.1. The Contractor shall allow the Department, CMS, HHS-OIG, the Comptroller General and their designees to inspect and audit any records or documents of the 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 – Exhibit M, the Contractor shall allow the Department, CMS, the HHS-OIG, the Comptroller General and their designees this authority for ten (10) 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. The 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.

17.10.9.3.1. In the event that right of access is requested, the Contractor and/or its Subcontractors or providers shall:

17.10.9.3.2. Make staff available to assist in any audit or inspection under the Contract – Exhibit M.

17.10.9.3.3. Provide adequate space on the premises to reasonably accommodate Department, state or federal or their designees' personnel conducting all audits, Site Reviews or inspections.

17.10.9.3.4. 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 the Contractor or its subcontractors pertaining to the ability of the Contractor or its subcontractor's ability to bear the risk of financial losses.

17.10.9.3.5. All inspections or audits shall be conducted in a manner that will not unduly interfere with the performance of the Contractor's, Subcontractor's or providers' provision of care.

17.10.9.3.6. The Contractor shall allow access to the Contractor's claims system and claims data by Department staff for program integrity activities.

17.10.9.3.7. In consultation with the Department, the 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.

17.10.9.4. The Contractor shall submit to the Department copies of any existing policies and procedures, upon request by the Department, within five (5) Business Days.

17.10.9.5. 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, the Contractor shall participate in a robust financial reporting program.

17.11.2. The 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 the Contractor's financial information as follows:

17.11.2.1. The 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

17.11.2.2. Quarterly financial report using a template that has been mutually agreed upon by the 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:

17.11.2.2.1. The amount and percentage of PMPM payments spent during the reporting period to support the following categories of work:

17.11.2.2.1.1. 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)

17.11.2.2.1.2. Care Coordination, with a break-down of dollars spent on contracted Care Coordination and that provided by the Contractor

17.11.2.2.1.3. Practice support to include specific information about the types of practices supported

17.11.2.2.1.4. Administration

17.11.2.2.1.5. Network development

17.11.2.2.1.6. Community infrastructure and Health Neighborhood participants

17.11.2.2.1.7. Systems support and capital infrastructure investments

17.11.2.2.1.8. Subcontractors

17.11.2.2.1.9. The categories listed above may be expanded as a result of the process of developing the reporting template

17.11.2.2.2. A breakdown of how the PMPM payments were spent for each category of work

17.11.2.3. The Contractor shall submit the Quarterly Financial Information to the Department. 1

17.11.2.3.1. DELIVERABLE: Quarterly Financial Information

17.11.2.3.2. DUE: No later than forty-five (45) days from the end of the state fiscal quarter.

17.11.3. The 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 the Contractor's Chief Financial Officer or their designee.

17.11.4. The 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 the 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 (6) months from the end of the fiscal year that the statement covers.

17.11.5. The 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 thirty (30) days after the submission of the report. The Contractor shall ensure that the Chief Program Officer and CFO are in attendance at these meetings.

17.11.6. The Contractor shall submit other financial reports and information as requested by the Department or its designee.

17.11.7. The 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, the Contractor shall produce an updated report that corrects all errors and includes all omitted data or information. The Contractor shall submit the updated report to the Department within ten (10) 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 (10) days from the Department's request for the updated report or statement.

17.11.9. The Contractor shall report to the Department, at least quarterly, costs incurred by the Contractor for Specialty Drugs with supporting invoice(s) from hospital, authorization data and Encounter Data.

17.11.10. The 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. The Contractor shall submit data quarterly according to the specifications provided by the Department. The Contractor shall certify all data submitted is accurate, complete and truthful based on the Contractor's best knowledge, information and belief. The 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. The 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 Statefor health maintenance organizations.

17.13.2. The Contractor shall not hold liable any Member for the Contractor's debts, in the event the Contractor becomes insolvent.

17.13.3. The Contractor shall not hold liable any Member for covered services provided to the Member, for which the Department does not pay the 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. The 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 the Contractor covered the services directly.

17.13.5. The 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 the Contractor's debt, in the event the Contractor becomes insolvent.

17.13.5.1. DELIVERABLE: Solvency Notification

17.13.5.2. DUE: Within two (2) Business Days of becoming aware of a possible solvency issue.

17.14. Warranties and Certifications

17.14.1. The 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

17.15.2. The 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:

17.15.2.1. Physicians participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and one million five-hundred thousand dollars ($1,500,000.00) in aggregate per year.

17.15.2.2. Facilities participating in the Contractor's Plan shall be insured for malpractice, in an amount equal to a minimum of five-hundred thousand dollars ($500,000.00) per incident and three million dollars ($3,000,000.00) in aggregate per year.

17.15.2.3. Sections 17.17.1.1.1 and 17.17.1.1.2 shall not apply to Physicians and facilities in the Contractor's network which meet any of the following requirements:

17.15.2.3.1. The Physician or facility is a public entity or employee pursuant to §24-10-103,

17.15.2.3.2. C.R.S. of the Colorado Governmental Immunity Act, as amended.

17.15.2.3.3. 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.

17.15.2.4. The 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, the Contractor shall notify the Department of such cancellation within two (2) Business Days of when the coverage is cancelled.

17.15.3. The Contractor shall notify the Department of:

17.15.3.1. 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.

17.15.3.2. Any action on the part of the Colorado Commissioner of Insurance, suspending, revoking, or denying renewal of its certificate of authority.

17.15.3.3. Any revocation, withdrawal or non-renewal of necessary licenses, certifications, approvals, permits, etc., required for Contractor to properly perform this Contract – Exhibit M.

17.15.3.3.1. DELIVERABLE: Notification of Actions Involving Licenses, Certifications, Approvals and Permits

17.15.3.3.2. DUE: Within two (2) 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 the Contractor:

17.16.1.1. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Contract – Exhibit M –with the Department, to a Member covered under the Contract – Exhibit M.

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 the Contractor, the State must provide the 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 the 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 the 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 – Exhibit M –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 – Exhibit M for cause and enroll any Member enrolled with the Contractor in other Plan, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the 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 the Contractor's Contract as described in this section, the Department shall:

17.17.2.1. Provide the 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 the 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 the Contractor that contains the effective date of the termination.

17.17.2.4.1. Upon receipt of the termination notice, the Contractor shall give Members enrolled with the 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.

17.17.2.5. Once the Department has notified the Contractor of its intent to terminate under this section, the Department may give Members enrolled with the Contractor written notice of the Department's intent to terminate the Contract.

17.17.2.6. The Department may choose to impose any of the following intermediate sanctions if the Contractor violates any applicable requirements of sections 1903(m) or 1932 of the Social Security Act and its implementing regulations:

17.17.2.6.1. Allow Members enrolled with the Contractor to Disenroll immediately, without cause;

17.17.2.6.2. Suspend all new enrollments to the Contractor's managed care capitation initiative, after the date the Secretary or the Department notifies the Contractor of a determination of violation of any requirement under sections 1903(m) or 1932 of the Act; and

17.17.2.6.3. Suspend payments for all new enrollments to the 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

17.17.2.7. 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), the 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 the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the 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 the 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 the Contractor, the 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 the Contractor

18.1.1. Compensation to the Contractor will consist of the following:

18.1.1.1. An actuarially certified monthly Capitated Payment, as specified in Section 19, Payment, for each active Member assigned to the 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 rate at the actuarially certified point estimate in accordance with 42 C.F.R. § 438.

18.2. Process for Administrative Per-Member Per-Month Payment and Capitated Payment

18.2.1. The Department will calculate the number of active Members enrolled in the Contractor's limited 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 the Contractor. The Department will provide the Contractor with a monthly payment report through the Colorado interChange.

18.2.2.1. The 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 the Contractor within the month for which the payment applies.

18.2.3.1. In the event that the Contractor is not compensated for a Member in a month for which the Contractor should have been compensated, the Department will compensate the Contractor for that Member retroactively.

18.3. Special Provisions

18.3.1. The Department will remove the amount submitted in the quarterly Third-Party Recovery Report, described in Section 14.10.7, from the calculation of the Monthly Capitation Rates. The Department will not seek recovery of reimbursement from the Contractor.

18.3.2. The monthly Capitated Payment shall be considered payment in full for all covered services set forth in this Contract – Section 19.1.

18.3.3. Actions Impacting Existing Rates

18.3.3.1. The 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.

18.3.4. The Department will reimburse the Contractor for Specialty Drugs according to the terms in this section.

18.3.4.1. The Department will reimburse the 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 the 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 the 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 the Contract, is calculated as the difference between Sections 18.3.4.4.1. and 18.3.4.4.2., whether they are lower or higher, on an actuarially sound basis.

18.3.4.5. The Department will pay the Contractor for Specialty Drugs quarterly within sixty (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 the Contractor.

18.3.4.7. The Department will determine drug selection, substitution effect calculation, and payment reconciliation.

18.4. Payment Calculation Disputes

18.4.1. In the event that the Contractor believes that the calculation or determination of any payment is incorrect, the Contractor shall notify the Department of its dispute within thirty (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.

18.5. Recoupments

18.5.1. The Contractor shall refund to the Department any overpayments due the Department within thirty (30) days after discovering the overpayments or being notified by the Department that overpayments are due. If the Contractor fails to refund the overpayments within thirty (30) days, the Department shall deduct the overpayments from the next payment to the Contractor.

18.5.2. The Department will recoup any capitation payment made to the Contractor for Members who have a stay in an Institution for Mental Disease that exceeds fifteen (15) days in a single month.

18.5.3. The Contractor's obligation to refund all overpayments continues subsequent to the termination of the Contract. If the Contract has terminated, the Contractor shall refund any overpayments due to the Department, by check or warrant, with a letter explaining the nature of the payment, within ninety (90) days of termination.

18.5.4. Payments made by the Department to the Contractor due to the Contractor's omission, fraud, and/or defalcation, as determined by the Department, shall be deducted from subsequent payments.

18.5.5. Where membership is disputed between two Contractors, the Department shall be final arbitrator of membership and shall recoup any Capitated Payments.

18.5.6. The Contractor's obligation to refund all calculated rebates continues subsequent to the termination of the Contract.

18.6. Closeout Payments

18.6.1. Notwithstanding anything to the contrary in this Contract - Exhibit M, all payments for the final month of this Contract - Exhibit M shall be paid to Contractor no sooner than ten (10) days after the Department has determined that Contractor has completed all of the requirements of the Closeout

19. RATES

19.1.

Category of Aid	SFY23 Rate
AFDC FEMALE	$387.25
AFDC MALE	$258.34
AwDC	$462.54
BC WOMEN	$714.66
EXPANSION PARENT F	$357.71
EXPANSION PARENT M	$264.62
ELDERLY	$166.80
DISABLED DUAL	$160.00
DISABLED NONDUAL	$1,534.16

19.2. Retrospective Rate Changes

19.2.1. In relation to unique circumstances and when the Contractor and the Department agree to retrospectively change the rates, the Department will recoup overpayments. The rates for the specified time periods will be adjusted according to Contract amendment or an Option Letter issued by the Department.

COHORT	SFY2017-18 Adjusted Rates
AFDC F	$ 360.08
AFDC M	$ 271.00
AwDC	$ 398.17
BC Pregnant Women	$ 1,146.42
Expansion Parent F	$ 292.12
COHORT	**SFY2018-19 Adjusted Rates**
AFDC F	$ 345.06
AFDC M	$ 260.44
AwDC	$ 446.17
BC Pregnant Women	$ 1,061.55
Nondual	$ 1,201.26

Expansion Parent F	$ 308.74
Expansion Parent M	$ 202.82
OAP-A	$ 173.31
OAP-B & AND/AB SSI Dual	$ 165.40
OAP-B & AND/AB SSI Nondual	$ 1,340.49

COHORT	SFY2019-20 Adjusted Rates
AFDC F	$ 348.47
AFDC M	$ 248.44
AwDC	$ 442.37
BC Pregnant Women	$ 1,116.69
Expansion Parent F	$ 326.62
Expansion Parent M	$ 222.47
OAP-A	$ 186.32
OAP-B & AND/AB SSI Dual	$ 178.44
OAP-B & AND/AB SSI Nondual	$ 1,307.28

EXHIBIT N-1, COVERED SERVICES

19.3. With the exception of EPSDT and preventive services as specified in this exhibit, covered services and supplies must be medically necessary and provided for the diagnosis or treatment of an illness, pregnancy, or accidental injury. A covered person and his or her physician decide which services and supplies are given, but contractors need only pay for the following covered services and supplies.

19.3.1. The Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits, within the scope of benefits stipulated in the contract.

19.3.2. The Contractor shall submit all necessary documentation and reporting required to the state to establish and demonstrate compliance with 42 CFR part 438, subpart K, regarding parity in mental health and substance use disorder benefits.

19.3.3. Abortion

19.3.3.1. Abortions are a Covered Service only in the following circumstances:

19.3.3.1.1. When a physician has found and certified in writing that in his or her professional judgment the life of the mother would be endangered if the fetus were carried to term, when documented in accordance with federal requirements. 42 C.F.R. § 441.203.

19.3.3.1.2. If the pregnancy is a result of rape or incest.

19.3.3.2. NOTE: For the purpose of this section, treatment for the following conditions is not considered to be an abortion:

19.3.3.2.1. Ectopic pregnancies (Pregnancy occurring in other than a normal position or place); and

19.3.3.2.2. Miscarriage (spontaneous abortion).

19.3.4. Ambulance Services

19.3.4.1. Covered ambulance services shall be provided to the nearest appropriate medical facility when any other form of transportation is not medically advisable and when the ambulance service is provided in conjunction with emergency medical care. Such covered ambulance services include the following situations:

19.3.4.2. Air ambulance

19.3.4.2.1. Air ambulance services, including rotary- and fixed-wing aircraft, are covered only if the client requires medical attention, the client is transported to the nearest appropriate medical facility, and

19.3.4.2.1.1. The point of pickup is inaccessible by land emergency transport vehicles,

19.3.4.2.1.2. Great distances or other obstacles are involved in transport to the nearest appropriate facility and prompt admission is essential; or

19.3.4.2.1.3. The client is suffering from an illness, injury, or psychiatric condition that makes all other forms of transport inadvisable.

19.3.4.2.2. Emergency Services which, due to the medical or psychiatric condition of the Client, are immediate in nature and cannot be arranged in advance.

19.3.4.2.3. Non-emergency Services that are preplanned but due to the medical or psychiatric condition of the Client are the only mode that can be utilized safely. Must be prior authorized.

19.3.4.3. If the Client is transported from home to hospital by ambulance for treatment of a condition which a prudent layperson would perceive as an emergency, as defined at 10 CCR 2505-10 Section 8.303, the ambulance shall be reimbursed, even if the healthcare services rendered are subsequently determined to be urgent or non- emergent in nature. 42 C.F.R. 438.114 (c) (1) (ii).

19.3.5. Ambulatory surgical care

19.3.5.1. The allowable surgical procedures identified for Medicare coverage are reimbursable and covered Medicaid benefits.

19.3.6. Amniocentesis

19.3.6.1. Amniocentesis performed for medical reasons other than sex determination.

19.3.7. Anesthesia Services

19.3.7.1. Administration of anesthetics to achieve general, regional or supplementation of local anesthesia related resuscitative and supportive procedures.

19.3.7.2. Administration of anesthesia or deep sedation in a hospital or outpatient facility when determined to be medically necessary for adults and children.

19.3.8. Audiology and Speech Pathology

19.3.8.1. Audiological services include medical/diagnostic ear testing using recognized diagnostic instrumentation/equipment in a clinical environment to assist or confirm in establishing a diagnosis.

19.3.8.2. Speech pathology services include performance of medical/diagnostic procedures including, but not limited to, those communicative problems resulting from medical conditions such as cerebral palsy, cleft palate/lip, or brain dysfunction.

19.3.8.3. NOTE: The EPSDT benefit covers screening and Medically Necessary ear exams and audiological testing.

19.3.9. Autism

19.3.9.1. Autism shall be treated as a physical disorder.

19.3.10. Consultation

19.3.10.1. Covered Services include medical services rendered by a provider whose opinion or advice is requested by a Client's primary care provider or the health plan medical director for further evaluation of an illness or injury. Clients shall be granted a second opinion when requested, subject to referral requirements. Consultations by non-participating providers may be subject to prior authorization.

19.3.11. Detoxification

19.3.11.1. Includes detoxification for withdrawal from the physiological effects of acute alcohol or drug abuse.

19.3.12. Dialysis, Hemodialysis or Peritoneal Dialysis

19.3.12.1. Coverage includes placement or repair of the dialysis route ("shunt" or "cannula").

19.3.12.2. The organization providing dialysis shall be responsible for the provision of all supplies and the maintenance of all equipment and necessary fixtures required for home dialysis.

19.3.12.2.1. Inpatient dialysis

19.3.12.2.1.1. Coverage is provided in those cases where hospitalization is required.

19.3.12.2.2. Outpatient dialysis

19.3.12.2.2.1. Coverage is provided when provided by a separate unit within a hospital or a freestanding Dialysis Treatment Center. Coverage is provided for any other medical condition for which the Medical Assistance Program provides payment when the eligible recipient receives regular Medically Necessary maintenance treatment on an outpatient dialysis program.

19.3.12.2.3. Home dialysis

19.3.12.2.3.1. The participating separate dialysis unit within a hospital or free-standing Dialysis Treatment Center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.

19.3.13. Durable Medical Equipment and Disposable Supplies

19.3.13.1. The following Durable Medical Equipment (DME) and supplies are Medicaid benefits for clients of all ages if Medical Necessity has been established and use outside of a medical facility is considered appropriate. DME shall be covered as described at 10 CCR 2505-10, Section 8.590.

19.3.13.1.1. Ambulation devices & accessories (canes, crutches, walkers).

19.3.13.1.2. Bath and bathroom equipment.

19.3.13.1.3. Bed and bedroom equipment and accessories, including specialized beds and mattress overlays.

19.3.13.1.4. Manual or power wheelchairs, seating system orthosis used for wheelchair positioning.

19.3.13.1.5. Diabetic monitoring equipment and related disposable supplies.

19.3.13.1.6. Elastic supports/stockings.

19.3.13.1.7. Monitoring equipment and supplies.

19.3.13.1.8. Oxygen Equipment for home use, including nursing facility residents, See Exclusions.

19.3.13.1.9. Transcutaneous and/or neuromuscular electrical nerve stimulators (tens) and related supplies.

19.3.13.1.10. Trapeze/traction/fracture frames.

19.3.13.1.11. Lymphedema pumps/compressors.

19.3.13.1.12. Rehabilitation equipment (specialized use).

19.3.13.1.13. Enteral formulas and supplies.

19.3.13.1.14. Parenteral equipment and supplies.

19.3.13.1.15. Repairs and extensive maintenance as needed to keep the DME item functional.

19.3.13.2. The contractor shall provide an adequate number of disposable supplies when used in connection with approved DME and/or when related to one of the following categories:

19.3.13.2.1. Surgical, wound and burn care.

19.3.13.2.2. Syringes/needles.

19.3.13.2.3. Bowel and bladder care.

19.3.13.2.4. Antiseptics/solutions.

19.3.13.2.5. Gastric feeding sets and supplies.

19.3.13.2.6. Tracheostomy and endotracheal care supplies.

19.3.13.2.7. Diabetic monitoring.

19.3.13.3. Covered Services include the rental or purchase of DME and supplies including repair, maintenance and delivery. The Contractor is only required to provide DME that is covered by Medicaid, but may provide other DME when medically appropriate. Preference should be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the equipment will be operated. Coverage in a particular case is subject to the requirement that the equipment be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. DME and supplies may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.

19.3.13.4. Medicaid clients for whom wheelchairs, wheelchair component parts, and other specialized equipment were authorized and ordered prior to enrollment in the Contractor's Plan, but for which delivery is delayed until after the HMO enrollment period begins, shall have those services provided by the Medicaid Program. The Contractor shall reimburse services approved and ordered by the Contractor providing the client remains Medicaid eligible, regardless of whether enrollment in the Plan continues. All other DME and disposable supplies approved by the Contractor shall be the responsibility of the Contractor.

19.3.14. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Benefits

19.3.14.1. The Contractor must meet all state and federal requirements for EPSDT benefits under 42 C.F.R. Sections 441.50 through 441.61 and 10 C.C.R. 2505-10, Section 8.280. EPSDT services include comprehensive well child examinations, immunizations, assessment, diagnosis and treatment necessary to correct or ameliorate conditions, defects and illnesses discovered by EPSDT screening to all covered persons through the age of 20. EPSDT services also include provision benefit information, scheduling assistance and case management.

19.3.14.2. Information about EPSDT benefits must be provided to clients and parents, to include:

19.3.14.2.1. Information about the periodicity table,

19.3.14.2.2. Scheduling and transportation to make EPSDT appointments, and

19.3.14.2.3. Information about the full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid.

19.3.14.3. Additionally, maintenance of a coordinated system to follow the client through the entire range of screening and treatment (case management) and coordination with other providers to ensure that clients receive Covered Services, must be provided.

19.3.14.4. If a requested EPSDT service is not covered under the capitation, the Contractor shall arrange for appropriate services regardless of diagnosis or the Medicaid party responsible for reimbursing the services.

19.3.15. Emergency Services

19.3.15.1. Emergency Services means covered inpatient and Outpatient Services that are as follows:

19.3.15.1.1. Furnished by a provider that is qualified to furnish these services under this Contract; and

19.3.15.1.2. Needed to evaluate or stabilize an Emergency Medical Condition.

19.3.15.2. Emergency services are exempt from Primary Care Provider referral.

19.3.16. Family Planning Services

19.3.16.1. Family Planning counseling, examination, treatment and follow-up; information on birth control (including insertion and removal of approved contraceptive devices); measurement for contraceptive diaphragms; and male/female surgical sterilization (see Surgical Services, Sterilization) is included even if the Member goes out of network. The fees are included in the rates. The Contractor shall reimburse out-of- network family planning services at a rate equal to Medicaid fee-for-service reimbursement rates, or the Contractor's contractual reimbursement rates, whichever is higher. No referral is required.

19.3.17. Federally Qualified Health Care (FQHC)

19.3.17.1. Core services are provided in outpatient settings only, including a Member's place of residence. Core services means covered Outpatient Services that may include:

19.3.17.1.1. Physician services.

19.3.17.1.2. Physician assistant services.

19.3.17.1.3. Nurse practitioner services.

19.3.17.1.4. Nurse midwife services.

19.3.17.1.5. Licensed psychologist services.

19.3.17.1.6. Licensed social worker services.

19.3.17.1.7. Pneumococcal and influenza vaccines and administration.

19.3.17.1.8. Services and supplies incident to health professional services.

19.3.17.1.9. Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area that is determined to have a shortage of home health agencies.

19.3.17.1.10. Any other reimbursable ambulatory services offered by the FQHC that are covered by the State Plan.

19.3.17.2. Notwithstanding a BHO primary diagnosis, services provided to Members by a physician (not a mental health practitioner) are covered (and have been included in the rates). The BHO diagnosis codes are attached as Exhibit F-1.

19.3.18. Habilitative Health Services

19.3.18.1. Habilitative therapy services shall have parity in amount, scope, and durations to rehabilitative therapies and will only consist of physical, occupational, and speech-language therapy services.

19.3.18.2. The procedure code set for Habilitative therapies is identical to that of Rehabilitative therapies.

19.3.18.3. All Habilitative Therapy Services require prior authorization.

19.3.18.4. Habilitative Therapy is only available to Expansion Members.

19.3.19. Hepatitis-C Therapies

19.3.19.1. The Contractor shall provide coverage for Members in accordance with the Department's criteria, outlined in the pharmacy billing manual.

19.3.19.1.1. Hepatitis-C therapies for Members shall include Hepatitis-C drugs found in the therapeutic classes W5Y, W0A, W0B, W0D, and W0E along with the supplementary drugs used in conjunction with the high cost drugs found in therapeutic class W5G (the "Therapies" or "Therapy").

19.3.20. Home Health Services

19.3.20.1. Upon enrollment, the contractor shall provide Acute Home Health Services as defined in 10 CCR 2505-10. Section 8.520. Members eligible for Acute Home Health Services must be eligible for services as set forth at 10 CCR 2505-10, Section 8.520. The contractor is not required to cover more than one nurse, home health aide or therapist at one time except when two aides are required for transfers or more than one nurse is needed to perform a procedure.

19.3.20.2. Services provided by other kinds of providers (i.e., other than a Medicaid-certified Home Health agency) to Members in their own homes are also Covered Services and are included in the capitation rates. These kinds of Covered Services include:

19.3.20.2.1. Professional services of an RN, LPN or LVN on an intermittent basis.

19.3.20.2.2. Home health aide services for purposes of providing skilled personal care, in conjunction with a nurse or therapist and under the supervision of a nurse or therapist.

19.3.20.2.3. Physical evaluations and therapy, and speech/hearing evaluations and therapy, occupational therapy by licensed therapists.

19.3.20.2.4. Medical/surgical supplies delivered to the Member's home (e.g., DME, prosthetics, disposable supplies), but not other Wrap Around services.

19.3.20.2.5. Services provided when the Member's medical condition requires teaching (e.g., self-care management training), which is most effectively accomplished in the Client's home on a short-term basis.

19.3.20.2.6. Developmental therapies and EPSDT screenings (e.g., Neuromuscular reeducation, Sensory integration, Cognitive skills development).

19.3.20.3. Nurse Home Visitor Program services provided in the Member's home are Wrap Around services. These services are billed on the 1500 claim form using CPT codes G9006 or T1017.

19.3.21. Imaging (Radiology or X-ray Services) Services authorized by a licensed physician

19.3.21.1. Services performed to diagnose conditions and illnesses with specific symptoms.

19.3.21.2. Services are performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.

19.3.21.3. Routine mammograms as described under Preventative Care Services.

19.3.22. Inpatient Hospital

19.3.22.1. Hospital services are a benefit of the Medicaid Program and include those items and services that are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a physician.

19.3.22.1.1. Semi-Private Room and Board

19.3.22.1.2. Private rooms must be covered:

19.3.22.1.2.1. When Medically Necessary.

19.3.22.1.2.2. When furnished by the hospital as the only accommodation.

19.3.22.1.2.3. If the hospital has no semi-private room available. Member must be moved to a semi-private room as soon as available.

19.3.22.1.3. Delivery and labor rooms, anesthesia, and equipment.

19.3.22.1.3.1. Limitations for a hospital stay following a normal vaginal delivery may be limited after 48 hours post delivery.

19.3.22.1.3.2. Limitations for a hospital stay following a cesarean delivery may be limitedafter 96 hours post delivery.

19.3.22.1.4. All other Medically Necessary services and supplies during the inpatient hospital stay including pharmacy, therapies, blood and blood products, anesthetics, Durable Medical Equipment (DME) and specialty care services.

19.3.22.1.5. Discharge oxygen

19.3.22.1.6. Routine Newborn care is limited to period of time that the mother remains hospitalized and is billed under the Mother's Medicaid Client ID. Inpatient newborn care following the mother's discharge is not a covered benefit under this Contract. The newborn will receive its own Medicaid Client ID retrospective to its date of birth and will be billed FFS.

19.3.22.1.7. Inpatient substance abuse rehabilitation DRG 772 is a wrap around. See Wrap Around Benefits Section.

19.3.23. Laboratory (clinical/pathological)

19.3.23.1. Services authorized by a licensed physician.

19.3.23.1.1. Services performed to diagnose conditions and illnesses with specific symptoms.

19.3.23.1.2. Services performed to prevent or treat conditions that are reimbursable under the Medical Assistance Program.

19.3.23.2. Services performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

19.3.23.3. LIMITATIONS

19.3.23.3.1. Collection, handling, and/or conveyance of specimens for transfer from the member's home, a nursing home or a facility other than the physician's office or place of practice is a benefit only if the member is homebound, bedfast, or otherwise non-ambulatory. However, when a specimen of this type could be reasonably mailed, the pickup is no longer considered Medically Necessary and therefore is non-reimbursable. The physician may be required to certify the Medical Necessity for the pick-up. Transfer of a specimen from one certified independent clinical laboratory to another is a benefit and reimbursable to the first certified laboratory only if the laboratory's equipment is not functioning or the laboratory is not certified to perform the tests ordered by the physician.

19.3.24. Medical Services

19.3.24.1. For specific procedures and indications of basic Medicaid coverage, the Provider Rates and Fees Schedule shall be considered the prevailing guide. The schedule can be found here: https://www.colorado.gov/hcpf/provider-rates-fee-schedule. The following is a general overview of such services.

19.3.24.1.1. Direct physical examination of the member's body and/or mental or cognitive status.

19.3.24.1.2. Examination of some aspect of the member's condition by means of radiological, non-radiological diagnostic imaging, pathology, laboratory, or electronic monitoring procedures.

19.3.24.1.3. Procedures for prescribing, administering, directing, or supervising medical treatment.

19.3.24.1.4. Manual manipulation. Department guidelines, which include manipulation by osteopathic physicians only, may be applied by the Plan.

19.3.24.1.5. Diagnosis and treatment of eye disease or injury. Administration of injectables and allergens.

19.3.24.1.6. Counseling: Diet and/or nutritional counseling when the diagnosis indicates or includes a clinical problem that is or could be impacted by obesity.

19.3.24.1.7. Treatment for ear or hearing problems.

19.3.25. Newborn Hospitalization

19.3.25.1. Newborn hospitalizations shall extend only for the period of the mother's hospitalization unless Medical Necessity exists for the newborn to remain hospitalized. If Medical Necessity for the newborn to remain hospitalized exists, the additional days shall be billed FFS.

19.3.26. Occupational/Physical Therapy

19.3.26.1. A physician may prescribe occupational or physical therapy for clients when Medically Necessary.

19.3.27. Outpatient Services

19.3.27.1. Covered Services include diagnostic, Therapeutic, Rehabilitative, Preventive, and Palliative Services furnished by or under the direction of a physician.

19.3.28. Outpatient Rehabilitation Services

19.3.28.1. Covered Services include speech therapy, occupational therapy, physical therapy, pulmonary therapy, and cardiac rehabilitation when ordered by the Covered Person's Primary Care or Referring Physician.

19.3.28.2. All Medically Necessary care and treatment of conditions discovered as a result of EPSDT medical screenings, including habilitation secondary to birth injury or developmental delay and rehabilitation services following illness or injury, shall be provided to Clients covered by the EPSDT Program.

19.3.29. Oxygen and Oxygen Equipment

19.3.29.1. Oxygen and oxygen equipment in a client's home, or place used as his/her home, and prescribed by the attending physician, is covered. Any form of oxygen for use by clients in an inpatient hospital setting must be provided by the hospital. The nursing facility must provide all forms of oxygen.

19.3.30. Physical Examinations

19.3.30.1. Physical examinations for the purpose of:

19.3.30.1.1. Diagnostic evaluation of disease.

19.3.30.1.2. Admission or placement in skilled nursing home care, intermediate nursing home care, residential care, or early and periodic screening, diagnosis and treatment.

19.3.31. Physical/Occupational Therapy

19.3.31.1. Occupational or physical therapy for clients when Medically Necessary and ordered by a physician.

19.3.32. Physician Services

19.3.32.1. Age 65 and over: All Medically Necessary services.

19.3.32.2. Under the age of 65: the following scope and range of benefits when Medically Necessary:

19.3.32.2.1. Inpatient hospital services.

19.3.32.2.2. Inpatient surgery.

19.3.32.2.3. Outpatient surgery.

19.3.32.2.4. Outpatient diagnostic services.

19.3.32.2.5. Physician services provided to residents in a skilled nursing facility.

19.3.32.2.6. Home and physician office calls.

19.3.32.2.7. Family Planning is considered in the same manner as for any other medical visit. Services provided in connection with medication and devices to be employed are supplied for the purpose of Family Planning, depending on the preference of the individual recipient/member. See Family Planning under Covered Services.

19.3.32.2.8. Dental care is a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones, including

dental splints or other devices. With respect to these services, a doctor of dental surgery or dental medicine, appropriately licensed, is classified as a physician and entitled to payment.

19.3.32.2.9. Foot care services

19.3.32.2.10. Vision care services are included as benefits in accordance with the following general policies:

19.3.32.2.10.1. Services performed within the scope of the Medical and Optometrist Practice Acts.

19.3.32.2.10.2. Services for the provision of eyeglasses and contact lenses following eye surgery.

19.3.32.2.10.3. Corneal transplants.

19.3.32.2.11. Services in regard to laboratory testing in accordance with the Imaging and Laboratory sections of this exhibit

19.3.32.2.12. Immunizations

19.3.33. Podiatry

19.3.33.1. Foot care services are included as a benefit in the Medical Assistance Program whether provided by a physician or licensed podiatrist.

19.3.34. Prescription Drugs

19.3.34.1. The Contractor is responsible for prescription drugs administered in compliance with prior authorization criteria.

19.3.35. Preventive Medicine

19.3.35.1. Examinations for the purpose of diagnosis and treatment of existing illness or injury are not included in this section. The client and the primary care physician will determine exam periodicity for members with a disability.

19.3.35.2. Physical exams

19.3.35.2.1. Under age 21, see Early Periodic Screening, Diagnosis and Treatment (EPSDT).

19.3.35.2.2. Age 21 - 35, at least once every 5 years but not more than once a year.

19.3.35.2.3. Age 36 - 50, at least once every 2 years but not more than once a year Over age 50, once every 12 months.

19.3.35.3. Women's health

19.3.35.3.1. Routine yearly breast and pelvic examination with PAP smear, hematocrit and urinalysis.

19.3.35.3.2. Routine mammograms as required by statute (Section 10-16-104 C.R.S.): a single baseline mammogram for women from age 35 to 39; at least once every two contract years for women from age 40 to 49, except women with risk factors to breast cancer, as determined by the primary care physician, shall be at least once per year; and at least once per contract year for women age 50 to 65 years.

19.3.35.4. Men's Health

19.3.35.4.1. Age 40 to 50 in high-risk categories (as determined by the primary care physician), in accordance with statute (Section 10-16-104 C.R.S.).

19.3.35.4.2. Age 50 years and older, screening for early detection of prostate cancer at least once per year.

19.3.35.5. Health education services

19.3.35.5.1. Instruction in personal health care measures, including those appropriate for clients with disabilities;

19.3.35.5.2. Instruction for a designated client representative, when the client is unable toreceive or understand such services due to a disability;

19.3.35.5.3. Information about services, including recommendations on generallyaccepted medical standards for use and frequency of such service.

19.3.35.6. Contingent on Federal Approval from the Centers for Medicare & Medicaid, the contractor must provide preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults. Documentation is available to support claiming of FMAP for such services. As changes are made to the USPSTF and/or ACIP, coverage and billing codes will be updated to comply with the changes. Cost sharing cannot be applied to any of these services.

19.3.36. Prosthetics and Orthotics

19.3.36.1. The following Prosthetic Devices and Orthotics, including but not limited to the following list, are Medicaid benefits for clients of all ages if Medical Necessity has been established and use in the home setting has been determined to be appropriate. Medical Necessity shall be determined based on criteria established by the Department, and in accordance with 10 CCR 2505-10, Section 8.590.2A:

19.3.36.1.1. Ankle-foot/knee-ankle-foot Orthotics.

19.3.36.1.2. Artificial limbs.

19.3.36.1.3. Augmentative communication devices and communication boards.

19.3.36.1.4. Colostomy (and other ostomy) bags and necessary accouterments required for attachment, including irrigation and flushing equipment and other items/supplies directly related to ostomy care.

19.3.36.1.5. Facial prosthetics.

19.3.36.1.6. Lumbar-sacral orthoses (LSO).

19.3.36.1.7. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements when an integral part of a leg or ankle brace.

19.3.36.1.8. Recumbent ankle positioning splints.

19.3.36.1.9. Rigid and semi-rigid braces.

19.3.36.1.10. Specialized eating utensils and other Medically Necessary activities of daily living aids.

19.3.36.1.11. Therapeutic shoes.

19.3.36.1.12. Thoracic-lumbar-sacral orthoses (TLSO).

19.3.36.2. Covered Services include the rental or purchase of Prosthetic Devices and supplies including repair, maintenance and delivery. Preference will be given to items with demonstrated strength, durability, ease of use and appropriateness for the Client and for conditions under which the devices will be operated. Coverage in a particular case is subject to the requirement that the devices be Medically Necessary for treatment of an illness, injury, condition, secondary disability, or for maintenance of health. Prosthetic Devices may be recommended by an appropriate licensed practitioner, but must be prescribed by a doctor of medicine or a doctor of osteopathy.

19.3.37. Radiology – see Imaging

19.3.38. Radiation Therapy

19.3.39. Rural Health Clinics (RHC)

19.3.39.1. All of the following are benefits of the program when provided by a rural health clinic that has been certified in accordance with 10 CCR 2505-10 8.740 insofar as these services provided are otherwise reimbursable under the Program.

19.3.39.1.1. Services furnished by a physician.

19.3.39.1.2. Services furnished by a physician assistant, nurse practitioner, or nurse midwife, under the medical supervision of a physician.

19.3.39.1.3. Services and supplies that are furnished as an incident to professional services under (2.1.36.1.1.) and (2.1.36.1.2) above.

19.3.39.1.4. Part-time or intermittent visiting nurse care and related medical supplies (other than pharmaceuticals).

19.3.39.1.5. Other ambulatory service that are otherwise a benefit of the program that meets specific programmatic requirements for the furnishing of that service. Such services are not subject to physician supervision requirements unless such supervision is generally required for such services under the Medicaid program.

19.3.39.1.6. EPSDT services furnished by a rural health clinic that are not part of rural health clinic services. Such services may be provided only if the clinic meets any supervision or other requirements for EPSDT that are generally applicable wherever these services are furnished.

19.3.40. Short-term Behavioral Health Services in a Primary Care Setting

19.3.40.1. The Contractor must reimburse up to six (6) short-term behavioral health service visits billed by a Primary Care Provider (PCP) per state fiscal year.

19.3.40.1.1. A visit is defined as a single date of service. Multiple procedure codes may be billed during a visit as long as they are in compliance with the National Correct Coding Initiative standards.

19.3.40.1.2. These visits do not require a covered behavioral health diagnosis or authorization.

19.3.40.1.3. These visits must be provided by licensed behavioral health practitioners and candidates for licensure (supervised in accordance with the rules of the Colorado Board of Psychotherapists).

19.3.40.1.4. These visits are not covered when services are billed with an ET modifier.

19.3.40.1.5. The procedure codes for short-term behavioral health services include:

19.3.40.1.5.1. 90791 Diagnostic Evaluation without Medical Services

19.3.40.1.5.2. 90832 Psychotherapy-30 minutes

19.3.40.1.5.3. 90834 Psychotherapy-45 minutes

19.3.40.1.5.4. 90837 Psychotherapy-60 minutes

19.3.40.1.5.5. 90846 Family Psychotherapy (w/o patient)

19.3.40.1.5.6. 90847 Family Psychotherapy (with patient)

19.3.41. Speech Pathology (see Audiology and Speech Pathology)

19.3.42. Substance Abuse

19.3.42.1. Includes the medical treatment for withdrawal from the physiological effects of acute alcohol or drug abuse.

19.3.43. Surgical Services

19.3.43.1. For specific procedures and indications of basic Medicaid coverage, the Provider Rates and Fees Schedule shall be considered the prevailing guide. The schedule can be found here: https://www.colorado.gov/hcpf/provider-rates-fee-schedule.

19.3.43.1.1. Reconstructive surgery

19.3.43.1.1.1. Medically Necessary reconstructive plastic surgery or surgery to correct disfigurement resulting from trauma or affecting function, regardless of when the injury, illness or defect occurred; or

19.3.43.1.1.2. Reconstructive services following mastectomy, subject to prior approval.

19.3.43.1.2. Male genital system

19.3.43.1.3. Female genital system

19.3.43.1.4. Oral Surgical Services (limited to treat certain conditions, as follows):

19.3.43.1.4.1. Accidental injury to jawbones or surrounding tissues;

19.3.43.1.4.2. Correction of non-dental pathophysiological condition which has resulted in a severe functional impairment, including temporomandibular disorder; or

19.3.43.1.4.3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof, floor of mouth.

19.3.43.1.5. Sterilization

19.3.43.1.5.1. Stipulations: In order to receive sterilization services, the following criteria must be met:

19.3.43.1.5.1.1. The client must be at least 21 years of age.

19.3.43.1.5.1.2. The client may not be currently institutionalized for the care and treatment of mental illness.

19.3.43.1.5.1.3. He or she must be mentally competent.

19.3.43.1.5.1.4. The MED 178 consent form, as utilized by the Medicaid Program, must be properly signed at least 30 but no more than 180 days prior to performance of the procedure. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that

the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and (1) in the case of premature delivery, must state the expected date of delivery; or (2) in the case of abdominal surgery, must describe the emergency.

19.3.44. Tobacco Cessation

19.3.44.1. Includes all FDA approved prescription medications and over-the-counter tobacco cessation products for a maximum of two 90-day sessions in a 12-month period, commencing upon beginning the first session. The Tobacco Cessation benefit includes group or individual counseling services.

19.3.44.2. Limitations

19.3.44.2.1. Counseling is limited to five (5) sessions per calendar year.

19.3.45. Telemedicine

19.3.45.1. No Medicaid managed care organization, on or after January 1, 2002, may require face-to-face contact between a provider and a client for services appropriately provided through Telemedicine if the client resides in a county with a population with one hundred fifty thousand residents or fewer and if the county has the technology necessary for the provision of Telemedicine. The use of Telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonabledistance.

19.3.45.2. Any health benefits provided through Telemedicine shall meet the same standard of care as in-person care.

19.3.46. Transplant Services

19.3.46.1. Includes services received in connection with bone, bone marrow/stem cell, cornea, heart, lung, heart-lung, kidney, liver (including living donor or partial liver), pancreas after kidney, simultaneous pancreas-kidney, skin, or small bowel transplant:

19.3.46.1.1. Charges for retrieval or harvest of donor organs or bone marrow, if not provided by any other health care program or insurance, including any necessary compatibility testing and donor search.

19.3.46.1.2. Living donor transplant: Contractor is required to cover services to donor for costs directly related to the transplant. Services required due to complications or non-related care will be the responsibility of the donor's carrier.

19.3.46.1.3. Immunosuppressive drugs as supportive therapy for the transplant.

19.3.46.1.4. Organ Transplant services must be covered according to the written standards in section 3.1_E of the Medicaid State Plan.

19.3.47. Vision Services

19.3.47.1. Members ages 21 and older:

19.3.47.1.1. Annual medically necessary eye exams.

19.3.47.1.1.1. Clients with certain medical conditions and/or disabilities such as diabetes, retinal dysplasia or glaucoma may require more frequent exams, which shall be determined by the primary care physician.

19.3.47.1.2. Eyeglasses and contact lenses are benefits following eye surgery only, and do not require prior authorization. The surgery may have been performed at any time during the patient's life.

19.3.47.2. Members ages 20 and younger:

19.3.47.2.1. Ocular prosthetics are a benefit.

19.3.47.2.2. There is no yearly maximum for eye exams or eyeglasses.

19.3.47.2.3. See EPSDT for more information.

19.3.47.3. Members ages 20 and younger and members ages 21 and older following eye surgery:

19.3.47.3.1. Standard eyeglasses (one or two single or multifocal vision clear glass lenses with one standard frame).

19.3.47.3.2. Glasses dispensed by an optician are a benefit when ordered by an ophthalmologist or optometrist.

19.3.47.3.3. Replacement or repair of frames or lenses (standard eyeglasses), not to exceed the cost of replacement.

19.3.47.3.4. Contact lenses must be medically necessary and prior authorized. Contact lenses, supplies, and contact lens insurance are not benefits.

19.3.47.4. If a Member requests a deluxe frame, the provider must obtain written agreement from the Member to pay the non-covered costs. Allowable non-covered costs that can be charged to the Member are those representing the difference between the provider's retail usual and customary charges for the Colorado Medicaid Assistance Program allowable frames and the retail amount for the upgraded frames requested by the Member.

EXHIBIT O, HIGH INTENSITY OUTPATIENT SOW

1. DEFINITIONS

1.1. High-intensity Behavioral Health Treatment Services – Intensive community-based, member and family-centered services designed to engage adults and youth with severe mental health and/or substance use conditions who are at risk for or experiencing complicating problems such as physical health problems, developmental challenges, involvement in criminal and juvenile justice systems, and/or institutionalization.

2. PROJECT REQUIREMENTS

2.1. The Contractor shall oversee the expansion and coordination of High-intensity Behavioral Health Treatment (HIT) offered by providers located in the Contractor's region, specifically focusing on supporting members who are transitioning to the community from a higher level of care and individuals at risk of institutionalization.

2.1.1. The Contractor shall partner with providers located in the Contractor's region to increase the availability of High-intensity Behavioral Health Treatment.

2.1.2. The Contractor shall create policies, programs, and processes to effectively coordinate the full range of High-intensity Behavioral Health Treatment among providers in the Contractor's region and statewide in order to ensure Members receive comprehensive, Member-focused complementary services that enable Members to remain in the community.

2.2. The Contractor shall complete all work pursuant to this Exhibit (Exhibit O) no later than June 30, 2024.

2.2.1. The Contractor shall design and implement strategies to expand capacity of providers located within the Contractor's region to deliver High-intensity Behavioral Health Treatment. The Contractor may partner with other Regional Accountable Entities to implement efforts with larger-scale providers who serve multiple regions. The Contractor's strategies shall include, but are not limited to:

2.2.1.1. Engaging Network Providers in the Contractor's region to offer new High-intensity Behavioral Health Treatment services.

2.2.1.2. Engaging Network Providers in the Contractor's region to offer more units of High-intensity Behavioral Health Treatment services.

2.2.1.3. Outreaching non-contracted providers located in the Contractor's region to incorporate more providers of quality High-intensity Behavioral Health Treatment into the Contractor's existing network of providers. The Contractor shall particularly outreach providers who can offer services that address any identified gaps in treatment modalities available in the Contractor's region.

2.2.1.4. Providing financial and other resources to Network Providers to assist them in overcoming barriers to providing High-intensity Behavioral Health Treatment.

2.2.1.5. Complementing and leveraging grants that providers may receive directly to implement related activities.

2.2.1.6. Linking Network Provider High-intensity Behavioral Health Treatment expansion to future value-based payment frameworks.

2.2.1.7. Providing technical assistance for providers or other centralized resources that support the coordination of High-intensity Behavioral Health Treatment in the network and the transitions of care between providers and levels of care.

2.2.1.8. Establishing agreements between Network Providers to ease transitions between levels of care.

2.2.2. The Contractor shall ensure the provision of Care Coordination to Members receiving High-intensity Behavioral Health Treatment, as well as Members transitioning both into and out of High-Intensity Behavioral Health Treatment.

2.2.3. The Contractor shall support development of a high-quality workforce delivering High-intensity Behavioral Health Treatment by, at a minimum:

2.2.3.1. Providing monetary support to Providers within the Contractor's region to enhance and/or expand High-intensity Behavioral Health Treatment.

2.2.4. The Contractor is encouraged to create flexible and creative solutions that lead members to obtaining sustainable access to services.

2.3. The Contractor shall work in collaboration with the Department to develop a HIT Capacity Enhancement and Expansion Plan and the HIT Quarterly Update Report templates.

3. DELIVERABLES

3.1. HIT Capacity Enhancement and Expansion Plan

3.1.1. The Contractor shall submit a HIT Capacity Enhancement and Expansion Plan using the Department-approved template to document the timeline, deliverables, and progress of the Work in this Exhibit O.

3.1.1.1. DELIVERABLE: HIT Capacity Enhancement and Expansion Plan

3.1.1.2. DUE: Within ninety (90) calendar days of the Department's approval of the Capacity Enhancement and Expansion Plan template.

3.2. HIT Quarterly Update Report

3.2.1. The Contractor shall submit HIT Quarterly Update Reports using the Department-approved template to demonstrate to the Department progress and outcomes of the implementation of the Contractor's HIT Capacity Enhancement and Expansion Plan.

3.2.1.1. DELIVERABLE: HIT Quarterly Update Report

3.2.1.2. DUE: Fifteen (15) business days after the end of each quarter, once the Contractor's HIT Capacity Enhancement and Expansion Plan is approved by the Department.

4. PAYMENT

4.1. The Contractor shall receive the total budget approved by the Department in order to implement the Contractor's approved Capacity Enhancement and Expansion Plan. Payment shall not exceed $2 million and will be paid following the submission and approval of the HIT Capacity Enhancement and Expansion Plan by the Department.